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**Euthanasia**

**(Vol 1: Text)**

**by**

**Gareth Griffith and Marie Swain**

**Background Paper 1995/3**

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**Gareth Griffith and Marie Swain**

**NSW PARLIAMENTARY LIBRARY RESEARCH SERVICE**

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July 1995

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## 1 INTRODUCTION

The purpose of this Background Paper is to present a survey of the contemporary euthanasia debate. It does not make recommendations or form conclusions on any of the matters raised. The Paper reflects the legal position as at July 1995.

With the enactment of the *Rights of the Terminally Ill Act 1995* in the Northern Territory the subject of euthanasia has been brought to the centre of the political stage. That the subject is controversial is obvious from the nature and volume of media comment concerning the making and passing of the Northern Territory legislation. The Act has been variously described among many other things as "tragic"<sup>1</sup> and "fraught with danger in practice",<sup>2</sup> on one side, and as a victory for freedom and human rights, on the other.<sup>3</sup> It is certainly the case that the specific legislation, along with the subject of euthanasia in general, raises complex and profound issues. Appropriately, one newspaper headline read "historic Territory Bill enters legal and ethical minefield".<sup>4</sup> Indeed the subject of euthanasia is at once spiritual, moral, legal, political, medical and administrative in nature. The following comment from the Report of the Inquiry by the Select Committee on Euthanasia suggests the tenor and content of the debate in the Northern Territory and beyond:

The theme that most recurred in submissions and evidence before the Committee was the matter of the individual's freedom of choice, relative to the protection of the right to life for all members of the community in the interests of the common good.<sup>5</sup>

As Lord Mustill observed in *Airdale NHS Trust v Bland*, the fundamental question posed by euthanasia is no more and no less than this: "Is it ever right to terminate the life of a patient, with or without his consent?".<sup>6</sup>

At common law, a competent adult can refuse medical treatment. Yet, as Dix et al explain, in some situations where treatment is withheld at the patient's request, and death

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<sup>1</sup> "The right to life is now compromised", *The Australian*, 3 June 1995.

<sup>2</sup> "The rush to euthanasia", *The Sydney Morning Herald*, 26 May 1995.

<sup>3</sup> H Kuhse, "Welcome victory for freedom and human rights", *The Australian* 26 May 1995.

<sup>4</sup> "States grapple with euthanasia: historic Territory Bill enters legal and ethical minefield", *The Australian*, 26 May 1995.

<sup>5</sup> Legislative Assembly of the Northern Territory, *The Right of the Individual or the Common Good?: Volume One - Report of the Inquiry by the Select Committee on Euthanasia*, May 1995, p 9.

<sup>6</sup> [1993] AC 789, p 890.

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results, the issue of whether or not an unlawful killing has been committed is not entirely free from doubt. At common law, a person cannot consent to being killed and any such consent will not relieve another person of criminal responsibility.<sup>7</sup> Importantly, the criminal law is based on intention, not motive. The fact that the motive in acts of euthanasia is to alleviate suffering is immaterial in terms of the imposition of a charge. At common law, therefore, a health care professional cannot deliberately terminate a patient's life.<sup>8</sup>

A further point to note at the outset is that, whilst neither suicide nor attempted suicide are crimes in New South Wales, under section 31C of the *Crimes Act 1900* it is a crime to aid or abet the suicide or attempted suicide of another person.

Other Australian jurisdictions, notably South Australia and Victoria, have legislated to address, in certain well-defined circumstances, aspects of the many dilemmas faced by the modern medical profession in regard to the patient's decision to refuse treatment. The importance of the Northern Territory Act is that it legalises what can be characterised as active voluntary euthanasia. For this reason, advocates of euthanasia have heralded it as a "test law" which goes beyond the decriminalisation of mercy killing in the Netherlands,<sup>9</sup> while critics have said it creates an "experimental situation - one with unforeseen side effects and from which there is no easy way to turn back".<sup>10</sup> Either way, the Act is unique. As the Canadian Special Senate Committee on Euthanasia and Assisted Suicide said in its recent report, "Under the Criminal Code all forms of euthanasia are illegal in Canada, as well as in all other jurisdictions, except in the Northern Territory of Australia".<sup>11</sup>

This Background Paper looks first at the definitional issues which arise in relation to the subject of euthanasia, before dealing with the underlying issues of moral philosophy and legal ethics that it raises. This section of the paper discusses the implications for both voluntary and non-voluntary euthanasia. The legal position in Australia is then outlined and analysed in some detail, after which the Paper looks at relevant legal arrangements in selected overseas jurisdictions. It ends with an account of the main arguments for and against euthanasia.

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<sup>7</sup> A Dix et al, *Law for the Medical Profession*, Sydney 1988, p 296.

<sup>8</sup> Footnote 14 discusses the situation where treatment is administered with the purpose of relieving the symptoms of the illness in the foreknowledge that this may or will hasten death.

<sup>9</sup> "Activists claim world will watch test case", *The Australian*, 26 May 1995.

<sup>10</sup> "Darwin goes too far on euthanasia", *The Australian*, 26 May 1995.

<sup>11</sup> Senate of Canada, Report of the Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death*, June 1995, p 75.

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## 2 DEFINING EUTHANASIA

**A hard word to define:** The term euthanasia, which derives from the Greek words "eu" and "thanatos", can be taken to mean gentle or "easy death". However, according to Patrick Thompson, in the context of the contemporary debate the term is difficult to define. Thompson explains this is because "people take from it a different meaning depending on their agenda", which results in variously broad or narrow definitions of the term euthanasia.<sup>12</sup>

**The active-passive distinction:** Nonetheless, there does seem to be general agreement concerning certain distinctions which operate in the debate. One is the distinction between passive and active euthanasia. As Alison Dines explains, passive euthanasia involves simply refraining from doing anything to keep a patient alive, for example, by withholding medication or other life-sustaining therapy or by refusing to perform surgery, in which case the patient dies naturally of whatever ills affect him or her. On the other hand, active euthanasia involves taking some positive action designed to kill the patient, for example, administering a lethal dose of potassium chloride.<sup>13</sup>

Bernadette Tobin explains that in either case euthanasia is intentional in nature (the intentional hastening of death). As such both active and passive euthanasia can be distinguished from the following standard and legal medical practices: (i) the withdrawing or withholding of life-sustaining treatment because that treatment itself is too burdensome for the patient, or because the treatment is medically futile; and (ii) the administration of a treatment with the purpose of relieving the symptoms of illness in the foreknowledge that this may or will hasten death.<sup>14</sup>

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<sup>12</sup> P Thompson, "The law and active euthanasia: whose life is it anyway?" (February 1995) 2 (3) *Journal of Law and Medicine* 233-246, p 233.

<sup>13</sup> A Dines, "Does the distinction between killing and letting die justify some forms of euthanasia?" (1995) 21 *Journal of Advanced Nursing* 911-916, p 912.

<sup>14</sup> B Tobin ed, *Euthanasia*, Sydney 1995, p ii. The second point does give rise to some vexed questions of terminology and interpretation. For example, the House of Lords Special Committee on Medical Ethics noted: "Some people also use the term passive euthanasia to describe the act of a doctor or other person who prescribes or administers pain-killers or other (eg sedative) drugs necessary for the relief of a patient's pain or severe distress, but in the knowledge that a probable consequence of the prescription is a shortening of the patient's life. Again we think that this usage is incorrect. We speak instead of the double effect" (page 10). The issue of the double effect in relation to palliative care was considered by Sopinka J in *Rodriguez v British Columbia (AG)* 3 SCR (1993) 519 at 607: "The administration of drugs designed for pain control in dosages which the physician knows will hasten death constitutes active contribution to death by any standard. However, the distinction drawn here is one based upon intention - in the case of palliative care the intention is to ease pain, while in the case of assisted suicide, the intention is undeniably to cause death". In a similar vein, Dr Brendan Nelson, President of the AMA, is reported to have said that if death is an unintended outcome of palliative care, "it is still appropriate medical practice": K



Perhaps inevitably, the appropriateness of the active/passive terminology has been disputed. For its part, the House of Lords Select Committee on Medical Ethics said it found the term passive euthanasia "misleading", preferring instead to speak of "withdrawing or not initiating treatment" or of a "treatment-limiting decision".<sup>15</sup>

**The doctrine of acts and omissions:** Relevant to the active-passive distinction is the doctrine of acts and omissions, the legal and ethical implications of which are discussed at pages 20-23. The distinction is important because, whereas a positive act which causes an unlawful killing will render its perpetrator liable to prosecution, an omission which causes or contributes to death will only do so where there is a duty to act.<sup>16</sup> Importantly, doctors are under a legal duty to provide medical treatment to patients in their charge. As Leanna Darvall explains, "If as a result of failure to discharge this duty, a patient's life is endangered, or his or her health impaired, a doctor may be charged with a criminal offence".<sup>17</sup>

Anticipating the later discussion of this issue, it can be said that the doctrine of acts and omissions has been questioned and criticised many times. It is questioned as to whether this legal distinction is based on sound moral principle. Is there a difference between causing death by the withholding of medical treatment, on one side, or by the administration of a lethal injection, on the other?<sup>18</sup> In the *Bland* case, Lord Browne-Wilkinson posed the question in this way: "Should society draw a distinction (which some would see as artificial) between adopting a course of action designed to produce certain death, on the one hand through the lack of food, and on the other from a fatal injection, the former being permissible and the latter (euthanasia) prohibited?".<sup>19</sup> In the same case Lord Goff of Chievely explained the rationale behind the doctrine in these terms: "in the end the reason for that difference is that, whereas the law considers that discontinuance of life support may be consistent with the doctor's duty to care for his patient, it does not, for reasons of policy, consider that it forms any part of his duty to give his patient a lethal injection to put him out of his agony".<sup>20</sup>

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Healey ed, *Issues for the Nineties - Life and Death Matters*, Sydney 1994, p 9.

<sup>15</sup> House of Lords, *Report of the select Committee on Medical Ethics*, Session 1993-94, HL Paper 21-I, p 10.

<sup>16</sup> A Dix et al, *Law for the Medical Profession*, Sydney 1988, p 29. Also, in some circumstances there may be a statutory obligation to act.

<sup>17</sup> L Darvall, *Medicine, Law and Social Change*, Dartmouth 1993, p 52.

<sup>18</sup> B McSherry, "Death by the withholding of medical treatment and death by lethal injection: is there a difference?" (October 1993) 1(2) *Journal of Law and Medicine* 71-72.

<sup>19</sup> [1993] AC 789, p 879.

<sup>20</sup> *Ibid*, p 866.

**Further distinctions:** Both the active/passive distinction and the acts/omissions doctrine are concerned primarily with the means by which euthanasia is achieved. In essence, they address the technical question: "how" was it done? As we have seen, this gives rise to difficult ethical issues. These issues can, however, be distinguished from those which arise in relation to the more fundamental questions: "why" and "when" should euthanasia be performed? These latter issues are addressed by the further distinction which is made in the debate between three different types of euthanasia: voluntary euthanasia; non-voluntary euthanasia; and involuntary euthanasia. Basically, voluntary euthanasia answers the "why" and "when" questions by reference to the patient's clearly expressed autonomous choice to end his or her life. In regard to non-voluntary euthanasia, the attempt is made to answer the same questions by reference to the patient's "best interests", which is clearly a difficult and contentious task, or by the equally problematic course of attempting to determine what the patient would have decided in the circumstances, using what the American courts call the "substituted judgment test". In the case of involuntary euthanasia, the "why" and "when" questions are answered by the ulterior purposes of some third party (Germany's Nazi regime is the prime example), where the purposes involved are formulated independently of the person concerned and without regard to his or her interests or autonomy.

**Voluntary euthanasia:** This is what is at issue under the Northern Territory legislation. James Rachels calls it the "standard case" of euthanasia in which the suffering terminal patient who, while rational, requests to be killed as an alternative to a slow, lingering death.<sup>21</sup> In these circumstances, therefore, a conscious and competent dying person requests a medical practitioner to end his or her suffering. The practice has been defined as the deliberate, intended and painless putting to death of one human person by another - the willed termination of human life.<sup>22</sup> An example would be when a health care professional gives a lethal substance to a patient who is both competent and suffering, at that patient's request.

The above constitutes a form of **active voluntary euthanasia**. However, there would seem to be no reason why, in certain circumstances, voluntary euthanasia could not be achieved by passive means; that is, where the patient requests the withdrawal of a life-support system. Indeed, David Lanham has argued that passive voluntary euthanasia has the strongest claim to legality, stating: "There is a substantial overlap between the withholding or withdrawal of unwanted medical treatment in order to allow the patient to die peacefully and the exercise of the patient's right to refuse medical treatment. Some see the withholding or withdrawal of life-saving treatment at the patient's request as passive voluntary euthanasia".<sup>23</sup>

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<sup>21</sup> J Rachels, *The end of life: euthanasia and morality*, Oxford 1986, p 152.

<sup>22</sup> P Thompson, *op cit*, p 233.

<sup>23</sup> D Lanham, *Taming Death by Law*, Melbourne 1993, p 156.

A further complicating factor in regard to voluntary euthanasia is that the wishes of a competent individual could be made known personally to the relevant medical authority, or by what the Canadian Special Senate Committee calls a "valid advance directive".<sup>24</sup> The position in the United States is based on the decision in the *Cruzan* case which is discussed below. According to Ronald Dworkin, "Every state in the United States now recognizes some form of advanced directive: either 'living wills' - documents stipulating that specified medical procedures should not be used to keep the signer alive in certain specified circumstances, or 'health care proxies' - documents appointing someone else to make life-and-death decisions for the signer when he no longer can".<sup>25</sup> In the Australian context, legislation in South Australia, Victoria and the Northern Territory bears upon the issue of a valid advance directive. This is discussed at pages 26-35.

Also of relevance is the distinction between active voluntary euthanasia and what has been called "physician assisted suicide".<sup>26</sup> The two are closely related, for in both cases the patient has formed a desire to end his or her life but requires help to perform the act. One way of distinguishing between the two is to say that physician assisted suicide is restricted to the case where, for example, a health professional makes a lethal substance and the means of administering it available to the patient. In these circumstances the patient dies at his or her own hand.<sup>27</sup> For the purposes of the criminal law, the difference is that a doctor found guilty of aiding or abetting the suicide of a patient would be liable to a penalty of 10 years imprisonment. Whereas a doctor engaging in active voluntary euthanasia could be convicted of murder, a crime punishable by penal servitude for life or for 25 years. Physician assisted suicide is discussed in more detail in relation to Oregon's *Death With Dignity Act* at pages 46-47.

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<sup>24</sup> Senate of Canada, Report of the Special Senate Committee on Euthanasia and Assisted Suicide, op cit, p 75.

<sup>25</sup> R Dworkin, *Life's Dominion*, London 1993, p 180.

<sup>26</sup> B Bix, "Physician Assisted Suicide and the United States Constitution" (May 1995) 58 *The Modern Law Review* 404-411.

<sup>27</sup> Interestingly, the constitutionality of prohibiting physician assisted suicide has been considered in a number of overseas cases. For example, in *Compassion in Dying v State of Washington* a federal trial court held that a state statute prohibiting assisted suicide was void as unconstitutional, at least in its application to physician assisted suicide for mentally competent, terminally ill patients. However, that decision has been overturned on appeal: B Bix, op cit, p 404. In *Rodriguez v British Columbia (AG)* 3 SCR (1993) 519 the appellant, a woman with a life expectancy of between two and fourteen months, applied for the law against assisting suicide to be declared invalid as it violated her rights under specific sections of the Canadian Charter of Rights and Freedoms. According to the Special Senate Committee's Report, "The appellant does not wish to die so long as she still has the capacity to enjoy life, but wishes that a qualified physician be allowed to set up technological means by which she might, when she is no longer able to enjoy life, by her own hand, at the time of her choosing, end her life". The application failed: Senate of Canada, Report of the Special Senate Committee on Euthanasia and Assisted Suicide, op cit, p A-69.

**Non-voluntary euthanasia:** Non-voluntary euthanasia has been defined to mean "killing someone, supposedly in his own interests, but where he is either not in a position to have, or not in a position to express, any views on the matter".<sup>28</sup> What is at issue here is that the patient cannot form or express his or her own rational desire. Clearly this applies where the patient is unconscious, kept alive by technological means in a persistent vegetative state. The *Cruzan* case<sup>29</sup> in the United States involved circumstances of this sort, as did the *Bland* case<sup>30</sup> from the United Kingdom. In the *Cruzan* case it was decided that, in the absence of a living will or some other formal document, the hospital could not withdraw life support in the relevant circumstances. However, it was recognised for the first time that competent people do have a constitutional right to direct that life support be withheld from them if they become permanently vegetative. In the *Bland* case the House of Lords decided that doctors may lawfully discontinue biochemical and other life support systems from a patient in a permanently vegetative state where the cessation of nourishment and hydration is an omission, not an act. Critically important to the case was the decision that it was not in the patient's best interests to be kept in a permanently vegetative state; on that basis, it was held that the doctors involved had no duty to provide Anthony Bland with medical care and food for an indefinite period and that the withdrawal of artificial feeding did not amount to a crime.

According to Danuta Mendelson, there have been no reported cases on withdrawal or withholding of life-sustaining medical treatment in Australia.<sup>31</sup>

**Involuntary euthanasia:** This is defined by Glover to mean, "killing someone, supposedly in his own interests, in disregard of his own views. It may be to kill him against his express preference for staying alive. Or it may be to kill him without taking the trouble to find out his views. What is crucial is that he is in a position to express views, but that any views he has are overridden".<sup>32</sup> This type of euthanasia amounts to, in other words, plain murder. As such it can be set aside as "morally odious".<sup>33</sup> Glover concludes, "all there is to be said about involuntary euthanasia is that it should be clearly repudiated".<sup>34</sup>

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<sup>28</sup> J Glover, op cit, p 190.

<sup>29</sup> *Cruzan v Director, Missouri Dept of Health*, 110 S CT 2841 (1990)

<sup>30</sup> *Airdale NHS Trust v Bland* [1993] AC 789.

<sup>31</sup> D Mendelson, "Jurisprudential Aspects of Withdrawal of Life Support Systems from Incompetent patients in Australia" (April 1995) 69 *The Australian Law Journal* 259-275, p 266.

<sup>32</sup> J Glover, op cit, p 191.

<sup>33</sup> J Rachels, op cit, p 179.

<sup>34</sup> J Glover, op cit, p 192.

### 3 ISSUES OF MORAL PHILOSOPHY AND LEGAL ETHICS

**Three levels of abstraction:** The subject of euthanasia touches on the most profound questions of moral philosophy, concerning such principles as human autonomy and the sanctity of life. Euthanasia also raises matters relevant to legal ethics, such as the application of the doctrine of acts and omissions, as well as those issues which are central to the debate in political theory about the balance that is to be struck between the rights of the individual, on one side, and the interests of the collectivity, on the other. Beyond that, more practical questions of an administrative kind are involved in the debate concerning the legalisation of voluntary euthanasia, relating for example to the way any proposed law sets out the procedures that must be followed. This account is far from exhaustive. What it does is focus attention on the different levels of abstraction at which the debate for and against euthanasia operates. For convenience, it can be said that there are the threshold issues encountered in moral philosophy; the concerns of what can be called applied or practical ethics, of the sort faced by health care professionals, which must be resolved in a legal and political context; and, thirdly, questions of a procedural, administrative nature.

The main concern of this section of the Paper is with the threshold issues of moral philosophy. As we shall see, however, a consideration of these leads inevitably into a debate about practical ethics, as well as about matters of a procedural and administrative kind.

**Utilitarianism and its problems:** Often the debate about the philosophical underpinnings of euthanasia begins with a discussion of utilitarianism.<sup>35</sup> Certainly, those who oppose euthanasia tend to assert that its advocates rely on some form of utilitarian argument, one basic premise of which is that we ought to live in such a way as to promote the greatest happiness, another being that the morality of an action can be determined by an evaluation of its consequences for the sum of pain and pleasure.<sup>36</sup> For utilitarians, killing is not intrinsically wrong, but is only wrong because of its implications for pain and pleasure. Viewed from this perspective, euthanasia is wrong to the extent that it reduces happiness or creates misery. The classic utilitarian position on active, voluntary

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<sup>35</sup> Utilitarianism was formulated in the eighteenth and nineteenth centuries and is associated primarily with the British philosophers Jeremy Bentham and JS Mill. A classic statement of the philosophy is found in JS Mill's *Utilitarianism*, published in 1861. The utilitarianism of Bentham and JS Mill is a form of act-utilitarianism, according to which an act is right if its consequences are at least as good as those of any alternative. Nowadays this is contrasted with other types, such as rule-utilitarianism and utilitarian generalisation. For a brief, authoritative account see: D Miller et al (ed), *The Blackwell Encyclopaedia of Political Thought*, Oxford 1991.

<sup>36</sup> B Pollard, *The Challenge of Euthanasia*, Sydney 1994, pp 64-69. Pollard asserts, "When they hold to any philosophy, the advocates of euthanasia are usually consequentialist utilitarians, of one kind or another".

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euthanasia is that killing a hopelessly ill patient, who is suffering great pain, at his or her own request, would decrease the amount of misery in the world and is therefore morally right.

Utilitarianism has been the subject of varied and stringent criticism. There are practical objections founded, for example, on the difficulties of predicting consequences of actions. Then there are the moral objections, based on the appeal to non-utilitarian values, notably the intrinsic value of human life and the principle of autonomy. One telling criticism is that utilitarianism is simply an incomplete account of the moral issues encountered in the debate on such life and death issues as abortion and euthanasia. In particular, in principle at least it leaves open the possibility of a paternalistic approach to curtailing the lives of other people. Glover makes the point that, at least in principle, it may be possible for some utilitarians to be "committed to a 'paternalist' policy of killing someone, *in what are taken to be his own interests, but against his expressed wishes*". The kind of hypothetical example Glover has in mind is that of a life prisoner, whose life in prison is not happy and can be calculated to deteriorate in the future. Further, the prisoner has no friends or relatives and so his death will have no harmful side-effects for others.<sup>37</sup>

In any event, it seems reasonably clear that the case for euthanasia needs to look beyond utilitarianism if it is to find anything like a sound philosophical basis. Two options can be noted here. First, to combine utilitarianism with certain ethical principles derived from other philosophical traditions. Alternatively, utilitarianism can be set aside in favour of a completely different ethical approach. Glover's work is a good example of the first option; Dworkin's of the second. Basically, Glover's strategy is to combine utilitarian ethics, which holds that it is wrong to shorten a worthwhile life as defined, with a regard for the principle of human autonomy. Dworkin, on the other hand, combines the principle of autonomy with his own account of the principle of the sanctity of life.

**Autonomy, best interests and the sanctity of life:** These are the three threshold issues identified by Dworkin in his analysis of the fundamental moral questions posed by euthanasia.<sup>38</sup> The following discussion of these issues anticipates to some extent the later account in this Paper of the arguments for and against euthanasia.

**Autonomy and self-determination:** It can be said that the principle that we ought to respect people's autonomy descends from the Kantian tradition in ethics.<sup>39</sup> It is sometimes referred to as the principle of self-determination. As expressed in Kantian philosophy, autonomous persons are ends in themselves, determining their own destiny, and are not to be treated merely as means to the ends of others. Helga Kuhse commented as part of her argument on behalf of active, voluntary euthanasia in the Northern Territory:

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<sup>37</sup> J Glover, *op cit*, p 73.

<sup>38</sup> R Dworkin, *op cit*, p 190.

<sup>39</sup> From the German philosopher Immanuel Kant (1724-1804).

Autonomy or self-determination is fundamental to what it means to be a person, or a moral agent. It is important because it allows people to shape their lives in accordance with their own values and beliefs, as long as their actions do not infringe the bounds of justice and allow others to do the same. Failing to recognise the individual as a pivotal decision maker fails to respect that person and is to disregard their capacity to form and pursue their own plans for life.<sup>40</sup>

Taking up this theme, Dworkin then states that advocates of euthanasia claim that "it is crucial to people's right to make central decisions for themselves that they should be allowed to end their lives when they wish, at least if their decision is not plainly irrational".<sup>41</sup> He favours what he calls "the integrity view of autonomy" which states that the value of autonomy derives from the capacity it protects: the capacity to express one's own character - values, commitments, convictions, and critical as well as experiential interests - in the life one leads.<sup>42</sup> In this way, the principle of autonomy, by permitting the individual the freedom to choose a merciful death by euthanasia, can be said to enhance the value of personal liberty. Glanville Williams has written in this vein, saying that in a matter like this, where people differ on a question of conscience, "there is surely everything to be said for the liberty of the individual".<sup>43</sup> Sometimes the idea of personal dignity is also employed in the context of the argument for autonomy. This combination of ideas found expression in the judgment of Hoffmann LJ in the *Bland* case:

the sanctity of life is only one of a cluster of ethical principles which we apply to decisions about how we should live. Another is respect for the individual human being and in particular for his right to choose how he should live his own life. We call this individual autonomy or the right of self-determination. And another principle, closely connected, is respect for the dignity of the individual human being: our belief that quite irrespective of what the person concerned may think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person.<sup>44</sup>

A number of complications arise at this point. For example, a distinction can be drawn between autonomous persons and autonomous choices. As Ruth Faden et al explain, the

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<sup>40</sup> Legislative Assembly of the Northern Territory, *Report of the Inquiry by the Select Committee on Euthanasia, Volume Three - Written Submissions*, May 1995, p 1732.

<sup>41</sup> R Dworkin, *op cit*, p 190.

<sup>42</sup> *Ibid*, p 224.

<sup>43</sup> G Williams, *The Sanctity of Life and the Criminal Law*, London 1958, p 309.

<sup>44</sup> [1993] AC 789, p 826. The paradox in this formulation is that the idea of dignity may not always be compatible with the principle of autonomy. Hoffmann LJ recognised the difficulty and went on to note the potential for conflict between the deeply rooted moral principles at issue.

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distinction is between (i) persons who have the capacity to be independent and in control, and (ii) the actions that reflect the exercise of those capacities.<sup>45</sup> Importantly, the *capacity* to act autonomously is distinct from *acting* autonomously, and possession of the capacity is no guarantee that an autonomous choice has been or will be made. The making of an autonomous choice is of central concern where informed consent to medical treatment is at issue, which in turn goes to the heart of the debate about voluntary euthanasia. The question is: what constitutes an authentically autonomous choice in this context? Faden et al contend that it is a common pattern in medical contexts for autonomous persons to fail - for a wide variety of reasons - to give informed consent: "The autonomous person may fail to act autonomously in a specific situation if ill in a hospital, overwhelmed by new information, ignorant, manipulated by a clever presentation of data, and so on".<sup>46</sup>

Opponents of euthanasia join the debate at this point with their own appeal to autonomy, which arises from the concern that if euthanasia were legal people would be killed who really wanted to stay alive. They contend that the terminally ill are vulnerable to pressure: "someone who is terminally ill, and whose care is expensive or burdensome, or whose situation is agonizing for relatives and friends, may well feel guilty about the money and attention being devoted to him".<sup>47</sup> From this standpoint, concern is focussed on the way that the informed decisions of competent patients can be skewed in extreme life and death circumstances, so that an autonomous person can make decisions which are not in his or her best interests. Conversely, advocates of voluntary euthanasia would contend that due respect must be shown to a person who makes a truly autonomous decision. What is required are procedural safeguards designed to ensure that a patient's decisions are of this kind. The British Humanist Association has suggested that "to refuse a considered request is to treat that person with contempt".<sup>48</sup>

Then there is the further complication of the incompetent and unconscious patient who is permanently unable to make decisions about his or her medical care, as in the cases of Nancy Cruzan and Anthony Bland. This is the issue that arises in relation to non-voluntary euthanasia. Dworkin comments, "We can respect the autonomy of someone who has become unconscious only by asking what he would have decided himself, under appropriate conditions, before he became incompetent".<sup>49</sup> Obviously this may prove a very difficult undertaking, even where there is an operative "living will", for there can be

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<sup>45</sup> R A Faden et al, *A History and Theory of Informed Consent*, Oxford 1986, p 8. For Faden et al, the autonomous person is to be perceived in terms of such capacities as resistance to social conformity, reflectiveness, understanding and insight, and resistance to manipulations attempted by others (page 236).

<sup>46</sup> Ibid, p 237.

<sup>47</sup> R Dworkin, *op cit*, p 190.

<sup>48</sup> House of Lords, Report of the Select Committee on Medical Ethics, *op cit*, p 24.

<sup>49</sup> R Dworkin, *op cit*, p 191.



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no guarantee that the patient has not changed his or her mind in the interim, or would have if he or she had thought about the matter again. However, the relevance of these reflections may not be limited to cases of non-voluntary euthanasia. They may also bear upon the issue of voluntary euthanasia in circumstances where the patient is conscious but not fully competent, or at least where the patient's competence is in doubt. Of concern here is where a patient's judgment is distorted by depression, illness, or medication. For the advocates of voluntary euthanasia, such concerns give rise again to the need for proper safeguards to ensure that the patient's decision is truly voluntary; for its opponents they call the integrity of any proposed scheme of voluntary euthanasia into serious question.

**Best interests:** Having discussed some of the difficulties encountered in connection with the principle of autonomy, it needs to be noted that the tradition of secular humanism to which many of the advocates of voluntary euthanasia belong does not adhere to any principle in absolute terms.<sup>50</sup> For example, Dworkin favours individual choice but not, it seems, where the decision is "plainly irrational". Introducing the alternative principle of best interests he says that many people are opposed to euthanasia on paternalistic grounds: "They think that even when people have deliberately and self-consciously chosen to die - when we know that is their genuine wish - it is still nevertheless bad for them to die. Almost all of us take that view in some cases".<sup>51</sup>

This suggests that what can be called the popular evidentiary view of autonomy is flawed. That view holds that we should respect the decisions people make for themselves, even when we regard these decisions as imprudent, because each person generally knows what is in his or her own best interests better than anyone else.<sup>52</sup> Generally speaking that may be so, but then every rule has its exception. It is for this reason that Glover, whilst stating a preference for autonomy, continues to find a place for utilitarian considerations where life and death issues are concerned. He notes: "If someone wants to kill himself, we often think it right to prevent him, on the grounds that he does have a worth-while life and that he will later be glad of our paternalist intervention. But if the only principle applying to matters of life and death were the autonomy principle, we would often find ourselves debarred from intervening".<sup>53</sup> His contention is that there must be limits to libertarianism, based on the idea that others may in a particular situation know better than the individual concerned what is in his or her best interests.

Advocates of voluntary euthanasia contend that this kind of objection simply does not apply in the case of a person who is terminally ill. Other things being equal, there would

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<sup>50</sup> AB Downing and B Smoker, *Voluntary Euthanasia: Experts Debate the Right to Die*, London 1986, p 97.

<sup>51</sup> R Dworkin, *op cit*, p 192.

<sup>52</sup> *Ibid*, p 223.

<sup>53</sup> J Glover, *op cit*, p 79.

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be no reason to contradict or set aside the informed choice of the patient. Yet, there may still be room for debate. The issue here comes back to the question of what constitutes informed consent in a life and death situation. Also, the problem may become more complex if voluntary euthanasia is proposed for circumstances other than where a patient is terminally ill. Then, at another level of argument, there are those who contend that it can never be in a person's best interests to die.

Obviously the term "best interests" is hard to define, since it is used by different people to mean different things in different circumstances, finding a place at times in the arguments of both the advocates and opponents of euthanasia. As with autonomy, the question of its meaning is particularly intense and problematic where non-voluntary euthanasia is concerned. Interestingly, the principle of best interests was central to the decision of the House of Lords in the *Bland* case. Indeed the contrast has been made in this context between the approach of United States courts to cases dealing with the termination of treatment, where the emphasis is on respecting patient autonomy, as against the English courts which often use the rubric of the "patient's best interests".<sup>54</sup> The practical effect of this is that in such cases in England the courts do not seek out a decision which purports to reflect the patient's wishes. Instead, they tend to defer to what medical opinion considers to be in the patient's best interests. In *Bland* the decision was based: (i) on the *Bolam* doctrine that the standard of care imposed on doctors by the law is itself a matter of medical judgment;<sup>55</sup> and (ii) on the view that there is responsible medical opinion which holds that life in a permanent vegetative state with no prospect of recovery is of no benefit to the patient.<sup>56</sup>

Alternative assessments of the case and its ethical implications have been offered. According to JM Finnis, the English courts went beyond asserting that Anthony Bland's continued existence was of no benefit to him to say that it was "actually a harm to him, a

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<sup>54</sup> B Bix, *op cit*, p 409.

<sup>55</sup> *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.

<sup>56</sup> Summing up this approach, the House of Lords Select Committee on Medical Ethics stated that the principle of best interests: "was articulated in the case of *In re F (Mental Patient Sterilisation)* [1990] 2 AC 1 where it was held that no-one could consent to medical treatment on behalf of an incompetent patient, but that a doctor could treat if it were in the patient's best interests to do so. In determining the patient's best interests, the doctor should act in accordance with a responsible and competent body of relevant professional opinion" (page 11). A similar approach was adopted in the New Zealand case, *Auckland Area Health Board v AG* [1993] 1 NZLR 235, where it was held that a doctor, acting in good faith and in accordance with good medical practice, was not under a duty to render life support necessary to prolong life if that was, in his or her judgment, contrary to the best interests of the patient. Whether a similar approach would be followed in Australia is a moot point, having regard to the High Court's decisive rejection of the *Bolam* doctrine in *Rogers v Whitaker* (1992) 175 CLR 479, a negligence case of duty to warn of risk. This case is discussed in D Mendelson, *op cit*, pp 274-275.

source of indignity, violation of his wish to be remembered well, humiliation".<sup>57</sup> Following this line of reasoning, one paradox Finnis finds in the *Bland* decision is that termination of treatment for such patients is actually required and not merely permitted, for to do otherwise would be to act against the patient's best interests, which would be a dereliction of the doctor's legal and ethical duty. Sheila McLean, on the other hand, has said that "there is little real principle" in the decision. She cites Lord Mustill's comment that his own logic had led him to the conclusion that Anthony Bland had no best interests to be served by being kept alive, a conclusion which then led McLean to observe that "the outcome might almost be thought to be morally neutral".<sup>58</sup> Alternatively, Danuta Mendelson concludes that the House of Lords decision upholds the traditional humanist approach to best interests and presents a "sensible analytical model of the best interests principle to be followed by courts and Guardianship Boards".<sup>59</sup> This can be contrasted in turn with Peter Singer's view, again written in support of the decision, that the case has rewritten the law of murder regarding the question of intention, by holding in effect that "it can be lawful intentionally to bring about the death of an innocent human being".<sup>60</sup>

**The sanctity of life:** Finnis comments that the House of Lords identified *Bland* as a case in which sanctity of human life should yield to self-determination or best interests.<sup>61</sup> The principle of the sanctity of human life is central to the moral critique of euthanasia in all its forms, a critique which is based generally on the precepts of religious doctrine. The NSW Council of Churches put it in these terms: "Christian teaching affirms the value of each individual, made in the image of God. Our lives are a gift from God. Neither our own lives nor the lives of others, are ours to take".<sup>62</sup> In the Christian tradition euthanasia is condemned as the intentional killing of innocent humans. However, the prohibition against euthanasia is by no means an exclusively Christian doctrine. Jewish

<sup>57</sup> JM Finnis, "Bland: Crossing the Rubicon?" (July 1993) 109 *The Law Quarterly Review* 329-337, p 336. Finnis is in fact quite critical of the *Bland* judgment, saying among other things: "Failure to distinguish being subjected to indignities from being (or being put) in an undignified condition (or position) is a deeply unsettling aspect of *Bland*. Many are those who might be rescued from undignified conditions by benevolent termination of their life".

<sup>58</sup> S McLean, "Letting Die or Assisting Death: How Should the Law Respond to the Patient in a Persistent Vegetative state?" (1993) 11(2) *Law in Context* 3-16, p 10.

<sup>59</sup> D Mendelson, *op cit*, p 268.

<sup>60</sup> P Singer, *Rethinking Life & Death*, Melbourne 1994, pp 68-73. Singer also cites the opposing view of J Keown to the effect that it was "a hard case which made bad law, largely by approving a consequentialist ethic radically inconsistent with the principle of the sanctity of life" (page 75).

<sup>61</sup> *Ibid*, p 336.

<sup>62</sup> NSWPD (proof LC), 6 June 1995, p 47.

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and Islamic law are at one with Christianity in this regard.<sup>63</sup>

At the core of this rejection of euthanasia is the view that taking life is intrinsically wrong and that the sanctity of human life has to be included among the ultimate principles of any acceptable moral system. Euthanasia is wrong on this basis, even when the patient desires death and even if it is in his or her best interests, because it violates the intrinsic value of human life. We can say that something is intrinsically valuable if its value is *independent* of what people happen to enjoy or want or need or what is good for them. It can be distinguished from something which is *subjectively* valuable to the person who wants it, or something which has *instrumental* value in that it helps people to get something else they want.<sup>64</sup>

Of course belief in the special worth of human life transcends religious commitment. It is at the heart of civilised society, being the fundamental value on which all others are based, and is the foundation of both law and medical practice. In *Auckland Area Health Board v AG*, Thomas J expressed it thus:

Life, and the concept of life, represents a deep-rooted value immanent in our society. Its preservation is a fundamental humanitarian precept providing an ideal which not only is of inherent merit in commanding respect for the worth and dignity of the individual but also exemplifies all the finer virtues which are the mark of a civilised order. Consequently, the protection of life is, and will remain, a primary function of the criminal law.<sup>65</sup>

A commitment to the value of human life is acknowledged therefore, finding expression for example in Article 6 (1) of the *International Covenant on Civil and Political Rights*, which states: "Every human being has an inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life".

Stated in this way the principle of the sanctity of life is not absolute in nature. The proponents of euthanasia say that this observation has a general application. In other words, hardly anyone advocates the principle in an absolute form: absolute pacifists are a rare breed. Thus, in practice the principle of the sanctity of human life may give way to other considerations in a range of circumstances, including self-defence, the fighting of just wars and even the imposition of capital punishment. For the proponents of euthanasia, we should not gloss over the way that the principle can be qualified in relation to certain special cases. After all, the claim that euthanasia makes is to be counted among any list of acceptable special cases, but only where well-defined principles and conditions have been satisfied. Conversely, the religious opponents of euthanasia might contend that,

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<sup>63</sup> J Rachels, *op cit*, pp 15-17.

<sup>64</sup> R Dworkin, *op cit*, p 71.

<sup>65</sup> [1993] 1 NZLR 235, p 244.

unlike the other special cases mentioned above, the difficulty with euthanasia (and abortion) is that it contradicts the rule against the taking of *innocent* human life. Daniel Callahan, Director of the Hastings Center, formulates the case in these terms: "To legitimize active euthanasia is to add a new category of killing. It is to add indeed the worst category of killing, namely private, self-determined killing between people, not for the sake of protecting the nation (as in war), not for the sake of justice (as in capital punishment), and not for the sake of saving a life (as in self-defense), but rather to satisfy private wants and desires".<sup>66</sup>

A number of further points can be made at this stage. First, in part in response to modern advances in medical technology the question is often asked as to where exactly are we to draw the boundary between life and death. A further question is: do we value "life" even if unconscious, or do we value life only as a vehicle for consciousness. As Glover suggests, the different attitudes found in the debate about euthanasia to the doctrine of the sanctity of life flow from the answer to this question. On one side, which for the sake of convenience can be called the religious attitude to the sanctity of life, it is held that *being alive is in itself intrinsically valuable* and that euthanasia, like abortion, is an insult to God's gift of life. Whereas the broadly secular attitude to the sanctity of life tends to maintain that *being conscious is intrinsically valuable*.<sup>67</sup> From the secular standpoint, therefore, the doctrine of the sanctity of life is bound up with considerations about the quality of a person's life. Often the dichotomy in the debate is explained as one between a commitment to the intrinsic value of life, which leads to the view that euthanasia is wrong in all circumstances, as against a commitment to a sense of the personal value of life to the patient, which becomes a question of judgment and calculation as to whether life is worth living. Speaking against this latter approach, Luke Gormally commented: "such a judgment expresses a calculation of another's value (whether as productive of pleasure, or satisfaction of preferences, or of some other utility) which ignores the dimension of spirit characteristic of human life".<sup>68</sup> Conversely, James Rachels spoke for the secular cause when he said, "there is a deep difference between *having a life* and merely *being alive*".<sup>69</sup> For his part, Dworkin told the House of Lords Special Committee on Medical Ethics that for him the special value of life "resides in the capacity to respond to an environment, to respond to challenges, to give and receive affection in relationships and, of course, a mental life is at the centre of that".<sup>70</sup> Summing up this view, Sopinka J in the *Rodriguez* decision said that while there is consensus that human life must be respected, there is support for the view that the quality of life is an essential component of this principle:

<sup>66</sup> M de Wachter, "Euthanasia in the Netherlands" (March-April 1992) *Hastings Center Report*.

<sup>67</sup> J Glover, op cit, pp 43-50.

<sup>68</sup> AB Downing and B Smoker eds, op cit, p 89.

<sup>69</sup> J Rachels, op cit, p 5.

<sup>70</sup> House of Lords, Report of the Select Committee on Medical Ethics, op cit, p 13.

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The principle of sanctity of life is no longer seen to require that all human life be preserved at all costs. Rather, it has come to be understood, at least by some, as encompassing quality of life considerations, and to be subject to certain limitations and qualifications reflective of personal autonomy and dignity.<sup>71</sup>

Importantly, for Dworkin there is a clear need for even the secular attitude to recognise the intrinsic value of life, as well as its subjective, personal value to the patient. Basic to his argument is that the principle of sanctity has a secular dimension: crucial to this is the idea of dignity, which means respecting the inherent value of our own lives. The implications of this idea reach out beyond the individual, Dworkin maintains, for the reason that the decisions people make about life and death issues like euthanasia and abortion "express a view about the intrinsic value of life and therefore bear on our own dignity as well".<sup>72</sup> Nonetheless, he expresses his own preference for individual freedom of choice in these matters. Ultimately, though our own dignity is at stake, according to Dworkin we should place the right of conscience at the centre of the moral universe. For Dworkin, that is the true lesson of dignity: because we cherish dignity, we insist on freedom and advocate the right to a dignified death. In fact his defence of euthanasia extends to both voluntary and, in certain circumstances, non-voluntary euthanasia: "People who want an early, peaceful death for themselves or their relatives are not rejecting or denigrating the sanctity of life; on the contrary, they believe that a quicker death shows more respect for life than a protracted one".<sup>73</sup>

Whatever one makes of this argument<sup>74</sup>, it does at least suggest the extent to which both sides in the euthanasia debate share a concern about life's sanctity: "they are united by that value, and disagree only about how best to interpret and respect it".<sup>75</sup>

**The individual and the common good:** Another focus in the euthanasia debate at the ethical level is the conflict between the rights of the individual, on one side, and the interests of the collectivity, on the other. As noted, the Northern Territory Select Committee on Euthanasia reported that this was the most common theme in the submissions it received.

Stated briefly, the advocates of euthanasia maintain that a decent society should not impose a collective judgment on individuals in relation to decisions of a profoundly spiritual and personal nature. Working from a regard for autonomy and dignity and the

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<sup>71</sup> 3 SCR (1993) 519, p 595.

<sup>72</sup> R Dworkin, *op cit*, p 238.

<sup>73</sup> *Ibid*, p 238.

<sup>74</sup> Reference was made to it by Sopinka J in the *Rodriguez* decision (page 585), and by Hoffmann LJ in *Bland* (page 826).

<sup>75</sup> *Ibid*, p 238.

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safeguards these require, they hold that it should be left to individuals to make the most fundamental judgments about their own lives. In succinct terms, the preference is for responsibility against coercion.<sup>76</sup>

Opposing this, the concern is that the legalisation of euthanasia, in any form, will seriously compromise the state's interest in protecting the right to life in the common good. In this way, the vulnerable are put at risk and the law's prohibition against taking human life is compromised, as is the general interest in the protection and preservation of human life. Typically, one would expect the argument to be accompanied by religious belief; but that need not be the case. The argument can be formulated in secular, instrumental terms, based for example on the value of upholding the right to life doctrine for the maintenance of social order.

From the standpoint of legal analysis, the dichotomy between individual rights and the interests of the state has been discussed by the American courts in the context of treatment refusal issues. Following Darvall's account, it can be said that they have characterised the right to refuse medical treatment as a necessary element of the individual's right to self-determination, which incorporates the notion of informed consent. It has been held that right will only be recognised if it outweighs all relevant state interests: "The relevant countervailing interests which American courts take into consideration include, preserving life, preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties".<sup>77</sup>

**The acts and omissions doctrine:** Reference has already been made to this doctrine which is prominent on the applied, legal ethics front of the euthanasia debate. The doctrine is important because it is used to justify the difference between killing and letting die. As noted, it also bears upon the distinction between active and passive euthanasia.

Basically, the acts/omissions doctrine holds that we are legally responsible for our acts but not for our omissions, except that is where there is a pre-existing duty of care. A person may not kill but, in the absence of a duty of care, he or she is under no legal obligation to save another person's life. In law, therefore, an omission to act is only significant where someone has a specific duty to act - for example a doctor who has a professional duty to care for a patient, or a parent who has a duty to care for a child - and fails to do so.<sup>78</sup>

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<sup>76</sup> Ibid, p 216.

<sup>77</sup> L Darvall, op cit, p 55; *Cruzan v Director, Missouri Department of Health* 110 S Ct 2841 (1990), p 2843.

<sup>78</sup> It has been said that a doctor's duty of care may be founded on contract, the special relationship between doctor and her or his patient, or a voluntary assumption of care by the doctor: "Decriminalising euthanasia" (June 1995) 19 *Criminal Law Journal* 125-127, p 125.

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In the context of the euthanasia debate, the acts/omissions doctrine has been discussed mostly in regard to patients in a permanent vegetative state. The issue has been whether the withdrawal of a life-support system can in certain circumstances be characterised as an omission.<sup>79</sup>

The doctrine was in fact a central feature of the decision in the *Bland* case, which has been defended by some theologians on the basis that "the withdrawal of artificial nutrition and hydration in the type of cases under discussion is to be seen as an omission which is not intending of death but a refusal to continue with inappropriate means of life preservation".<sup>80</sup> Consistent with the principle of best interests, it was held in the case that the doctors concerned had no duty to provide Anthony Bland with medical care and food for an indefinite period. On this basis, it was decided that an omission to provide medical treatment in circumstances where it was not in the best interests of the patient to continue the invasive medical care involved in artificial feeding was lawful. However, use of the acts/omissions doctrine in *Bland* was accompanied by a distinct sense of unease, with Lord Mustill for instance saying it was founded on a "morally and intellectually dubious distinction".<sup>81</sup>

The question that arises from this is whether the acts/omissions doctrine represents a real moral position, or is it merely a distinction without a difference?<sup>82</sup> The following statement by Dix et al suggests some of the ethical and practical difficulties involved:

Many omissions to act may be viewed in law as merely part of a course of conduct which overall can be described as a positive action. If this is the case, the difficult distinction between an act and an omission will cease to have relevance. It is arguable, and it is put no higher than this, that once some types of treatment have commenced, an unlawful killing would be committed if they were to be subsequently withdrawn, even at the request of the patient. That is, the doctor would be seen as actively killing the patient, rather than merely omitting to treat him. For example, should a

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<sup>79</sup> The clearest articulation of this approach and its relation to the best interests doctrine is found in the judgment of Lord Mustill in *Bland* at page 897.

<sup>80</sup> House of Lords, Report of the Select Committee on Medical Ethics, op cit, p 18. On the issue of intention, it was in fact accepted in the judgment that the whole purpose of stopping artificial feeding was to bring about the death of Anthony Bland: S McLean, op cit, p 9; P Singer, op cit, pp 68-73. As noted, for Singer this acceptance amounts to nothing less than "rewriting the law of murder regarding the question of intention". Singer welcomes the development, stating: "the British law lords have shown a clarity and forthrightness that should serve as a model to many others who try to muddle through these difficult questions". The upshot for Singer is that it can be lawful to intentionally bring about the death of an innocent human being.

<sup>81</sup> [1993] AC 789, p 898.

<sup>82</sup> S McLean, op cit, p 8.



patient whose life is being maintained on a life support apparatus request it to be turned off, to do so may constitute murder.<sup>83</sup>

Due to such difficulties, there are those who maintain that the acts/omissions doctrine is "philosophically disingenuous" and that it should be abandoned.<sup>84</sup> The same fate is sometimes recommended for the related, "highly suspect" distinction between active and passive euthanasia.<sup>85</sup> Lord Mustill did not go that far but he did say, with reference to the acts/omissions doctrine: "The acute unease I feel about adopting this way through the legal and ethical maze is I believe due in an important part to the sensation that however much the terminologies may differ the ethical status of the two courses of action is for all relevant purposes indistinguishable".<sup>86</sup>

Perhaps the better view is that, despite its difficulties, the acts/omissions doctrine should be retained in some form, for there really is some point to the traditional view that killing and letting die are not morally equivalent: "Not rescuing the drowning child is less frowned on than pushing him in to start with".<sup>87</sup> In terms of the euthanasia debate, the Anglican Archbishop of Melbourne, Dr Keith Rayner, has said: "Ethically there is all the difference in the world between letting people die naturally and killing them. There are times when it may be wrong to intervene medically to keep a person alive. It is certainly not a part of the Christian doctrine to insist that life be sustained at all costs".<sup>88</sup>

At the same time, however, it should be recognised that using the acts/omissions doctrine as a way of distinguishing between unlawful, active forms of euthanasia, on one side, and lawful terminations of treatment which seem to amount to "indirect" forms of passive euthanasia, on the other, can result in a technical, legalistic mode of argument which at times can seem questionable and artificial.<sup>89</sup> For Lord Goff of Chievely the rationale

<sup>83</sup> A Dix et al, op cit, p 296.

<sup>84</sup> House of Lords, Report of the Select Committee on Medical Ethics, op cit, p 19. Reference is made to the submission of S McLean.

<sup>85</sup> "Decriminalising Euthanasia", op cit, p 127.

<sup>86</sup> [1993] AC 789, p 887. He said later: "No doubt it would be too stern a morality to place human beings on the same footing as regards criminal responsibility for allowing an undesirable state of affairs to continue as for bringing that state of affairs into being, but even if there is sense in the distinction the current state of the law is unsatisfactory both morally and intellectually..." (page 893).

<sup>87</sup> J Glover, op cit, p 108.

<sup>88</sup> "Euthanasia 'Nazi' Threat", *The Age*, 4 July 1995.

<sup>89</sup> The arguments for and against the doctrine are considered by Sopinka J in the *Rodriguez* decision at page 606. They were also considered by the US President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research. David Lanham reports: "Having decided that there was no

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behind the doctrine was to be found in public policy considerations and not in the precepts of legal reasoning.<sup>90</sup> The general sense of unease felt by the House of Lords in the *Bland* judgment was stated in these terms by Lord Browne-Wilkinson (who expressed the hope that Parliament would review the law):

the conclusion I have reached will appear to some to be almost irrational. How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question.<sup>91</sup>

**In summary:** The foregoing discussion of the moral issues involved in the euthanasia debate suggests the different ways in which we can begin to answer the question: is it ever right to terminate the life of a patient, with or without his or her consent? For those who believe that it is, the argument comes down primarily to a regard for mercy, liberty, quality of life considerations and a secular sense of the sanctity of human life. Those who think otherwise consider euthanasia to be immoral, contrary to God's law and against the interests of the state; its legalisation is seen to be a mortal danger to the vulnerable members of society, it being impossible to devise any workable laws or to establish any meaningful limits once we have crossed the Rubicon which runs between the care of the living patient, on the one hand, and euthanasia, on the other.

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watertight moral distinction between acts and omissions in the medical sphere, the Commission nonetheless supported the distinction on public policy grounds. The law, in relying on the distinction, seeks an accommodation which adequately protects human life while avoiding the officious overtreatment of dying patients. The commonly accepted prohibition of active killing helps to produce the correct decision in the great majority of cases" - D Lanham, *Taming Death by Law*, Melbourne 1993, p 162.

<sup>90</sup> [1993] AC 789, p 866 (see page 6 above).

<sup>91</sup> *Ibid*, p 885.

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#### 4 THE LAW RELATING TO EUTHANASIA IN AUSTRALIA

The next two sections of this Paper outline common law principles and statute law relevant to the euthanasia debate. In the first section an examination of the current Australian position is given. The second section deals with the position overseas with specific reference to the Netherlands and Oregon. Apart from the Northern Territory these two places are the only other jurisdictions where euthanasia has been formally sanctioned: in the Netherlands by the government and the courts; in Oregon by a majority of voters at a citizen initiated referendum held in November 1994.

##### (a) Common Law <sup>92</sup>

The general position under the common law can be summarised as follows:

###### *Civil law*

- a competent adult can refuse medical treatment;
- medical treatment and treatment of a patient without the patient's consent constitute the tort of trespass to the person, which may give rise to civil actions for assault, battery or false imprisonment. There are exceptions to this general principle, for example in an emergency where the patient is unconscious and there is no indication of contrary wishes, treatment can be administered without consent;
- however, a person has no legal right to insist on treatment that would result in death.

###### *Criminal law*

- suicide and attempted suicide are no longer crimes in the majority of Australian States, although the crime of attempted suicide seems to have been retained in the Northern Territory - Section 169 of the *Northern Territory Criminal Code Act*;
- it is a crime to incite, counsel or assist another person to suicide or attempt suicide. A person found guilty of this may be charged with murder or manslaughter or breach of the statutory offence of assisting a suicide, depending on the circumstances;
- if a person has a duty to provide medical treatment or sustenance and that person fails to do so and death results, then that person may be exposed to criminal liability;

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<sup>92</sup> Some of the information below is taken from Research Note Number 12, 2 March 1995, prepared by Jennifer Norberry for the Commonwealth Parliamentary Research Service.

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- at common law a person cannot consent to his or her own death and any such consent will not relieve another person of criminal responsibility.

**Specific statutory offences:** Apart from possible murder or manslaughter charges, involvement in the death of a person may give rise to the following offences under the New South Wales *Crimes Act 1900*:

- aiding and abetting a suicide or attempted suicide, which carries a penalty of imprisonment for 10 years - Section 31C(1);
- inciting or counselling suicide, which carries a penalty of 5 years imprisonment - Section 31C(2);
- accessory before or after the fact (for instance, where a person does not directly help someone to die, but helps another person who is assisting) - Sections 346-351. The penalty for these offences varies depending on how the original offence is classified. If the original offence is a felony then the penalty is a long gaol sentence, if the original offence is a misdemeanour, then the penalty will be a lesser gaol sentence or a fine;
- where efforts are made to disguise how the person died:
  - tampering with evidence - Section 317, which carries a penalty of 10 years penal servitude;
  - hindering an investigation - Section 315, which carries a penalty of 7 years penal servitude;
  - concealing the fact that a serious crime has been committed - Section 316, which carries a penalty of 2 years imprisonment;

A person may also be charged with offences such as falsifying a death certificate (an offence under the *Registration of Birth, Deaths and Marriages Act*), which carries a penalty of \$200 or 6 months imprisonment or both.

## (b) Legislation

To date the majority of legislation has been merely a statutory reflection of the common law position where a person can refuse medical treatment. This legislation enables competent adults in certain specified situations to direct that medical treatment be withdrawn or withheld. Giving this right legislative status offers protection to those with terminal or incurable illnesses, or health professionals who treat them, from potential criminal or civil liability. The recent Northern Territory legislation is the first to permit active voluntary euthanasia in certain circumstances although a number of attempts have been made over recent years to bring in legislation of this nature. In light of this development, efforts to bring in similar legislation in other jurisdictions throughout

Australia have been foreshadowed.

(i) **South Australia**

In 1983 the *Natural Death Act* was enacted in South Australia [See Appendix 1]. This Act provided for, and gave legal effect to, directions against artificial prolongation of the dying process:

- It enabled an adult (someone who has attained 18 years of age) of sound mind to make a direction refusing extraordinary measures for the preservation of life in the event of a terminal illness.
- "Extraordinary measures" are defined as "medical or surgical measures that prolong life, or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation".
- The form to be completed is specified in the legislation and requires witnessing by two witnesses.
- A duty on the medical practitioner to follow the direction was created.
- It was clearly stated that the Act did **not** authorize an act that causes or accelerates death as distinct from an act that permits the dying process to take its natural course - Section 7(2).

In 1992 the *Consent to Medical Treatment and Palliative Care Bill* was introduced. It lapsed in 1993 but has since been passed and assent given in April 1995 [See Appendix 2]. This Act repeals the earlier *Natural Death Act 1983* and *Consent to Medical and Dental Treatment Act 1985*.

Its objects are:

- to make certain reforms to the law relating to consent to medical treatment: (i) to allow persons of or over the age of 16 years to decide freely for themselves on an informed basis whether or not to undergo medical treatment and (ii) to allow persons of or over the age of 18 years to make anticipatory decisions about medical treatment and (iii) to provide for the administration of emergency medical treatment in certain circumstances without consent;
- to provide for medical powers of attorney under which those who desire to do so may appoint agents to make decisions about their medical treatment when they are unable to make such decisions for themselves;
- to allow for the provision of palliative care, in accordance with proper standards, to people who are dying and to protect them from medical treatment that is

intrusive, burdensome and futile.

The legislation provides for an advance directive to be given by a competent adult about the medical treatment he or she wants, or does not want, if at some future time he or she is in the terminal phase of a terminal illness, or in a persistent vegetative state and incapable of making decisions about medical treatment when the question of administering the treatment arises.

On 9 March 1995 a Private Member's Bill, the *Voluntary Euthanasia Bill*, was introduced and read a second time in the South Australian Legislative Assembly <sup>93</sup> [see Appendix 3]. This Bill is modelled on the Northern Territory's *Rights of the Terminally Ill Act 1995*.

Under the South Australian proposal:<sup>94</sup>

- any adult of sound mind, who has been diagnosed as suffering from a terminal illness that is likely to cause the person's death within 12 months may request euthanasia - Clause 4.
- two doctors must confirm in writing that this is the case and that they consider euthanasia appropriate in the circumstances - Clause 10.
- the Bill has safeguards to ensure that the person concerned has been fully informed of all relevant medical facts - Clause 5; and provides that the request must be made in writing in front of two witnesses, one of whom must be a doctor - Clauses 6 and 7.
- if the person cannot write, the request may be made verbally and written down by the witnesses, but in these cases a videotape of the request must be made if possible - Clause 6(3)(b).
- euthanasia may be by the doctor administering a lethal dose of drugs, or prescribing drugs for self-administration, or withdrawing life-sustaining treatment - Clause 10(2).
- those administering euthanasia in accordance with the Act are protected from civil and criminal liability - Clause 12.
- all euthanasia deaths must be reported to the State coroner and the Minister for Health - Clause 13; and the Minister for Health must report annually to Parliament

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<sup>93</sup> *SAPD*, House of Assembly, 9 March 1995, p 1863. The Bill was introduced by Mr Quirke, the Shadow Treasurer.

<sup>94</sup> 'Details of South Australian V.E. bill', *Voluntary Euthanasia Society of New South Wales Newsletter*, Number 73, May 1995, p 9.

- Clause 16.

- doctors have the right to refuse to administer euthanasia, as do hospitals and other health care institutions, but they must advise patients of their policy on admission - Clause 11.
- the cause of death where euthanasia has been administered is taken to have been the patient's illness - Clause 14.

(ii) **Northern Territory**

In 1988 the Northern Territory enacted the *Natural Death Act* [see Appendix 4] which mirrored the provisions in the earlier South Australian Act.

**Rights of the Terminally Ill Act 1995**<sup>95</sup> [see Appendix 5].

On 22 February 1995 the *Rights of the Terminally Ill Bill* was introduced into the Legislative Assembly as a Private Member's Bill [See Appendix 6 for the Second Reading Speech]. A Select Committee was set up to inquire into the Bill and report back to the Legislative Assembly by 16 May 1995. On 25 May 1995 the Bill was passed by 15 votes to 10 after more than 50 amendments. Under this legislation, which commences on a date to be fixed by the Administrator of the Northern Territory by notice in the Gazette, active voluntary euthanasia may be requested and lawfully administered.

Details of the Act are:

**Who can make a request and in what circumstances ?**

- A competent adult suffering from a terminal illness can request his or her medical practitioner for assistance in terminating his or her life.
- The request must be voluntary, sufficiently informed and made after due consideration. It can only be acted upon if made in the appropriate form and if specified conditions are met.
- It will not apply to individuals who are of "unsound mind", to persons under the age of 18 years or to the clinically depressed.
- In the Act "assistance" provided by a medical practitioner includes prescribing a substance, preparing a substance, giving a patient a substance for self-administration and administering a substance to the patient.

<sup>95</sup> The information on this legislation outlined below is taken from a Research Note prepared for the Commonwealth Parliamentary Research Service by Jennifer Norberry. At the time of writing this document was yet to be published

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- An "illness" includes "injury or degeneration of mental or physical faculties".
  - A "medical practitioner" is a person who has been entitled to practise in Australia for a continuous period of not less than five years and who is entitled to practise medicine in the Northern Territory.

**Conditions:** There are many preconditions to be met before a medical practitioner can assist a person to end his or her life. The patient must be 18 years, have a terminal illness which causes severe pain or suffering, and there must be no medical measure acceptable to the patient that could effect a cure. The medical practitioner must have informed the patient about the likely course of the illness and available medical treatment, palliative care, counselling and psychiatric support. Having been so informed the patient must then have indicated a desire to end his or her life. The medical practitioner needs to be assured that the patient is of sound mind, acting voluntarily and after due consideration.

**Cooling off period:** There is a mandatory "cooling off" period of seven days from the time the patient informs the medical practitioner of the wish to end his or her life before the patient can complete a certificate of request. This certificate must be signed by the patient in the presence of the patient's medical practitioner and another medical practitioner. Both medical practitioners must sign requisite declarations that they have discussed the case. There is a second cooling off period after the certificate of request has been signed. It cannot be acted upon for at least 48 hours after the certificate has been completed.

A second independent medical opinion must be obtained from a medical practitioner who holds a diploma of psychological medicine or equivalent, who has examined the patient and who confirms the diagnosis and prognosis of the first medical practitioner and that the patient is not suffering from a treatable clinical depression relating to the illness.

**Rescinding a request:** This can be done at any time and in any way. The rescission must be noted on the patient's medical file and the certificate of request must be destroyed.

**Interpreters:** Where the medical practitioner does not speak the same first language as the patient, he or she cannot assist the patient to end his or her life unless an accredited interpreter is present at the time the request is made. The interpreter must also be present during the signing of the certificate of request and must confirm that the patient has understood the request for assistance.

**Palliative care:** A medical practitioner may not assist a patient if palliative care options are reasonably available and are acceptable to the patient.

**Patients who are physically unable to sign a certificate of request:** In this situation another adult may sign on the patient's behalf. However, that person cannot be one of the medical practitioners referred to earlier or a person likely to receive a financial



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benefit from the patient's estate.

**Penalties:** It is an offence to make inducements or threats to a medical practitioner or any other person regarding a request for assistance to end life. This carries a penalty of \$1000. A penalty of \$20,000 or imprisonment for 4 years may be imposed on a person who by deception or improper influence procures the signing or witnessing of a certificate of request. A person found guilty forfeits any benefit he or she would otherwise obtain as a result of the patient's death. A penalty of \$10,000 or 2 years imprisonment applies to a medical practitioner who fails to comply with record keeping and reporting requirements.

**Records and reporting of death:** Medical practitioners who assist in a termination of life must comply with specified record keeping requirements. These include keeping: a note of any oral request for assistance; the certificate of request; an opinion about patient's state of mind when the request was made; the report prepared by the second medical practitioner; and the substance prescribed. Where a medical practitioner has assisted in the termination of life, the death certificate must be sent to the coroner with the medical record that relates to the patient's terminal illness and death. The coroner must report annually to the Attorney-General on the number of patients who died as a result of assistance given under this legislation and the Attorney-General must report to the Legislative Assembly. The coroner may report at any time on the operation of this legislation and this report must be tabled in the Legislative Assembly by the Attorney-General.

**Insurance or annuity policies:** Death as a result of assistance given under this Act is not to affect insurance or annuity policies.

**Immunities:**

- A person is not liable to civil or criminal action or professional disciplinary action for anything done in good faith and without negligence in compliance with the legislation.
- A medical practitioner may refuse to assist a person to end their life.
- A health care provider (including a hospital, nursing home or nurse) is not under any duty to assist a medical practitioner in the termination of a patient's life.

**Critical responses to the Act:** Michael Eburn,<sup>96</sup> while not opposed in principle to the Act, says that there are a number of problems with it, many of which are simple drafting problems arising out of the lengthy debate and amendment in Committee process. To illustrate this point he gives the following examples of what he believes are

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<sup>96</sup> M Eburn, " Voluntary Euthanasia: Making the Law" (July 1995) 33 *Law Society Journal* 40-44, p 42.

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inconsistencies or lack of clarity in the Act:

- The criteria that must be met before a patient may request assistance to die (Section 4) are different to the criteria that must be met before the medical practitioner may give such assistance (Section 7). To request euthanasia a person must be suffering from **"pain, suffering and/or distress to an extent unacceptable to the patient"**. However in order to administer euthanasia the medical practitioner must be satisfied that the illness is causing **"severe pain and suffering"** - Section 7(1)(d). [Emphasis added].

According to Eburn:

the omission of **"distress"** as a ground for the administration of euthanasia was deliberate and designed to limit the cases which are considered acceptable ... however for the sake of consistency the reference should also have been deleted from Section 4.<sup>97</sup>

This failure to use the same words in the requirements that must be met before euthanasia may be administered, may, Eburn suggests, lead the courts to find an objective test or a test that requires the medical practitioner rather than the patient to decide whether pain is "severe".

- There are other sections where it is not clear whether the requirement is to be determined by the person seeking assistance to die or by the medical practitioner involved. One example is Section 8, which says that a medical practitioner may not administer euthanasia if **"there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient ..."**. It is not clear in whose view the care is to be considered **"reasonably available"**.

Eburn continues that, given the patient driven focus of the Act, it could be assumed that the question of what is reasonable is a matter for the patient. However, that conclusion is not so clear where some sections of the Act refer to available treatment being **acceptable to the patient** and others, such as Section 8, do not. This may lead to a court concluding that where no specific reference to the patient is made, then it is the view of someone else, most likely the medical practitioner, which is relevant.

Eburn next outlines what he describes as **"a major internal inconsistency with the Act and the power of a person to rescind their request for euthanasia"**.

- Under Section 10 where a patient rescinds their request, the certificate must be destroyed and the fact that the patient rescinded the request noted on the medical records. Under Section 8, however, a patient may elect to receive palliative care

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<sup>97</sup> Ibid, p 43.

after he or she has signed the certificate. That care may cause a remission of the pain and suffering; but should the treatment cease to be effective, the person may indicate that they wish to proceed with the decision to end their lives. The effect of these two sections is that the request for euthanasia may be stayed during effective palliative care.

Alternatively Eburn argues that if these sections are not inconsistent, there is a problem in that there is no time limit in Section 8. The effect of this is that a patient may receive palliative care that causes a remission of the pain and suffering which may be effective for 12 months. At which time the patient may then restore the request for euthanasia without the need for re-assessment by a psychiatrist or palliative care expert. Eburn suggests that at this point the decision should again be confirmed to ensure that it is still voluntary and that the person is not now suffering from a treatable depression.

If there is to be a process when the request can be "stayed", Eburn says that it should be limited to a relatively short time period after which re-assessment would be required.

Unlike the Oregon legislation (discussed below at pages 46-47), which only applies to Oregon residents, the application of the Northern Territory *Rights of the Terminally Ill Act 1995* appears to be unrestricted. Silence on this matter in the Act may be because it is intended to be addressed through the regulation making powers or simply because it was not identified as an issue requiring regulation.

### (iii) Victoria

In 1988 Victoria enacted the *Medical Treatment Act* [see Appendix 7]. Under this Act a competent adult may sign a refusal of treatment certificate relating to medical treatment in general or to treatment of a particular kind.

- "Medical treatment" means the carrying out of an operation; or the administration of a drug or other like substance; or any other medical procedure but does not include palliative care.
- "Palliative care" includes the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or the reasonable provision of food and water.
- A refusal of treatment certificate applies only to a current medical condition. However, there is no express requirement that the medical condition be a terminal or incurable one.
- A statutory offence of medical trespass is created whereby a medical practitioner must not, knowing that a refusal of treatment certificate applies to a person, undertake or continue to undertake any medical treatment to which the certificate applies, being treatment for the condition in relation to which the certificate was given.

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Following amendments made to this Act in 1990 (*Medical Treatment (Enduring Power of Attorney) Act*) [see Appendix 8], and 1992 (*Medical Treatment (Agents) Act*) [see Appendix 9], a competent adult may confer power on another person to make a decision about medical treatment on his or her behalf in the event that he or she becomes incompetent.

The preamble to the *Medical Treatment Act* states that the Parliament recognises that it is desirable:

- to give protection to the patient's right to refuse unwanted medical treatment;
- to give protection to medical practitioners who act in good faith in accordance with a patient's express wishes;
- to recognise the difficult circumstances that face medical practitioners in advising patients and providing guidance in relation to treatment options;
- to state clearly the way in which a patient can signify his or her wishes in regard to medical care;
- to encourage community and professional understanding of the changing focus of treatment from cure to pain relief for terminally ill patients; and
- to ensure that dying patients receive maximum relief from pain and suffering.

In 1993 the Victorian Voluntary Euthanasia Society prepared a Bill, the *Medical Treatment (Assistance to the Dying) Bill* [see Appendix 10], which proposed to legalise medical assistance for the terminally ill who wished to end their own lives. The main purposes of this Bill were expressed to be:

- to recognise the right of a doctor to provide medical assistance to a competent adult patient who has decided to end his or her life when he or she is suffering from a terminal illness;
- to grant a doctor who does so immunity from liability in criminal, civil and disciplinary proceedings; and
- to provide procedural protections against the possibility of abuse of the rights recognised by this Bill.

However the Bill was not adopted by any Member of Parliament. It is now being revised by the Voluntary Euthanasia Society in light of the Northern Territory legislation.

**(iv) Tasmania**

Since 1985 at least six attempts have been made by the Greens in Tasmania to bring in a *Medical Treatment and Natural Death Bill*, modelled on the Victorian *Medical Treatment Act*. To date all attempts have been unsuccessful. In 1992 the Bill was passed by the Lower House, but failed in the Upper House [see Appendix 11].

The Preamble to this Bill stated that Parliament recognises that it is desirable:

- to give protection to the patient's right to refuse unwanted medical treatment;
- to give protection to medical practitioners who act in good faith in accordance with a patient's express wishes;
- to recognise the difficult circumstances that face medical practitioners in advising patients and providing guidance in relation to treatment options;
- to state clearly the way in which a patient can signify his or her wishes in regard to medical care;
- to encourage community and professional understanding of the changing focus of treatment from cure to pain relief for terminally ill patients;
- to ensure that dying patients receive maximum relief from pain and suffering;
- to preserve the dignity of those who are terminally ill.

The Liberal Government is currently working towards a set of "dying with dignity" guidelines<sup>98</sup> and the Labor Opposition has a "right to die" proposal in its law reform options paper.<sup>99</sup>

**(v) Western Australia**

In 1988 the Western Australian Law Reform Commission was given a reference:

to review the criminal and civil law so far as it relates to the obligations to provide medical or life supporting treatment to persons suffering conditions which are terminal or recovery from which is unlikely and in particular to consider whether medical practitioners or others should be permitted or required to act upon directions by such persons against artificial

<sup>98</sup> 'Rights of Tasmanian patients to be spelt out in month', *Examiner*, 26 May 1995.

<sup>99</sup> 'Reforming Tasmania's Laws for the 21st Century: An Options Paper', Parliamentary Labor Party, February 1995, pp 38-40.

prolongation of life.<sup>100</sup>

A Report, *Medical Treatment for the Dying* was produced in 1991 and recommended legislation broadly modelled on the Victorian *Medical Treatment Act*. To date none of the recommendations have been acted upon. However a Private Member's Bill, *Medical Care of the Dying Bill 1995* [see Appendix 12] implementing part of the Law Reform Commission's recommendations, was introduced in May this year.<sup>101</sup>

This Bill is for:

An Act to affirm and protect the rights of terminally ill persons to refuse unwanted medical treatment, to protect medical practitioners and for related purposes.

(vi) ACT

In 1993 a Private Member's Bill, the *Voluntary and Natural Death Bill*, was introduced into the Legislative Assembly.<sup>102</sup> [See Appendix 13].

It contained provisions enabling a competent adult suffering from a terminal illness to make a direction that a death-inducing drug be administered or provided to him or her. The Bill, which would have made active voluntary euthanasia lawful in specified circumstances, was referred to a Select Committee which recommended that it not be proceeded with and that the chair of the Select Committee be given leave to bring in a Bill with respect to the withholding or withdrawing of medical treatment.<sup>103</sup>

Such a Bill was introduced and the *Medical Treatment Act*, modelled on the Victorian legislation, was passed in 1994 [See Appendix 14]. Under this Act a competent adult may make a direction refusing medical treatment or for its withdrawal. This direction, which applies only to a current condition, may relate to general medical treatment or medical treatment of a particular kind. A competent adult may also grant a medical power of attorney, conferring on another person the power to consent to the withdrawal or withholding of medical treatment if he or she becomes incapacitated. This Act also guarantees the right of patients to receive relief from pain and suffering to the maximum extent that is reasonable in the circumstances.

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<sup>100</sup> Law Reform Commission of Western Australia, *Report on Medical Treatment for the Dying*, Project No 84, February 1991, p 1.

<sup>101</sup> WAPD, LA, Hon Ian Taylor, 24 May 1995, p 4062.

<sup>102</sup> ACTPD, LA, Mr Moore, 16 June 1993, p 1878.

<sup>103</sup> Legislative Assembly for the ACT, Select Committee on Euthanasia, Report: Voluntary and Natural Death Bill 1993, March 1994.

The Independent Member, Mr Michael Moore MLA, intends to introduce another Private Member's Bill on voluntary euthanasia, incorporating aspects of the Northern Territory legislation for debate later this year.<sup>104</sup>

### (vii) Queensland

There appears to have been no specific legislation introduced to date and from recent comments made by the Attorney-General of the day the "issue of euthanasia is not on the Government's agenda".<sup>105</sup> However the recently amended *Criminal Code* contains a provision relating to surgical operations and medical treatment (Section 82) which may, it has been suggested, permit euthanasia.[See Appendix 15].

The current wording of the Section differs from that suggested by the Criminal Code Review Committee in its Final Report.<sup>106</sup> The Committee recommended that palliative care be dealt with in the following way:

A person is not criminally responsible if he or she gives such palliative care as is reasonable in the circumstances, for the control or elimination of a person's pain and suffering even if such care shortens that person's life, unless the patient refuses such care.<sup>107</sup>

Mr Rob O'Regan QC, a lawyer who worked on the Criminal Code Review Committee argues that with the revised wording in Section 82 "the Goss Government has opened the door to legal euthanasia ...".<sup>108</sup>

Under this Section a person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation or medical treatment ... if performing the operation or providing the medical treatment is reasonable having regard to the patient's state at the time and all the circumstances. "Medical treatment" is then defined to include pain relief and "providing medical treatment" to include withdrawing medical treatment. Mr O'Regan states that this provision means Queensland doctors will not be criminally negligent if they withdraw medical treatment for a patient's

<sup>104</sup> 'Passing of Bill forces States to tackle issues', *The Australian*, 26 May 1995.

<sup>105</sup> 'The new disciples of death', *The Australian*, 27 May 1995.

<sup>106</sup> Final Report of the Criminal Code Review Committee to the Attorney-General, June 1992, p 56.

<sup>107</sup> This provision was based on a similar recommendation made by the Law Reform Commission of Canada in its 1987 revision of the Canadian Criminal Code. The Queensland Committee was of the view that such a justification is appropriate if the provision of such palliative care to control or eliminate pain and suffering meets the objective standard of being reasonable in the circumstances, *ibid*, p 195.

<sup>108</sup> David Fagan, 'QC attacks 'simplistic' Criminal Code draft', *The Australian*, 7 June 1995.

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benefit and "... creates a possibility of legalised euthanasia".<sup>109</sup>

It should be pointed out however that the Minister for Justice and Attorney-General said during the Parliamentary Debate on the *Criminal Code* that:

In order to further clarify the intention of the Parliament I put into the Explanatory Note an additional page. That page said that it is not the intention of this Parliament by this provision [section 82] to legalise euthanasia and there is no intention in this Parliament to diminish the force of existing prohibitions against euthanasia ... if there is any member of this Parliament who, by this section, wishes to legalise euthanasia and wishes this Bill here and now to legalise euthanasia, let them now speak. Let the Hansard record show that no member of this House spoke. Let the Hansard record show that the intention of this Parliament is translucently clear.<sup>110</sup>

#### (viii) New South Wales

In 1990 a Discussion Paper entitled *Proposed legislation to give legal effect to directions against artificial prolongation of the dying process* was circulated by the Department of Health. The proposal being put forward was the introduction of legislation similar to the South Australian *Natural Death Act 1983*, which would permit terminally ill patients in NSW hospitals to request that they not be resuscitated or kept alive by artificial means.<sup>111</sup> Unexpected opposition from doctors' groups led to the hosting of a Forum on Natural Death in June 1991. At this forum the AMA argued that little support existed for a general legislative solution to the problems, but a need to develop guidelines to assist in the management of dying patients was identified.<sup>112</sup> In July 1991 the then Minister for Health and Community Services, Hon J Hannaford, announced that the foreshadowed legislation would not be introduced.<sup>113</sup>

In 1993 after a process of consultation with medical and community groups the Health Department issued interim guidelines for the management of the dying patient to be used throughout the NSW Health System - *Dying with Dignity: Interim Guidelines on Management* [see Appendix 16]. These cover issues such as: advance directives; the patient's wishes regarding life supporting treatment and resuscitation; the nomination by the patient of an advocate, that is a person familiar with the patient's views and

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<sup>109</sup> Ibid.

<sup>110</sup> QPD, 16 June 1995, p 12702.

<sup>111</sup> 'NSW backs death with dignity', *Sydney Morning Herald*, 17 August 1990.

<sup>112</sup> M Chiarella, 'Dying with dignity' (June 1993) 1(9) *Australian Health Law Bulletin* 93-103.

<sup>113</sup> 'Plans for natural death bill shelved', *Sydney Morning Herald*, 26 July 1991.



philosophies who can speak on behalf of the patient; and for the patient's wishes to be documented in his or her medical records.

While many important issues are covered by these guidelines, they remain only guidelines in relation to the care of the dying.

Following the passage of the Northern Territory *Rights of the Terminally Ill Act 1995*, the Hon. Paul O'Grady, MLC, obtained party support on 30 May to introduce a Private Member's Bill "for an Act which provides for regulation to protect medical practitioners who assist the terminally ill to end their lives".<sup>114</sup> On 31 May 1995 the Leader of the Opposition and the Leader of the National Party indicated that they would permit Coalition MPs a conscience vote on a planned Bill to legalise euthanasia.<sup>115</sup>

On 27 June 1995 the Aids Council of New South Wales (ACON) launched a *Voluntary Euthanasia Bill*, [see Appendix 17] which they would like to see adopted. According to Bruce Meagher, President of ACON:

the Bill was developed after extensive consultation with community groups. It will enable competent adults who are terminally ill or who have a serious physical condition or illness which causes them unacceptable pain or distress to end their lives with dignity. Most importantly, the Bill will allow people to make an informed and legal choice between all health care options: therapeutic care, withdrawing from care, palliative care and voluntary euthanasia.<sup>116</sup>

While many aspects of this Bill are similar to provisions contained in the Northern Territory legislation, some differences are:

- the Bill refers to "a person" not "a patient";
- it would apply to those informed by a medical practitioner that they have a terminal illness and are likely to die within 12 months as a result of the illness. (The Northern Territory legislation does not specify a time frame.)
- it would also apply to a person who has a serious physical condition or illness which causes unacceptable pain or distress, who has been advised by a medical practitioner that (i) the condition or illness is unlikely to improve significantly with treatments reasonably available and acceptable to the person and (ii) that the medical practitioner is of the opinion that the person is unlikely to experience a

<sup>114</sup> 'Way cleared for a vote on euthanasia', *Sydney Morning Herald*, 31 May 1995.

<sup>115</sup> 'Libs' euthanasia conscience vote', *The Australian*, 1 June 1995.

<sup>116</sup> Press Release, ACON, 'ACON launches Euthanasia Bill', 27 June 1995.

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significant improvement in his or her quality of life. (The Northern Territory legislation applies only to those with a terminal illness.) However, a person with an emotional or psychiatric condition or illness or with intellectual disabilities cannot access the Bill on the ground of any of those conditions.

- if the person seeking assistance under this legislation were physically unable to administer the substance him or herself, he or she would be able to nominate a person to administer the substance. (The Northern Territory legislation only permits a medical practitioner or the patient to administer the substance.)
- although a second medical opinion is required, the second medical practitioner need only be a psychiatrist if a person requesting assistance does so on the grounds of a serious physical illness or condition. In the case of a person with a terminal illness, the second medical practitioner must have experience in diagnosis and treatment of the particular disease. (As the Northern Territory legislation only provides for assistance in the case of a terminal illness, the second opinion must always be that of a medical practitioner who holds a diploma of psychological medicine or its equivalent.)
- for a person with a terminal illness, the initial request for assistance must be confirmed at least 14 days after the initial request. For a person with an unacceptable quality of life, the confirmation period is 90 days after the initial request. (The Northern Territory has a mandatory "cooling off" period of seven days from the time the patient informs the medical practitioner of the wish to end his or her life before the patient can complete a certificate of request. There is a second cooling off period after the certificate of request has been signed. It cannot be acted upon for at least 48 hours after the certificate has been completed.)
- "voluntary euthanasia" to be recorded on the death certificate as the primary cause of death and the antecedent condition(s) as the secondary cause. (Northern Territory legislation does not specifically address this issue.)
- a medical practitioner who provides assistance under this legislation is to send relevant documentation to the coroner, who is to report annually to the Attorney-General on the number of deaths. The Attorney-General is then to report this figure to Parliament. The Minister for Health is to provide a more comprehensive report to Parliament annually. This report would look at the number of deaths by Area or District Health service region, by antecedent causes in relation to such deaths and would present details on palliative care services offered within each Area or District. (The Northern Territory legislation requires the coroner to report the number of deaths to the Attorney-General, who is then to report this figure to the Parliament. However, the coroner may exercise his or her discretion to report at any time to the Attorney-General on the operation of the legislation. The Attorney-General is then to table a copy of the report within 3 sitting days of the Legislative Assembly.)

- it includes in the immunities an action taken to educate or provide information to people about their rights and entitlements under this proposed legislation. Such action would not come within any of the offences contained in the *Crimes Act 1900*. (This particular issue not addressed in the Northern Territory legislation.)

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## 5 THE LAW RELATING TO EUTHANASIA IN OVERSEAS JURISDICTIONS

### (i) Overview

A useful starting point is the review of assisted suicide and voluntary euthanasia legislation in other countries presented by Judge Sopinka in the Canadian case of *Rodriguez*.<sup>117</sup>

In the introductory statement of this section of the judgment, Sopinka J makes the point that:

A brief review of the legislative situation in other Western democracies demonstrates that in general, the approach taken is very similar to that which currently exists in Canada. Nowhere is assisted suicide expressly permitted and most countries have provisions expressly dealing with assisted suicide which are at least as restrictive as our Section 241, for example, the Austrian *Penal Act 1945* Section 139(b), and the Spanish *Penal Code* Article 409 have virtually identical provisions.

Other relevant legislative examples cited were:

- The Italian *Penal Code of 1930* Article 580 is even more broadly drafted "whoever brings about another's suicide or reinforces his determination to commit suicide or in any way facilitates its commission shall be punished".
- The UK *Suicide Act 1961* punishes "a person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide" - Section 2. (This form of prohibition is echoed in the criminal statutes of all State and Territorial jurisdictions in Australia).

This UK provision was examined by the European Commission of Human Rights in *R v United Kingdom* which was heard on 4 July 1983. At issue was whether Section 2 violated either the right to privacy in Article 8 or the right to freedom of expression in Article 10 of the *Convention for the Protection of Human Rights and Fundamental Freedoms*. The Commission held that the acts of aiding, abetting, counselling or procuring suicide were "excluded from the concept of privacy by virtue of their trespass on the public interest of protecting life". It also upheld the restriction on the applicant's freedom of expression.

Sopinka J then outlines examples of some European countries which have mitigated the prohibitions on assisted suicide.

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<sup>117</sup> *Rodriguez v British Columbia (Attorney-General)* 3 SCR (1993) 519, pp 601-605.

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- In the Netherlands, although assisted suicide and voluntary active euthanasia are officially illegal, prosecutions will not be laid so long as there is compliance with medically established guidelines. (The position in the Netherlands is discussed in further details below at pages 43-46).
  - Certain other European countries such as Switzerland and Denmark emphasize the motive of the assistor in the suicide: the Swiss *Penal Code* Article 115 criminalizes only those who incite or assist a suicide for a selfish motive; the Danish *Penal Code* Article 240 punishes all assistance but imposes a greater penalty upon those who act out of self interest.
  - In France there is no provision of the *Penal Code* which addresses specifically the issue of assisted suicide, but failure to seek to prevent someone from committing suicide may still lead to criminal sanctions under Article 63(2) - (omission to provide assistance to a person in danger) or Article 319 - (involuntary homicide by negligence or carelessness). Moreover, two new articles introduced to the *Penal Code* in 1987 (Articles 318-1 and 318-2), created an offence of provocation of suicide. This offence requires a form of incitement over and above merely aiding in the commission of a suicide.
  - A few American jurisdictions take into account whether the accused caused the victim to commit suicide by coercion, force, duress or deception in deciding whether the charge should be murder, manslaughter or assisted suicide (Connecticut, Maine and Pennsylvania) or whether the person is guilty of even assisted suicide (Puerto Rico and Indiana).

However, the vast majority of those American States, which have statutory provisions dealing specifically with assisted suicide, have no intent or malice requirement beyond the intent to further the suicide, and those States which do not deal with the matter statutorily appear to have common law authority outlawing assisted suicide.

Recent attempts in two States to legalise physician-assisted suicide have been unsuccessful. In November 1991 Washington State voters defeated Initiative 119 which would have legalized physician assisted suicide where two doctors certified the patient would die within six months and two disinterested witnesses certified that the patient's choice was voluntary. In 1992 Proposition 161, which would have legalized assisted suicide in California and which incorporated stricter safeguards than did Initiative 119 was defeated by California voters by the same margin as that in Washington - 54% to 46%. (The judgment in *Rodriguez* was handed down prior to the successful outcome of Ballot Measure 16 put to Oregon voters in November 1994, which is discussed in detail below at pages 46-47).

Sopinka J concludes by saying:

Overall, then, it appears that a blanket prohibition on assisted suicide

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similar to that in Section 241 is the norm among Western democracies, and such a prohibition has never been adjudged to be unconstitutional or contrary to fundamental human rights.<sup>118</sup>

## (ii) Netherlands

While it is commonly said that the practice of voluntary euthanasia is legal in the Netherlands, this is not strictly correct. Euthanasia and assisted suicide remain criminal offences but neither action will be prosecuted if certain conditions are met and safeguards are observed.

Under Article 293 of the Netherlands *Penal Code* euthanasia is clearly defined as a criminal offence: "Anyone who takes the life of another person at that person's explicit and serious request, will be punished with a prison sentence of a maximum of 12 years or a category five fine". Assistance in committing suicide is also defined as a criminal offence under Article 294: "Anyone who deliberately incites another to commit suicide, assists him in so doing or provides the means for him so to do will, if suicide follows, be punished with a prison sentence of a maximum of three years, or a category four fine".

However, Article 40 of the *Penal Code* states: "It is a defence to a criminal charge if the accused was compelled to action by 'force majeure'". The courts have applied this doctrine of "force majeure" or "necessity", when the issue of doctors assisting patients who have requested to die, has been before them. The necessity arises from the doctor having to make a choice between two conflicting and incompatible obligations: on the one hand, the professional duty to relieve a patient's suffering by ending life of unbearable and irreversible suffering and, on the other, the civil duty to respect the law. Since doctors cannot fulfil both duties, the courts have taken the view that doctors who put their duty to their patients first, cannot be held responsible for failing to fulfil their duty as citizens.

Whether common law countries such as Australia would recognize the defence of necessity in such a situation remains to be seen, although it would appear unlikely. Sneiderman and Verhoef in a recent paper on the defence of necessity at common law say:

... the public policy of the common law is that the defence of necessity cannot be allowed to undermine the prohibition against active voluntary euthanasia (or for that matter, physician-assisted suicide). In fact, in none of the small handful of mercy-killing cases against physicians has the accused even raised a necessity defence.<sup>119</sup>

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<sup>118</sup> Ibid, p 605. See Appendix 18 for further details on assisted suicide and euthanasia in foreign jurisdictions.

<sup>119</sup> Cited in the Canadian Senate Report, op cit, p A-125.

*Political and legislative responses*<sup>120</sup>

In recent years, however, there have been various unsuccessful attempts to enact legislation dealing with euthanasia. At the beginning of 1988, there were two draft laws before the Parliament. After the general elections in 1989, a new coalition government was formed, which decided that, prior to enacting any legislation on euthanasia, a national investigation should be conducted.

In January 1990 a commission of inquiry into medical practice with regard to euthanasia (the Rummelink commission) was set up by the Minister for Justice and the State Secretary of Welfare, Health and Cultural Affairs. The Commission was chaired by Professor Rummelink, the then Attorney-General. An independent investigatory team, led by Professor PJ van der Maas, was contracted to conduct a wide-ranging study of the existing situation.<sup>121</sup>

To encourage the co-operation of the Royal Dutch Medical Society, the Ministry of Justice guaranteed legal immunity to participating doctors and agreed to a procedure for notifying euthanasia and assisted suicide. Instead of issuing a declaration of a natural death the doctor was to inform the medical examiner by means of an extensive questionnaire; and the medical examiner was to report to the public prosecutor who reviews the case and decides whether a prosecution should follow.

Information to be provided to the medical examiner included:

- a summary of the history of the illness, indicating among other things the approximate date on which the patient could have been expected to die if the doctor had not intervened;
- an opinion on the seriousness of the request and the likelihood of retraction;
- whether or not there was a codicil - a written advance directive;
- whether the doctor consulted a colleague and, if so, whether the other doctor was a specialist.

Following the recommendations of the Rummelink Committee which reported in September 1991, the government introduced a Bill to give legislative force to the voluntary 1990 guidelines.

This law, which came into force on 1 June 1994, amended the *Burial Act 1955* to specify

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<sup>120</sup> The information in this section of the Briefing Paper is taken from the Canadian Senate Report, *op cit*, pp A127-A130.

<sup>121</sup> See Appendix 19 for further information on the findings of the Rummelink Commission and the Government response.

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the required reporting procedure. Where the correct procedure is followed and the specified criteria fulfilled, a policy of non-prosecution prevails. Reporting is mandatory and a doctor who does not comply can be prosecuted. The substantive and procedural requirements to be met are:

*Substantive*

- the request for euthanasia must come from the patient and be entirely voluntary, well-considered and persistent;
- the patient must have adequate information about his or her medical condition, the prognosis and alternate treatments;
- there must be intolerable suffering with no prospect of improvement, although the patient need not be terminally ill;
- other alternatives to alleviate the suffering must have been considered and found ineffective, unreasonable or not acceptable to the patient.

*Procedural*

- euthanasia must be performed by a doctor who has consulted an independent colleague;
- the doctor must exercise due care, and there should be a written record of the case; and
- the death must not be reported to the medical examiner as a natural death.

It is possible however that even where a doctor is not prosecuted under the *Penal Code*, he or she could be found guilty of bad medical practice by a medical disciplinary court.

Concern has been expressed that, although advocates of euthanasia and assisted suicide insist the practice in the Netherlands is strictly controlled, there is no guarantee that it will not be extended to categories of patients currently beyond the existing guidelines.<sup>122</sup> This concern has been heightened by two cases recently dealt with by the courts, where punishment was not imposed.

In the first a doctor assisted in the suicide of a patient with psychological and emotional suffering, who had no physical disease.<sup>123</sup> Dr Chabot was charged under the Dutch

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<sup>122</sup> B Pollard, "Euthanasia in Holland" (November 1992) 16(2) *Quadrant* 42-46.

<sup>123</sup> 'Dutch face fresh row over mercy-killing policy', *Reuter Newswire*, 16 February 1995, cited in a publication by the Northern Territory Parliamentary Library, 'Euthanasia in the Netherlands', Readings No 1, May 1995.



*Penal Code* with assisting one of his patients to commit suicide. He was convicted by the District Court but this conviction was then quashed by the Court of Appeal, which held that Dr Chabot could avail himself of the defence of necessity. The prosecution appealed to the Supreme Court, which restored the conviction but did not impose any punishment.<sup>124</sup> In the second, a doctor (with the consent of the parents) ended the life of a severely handicapped newborn baby, who was in great pain and only had weeks to live.<sup>125</sup> The District Court ruled that, although Dr Prins was guilty of murder, his action was justified and it therefore convicted him but declined to impose any punishment. However, an appeal to the Supreme Court has been lodged which may result in a different finding.<sup>126</sup>

### (iii) Oregon

At the general election held on 8 November 1994, Ballot Measure 16 [see Appendix 20] was put to the people of Oregon. The question to be answered was: "Shall law allow terminally ill adult patients (Oregon residents) voluntary informed choice to obtain physician's prescription for drugs to end life?". By a margin of 51% to 49%, Oregon voters approved the notion of physician-assisted suicide.

Although the *Oregon Death with Dignity Act* was supposed to take effect on 8 December 1994, a challenge to its constitutionality was brought in the Oregon Federal District Court,<sup>127</sup> and a temporary restraining order was issued. In this case the plaintiffs (two doctors, four terminally ill or potentially terminally ill patients, a residential care facility and individual operators of residential care facilities) are claiming that Measure 16 violates: the Equal Protection and Due Process Clauses of the Fourteenth Amendment; the First Amendment rights of freedom to exercise religion and to associate; and the *Americans with Disabilities Act*. At the time of writing the matter is still before the court. It is anticipated that whichever side loses will appeal to a higher court.

Under the *Oregon Death with Dignity Act*:

- terminally ill, adult Oregon residents may make a voluntary informed choice to obtain from a doctor a prescription for drugs to end their life;

<sup>124</sup> J Keown, 'Physician-assisted suicide and the Duth Supreme Court' (July 1995) 111 *The Law Quarterly Review*, 394-396.

<sup>125</sup> Case cited in a publication by the Northern Territory Parliamentary Library, 'Euthanasia on the Internet', Readings No 3, May 1995.

<sup>126</sup> Ibid.

<sup>127</sup> The original decision in *Gary Lee et al v State of Oregon*, appears in a publication prepared by the Northern Territory Parliamentary Library, 'Readings No 2', May 1995.

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- a "terminal disease" is defined as "an incurable and irreversible disease that will, within reasonable medical judgement, produce death within six months";
  - no details on how "resident" status will be determined are given, for instance, whether a person needs to have lived in Oregon for a specified period of time;
  - the opinion of two doctors is required before the prescription is issued: the attending doctor, who has primary responsibility for the patient and a consulting doctor, who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease;
  - either doctor can refer a patient to "counselling" with a state licensed psychiatrist or psychologist, if it is believed that the patient is suffering from a mental disorder or depression which is causing impaired judgement. In this situation, no medication can be prescribed until the patient is determined not to be so suffering;
  - the patient is required to make both an oral and a written request. No less than 15 days after the original oral request, the patient is to put the request in writing and re-iterate the oral request. At the time of this second oral request, the doctor is to formally offer the patient an opportunity to rescind the request. No less than 48 hours has to elapse before the patient's written request can be acted upon;
  - the patient has the right to rescind the request at any time and in any manner. No medication can be offered to a patient unless the right to rescind has been offered;
  - the patient has the choice of notifying the next of kin of request;
  - only the patient him or herself may administer the medication;
  - health care providers are given immunity from civil and criminal liability or professional disciplinary action for participating in good faith compliance with the Act;
  - doctors are required to maintain substantial medical records and the Health Division shall conduct an annual review of a sample of these records. While the information maintained is not available for public inspection, the Health Division will make available to the public an annual statistical report of the information.

(iv) Canada

On 23 February 1994 a Special Committee of the Senate of Canada was appointed "to examine and report on the legal, social and ethical issues relating to euthanasia and

assisted suicide".<sup>128</sup> In part the impetus for the establishment of this Committee came from decisions handed down by Canadian courts in recent years. Further background details are provided in the Senate Committee Report:<sup>129</sup>

A series of decisions established the right of persons to make some decisions regarding their own medical treatment. Case law strengthened the right of individuals to withhold and withdraw treatment, for example, the 1992 *Nancy B* decision.<sup>130</sup> In that case the Quebec Superior Court granted a competent woman suffering from Guillain-Barre syndrome, an incurable neurological disease which left her incapable of movement, permission to cease treatment with a respirator at a time of her choosing. This ruling by the Court is reflected in the consideration and enactment by most provincial legislatures, that had not already done so, of some form of legislation regarding advance directives, living wills and substitute decision makers.

More recently the focus has been to consider assisted suicide and euthanasia. In 1993 the Supreme Court of Canada in the *Sue Rodriguez* decision<sup>131</sup> canvassed the issue of whether the prohibition in the *Criminal Code* against assisted suicide violates the *Canadian Charter of Rights and Freedoms*. The majority of the Court upheld the prohibition but the public debate continues.

The Report was tabled on 6 June 1995. Listed below are some of the key recommendations:<sup>132</sup>

- the *Criminal Code* should be amended to recognize and clarify the circumstances in which the withholding and withdrawal of life-sustaining treatment is legally acceptable;
- those provinces and territories that do not have advance directive legislation should adopt such legislation;
- there should be no amendments to the offence of counselling suicide;

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<sup>128</sup> Senate of Canada, Report of the Special Senate Committee on Euthanasia and Assisted Suicide, op cit, p 2.

<sup>129</sup> Ibid, p 1.

<sup>130</sup> *Nancy B. v Hotel-Dieu de Quebec et al.* 86 DLR (4th) 385.

<sup>131</sup> *Rodriguez v British Columbia (Attorney-General)* 3 SCR (1993) 519.

<sup>132</sup> Ibid, p ix-xi. See Appendix 21 for the full list of recommendations made by the Senate Committee.

- non-voluntary euthanasia should remain an offence;
- the *Criminal Code* should be amended to provide for a less severe penalty in cases where there is the essential element of compassion or mercy. Parliament should consider the following options:
  - a third category of murder could be created that would not carry a mandatory life sentence but rather would carry a less severe penalty; or
  - a separate offence of compassionate homicide could be established that would carry a less severe penalty.
- voluntary euthanasia should remain a criminal offence but the *Criminal Code* should be amended to allow for a less severe penalty similar to that provided for non-voluntary euthanasia in cases where there is the essential element of compassion and mercy; and
- the prohibition against involuntary euthanasia should continue under the present murder provisions in the *Criminal Code*.

#### (v) United Kingdom

As early as 1936 a Bill based on efforts of the Voluntary Euthanasia Legalisation Society was introduced into the House of Lords.<sup>133</sup> This Bill would apply to patients over 21, who were suffering from an incurable and fatal disease which was accompanied by severe pain. Any question of compulsory euthanasia was excluded.<sup>134</sup> It included a number of safeguards: the patient would have to sign a statutory form, in the presence of two witnesses, requesting euthanasia; the form, accompanied by two medical certificates would be sent to an official euthanasia referee, appointed by the Minister for Health, who interviews the patient and makes sure that patient really wants it. Then euthanasia would be administered in the presence of an official witness, namely a justice of the peace, a barrister, a solicitor, a doctor, a minister of religion or a registered nurse.<sup>135</sup> The Bill was, however, unsuccessful. Over the years other unsuccessful attempts have been made to introduce legislation permitting voluntary euthanasia.

In early 1993 a Select Committee of the House of Lords was appointed to consider:

- the ethical, legal and clinical implications of a person's right to withhold consent to life-prolonging treatment, and the position of persons who are no longer able to

<sup>133</sup> G Williams, *The Sanctity of Life and the Criminal Law*, London 1958, Chapter 8 - "Euthanasia", pp 277-312.

<sup>134</sup> *Ibid*, p 297.

<sup>135</sup> *Ibid*, p 298.

give or withhold consent;

- whether, and in what circumstances, actions that have as their intention or a likely consequence the shortening of another person's life may be justified on the grounds that they accord with that person's wishes or with that person's best interests; and
- in all the foregoing considerations to pay regard to the likely effects of changes in law or medical practice on society as a whole.<sup>136</sup>

In essence the Committee recommended that the law should not be amended to permit voluntary euthanasia or assisted suicide.<sup>137</sup>

#### (vi) In summary

It is evident from the information presented above that a variety of options exist, both in Australia and overseas, to deal with the issue of euthanasia and/or physician assisted suicide. These options fall essentially into two categories - legislative or non-legislative.

#### Legislative options

Many proponents of euthanasia and physician assisted suicide argue that, as these practices already occur in Australia, there is much to be said for bringing them into the open by defining circumstances in which they can lawfully be performed. Establishing a regulatory framework would, they say, provide essential safeguards for the protection of patients and at the same time protect doctors from the risk of prosecution if they have complied with the requirements of the legislation.<sup>138</sup>

This view is by no means universal, with doubt being expressed as to whether adequate safeguards can be expressed in legislation.<sup>139</sup> Another perceived problem is that if the legislation sets down substantive and procedural requirements to be met prior to a medical practitioner assisting a patient to die, any future legal scrutiny may be limited to issues of administrative law only. The focus could shift from whether the particular action taken by a medical practitioner was correct, to whether the procedure had been correctly followed.

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<sup>136</sup> House of Lords, Report of the Select Committee on Medical Ethics, p 7.

<sup>137</sup> During the course of the Committee's enquiry, a Private Member's Bill was introduced - *Termination of Medical Treatment Bill* [HL], HL Bill 70, Session 1992-93, referred to at page 17 of the Committee's Report. See Appendix 22 for a full account of the Committee's recommendations.

<sup>138</sup> M Otlowski, "Law Reform - Euthanasia" (April 1995) 20(2) *Alternative Law Journal* 90-91, p 91.

<sup>139</sup> 'A right to die' (October 1993) 2(3) *Australian Health Law Bulletin*, pp 29-37.

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Even where the legislative solution is chosen, the form that legislation takes will vary depending on whether the fundamental objective is to legalize or decriminalize the particular behaviour or actions. This distinction between legalization and decriminalization is largely a matter of degree. Legalization is a positive action, which permits certain behaviour or actions. Decriminalization, while not sanctioning behaviour or actions, means they do not attract criminal penalties. The question of decriminalization is often raised in the context of issues which touch on the rights of the individual as well as the interests of society at large. A commonly cited example is that of possession of cannabis for personal use. In most Australian jurisdictions this offence attracts a criminal penalty. However, in South Australia, while drug offences such as trafficking or supply continue to attract heavy criminal penalties, possession of cannabis for personal use is punished in a fashion similar to an "on-the-spot" fine. It is possible therefore to enact legislation which does not necessarily legalize or condone a particular practice, but decriminalizes certain behaviour or actions in specified situations.

It should be pointed out that what is actually meant by the term "decriminalization" in the context of euthanasia and assisted suicide varies. It is sometimes used loosely in relation to natural death legislation such as that in existence in South Australia and the Northern Territory which clarifies that a doctor will not be liable for withholding or withdrawing life prolonging treatment. In a situation such as that existing in the Netherlands where certain requirements have been laid down in a government sanctioned policy, it could be said that a form of de facto decriminalization has occurred since failure to comply with those requirements will not necessarily give rise to a criminal penalty. It would appear that the degree of failure to comply influences the penalties which attach. A failure to comply with a procedural requirement, for instance, if seen as minor, may give rise to disciplinary proceedings and/or administrative law actions. However a major failure to comply with substantive requirements, such as the need for a voluntary request to be made before a doctor administers euthanasia, would take away the protection from criminal sanction offered by the guidelines. In such a case it would be open to the public prosecutor to lay criminal charges. The term "decriminalization" is used in a third sense by proponents of euthanasia who argue that an individual should have a general right to request a medical practitioner to assist them in ending their life in certain specified circumstances, and that the subsequent actions of the medical practitioner should not be categorised as criminal.

In its true sense, however, decriminalization does not make an offence a non-offence. It retains the offence but imposes a penalty other than a criminal sanction, as typified by the South Australian approach to cannabis possession. To translate this to the euthanasia context may in practice be difficult. One possible way of achieving such a solution may be to retain euthanasia as an offence but, rather than imposing a criminal sanction, referring doctors found guilty of participating in the practice to a body such as the Medical Tribunal for some form of action.

## Non-legislative options

It is also possible to deal with the matter in a non-legislative way. Again the choice of option would depend on the objective to be achieved. Guidelines such as those currently in place in New South Wales reflect the "decriminalization" position, whereas the policy adopted by the government, the courts and the medical profession in the Netherlands is closer to the "legalization" end of the spectrum. A potential problem with an approach such as that adopted in the Netherlands could be fluctuations in the policy may occur with a change in government, the make up of the courts or those involved in the medical professional organizations.

## The continuum

It can be seen from the discussion above that a mix of legislative and non-legislative options exist along a continuum. These are:

- do nothing

This option maintains the status quo, that is, having no legislation permitting the practice of euthanasia or assisted suicide, where doctors remain faced with potential criminal sanctions for administering euthanasia or assisting a patient to die.

- enacting natural death legislation

This option enshrines in statute the common law right of people to refuse medical treatment which is keeping them alive and would clarify that medical practitioners will not be liable for action taken in such a situation. Victoria, South Australia, Queensland, the ACT and the Northern Territory already have such legislation.

- permitting physician assisted suicide

This option allows a doctor to assist terminally ill patients to end their life by prescribing drugs on request knowing that the patients intend to end their own life. Provided doctors comply with the legislative requirements, no criminal or civil liability nor professional disciplinary action will be incurred. The most significant difference between this option and that available under the Northern Territory legislation is that, in this case, only the patient him or herself may administer the medication.

- amending the *Crimes Act 1900* to deal specifically with euthanasia

This type of approach was one of the recommendations made by the Canadian Special Senate Committee and would provide for a less severe penalty where the essential element of compassion or mercy could be established. The Committee suggested this could be achieved by creating a new category of murder that would not carry a mandatory life sentence or by creating a separate offence of "compassionate homicide" that would carry a less severe penalty. If such an approach were adopted consideration would need to be

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given as to whether it would apply only in situations where a person was terminally ill or whether the concept of "mercy killing" would be available in a wider context.

- adopting a government sanctioned policy permitting euthanasia and/or assisted suicide in specified circumstances

This option is the one adopted in the Netherlands where medical practitioners will not be liable to civil or criminal charges, provided a number of substantive and procedural requirements agreed upon by the government, the courts and the medical profession have been met. Whether there has indeed been the requisite compliance is to be determined by the coroner in the first instance, with each matter then being reviewed by the public prosecutor's office.

- enacting legislation for active voluntary euthanasia

One option is that adopted in the Northern Territory legislation which permits doctors, in certain specified circumstances, to assist people suffering from a terminal illness to terminate their own lives. Similar substantive and procedural requirements to those stipulated in the Netherlands must be met and provided compliance with the legislative provisions are established, no criminal or civil liability or disciplinary action will be incurred.

Another approach is that proposed by the Aids Council of New South Wales, which extends the option outlined above. This option would permit doctors to assist not only those with a terminal illness but also people with a serious physical condition or illness which causes unacceptable pain or distress, that affects their quality of life and which on medical advice is unlikely to improve.

It would of course be possible to enact even broader legislation permitting euthanasia in certain circumstances for instance where seriously handicapped newborns have a limited life expectancy and consent of the parents has been given. At the current stage of the euthanasia debate, however, such proposals are unlikely.



## 6 ARGUMENTS FOR AND AGAINST EUTHANASIA

The main arguments found in the contemporary debate for and against euthanasia are set out below. These arguments are presented here without commentary or analysis. Arguments on behalf of the legalisation of euthanasia are considered first; unless the contrary is stated, in this context the term euthanasia refers exclusively to the active, voluntary euthanasia model adopted in the Northern Territory.

### (i) *Arguments for euthanasia*

- **The argument from mercy:** This is most common argument in support of euthanasia. It says that euthanasia is justified because it puts an end to the terrible suffering sometimes endured by terminally ill patients.<sup>140</sup> In the words of Glanville Williams: "Those who plead for the legalization of euthanasia think that it is cruel to allow a human being to linger for months in the last stages of agony, weakness and decay, and to refuse him his demand for merciful release".<sup>141</sup> To allow a person to suffer, when nothing can be done to relieve the suffering and when the person wants to end his or her suffering, is inhumane.

Another aspect to the argument from mercy, though not so compelling as the first, is the anguish suffered by relatives and friends in seeing their loved one in a desperate plight.

- **Preserving human dignity:** Due to advances in modern medicine, many individuals find themselves facing a prolonged disintegration of their self-integrity, physically and psychologically, without any hope of cure. In such circumstances, an individual should have the choice to avoid the suffering entailed, thereby preserving their right to dignity. The appellant in the *Rodriguez* case argued in these terms. She was a 42 year old woman, suffering from amyotrophic lateral sclerosis who, at the time of the hearing, had between 2 and 14 months to live. She would soon lose the ability to swallow, speak, walk and move her body without assistance. Her plea was to be allowed to die by a form of physician assisted suicide when she was no longer able to enjoy life. To do otherwise, she claimed, would be to submit her to needless suffering and to rob her of her dignity. She envisaged a time, therefore, when her life would not be worthwhile. This is not to say that her life would be valueless, but that it would be unendurable. Nor is it to say that palliative care is not important; rather, it asserts that there will be times when the alleviation of pain is not enough.
- **Autonomy and self-determination:** A society such as ours is based on the notion that individuals have the freedom and right to make self-governing choices. Individuals should only be denied freedom of action by the state when there is

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<sup>140</sup> J Rachels, op cit, p 152.

<sup>141</sup> AB Downing and B Smoker, op cit, p 156.

demonstrable harm to others. In a liberal society it is not legitimate to restrict one person's liberty merely because his or her action conflicts with somebody else's moral code; for Helga Kuhse there must be "a clear dividing line between the sphere of private morality and the sphere of public policy and the law".<sup>142</sup> As autonomous, self-determining beings we have a right to choose our own death.

Against those who argue that a commitment to personal autonomy leads to an isolationist and antisocial individualism, it is said by Max Charlesworth: "Autonomy does not mean that I cannot take advice from others about my life and death or defer to others' opinions, or entrust myself to their care and compassion. It means, however, that in the last resort it is I, this autonomous agent, who has to make such decisions". Charlesworth goes on to quote Dworkin to the effect that: "Making someone die in a way that others approve, but he regards as a horrifying contradiction of his life, is a devastating, odious form of tyranny".<sup>143</sup> Euthanasia is right in principle in a secular, pluralistic society founded on liberal values.

- **Respect for the autonomy of others:** Moreover, it is argued that assertion of a patient's right to autonomy would not contradict or conflict with the equivalent freedom of action of health care professionals. The point is that, so long as the principle of autonomy is adhered to, a patient's right to self-determination cannot require doctors or other health care professionals to participate in practices against which they have grave moral or religious objections. As the Royal Australasian College of Physicians stated in its 1993 issues paper canvassing the arguments for and against voluntary euthanasia, "If voluntary euthanasia were to be legalised, the only moral and professional duty a doctor opposed to euthanasia would have would be to advise the patient requesting it of his or her professional objection to the practice".<sup>144</sup>

Another perspective on the doctor/patient relationship is that the right to die with dignity may also enhance the doctor's own liberty or self-determination. Glanville Williams explains: "It is the doctor's responsibility to do all he can to prolong worth-while life, or, in the last resort, to ease his patient's passage. If the doctor honestly and sincerely believes that the best service he can perform for his suffering patient is to accede to his request for euthanasia, it is a grave thing that the law should forbid him to do so".<sup>145</sup>

<sup>142</sup> H Kuhse (ed), *Willing to listen - wanting to die*, Melbourne 1994 p 250.

<sup>143</sup> *Ibid*, p 209.

<sup>144</sup> The Royal Australasian College of Physicians, *Ethics: Voluntary Euthanasia*, Sydney 1993, p 16. It seems the College does not have a formal view on euthanasia.

<sup>145</sup> AB Downing and B Smoker eds, *op cit*, p 157.

- **Euthanasia is practised now:** The claim is often made that euthanasia is practised now.<sup>146</sup> Peter Baume reports that surveys have shown clearly that a minority of medical practitioners (about 14 per cent) will admit in writing to practising active voluntary euthanasia, that most of these have carried out active voluntary euthanasia more than once, and that most felt that they had "done the right thing".<sup>147</sup> The empirical field work undertaken by Helga Kuhse and Peter Singer is often cited in this context. For example, David Kelly,<sup>148</sup> former Chairman of the Victorian Law Reform Commission, notes that in 1987 Kuhse and Singer conducted a questionnaire survey of 2000 Victorian doctors. 869 doctors returned the questionnaire (a 46% response rate): 60% said that the law should be changed to allow doctors to take active steps to end a patient's life in some circumstances, with 59% favouring the Netherlands approach; 40% said that they had been asked to hasten death; and 12% claimed to have taken active steps in response.<sup>149</sup> In 1993 they also investigated the opinions of nurses on voluntary euthanasia. Questionnaires were sent to 1942 registered nurses in Victoria; 943 responded (a 49% response rate). Of these: 78% said that new laws should be introduced allowing doctors to end the life of a patient who wanted to die; 65% indicated that they would be willing to collaborate with doctors in the provision of active voluntary euthanasia; many nurses said they had collaborated with doctors in the provision of active voluntary euthanasia; and a few had acted without consulting a doctor.<sup>150</sup>

In the light of such findings, it is said that to relax the law to allow euthanasia in certain circumstances would allow humane decisions to be made by patients and practitioners. Also, it would allow for a clear statement of what is acceptable practice and what is not. Lach has argued that the decision would thereby be taken out of the hands of private individuals and placed in the public arena where it can be the subject of proper scrutiny and accountability.<sup>151</sup>

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<sup>146</sup> On 25 March 1995 a group of doctors admitted they had practised euthanasia in an open letter to the Victorian Premier, which was published on the front page of *The Age* newspaper.

<sup>147</sup> P Baume, "Voluntary Euthanasia - Mercy or Sin?" (Winter 1995) 63 *New Doctor* 13-14, p 13.

<sup>148</sup> D Kelly. "Treating the Dying - Emerging Issues" (1994) 12(3) *Bioethics News* 37-46.

<sup>149</sup> H Kuhse and P Singer, "Doctors' Practices and Attitudes Regarding Voluntary Euthanasia" (1988) 148 *Medical Journal of Australia* 623-627.

<sup>150</sup> H Kuhse and P Singer, "Voluntary Euthanasia and the Nurse: an Australian Study" (1993) 30(4) *International Journal of Nursing Studies* 311-322.

<sup>151</sup> J Lach, "Active Euthanasia" (1990) 1(2) *Journal of Clinical Ethics* 113-115.

Further, it is argued that it is wrong to suggest that the status quo should be maintained when this involves the intentional disregard of the law. Michael Eburn states: "It is bad law, however, where the law is ignored and where the law does not in fact represent the desire of the people living under the law. If we accept that the assistance is given, and that it is right and proper that such assistance is given, then it is not good enough for the law to prohibit such behaviour and 'turn a blind eye' to illegal activity".<sup>152</sup>

- **Disingenuous distinctions:** It is said that the distinctions used in the debate between killing and letting die, acts and omissions, active and passive euthanasia, as well as the terminology of direct as against indirect termination of life and intending as opposed to foreseeing death are all highly problematic, leading to disingenuous, illogical and artificial arguments designed, in effect, to permit euthanasia in some circumstances but not in others. Such distinctions operate as legal and moral camouflage, owing much at times to convenience and little to principle.<sup>153</sup> It is better to make an honest, forthright statement of approval of euthanasia and the specific circumstances in which it is permissible.
- **Debunking misleading claims:** Many of the arguments and much of the evidence put forward by the opponents of euthanasia is simply spurious, it is claimed. This is particularly true of the way that the experience with the de facto decriminalisation of euthanasia in the Netherlands is reported: that it is used as an easy option by doctors; that it confirms the slippery slope argument; and that it has resulted in a failure to commit resources to palliative care. The advocates of euthanasia dispute such claims, saying that they misinterpret the findings of the Rummelink Report: they are based "on some very muddle-headed thinking or on a deliberate distortion of facts". For instance, Pieter Admiraal, a senior anaesthetist in the Netherlands writes: "While we have only two hospices, which cater specifically for those who are dying, we have integrated palliative care into the delivery of health care as a whole"<sup>154</sup>

In regard to the Rummelink Report, Peter Singer maintains that it cannot be used to support the slippery slope argument: "the Dutch figures cannot possibly show an 'increasing practice' of anything, because to show that we would need figures from two different years, preferably separated by a substantial gap. No such figures exist. The authors of the Dutch study are therefore surely right when they say, after discussing attempts to use their study as a basis for a slippery-slope argument, 'We conclude that no empirical data can be marshalled to support the

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<sup>152</sup> M Eburn, op cit, p 42.

<sup>153</sup> The arguments are canvassed by D Lanham, op cit, p 159.

<sup>154</sup> H Kuhse ed, op cit, p 237 and p 257. On the issue of palliative care in the Netherlands please refer to Appendix O of the Canadian Senate Report of the Special Senate Committee on Euthanasia and Assisted Suicide.

slippery slope argument against the Dutch'.<sup>155</sup>

Writing against the use of the slippery slope or "wedge" argument generally in the context of the euthanasia debate, Glanville Williams has said: "It is the trump card of the traditionalist, because no proposal for reform, however strong the arguments in its favour, is immune from the wedge objection".<sup>156</sup> Stated in this way, the slippery slope argument is a form of intellectual obstructionism, the logical implication of which is that you must resist every proposal, however admirable in itself, because otherwise you will never be able to draw the line. Williams counters this approach with the view that in liberal democratic countries issues are debated on their merits; in practical political terms, lines are in fact drawn between what is acceptable and what is unacceptable practice in all sorts of legal and moral hard cases. Seen in this light, the prospect of euthanasia opening the door to Nazi experimentation or whatever is misleading to the point of ridiculousness.

Further, Pieter Admiraal seeks to correct the "misleading" claim that modern methods of pain control will obviate the need for active voluntary euthanasia. In around 5% of cases pain cannot be controlled and in some cases it can only be controlled by rendering the patient unconscious. Also, in his experience in only around 5% of cases was pain the sole reason for patients requesting euthanasia: other reasons included loss of strength, dignity and complete dependence on others. He notes, too, that even the best of palliative care cannot alleviate all suffering or make it bearable.<sup>157</sup>

- **Public support for change:** The argument is put that there is a sizeable proportion of the community in favour of some kind of euthanasia legislation. A Time Morgan Poll published in June 1994 found that 71% of Australians believed that a doctor should allow a hopelessly ill patient in great pain to die; whereas 78% believed that, if a patient in great pain and with absolutely no chance of recovery asks for a lethal dose, a doctor should be allowed to administer it.<sup>158</sup> A Herald-AGB McNair Poll published in June 1995 found that, in NSW, 77% would support the introduction of euthanasia legislation; that level of support was similar among backers of different political parties and across the States and Territories - 78% in Tasmania; 77% in NSW, Victoria and Western Australia; 72% in Queensland; 71% in South Australia and the Northern Territory; and 67% in the ACT. Those over 55 expressed the lowest rate of support for euthanasia legislation, but even then it stood at 70%; those aged between 25 and 39 expressed

<sup>155</sup> P Singer, *op cit*, p 153.

<sup>156</sup> AB Downing and B Smoker eds, *op cit*, p 165.

<sup>157</sup> H Kuhse ed, *op cit*, pp 237-238.

<sup>158</sup> "Most Accept Euthanasia", *Time*, 4 July 1994.

the strongest support for (80%) and the least opposition to (13%) euthanasia legislation.<sup>159</sup>

(ii) *Arguments against euthanasia*

- **Religious objections:** The basic argument is that euthanasia in all its forms contradicts the principle of the sanctity of human life. The 1980 Declaration on Euthanasia of the Catholic Church rejected euthanasia on these grounds. The Declaration holds that doctors must not terminate the life of a dying patient, whether at his or her own request or out of pity. To do so would violate fundamental tenets of divine law and would constitute a crime against life itself.<sup>160</sup>

It is argued that Christianity, Judaism, Islam and Buddhism all proscribe intentional killing, and do not tolerate a doctor deliberately killing a patient by whatever means, act or omission.<sup>161</sup>

- **A critique of the liberal ideal of autonomy:** The Royal Australasian College of Physicians notes that the philosophical objections to euthanasia have been set out by Daniel Callahan, the Director of the Hastings Center. He contends that the central argument based on respect for autonomy fails to recognise that there are limits to self-determination. While conceding that a person may have a moral right to commit suicide, he asserts that this does not give the doctor or anyone else the moral right to kill the patient. He does not accept that we can waive our right to life and then give to another the power to take that life. Callahan also questions the nexus between autonomy and the maximisation of well-being (relief of suffering). What, he asks, is the position when a person who is competent but not suffering requests euthanasia? And what of the person who is not competent but is suffering? In other words, if autonomy is all-important what has suffering to do with it? And if suffering is all-important what has autonomy got to do with it?<sup>162</sup>

Elsewhere the secular objections to the liberal ideal of autonomy have been summed up in these terms: "certain political philosophers claim that no one is really capable of the kind of autonomy and self-determination required by the

<sup>159</sup> "Mercy Killing Favoured by Most", *The Sydney Morning Herald*, 7 June 1995.

<sup>160</sup> It should be noted, however, that according to the Declaration a patient has the right to refuse medical treatment: Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Vatican City 1980.

<sup>161</sup> D Phillips ed, "Australian Festival of Light Resource Paper: Doctors of Death? The Euthanasia Debate" (May 1995) *Light* 9. It notes that Anglican, Catholic, Lutheran and Uniting Churches in South Australia issued a joint statement on 9 March 1995 opposing an attempt to legalise euthanasia in that State.

<sup>162</sup> The Royal Australasian College of Physicians, op cit, p 24.

protagonists of liberalism, and further that the so-called liberal society is based upon atomistic individualism which allows no scope for community life".<sup>163</sup> Basically, the objection is that the liberal ideal of autonomy is a fiction and that its limits and problems need to be understood if the arguments for and against euthanasia are to be assessed properly.

For Brian Pollard, one paradox of the self-determination argument is that "A decision to kill a person on request will be a separate autonomous decision, and it alone will determine whether euthanasia ever takes place. Thus, the incidence of euthanasia has little to do with the autonomy of the one who asks and always depends on the autonomy of the provider".<sup>164</sup>

- **Maintaining in the social interest the prohibition against intentional killing:** The House of Lords Select Committee on Medical Ethics said that society's prohibition of intentional killing is the cornerstone of law and social relationships: "It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. Moreover, dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole".<sup>165</sup>
- **The slippery slope:** This maintains that advocates of legalised active voluntary euthanasia invariably frame their proposals so that they only apply to a very narrow range of cases; further, they claim that acceptance of their proposal will not lead to the approval of any other types of euthanasia, notably the forms of non-voluntary euthanasia discussed above. But in fact, the argument continues, if voluntary euthanasia is accepted then we will invariably be pushed to accept the legalisation of those forms of non-voluntary euthanasia as well. Rachels, an advocate of voluntary euthanasia, concedes that this is "probably true".<sup>166</sup> Indeed, it is noteworthy that most of those who advocate euthanasia, based on deep philosophical reflection, in fact advocate both active, voluntary euthanasia and, in certain circumstances, non-voluntary euthanasia: Dworkin, Glover and Rachels can all be included here. In other words, it can be argued that the logic of

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<sup>163</sup> H Kuhse ed, op cit, p 205.

<sup>164</sup> B Pollard, op cit, p 78.

<sup>165</sup> House of Lords, Report of the Select Committee on Medical Ethics, op cit, p 48.

<sup>166</sup> J Rachels, op cit, pp 179-180.

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voluntary euthanasia leads inevitably to an acceptance of non-voluntary euthanasia.

On the theme of securing limits, the House of Lords Select Committee on Medical Ethics concluded that it is not possible to set secure limits on voluntary euthanasia, stating: "issues of life and death do not lend themselves to clear definition, and without that it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused. Moreover to create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence, or by the human tendency to test the limits of any regulation".<sup>167</sup> In effect, the concern is that one cannot quarantine non-voluntary euthanasia from voluntary euthanasia.

One difficulty is that the terms of the debate need only be shifted very slightly for euthanasia to apply to a wide range of people. For example, if the complex argument for *dignity* is construed as an argument against an *undignified* existence then the case for euthanasia could apply to any number of categories of persons: the old; the infirm; severely handicapped new born infants. It is said in this regard that the worrying thing about the euthanasia debate is that arguments are put forward for killing people who are not necessarily suffering from pain but appear to have miserable, poor quality, meaningless lives. One health professional working in the field of mental health services for the elderly has commented: "This applies particularly to those labelled as suffering from one of the dementias. It is said that they end up as vegetables, lacking all human feelings or experiences. This is arrogant human stupidity. All of us, until we are dead, experience something of being a human being, and quality of life is not something that others can judge".<sup>168</sup> In a similar vein, Archbishop Keith Rayner has expressed his fears that a different agenda lies behind the argument for voluntary euthanasia: "He feared that once the principle of active euthanasia was accepted for those suffering pain, it would soon be extended to other categories, such as the increasing number of long-term geriatric patients who already posed a problem in a vexed debate between 'quality of life' and 'sanctity of life'".<sup>169</sup>

The idea that there is such a thing as "a life not worthy to be lived" had a powerful influence on Nazi thought and practice, resulting in a series of escalating measures through the 1930s and 40s, beginning with compulsory sterilisation for people with hereditary medical conditions and culminating in the extermination of

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<sup>167</sup> House of Lords, Report of the Select Committee on Medical Ethics, op cit, p 49.

<sup>168</sup> T Whitehead, "Variations on the Theme of Euthanasia" (1994) 164 *British Journal of Psychiatry* 131.

<sup>169</sup> "Archbishop Backs Keating on President", *The Australian*, 4 July 1995.



whole races.<sup>170</sup> One version of the slippery slope argument says that the legalisation of voluntary euthanasia will set us on a road down which the value of the lives of different categories of persons is calculated in terms of "more or less". Ultimately, some people may be judged to have a life not worthy to be lived. By this means, legalisation of voluntary euthanasia may open the way to involuntary euthanasia, haunted as this is by the spectre of Nazi extermination.<sup>171</sup>

- **Vulnerable people and economic considerations:** There is the claim that the euthanasia debate conceals, under the cloak of the best interests of the patient, a hidden agenda in support of the best interests of the community, expressed in terms of the efficient allocation of scarce economic resources. Lord Mustill observed in the *Bland* case: "Threaded through the technical arguments addressed to the House were the strands of a much wider position, that it is in the best interests of the community at large that Anthony Bland's life should now end. The doctors have done all they can. Nothing will be gained by going on and much will be lost. The distress of the family will get steadily worse...The large resources of skill, labour and money now being devoted to Anthony Bland might in the opinion of many be more fruitfully employed in improving the condition of other patients, who if treated may have useful, healthy and enjoyable lives for years to come".<sup>172</sup> As Lord Mustill noted, this argument (which he rejected) was only hinted at, never squarely put. From the standpoint of Archbishop Rayner, it is precisely this kind of thinking which sets the euthanasia debate on the slippery slope, extending its ambit, by apparently rational means, to include various categories of vulnerable people.
- **Vulnerable people and the problem of consent:** The argument is that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death. It is suggested that in some cases pressure might be applied on the patient by his or her relatives, acting from questionable motives. Professor Malcolm Fisher, of the intensive care unit at Sydney's Royal North Shore Hospital, is reported to have said this occurs already in the Netherlands. On the same issue, former AMA President Dr Brendan Nelson has commented: "We will see people who feel pressure to die from a sense of guilt because they are a burden to family and friends, particularly given the depressive nature of a fatal illness".<sup>173</sup>

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<sup>170</sup> R Gott and R Linden, *No Easy Way Out: The Euthanasia Debate*, Melbourne 1993, p 17.

<sup>171</sup> This is discussed in D Lanham, op cit, p 169; see also G Sereny, *Into that darkness: from mercy killing to mass murder*, London 1974.

<sup>172</sup> [1993] AC 789, p 896.

<sup>173</sup> D van Gend, "Painful Arguments in Favour of Euthanasia", *Australian Doctor*, 23 June 1995.

In any case, euthanasia laws may send the wrong message to the vulnerable and disadvantaged, however obliquely, encouraging them to seek death instead of assuring them of our care and support in life.<sup>174</sup>

- **Palliative care:** The provision of adequate palliative care for all who need it should remain as the principal public policy and health care response to those in pain. Palliative care refers to the relief of pain and other physical and psychological symptoms in combination with social support for those experiencing terminal or severe chronic illness. The case for palliative care is made out by Brian Pollard in these terms: "Current standards of palliative care can now relieve most pain, including that due to cancer, or reduce it to levels acceptable to the patient. It is not necessary to take life to control pain. It can also successfully address most of the fear and anxiety due to the illness but cannot, of course, correct those causes of anguish commonly found in people in crisis, due to their personality or circumstances".<sup>175</sup>

Then there is the argument that a "good death", understood in the context of palliative care, can be a positive experience. Caroline Jones writes: "There are many stories of patients, families and carers being transformed by the experience which unexpectedly offered opportunities for reconciliation and a new perspective of what matters in a life well lived, and a good death".<sup>176</sup>

- **Experience in the Netherlands:** Various aspects of the Dutch experiment with the decriminalisation of voluntary euthanasia are cited as empirical evidence of the legal, moral and administrative problems involved in adopting what is said to be a dangerous public policy. Reference is made to the lack of palliative care in the Netherlands and to the potential for abuse. For example, it is reported that Herbert Hendin, Professor of Psychiatry at the New York Medical School, found that most of the key figures involved in the Dutch euthanasia experiment were prepared to concede privately that the Rummelink Report provided evidence of widespread non-voluntary killings of patients.<sup>177</sup> John Keown reached the same conclusion in 1992, stating that euthanasia is being practised in the Netherlands "on a scale vastly exceeding the 'known' (truthfully reported and recorded) cases".<sup>178</sup>
- **Problems of procedure:** David Lanham cites the argument that there would be very real difficulty in devising satisfactory procedural safeguards if active

<sup>174</sup> House of Lords, Report of the Select Committee on Medical Ethics, op cit, p 49.

<sup>175</sup> "The Right to Live", *The Australian*, 3 June 1995.

<sup>176</sup> C Jones, "A Full Life, and a Good Death", *The Sydney Morning Herald*, 5 July 1995.

<sup>177</sup> D Phillips ed, op cit, p 11.

<sup>178</sup> J Keown, "The law and practice of euthanasia in the Netherlands" (January 1992) 108 *The Law Quarterly Review* 51-78, p 78.

euthanasia were legalised. He cites the contention that leaving the safeguards to the ordinary rules of evidence could give rise to massive abuse: "Yet a procedure which made sure that the medical conditions, voluntariness, informed consent and competence were all satisfied could lead to the kinds of delay that the substantive reform would be trying to avoid".<sup>179</sup>

Brian Pollard has said: "In the absence of certainty about coercion and in the uncertain presence of mental illness which is difficult to diagnose, how is it to be decided that the patient's decision is undoubtedly free? It is unlikely that any euthanasia Bill could be safe".<sup>180</sup>

- **The validity of opinion polls questioned:** The majority of the Canadian Special Senate Committee on Euthanasia and Assisted Suicide commented that they were sceptical as to the validity of opinion poll results often cited by witnesses in favour of introducing euthanasia legislation. They said they were concerned with the acceptance of such poll results at face value without close analysis of the questions asked and the knowledge of the respondents with respect to the issues polled. Also, they noted "the confusion as to the terms used".<sup>181</sup>
- **The Hippocratic Oath:** The point is made by several commentators<sup>182</sup> that the foremost rule of medicine dating back 2,500 years to the teachings of the Greek physician Hippocrates, has been that doctors shall not kill. This tenet is reflected in the wording of the Hippocratic Oath itself, which has been affirmed and reaffirmed by doctors for centuries: "I will give no deadly drug to any, though it be asked of me, nor will I counsel such". Adherence to this oath, explains in part the view put forward by the former President of the Australian Medical Society, Brendan Nelson, when he said that "doctors were obliged to preserve life"<sup>183</sup> and that 'there is no principle, ethic or legislation that can cover all situations and the AMA is opposed to the introduction of legislation, as I am, that would sanction doctors to end lives'.<sup>184</sup>

<sup>179</sup> D Lanham, op cit, p 172. Lanham makes reference to the Law Reform Commission of Canada, *Euthanasia Working Paper 28*, 1982, p 47.

<sup>180</sup> "The Right to Live", *The Australian*, 3 June 1995.

<sup>181</sup> Senate of Canada, Report of the Special Senate Committee on Euthanasia and Assisted Suicide, op cit, p 87.

<sup>182</sup> J Shapiro and D Bowermaster, 'Death on Trial', *US News and World Report*, 25 March 1994; D Oldberg, 'Dying with dignity ignores the basic good of living', *Financial Review*, 22 March 1995.

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