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Euthanasia: An Update

by

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EXECUTIVE SUMMARY

On 27 February 2001 the Green MLC Ian Cohen moved a notice of motion to introduce a private members Bill to legalise voluntary euthanasia. The purpose of this paper is to update the legal situation, review recent developments in the euthanasia debate, and to present an overview of the issues involved. Where appropriate, particularly in relation to the arguments for and against active voluntary euthanasia, the paper draws upon the previous publications of the Parliamentary Library – Background Paper No 3/1995 and Briefing Paper No 4/1996.

1. INTRODUCTION

In 1995 the NSW Parliamentary Library Research Service published a Background Paper on euthanasia, and an update paper was then published in the following year. Since then many important development have taken place in this area of medical and legal ethics, including the passing of the Commonwealth's *Euthanasia Laws Act 1997* which rendered inoperative the Northern Territory's *Rights of the Terminally Ill Act 1995*, the first law of its kind anywhere in the world to legalise active voluntary euthanasia.¹ Whilst in operation, the Northern Territory law permitted active voluntary euthanasia to be carried out on four people.² The first of these deaths took place on 22 September 1996. Four days later the NSW Premier, Bob Carr, described euthanasia in a ministerial statement as 'the most monumental of ethical questions' and said that, for his part, he had 'come down against the attempt at codifying in law circumstances under which a life can be extinguished'.³ Nonetheless, acknowledging that the issue had been placed firmly on the public agenda, and responding to calls by the independent MP, Dr Peter Macdonald, that either a parliamentary committee inquiry be established or a referendum held on the issue of euthanasia, the Premier announced that a special debate would be held on the subject on 16 October 1996.⁴ For that debate two eminent members of the community, Professor Peter Baume of the Voluntary Euthanasia Society and Mr Tony Burke of Euthanasia-No!, were invited to address the Legislative Assembly. No vote was taken at the close of the debate.

Since the repeal of the Northern Territory Act, the debate in Australia has continued on several fronts, including the introduction in South Australia⁵ and Western Australia⁶ of private members Bills for the legalisation of active voluntary euthanasia. The issue has also attracted parliamentary committee inquiries in South Australia⁷ and Tasmania.⁸ In NSW,

¹ The Northern Territory Act came into force on 1 July 1996; the Commonwealth Act was assented to on 27 March 1997. In fact, it also legalised physician-assisted suicide.

² D Kissane, A Street, P Nitschke, 'Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia' (1998) 352 *The Lancet* 1097. Seven patients made formal use of the Northern Territory Act. Of these, two had died before the Act became law and one died after the legislation was invalidated by the Commonwealth statute.

³ *NSWPD*, 26 September 1996, p 4704.

⁴ *NSWPD*, 16 October 1996, p 4850.

⁵ Voluntary Euthanasia Bill 1996, sponsored by the Hon Anne Levy. The Bill was introduced into the Legislative Council on 6 November 1996. It passed the second reading stage by 13 votes to eight, and was referred to a Select Committee in July 1997. The Bill lapsed after a State election was called for October later that year, but was referred to the Social Development Committee for inquiry on 25 March 1998. More recently, a Dignity in Dying Bill was introduced into the Legislative Council on 14 March 2001 by the Australian Democrat, Sandra Kanck. The following day an identical Bill was introduced into the House of Assembly by the Independent member, RB Such. This Bill is set out at Appendix A.

⁶ The Hon Norm Kelly has introduced Voluntary Euthanasia Bills into the Legislative Council in 1997, 1998 and 2000 (two Bills).

⁷ Parliament of South Australia, Social Development Committee, *Inquiry into the Voluntary*

a short-lived television advertising campaign by the Voluntary Euthanasia Society of NSW was launched in March 1999.⁹ More recently, following the death in controversial circumstances of Mrs Norma Hall,¹⁰ on 27 February 2001 the Green MLC Ian Cohen moved a notice of motion to introduce a private members Bill to legalise voluntary euthanasia.¹¹ As well, it is reported that Australia's first criminal euthanasia case is now under way in Western Australia where a Perth doctor, Daryl Stephens, together with a brother and sister from Sydney, have been charged over the death of Freda Hayes. It seems the three will face wilful murder charges, plus an alternative charge of aiding a suicide.¹²

Developments elsewhere in the world include significant decisions by the US Supreme Court in 1997 on the subject of physician-assisted suicide; in the same year, after voters had re-affirmed at referendum the Death with Dignity Act, Oregon became the only US State allowing legal physician-assisted suicide. Having already 'decriminalised' voluntary euthanasia in the Netherlands, in November 2000 the lower house of the parliament passed legislation which, if approved by the upper house, will make it the first country to legalise voluntary euthanasia under certain conditions.

This paper reviews these recent developments and presents an overview of the general debate about euthanasia. Where appropriate, particularly in relation to the arguments for and against euthanasia, the paper draws upon the previous publications of the Parliamentary Library. It begins with a note on terminology.

2. TERMINOLOGY

The debate about euthanasia is riddled with legal and ethical terms and concepts which are themselves the subject of controversy and argument. Indeed, to prefer one definition over another can itself be construed as taking a position for or against some euthanasia in some form.

Literally, 'euthanasia' refers to a good death, or a gentle and easy death, from the Greek *eu* for good and *thanatos* for death. In common usage, where it is rarely used in this way,

Euthanasia Bill 1996, 20 October 1999.

⁸ Parliament of Tasmania, House of Assembly, Community Development Committee, *Report on the Need for Legalisation of Voluntary Euthanasia*, Report No 6, 1998.

⁹ Editorial, 'Euthanasia revisited', *The Sydney Morning Herald* 17 March 1999.

¹⁰ M Brown, 'Euthanasia camp accused of "playing on the emotions"', *The Sydney Morning Herald* 24 January 2001.

¹¹ Ian Cohen MLC, 'First step towards legalising voluntary euthanasia', *Media Release* 27 February 2001; 'Euthanasia Bill to ease pain and suffering', *Media Release* 23 January 2000.

¹² D Reardon, 'Euthanasia election debate as approval given for clinic', *The Sydney Morning Herald* 16 January 2001; KA Walsh, 'Is it mercy or murder: the euthanasia dilemma', *The Sydney Morning Herald* 3 December 2000.

‘euthanasia’ is more usually employed ‘to refer to the act of deliberately inducing the death of a patient who is in severe pain and distress as a result of a terminal or incurable illness’.¹³ As Margaret Otlowksi writes, this contemporary understanding of euthanasia ‘envisages a clinical situation where a doctor assists a terminal or incurable patient to die’.¹⁴ In this context, euthanasia has been defined as ‘the intentional killing of a patient, by act or omission, as part of his or her medical care’.¹⁵

The word ‘euthanasia’ can also be sub-divided into its various ‘active’ and ‘passive’ categories. **Active euthanasia** and its sub-categories can be defined as follows:

- *Active euthanasia*: a deliberate act to end the life of a terminal or incurable patient, which in fact results in the patient’s death.
- *Active voluntary euthanasia*: where euthanasia is performed at the request of the patient.
- *Active involuntary euthanasia*: where euthanasia is performed without the consent or against the will of a competent patient.
- *Active non-voluntary euthanasia*: where euthanasia is performed on persons who are incompetent and therefore not capable of giving a consent.

Passive euthanasia can be defined as the deliberate withholding or withdrawing of life-prolonging medical treatment in respect of a terminal or incurable patient, with the object of hastening the patient’s death, and as a result of which the patient dies at an earlier time than he or she would have died, had the treatment been carried out. This, too, can be voluntary, involuntary or non-voluntary in nature.

Otlowksi writes that describing the practice of withholding or withdrawing life prolonging treatment as a form of euthanasia is itself controversial:

According to one view which has frequently been expressed in medical circles, the discontinuation of medical treatment in appropriate circumstances is proper medical practice, and to describe it as ‘passive euthanasia’ is misleading and creates unnecessary confusion. Thus, it has been argued, there is a distinction between intentional killing on the one hand, and appropriate treatment for the dying or terminally ill on the other.¹⁶

¹³ M Otlowksi, *Voluntary Euthanasia and the Common Law*, Paperback edition, Oxford University Press 2000, p 5. Otlowksi is in favour of active voluntary euthanasia and physician-assisted suicide. The use of her work in this definitional section is not intended to convey any position on these issues.

¹⁴ Ibid, p 6.

¹⁵ D Giesen, ‘Dilemmas at life’s end: a comparative legal perspective’ in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* edited by J Keown, Cambridge University Press 1995, p 200.

¹⁶ M Otlowski, n 13, p 6.

Various religious denominations have also objected to the use of the term 'passive euthanasia'. Otlowski comments on the particular objections voiced by the Catholic Church:

According to traditional principles of Catholic teaching, there is a fundamental distinction between 'ordinary' and 'extraordinary' means of prolonging life. The distinction has its origins in moral theology and is used to distinguish between forms of care which are obligatory (ordinary means) and non-obligatory care (extraordinary means). On the basis of this distinction, the Catholic view is that the term 'passive' euthanasia does not apply in respect of the withholding or withdrawing of 'extra-ordinary' treatment, whereas the omission of an 'ordinary' means of prolonging life would be regarded as euthanasia.

It was said in the previous Briefing Paper that the term 'passive euthanasia' conceals a myriad of difficulties.¹⁷ Despite this, Otlowski concludes that the use of the terms 'active' and 'passive' euthanasia is justified, both because they have gained 'widespread usage and understanding', as well as for the reason that the distinction between 'active' and 'passive' euthanasia 'is closely paralleled by the acts/omissions doctrine which underlies the criminal law and which is of central relevance in determining criminal liability'.¹⁸ But note that opting to use, or to refrain from using, the 'passive euthanasia' terminology tends of itself to situate a person on the for/against continuum in the euthanasia debate.

Acts and omissions: The acts/omissions distinction raises difficult issues of its own, in particular where 'passive euthanasia' is concerned.¹⁹ For example, in certain circumstances the initial withholding of treatment could be classified as an omission, whereas the withdrawing of treatment once instituted could be said to amount to an act, with the result that it may attract different legal consequences. In fact, the assumption which is sometimes made - that acts are unlawful, but omissions lawful - can break down in the context of the doctor/patient relationship where a doctor's duty to a patient may give rise to criminal liability for omissions to act. Legally, this also suggests the difficulties which attend the distinction between 'killing' and 'letting die', or between 'causing death' and 'allowing

Physician-assisted suicide: The Northern Territory's *Rights of the Terminally Ill Act* not only legalised active voluntary euthanasia, it also legalised the related practice of physician or doctor-assisted suicide.²⁰ On the other hand, Oregon's Death with Dignity Act only

¹⁷ G Griffith, *Euthanasia: Summary and Update*, Parliamentary Library Research Service Briefing Paper No 4/1996, p 4.

¹⁸ M Otlowski, n 13, p 7.

¹⁹ The distinction is discussed mostly in regard to patients in a permanent vegetative state where the issue is whether the withdrawal of a life-support system can in certain circumstances be characterised as an omission. It was a central feature of the decision in *Airdale NHS v Bland* [1993] AC 789.

²⁰ Section 3 of the Act defined 'assist' to include 'the prescribing of a substance, the

legalises the latter practice. The key difference is that, whereas active voluntary euthanasia requires the direct participation of another in bringing about the person's death, in the case of physician-assisted suicide the death inducing agent is ultimately self-administered. In other words, physician-assisted suicide involves a doctor making a lethal substance available to the patient who has formed a desire to end his or her life; the lethal substance in question may be prescribed and/or prepared and/or given to a patient by a doctor for self-administration. In these circumstances one person contributes to the death of another, but the person who dies directly takes his or her own life. In the language of the criminal law, the difference can be explained as one between perpetrators and accessories. In the case of active voluntary euthanasia the doctor determines the eventual course of action; where physician-assisted suicide is concerned he merely assists the patient to realise his autonomous decision to end his life.

Double effect: the administration of drugs (eg large doses of opioids) with the intention of relieving pain, but foreseeing that this might hasten death even though the hastening of death is not actually intended.²¹

Palliative care is the 'provision of therapy or drugs with the aim of relieving pain and making the patient comfortable until death occurs even if it may indirectly shorten the patient's life'. Such treatment is held to be ethically justifiable under the doctrine of 'double
²²

3. OVERVIEW AND UPDATE OF THE LAW

Basically, the relevant legal position in Australia can be discussed under two broad headings. First, those jurisdictions which do not make any statutory provision for the making of advanced directives or 'living wills', but rely instead on non-statutory 'dying with dignity' guidelines, as in the case of NSW, Tasmania and Western Australia. Secondly, those jurisdictions which have enacted some form of 'natural death legislation', providing for advanced directives and for the appointment of agents or medical powers of attorney, as in the case of South Australia, Queensland, Victoria, and the ACT. With the demise of the *Rights of the Terminally Ill Act 1995* (NT), the most relevant legislation in the Northern Territory at present is the *Natural Death Act 1988* which permits a person to make a direction that he or she does not wish to have 'extraordinary measures' used if he or she is suffering from a terminal illness; the Act does not provide for the appointment of

preparation of a substance and *the giving of a substance to the patient for self-administration*, and the administration of a substance to the patient' (emphasis added).

²¹ This definition of 'double effect', which is taken from the Senate Legal and Constitutional Committee's report on the Euthanasia Laws Bill 1996, has not escaped criticism. Dr Bob Brown called it 'extremely unhelpful', adding that 'It is completely unclear when a doctor administering such drugs can be said to possess "the intention of relieving pain" and when hastening of death can be said to be "actually intended" by the doctor': The Parliament of the Commonwealth of Australia, Senate Legal and Constitutional Legislation Committee, *Consideration of Legislation Referred to the Committee - Euthanasia Laws Bill 1996*, March 1997, p 162.

²² D Giesen, n 15, p 205.

medical powers of attorney.

This overview and update of the law confines itself to a comment on the law in NSW, as an example of a ‘guideline’ jurisdiction, followed by a comment on the various jurisdictions with advanced directives legislation.

3.1 A Guideline Jurisdiction - New South Wales²³

The Briefing Paper of 1996 stated that the legal position in NSW is a combination of the criminal law, supplemented by the common law and non-legislative guidelines. In essence, the situation remains unaltered, although some developments can be noted.

Criminal law: It remains the case that, potentially, both euthanasia and physician-assisted suicide carry heavy penalties under the criminal law. A doctor found guilty of aiding or abetting the suicide of a patient would be liable to a penalty of 10 years imprisonment; section 31C of the *Crimes Act 1900*. Whereas a doctor found guilty of engaging in active voluntary euthanasia could be convicted of murder and liable to life imprisonment; section 19A of the *Crimes Act 1900*.

Note that murder can be committed by both ‘acts’ and ‘omissions’ – ‘Murder shall be taken to have been committed where the act of the accused, or thing by him or her omitted to be done, causing the death charged, was done or omitted with reckless indifference to human life, or with intent to kill...’; section 18(1) of the *Crimes Act 1900*. But note, too, the qualification that ‘No act or omission which was not malicious, or for which the accused had lawful cause or excuse, shall be within this section’; section 18(2) of the *Crimes Act 1900*. These provisions can, in turn, be said to raise complex interpretive questions concerning causation, the legal duty of a doctor to act, as well as the mens rea²⁴ for the crime of murder. These complexities may be particularly acute where the withdrawing of medical treatment is concerned.

Common law: This statutory regime is supplemented and informed by the common law which says among other things:

- A competent adult can refuse medical treatment;²⁵

²³ Similar guidelines also operate in Tasmania and Western Australia – C Corns, ‘Withdrawal of life-support: some criminal prosecution aspects’ in *Controversies in Health Law* edited by I Freckleton and K Petersen, The Federation Press 1999, p 48.

²⁴ The expression ‘mens rea’ is broadly synonymous with the notion of a guilty mind, or a criminal state of mind.

²⁵ For a commentary on the capacity of a competent adult to refuse treatment see – C Stewart, ‘Qumsieh’s case, civil liability and the right to refuse medical treatment’ (2000) 8 *Journal of Law and Medicine* 56. The situation with respect to minors is more complex. Whatever the circumstances, there is a common law requirement to act in the best interests of the child.

- Treatment without consent (unless in an emergency) can constitute the tort of trespass to the person;
- That a person has no legal right to insist on treatment that would result in death.

Guidelines: In 1993 the NSW Health Department issued guidelines, *Dying with Dignity: Interim Guidelines on Management*, designed to assist health professionals in their dealings with end-of-life situations. Among other things, they look at the making of advanced directives or living wills by the patient. According to the revised draft guidelines²⁶ released by the Health Department in November 2000, 'Legal authority suggests that a medical practitioner should not provide treatment or perform a procedure in an emergency where there is an unequivocal written direction by the patient that such treatment is not to be provided in any circumstances'.²⁷ The suggestion, in other words, is that an advanced directive can be legally binding at common law.²⁸ However, much could depend on the circumstances of the case, particularly whether the advanced directive in question took into account the precise clinical situation at issue. A NSW Health Department circular from February 1999 advised that, where a patient has given an unequivocal written direction:

...a medical practitioner should take reasonable steps to ascertain the true scope of the patient's refusal to consent and whether the patient had the capacity to decide at the time the direction was signed. In such a case if the medical practitioner establishes that the patient's refusal was based on a false assumption or misinformation or if the patient lacked the capacity to give the direction, the medical practitioner can treat the patient in accordance with his or her professional judgement of the patient's best interests.²⁹

The revised draft guidelines document adds:

²⁶ For a commentary on these see – T Smyth and C Hogan, 'Dying with dignity – the need for guidelines' (2001) 9 *Australian Health Law Bulletin* 41-47.

²⁷ NSW Health Department, *Dying with Dignity: Revised draft guidelines for clinical decision making at the end of life, Discussion Document – Part A*, November 2000, p 13. See also – NSW Health Department, *Patient Information and Consent to Medical Treatment*, Circular No 99/16, p 11.

²⁸ For an account of the complex issues involved see – C Stewart, 'Advanced directives, the right to die and the common law: recent problems with blood transfusions' (1999) 23 *Melbourne University Law Review* 161. Based mainly on overseas case law, Stewart concludes: 'After capacity has been established, the tribunal of fact needs to determine whether the decision covers the circumstances that have arisen. The evidence must confirm the true scope and basis of the decision, that is, that the anticipatory decision was based on an informed opinion and was intended to apply to the circumstances which have arisen' (page 175). See also –P Biegler et al, 'Determining the validity of advanced directives' (2000) 172 *Medical Journal of Australia* 545. It is noted that the validity of an advance directive at common law is yet to be judicially tested in Australia.

²⁹ NSW Health Department, *Patient Information and Consent to Medical Treatment*, Circular No 99/16, p 11.

To ensure that an advance directive clearly conveys to the treating health professionals that it represents a solemn, well informed and current declaration of the patient's directions about his/her treatment, which can be relied upon by the treating professionals, it is preferable that the advanced directive is prepared by the person, signed and witnessed and reviewed periodically and updated.³⁰

The 1993 the NSW Health Department guidelines, *Dying with Dignity: Interim Guidelines on Management*, also deal with the nomination by the patient of an advocate. In fact, the guidelines leave the legal status of an advocate open for later determination, noting that the role of the advocate was to be the subject of discussions between the Department of Health and the Guardianship Board. The only progress that appears to have been made in this respect in the intervening years is that, since 1997, competent adults can now appoint 'enduring guardians'.³¹ Under the hierarchy established under the *Guardianship Act 1987*, these enduring guardians can make decisions about medical care and treatment on behalf of a person in the event that the person ceases to be competent to make decisions for him or herself.³² However, these arrangements are unlikely to have any bearing on either the active voluntary euthanasia debate, or regarding decisions to withhold or withdraw treatment. This is because the purpose of the relevant provisions is to ensure that medical treatment is carried out on incompetent persons 'for the purpose of promoting and maintaining their health and well-being'.³³ Neither the ending of a person's life, nor yet the discontinuance or holding back of treatment is contemplated under this scheme of things.

Note that the 1993 interim guidelines do not alter the regime of potential criminal (and civil) sanctions in force. Note, too, that in a recent NSW Supreme Court case Justice O'Keefe commented on the lack of adequate guidance for medical practitioners in regard to their management of end-of-life situations in this State. He went to say: 'there are only interim guidelines that have been produced by the New South Wales health authorities. This should also be rectified. Furthermore, even the interim guidelines on management of unconscious patients are not easy to come by'.³⁴

What the interim guidelines say in relation to the withdrawal or withholding of treatment

³⁰ NSW Health Department, *Dying with Dignity: Revised draft guidelines for clinical decision making at the end of life, Discussion Document – Part A*, November 2000, p 13.

³¹ Sections 5-6N, *Guardianship Act 1987* (NSW).

³² Part 5 of the *Guardianship Act 1987* (NSW) establishes a hierarchy for determining who is the 'person responsible' for a person unable to consent to treatment. If the incompetent person is not under guardianship, then it is the enduring guardian who makes decisions regarding medical care.

³³ Section 32(b), *Guardianship Act 1987* (NSW).

³⁴ *Northridge v Central Sydney Area Health Service* [2000] NSWSC 10583/00.

is that: (a) the patient has a right to refuse treatment; (b) if the patient cannot take part in the decision, then his or her advocate should be involved; (c) the contents of an advanced directive should be taken into account; (d) where there is a request for continuation of medically futile treatment, the Attending Medical Officer should consider the request in the context of the overall management plan and the best interests of the patient at that time; (e) where the patient is not capable of involvement and no advocate or advance directive has been arranged, any views that the patient was known to hold should be taken into consideration; and (f) if the patient's views are not known to anyone, then decisions should be made at the discretion of the Attending Medical Officer, after consultation with the family, in the best interests of the patient.

Case law – *Northridge v Central Sydney Area Health Service*: This case involved a request from a Mrs Annette Northridge to the Court seeking an order preventing the administration of Royal Prince Alfred Hospital (RPAH) from withdrawing treatment and life support from a patient, her brother Mr John Thompson, who she claimed would die if not treated and supported. Mr Thompson had been admitted to hospital on 2 March 2000 in an unconscious state, having suffered a cardiac arrest as a result of an overdose of heroin. In a judgment handed down on 29 December 2000, Justice O’Keefe traced the subsequent history of the disagreements between the Thompson family and RPAH medical staff regarding the termination of antibiotic treatment for the patient on 9 March 2000 and subsequent health care decisions. It was explained that the medical staff had formed the view that Mr Thompson was in a ‘chronic vegetative state’ and that any further treatment would be ‘futile’. Due to the Court’s intervention, treatment was resumed and at the date of judgment the patient was ‘unarguably alive’.³⁵

The case raises a number of issues of principle, policy and procedure. On the procedural and policy fronts, one matter discussed by Justice O’Keefe is that there are no ‘adopted or recognised standards in Australia’ for the diagnosis of chronic or permanent vegetative state: ‘On different occasions during the course of the matter the defendant confirmed that there was no standard for the making of such a diagnosis and, a fortiori, no standard or guidelines in relation to the withdrawal of conventional medical treatment and artificial feeding from patients who are diagnosed as being in such a vegetative state’.³⁶ His Honour added that ‘This is in marked contrast with the situation in the United Kingdom where there are published guidelines, criteria or requirements which must be met before a diagnosis of permanent vegetative state is made and before there can be a termination of artificial feeding, treatment and support’.³⁷ That ‘clear and precise criteria’ be introduced in Australia was recommended as a matter of ‘obvious need’.

On the policy and principle fronts, the case confirmed the *parens patriae* jurisdiction of the Supreme Court to ‘act to protect the right of the unconscious person to receive ordinary reasonable and appropriate (as opposed to extra-ordinary, excessively burdensome,

³⁵ Ibid, para 106. Reference is made to Practice Note (1996) 4 All ER 766.

³⁶ Ibid, para 107.

³⁷ Ibid, para 108.

intrusive or futile) medical treatment, sustenance and support'.³⁸ With this in mind, Justice O'Keefe observed:

The law in Australia is well settled that it is lawful for, and the duty of, a hospital which or doctor who has undertaken the care of a patient who is unconscious, to carry out such treatment as is necessary and appropriate to safeguard the life, health and welfare of that patient, even though such patient is in no position to give or refuse consent to the course taken.³⁹

The very scarcity of Australian case law on the issues raised here lends importance to *Northridge*. The fact that Justice O'Keefe was so critical of the policies and procedures in place in NSW (and in Australia generally) adds to its significance. According to Smyth and Hogan:

The case reinforces the need in NSW to review and update the interim guidelines of 1993. In particular, there is a need for further consideration of the process of determining that a patient is in a persistent or chronic vegetative state and the importance of appropriate (and documented) consultation and involvement of next of kin in the clinical decision making process.⁴⁰

The same authors suggest that the Health Department should look to the comprehensive models which have been devised in recent years in the UK and US. Cited are the British Medical Association's report of June 1999, *Withholding and Withdrawing Life-prolonging Medical Treatment: Guidance for Decision Making*⁴¹ and a comprehensive education package released by the American Medical Association's Institute of Ethics titled, *Education for Physicians on End-of-Life Care*.

One might ask what the likely outcome would have been in *Northridge* had an appropriate advanced directive been in place. Might this have been used to override family objections about the withdrawal of treatment? Presumably, the family might still have involved the Court in the matter, perhaps to question whether the requirements of any advanced directive had been satisfied in the circumstances of the case.

³⁸ Ibid, para 24.

³⁹ Ibid, para 23.

⁴⁰ T Smyth and C Hogan, n 26 at 46.

⁴¹ These guidelines were revised in 2000 following the commencement of the UK *Human Rights Act 1998* – <http://www.bmj.com/withwith/contents.htm>

3.2 Jurisdictions With Advanced Directives Legislation – South Australia, Queensland, Victoria, the ACT and the Northern Territory⁴²

Each of these States and Territories has enacted ‘advanced directives’ or natural death legislation in some form or another. Typically, the purpose of such legislation is to enshrine the patient’s common law right to refuse medical treatment which is keeping them alive. The legislation also makes it clear that medical practitioners will not be liable for action taken in such a situation. As well, it can enable end-of-life decisions to be made on a patient’s behalf by a medical agent or attorney. Further, some of these statutes expressly provide that they do not authorise medical treatment to cause a patient’s death, or that they do not authorise assisted suicide. The relevant statutes followed on from the South Australian *Natural Death Act 1983*, which has now been repealed by the *Consent to Medical Treatment and Palliative Care Act 1995* (SA). Queensland is the latest jurisdiction to have introduced statutory advanced directives, under the *Powers of Attorney Act 1998* (Qld). The relevant law is set out in tabular form in Appendix B.

South Australia: The *Consent to Medical Treatment and Palliative Care Act 1995* permits an adult of sound mind to make a direction about the medical treatment he or she does not want if at some time in the future the person is in the final stages of a terminal illness or is in a persistent vegetative state, and is ‘incapable of making decisions about medical treatment when the question of administering the treatment arises’.⁴³ Provided these conditions apply, and there is no reason to suppose that the person has revoked, or intended to revoke, the direction, the direction will be a valid expression of the patient’s intentions with respect to medical treatment.⁴⁴ The South Australia legislation also allows an adult of sound mind to appoint an agent, by medical power of attorney, to make decisions about his or her medical treatment. A medical power of attorney does not authorise the agent to refuse: (a) the natural provision or natural administration of food and water; (b) the administration of drugs to relieve pain or distress; or (c) medical treatment that would result in the grantor [the patient] regaining the capacity to make decisions about his or her own medical treatment unless the grantor is in the terminal phase of a terminal illness. The Act also requires the Minister to establish a register of treatment directions and medical powers of attorney.⁴⁵

Queensland: Under the *Powers of Attorney Act 1998* (Qld) a person can make what is called an ‘advance health directive’. This can include a directive to withhold or withdraw a ‘special life-sustaining measure’,⁴⁶ but only where certain conditions apply. For example,

⁴² With the exception of Queensland, more detailed accounts of these statutory regimes are found in – B Bennett, *Law and Medicine*, LBC Information Services 1997; N Cica, *Euthanasia – the Australian Law in an International Context: Part 1 – Passive Voluntary Euthanasia*, Commonwealth Parliamentary Library Research Paper No 3 1996-97.

⁴³ Section 7(1), *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

⁴⁴ Section 7(3).

⁴⁵ Section 14(1).

⁴⁶ The term is defined in Schedule 2, section 16, *Powers of Attorney Act 1998* (Qld). The

where a person has a terminal illness, or a condition that is incurable or irreversible and as a result of which, in the opinion of a doctor who is treating the person and another doctor, he can reasonably be expected to die within one year; a second circumstance is where a person is in a persistent vegetative state (PSV).⁴⁷ Significantly, provision is made for the appointment of a statutory health attorney, but the attorney would not have the power to make decisions about 'special' health matters which are defined to include the withholding or withdrawing of life-sustaining treatment.⁴⁸ Only the principal, to use the language of the Act, can give a direction concerning his or her 'special health care'.

Section 103 of the Act provides protection from liability for a 'health provider' who does not act in accordance with an advance health directive, but only where the health provider has reasonable grounds to believe that a direction 'is uncertain or contrary to good medical practice or that circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate'.

To avoid doubt, the Act declares that nothing in it 'authorises, justifies or excuses killing a person', and that it does not affect specified provisions of the Criminal Code dealing with such matters as aiding suicide.⁴⁹

Victoria: The Medical Treatment Act 1988 (Vic) provides a statutory mechanism for refusal of medical treatment, but only where this relates to a 'current condition'. In other words, provision is not made for refusal of treatment for future illnesses or conditions. It does, however, permit a person to appoint an agent to make decisions about medical treatment on the person's behalf.⁵⁰ This appointment only becomes effective if and when the person becomes incompetent. Another feature of the Victorian legislation is that it does not apply to decisions concerning 'palliative care'.⁵¹

Australian Capital Territory: In its original form, the ACT's Medical Treatment Act 1994 was similar to the Victorian legislation. It referred to the refusal or withdrawal of medical treatment 'generally', or of a 'particular kind', for a 'current condition'. This reference to 'current condition' was removed in 1997,⁵² so that now the relevant provision states that an adult of sound mind may 'make a direction in writing, orally or in any other way in

definition excludes blood transfusions.

⁴⁷ Section 36(2), *Powers of Attorney Act 1998* (Qld). PVS is defined to mean 'a condition involving severe and irreversible brain damage which, however, allows some or all of the principal's vital bodily functions to continue, including, for example, heart beat or breathing'.

⁴⁸ Section 32(1) read with Schedule 2, section 6-7, *Powers of Attorney Act 1998* (Qld).

⁴⁹ The following sections of the Criminal Code are not affected: section 284 ('Consent to death immaterial'), section 296 ('Acceleration of death'), and section 311 ('Aiding suicide').

⁵⁰ *Medical Treatment Act 1988* (Vic), section 5A.

⁵¹ Section 4(2).

⁵² *Medical Treatment (Amendment) Act 1997* (ACT).

which the person can communicate to refuse, or for the withdrawal of, medical treatment - (a) generally; or (b) of a particular kind'. The Act also permits an adult of sound mind to complete an enduring power of attorney, thereby giving the agent the power to consent to the withdrawal or withholding of medical treatment if the grantor becomes incapacitated.⁵³ As in Victoria, the ACT legislation does not apply to palliative care.⁵⁴

Northern Territory: As noted, with the demise of the Rights of the Terminally Ill Act 1995 (NT), the most relevant legislation in the Northern Territory at present is the Natural Death Act 1988 which permits a person to make a direction that he or she does not wish to have 'extraordinary measures' used if he or she is suffering from a terminal illness. The Act does not provide for the appointment of medical powers of attorney.

Under the terms of the Commonwealth's *Euthanasia Laws Act 1997* the Northern Territory's Legislative Assembly does not have the power to make laws which permit 'the form of intentional killing of another called euthanasia (which includes mercy killing) or the assisting of a person to terminate his or her life'. On the other hand, it does have the power to make laws with respect to:

- (a) The withdrawal or withholding of medical or surgical measures for prolonging the life of a patient but not so as to permit the intentional killing of the patient; and
- (b) Medical treatment in the provision of palliative care to a dying patient, but not so as to permit the intentional killing of the patient; and
- (c) The appointment of an agent by a patient who is authorised to make decisions about the withdrawal or withholding of treatment; and
- (d) The repealing of legal sanctions against attempted suicide.

Clearly, under point (c) the Northern Territory has the power to legislate for medical powers of attorney who are authorised to make decisions about the withdrawal or withholding of medical treatment. However, the prohibition against 'intentional killing' could make the formulation of any such law a complex undertaking, especially bearing in mind the Criminal Code Act's declaration that 'Any person who causes the death of another *directly or indirectly by any means* is deemed to have killed that other person' (emphasis added).⁵⁵

3.3 Summing up

Active voluntary euthanasia and physician-assisted suicide are illegal in all Australian jurisdictions. The former is forbidden as a consequence of the criminal law's prohibition

⁵³ Section 13, *Medical Treatment Act 1994* (ACT).

⁵⁴ Section 5(2).

⁵⁵ Section 157, *Criminal Code Act* (NT).

against intentional killing. The latter is forbidden as a consequence of the criminal law's prohibition against assisting another person to commit suicide. That said, both common law and statute law recognise occasions where life-saving and life-sustaining treatment can be legally withdrawn or not undertaken. The law varies from one jurisdiction to another, but in broad terms these occasions are as follows:

- If it is a direction of a competent adult patient who has made a voluntary choice;
- If it is a direction contained in a valid refusal of treatment certificate or an advanced direction executed by a competent person;
- If it is a valid decision made on behalf of an incompetent person by an agent vested with the enduring power of attorney appointed by the patient while he or she was still competent.⁵⁶

4. PHYSICIAN-ASSISTED SUICIDE – DEVELOPMENTS IN THE US

Reviewing overseas legislation in the 1993 Canadian case of Rodriguez, Justice Sopinka commented that a blanket prohibition on assisted suicide 'is the norm among Western democracies, and such a prohibition has never been adjudged to be unconstitutional or contrary to fundamental human rights'.⁵⁷

Two US cases: As to the constitutionality of prohibitions against assisted suicide, this was upheld in two US cases in which judgment was handed down in 1997. In *Washington v Glucksberg*⁵⁸ the Supreme Court held that Washington's ban on physician-assisted suicide does not violate the Fourteenth Amendment's Due Process Clause by denying competent terminally ill adults the liberty to choose death over life. Similarly, in *Vacco v Quill*⁵⁹ the Supreme Court held that New York's ban on physician-assisted suicide did not violate the Fourteenth Amendment's Equal Protection Clause by, on one side, allowing competent terminally ill adults to withdraw their own life saving treatment, but on the other denying the same right to patients who could not withdraw their own treatment and could only hope that a physician would do so for them.

In *Washington v Glucksberg* the previous decision of the Court in *Cruzan*⁶⁰ establishing the right of a terminally ill patient to direct the withdrawal of life-sustaining treatment was approved. However, it was explained that the right assumed in *Cruzan* did not derive from 'abstract concepts of personal autonomy' but from the common law right to bodily integrity

⁵⁶ D Mendelson, 'End of Life –Legal Framework' in I Freckleton and K Petersen, n 23, p 63.

⁵⁷ [1993] 3SCR 519 at a605

⁵⁸ 117 S Ct 2258 (1997).

⁵⁹ 117 S Ct 2293 (1997).

⁶⁰ *Cruzan v Director Missouri Department of Health* 497 US 261 (1990).

and freedom from unwanted physical contacts. The Court gave 'no intimation' in *Cruzan*, it was said, that this right to refuse unwanted medical treatment 'could be somehow transmuted into a right to assistance in committing suicide'. The admittedly fine distinction in some cases - between 'killing' and 'letting die', a distinction which in *Quill* was said to accord with the 'fundamental legal principles of causation and intent' - is to be maintained. The ban on physician-assisted suicide was found in *Glucksberg* to be rationally related to important public interests including: the preservation of human life; preventing of suicide; protecting the integrity and ethics of the medical profession; protecting vulnerable groups; and preventing voluntary and perhaps even involuntary euthanasia. Accordingly, since a right to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process clause, the constitutionality of Washington State's prohibition against causing or aiding suicide was upheld. Similar considerations were applied in *Quill* where the constitutionality of the New York statute was upheld.

On the other hand, the upshot of these cases is that, just as States are free to ban physician-assisted suicide in the US, they are also free to permit it.

Physician-assisted suicide in Oregon:⁶¹ As to the incidence of the prohibition on assisted suicide, the Supreme Court found that Oregon is the one exception to that rule. Oregon's Death with Dignity Act, a citizens' initiative, was first passed by voters in November 1994 by a margin of 51% in favour and 49% opposed. Its implementation was then delayed by a legal injunction. Only after multiple legal proceedings was the injunction lifted on 27 October 1997 and physician-assisted suicide became a legal option for terminally ill patients in Oregon. In November 1997, Measure 51 was placed on the general election ballot and asked Oregon voters to repeal the Death with Dignity Act. Voters chose to retain the Act by a margin of 60% to 40%.

The Death with Dignity Act permits terminally ill Oregon residents to obtain from their physicians prescriptions for lethal medications which they are then enabled to administer to themselves. The Act states that ending one's life in accordance with the law does not constitute suicide. It also expressly prohibits euthanasia, that is, where a physician or other person directly administers a medication to end a patient's life.

To request a prescription for lethal medication, the Oregon legislation requires that a patient must be: an adult; a resident of Oregon; capable (defined as able to make and communicate health care decisions); and diagnosed with a terminal illness that will lead to death within six months. Various steps must then be followed including: the patient must make to two oral request to their physician, separated by at least 15 days; the patient must provide a written, witnessed request to their physician; the prescribing physician and a consulting physician must confirm the diagnosis and prognosis, and determine whether the patient is capable; the patient must be informed of feasible alternatives to physician-assisted suicide; and the prescribing physician must request, but may not require, the patient to notify their next of kin of the prescription request. In 1999 a requirement was added that pharmacists must be informed of the prescribed medication's ultimate use.

⁶¹ The information in this section is based on the Web site of the Oregon Health Division – <http://www.ohd.hr.state.or.us>

An annual reporting mechanism is in place, which basically requires the Oregon Health Division to monitor and collect information on the operation of the Act. The Annual Report for 2000 was released recently, presenting an overview of three years of legalised physician-assisted suicide. It found:

- In 2000, 39 prescriptions for lethal doses of medication were written, compared with 24 in 1998 and 33 in 1999;
- In 2000, 27 patients died after using the prescribed medication. Of these patients, 26 obtained their prescription in 2000 and one in 1999. In addition, eight patients died from their underlying disease; five were alive on 31 December 2000.
- In 1999, 27 patients died under the Death with Dignity Act; 16 died in 1998, making a total of 70 to date.
- The 27 patients who ingested lethal medication in 2000 represented an estimated 9/10,000 total Oregon deaths, compared with 6/10,000 in 1998 and 9/10,000 in 1999. The report commented, 'The number of patients choosing legal PAS [physician-assisted suicide] has remained small over the last three years...While these numbers increased from the first year to the second, the third year's findings indicated that this increase was not part of a trend';
- The median age of the 27 patients who took lethal medication in 2000 was 69 years. Twelve were male; 26 were white; 18 (67%) were married; 13 were college graduates; 8 had advanced graduate degrees. The report commented, 'Patients participating in 2000 were demographically similar to those participating in previous years, except that they were increasingly likely to be married...Overall, the patients who participated in 2000 were demographically comparable to other Oregonians who died from similar underlying illnesses, with the exception of educational attainment. Patients having a college or post-baccalaureate education were very much more likely to participate'.
- Twenty one of the year 2000 patients had end-stage cancer. Twenty three were in hospice before death;
- One physician was reported in 2000 to the Oregon Board of Medical Examiners for submitting a written consent form with only one signature, although other witnesses were also present;
- The only complication reported in 2000 was that one patient regurgitated some of the medication, but nonetheless became unconscious within one minute and died within seven minutes.
- Physicians reported that patient concern about becoming a burden has increased during the last three years, although 'all patients expressed multiple concerns in the third year'. The most frequently noted end-of-life concern across all three years were loss of autonomy (2000, 93%; 1999, 78%; 1998, 75%) and participation in activities that

make life enjoyable (2000, 78%; 1999, 81%; 1998, 69%). Patients have increasingly expressed concern about becoming a burden to family, friends or caregivers (2000, 63%; 1999, 26%; 1998, 12%). The report commented, 'a negative interpretation of concern about becoming a burden is that patients may feel pressured by others into using PAS. No evidence indicates that such pressure has been a primary motivating influence among the 70 Oregon patients participating to date, but this possibility should be discussed by physicians, patients and family members'. All but one patient expressing this concern in 2000 also expressed concern about losing autonomy.

Other States: Whether the Oregon example will start a trend in legal reform in the US is hard to say. At present, 37 States prohibit assisted suicide, including physician-assisted suicide, by statute; a further eight States prohibit it under the common law or a homicide statute. In 1997 and 1998, Bills on assisted suicide were introduced in 26 States. All were defeated. Voters in Michigan and Washington State rejected State ballot-initiatives that would have legalised physician-assisted suicide. A number of States, including Virginia, Michigan, South Carolina, Iowa and Rhode Island, approved new bans on assisted suicide.⁶² In *Glucksberg*, the US Supreme Court also noted that, on 30 April 1997, former President Bill Clinton signed the Federal Assisted Suicide Funding Restriction Act of 1997, prohibiting the use of federal funds in support of physician-assisted suicide. It was also noted with approval that, in a case involving Jack Kevorkian, the Michigan Supreme Court rejected the argument that the distinction 'between acts that artificially sustain life and acts that artificially curtail life' is merely a 'distinction without constitutional significance – a

5. TOWARDS THE LEGALISATION OF EUTHANASIA – THE NETHERLANDS

Decriminalisation: In the Netherlands the 'decriminalisation' of euthanasia amounts to a government sanctioned policy to refrain from prosecution, but only if due care requirements have been complied with. Decriminalisation does not make an offence a non-offence. The current legal position in the Netherlands was explained in the 1996 Briefing Paper in the following terms:

Article 293 of the Dutch *Penal Code* defines euthanasia as a criminal offence; Article 294 defines assisting suicide in the same terms.

However, Article 40 of the Code provides the defence of necessity to a criminal charge where the accused was compelled to act. The necessity here arises where the doctor must choose between 2 conflicting obligations: to relieve a patient's suffering; and the duty to respect the law. The courts have taken the view, that where

⁶² L Snyder, 'Assisted suicide: finding common ground' (2000) 132 *Annals of Internal Medicine* 468.

doctors put their duty to patients first, they cannot be held responsible for failing to fulfil their duty as citizens.

Added to this is the government policy of non-prosecution provided a number of substantive and procedural requirements are satisfied. Reporting is now mandatory and a physician who does not comply can be prosecuted. These requirements are set out in the *Burial Act 1955* as amended in June 1994. That Act did not amend the *Penal Code*, however, and euthanasia remains a criminal offence.

At present, therefore, the termination of life on request is a criminal offence, though prosecutions are not brought provided it is carried out by a physician and certain requirements of due care have been met. For example, physicians must report their actions and these are then examined by one of five regional review committees.⁶³ These committees then send an opinion to the Public Prosecution Service which must decide if criminal proceedings are to be instituted. In essence, the current Bill to legalise active voluntary euthanasia under certain conditions, which is discussed below, places these arrangements on a formal legislative basis.

Figures on euthanasia in the Netherlands: The relevant statistical information on euthanasia in the Netherlands is available from the Dutch Ministry of Justice.⁶⁴ It explains that, in two large-scale studies in 1990 and 1995, Professors G van der Wal and PJ van de Maas calculated the total number of cases of requested euthanasia and requested assistance in committing suicide in those years. For other years, the only figures available are for the number of reported instances of euthanasia and assistance in committing suicide. The figures are presented in following format:⁶⁵

Year	Total	Reported (percentage)	Summoned
1990	2,700	484 (18%)	0
1991	n/a	866	1
1992	n/a	1,201	2
1993	n/a	1,304	4
1994	n/a	1,487	5
1995	3,600	1,466 (41%)	1
1996	n/a	1689	4
1997	n/a	1986	2
1998 (until 1 November)	n/a	2241	1
1998 (remainder)	n/a	349	0
1999	n/a	2,216	0

⁶³ These were introduced in 1995.

⁶⁴ <http://www.minjust.nl>

⁶⁵ The estimated 'total' figures for 1990 and 1995 referring to the findings of the research studies undertaken in those years. The 'summoned' column presumably refers to the number of doctors prosecuted for failing to follow the guideline requirements.

Predictably, these figures, especially those relating to the two large-scale studies, have been found to support very different conclusions. Some say, on the basis of more detailed analysis of the findings, that they support the ‘slippery slope’ argument – that voluntary euthanasia leads to involuntary euthanasia;⁶⁶ others say they do nothing of the sort.⁶⁷ All the varying interpretations were canvassed in the Senate Legal and Constitutional Legislation Committee report on the Euthanasia Laws Bill 1996, including the differing views on the implications of these findings for Australia.⁶⁸ Further, owing to their significance for the euthanasia debate generally, the Committee set out some of the findings of the 1990 and 1995 studies as follows:

	1990	1995
<i>Total deaths (all causes)</i>	128,786	135,546
1. Active voluntary euthanasia	1.7%	2.4%
2. Physician-Assisted suicide	0.2%	0.2%
3. Intentional life-terminating acts without explicit concurrent request	0.8%	0.7%
4. Opioids in large doses	18.8%	19.1%
5. Withdrawing/withholding potentially life-prolonging treatment	17.9%	20.2%
6. Total of 1 – 5	39.4%	42.6%

The Committee said its attention had been drawn to the increase in Dutch voluntary euthanasia between 1990 and 1995. Noted, too, was the argument that ‘this increase is a natural consequence of the aging of the population in Holland’, together with the point made by the authors of the 1995 report that ‘the increase may be due to a combination of

⁶⁹ Having canvassed the contrasting interpretations, the Committee concluded: ‘There seems to be no consensus on how to interpret the Dutch data in the Dutch context. The relevance of the Dutch experience to Australia provided further grounds for disagreement’.⁷⁰

⁶⁶ M Bagaric, ‘Euthanasia: patient autonomy versus the public good’ (1999) 18 *University of Tasmanian Law Review* 146 at 157-161.

⁶⁷ M Otłowski, n 13, p xii.

⁶⁸ The Parliament of the Commonwealth of Australia, Senate Legal and Constitutional Legislation Committee, *Consideration of Legislation Referred to the Committee - Euthanasia Laws Bill 1996*, March 1997, pp 101-106.

⁶⁹ Ibid, p 102.

⁷⁰ Ibid, p 114. In his response to the Committee report Dr Bob Brown said that its account of the empirical research conducted in the Netherlands ‘contains many misleading

Towards legalisation: In November 2000 a Bill – the Termination of Life on Request and Assisted Suicide (Review Procedures) Bill - passed through the lower house of the Dutch Parliament. It has the effect of legalising active voluntary euthanasia and physician-assisted suicide under certain conditions. The Bill achieves this by amending Articles 293 and 294 of the Penal Code. As amended by the lower house, Article 293 reads:

1. A person who terminates the life of another person at that other person's express and earnest request is liable to a term of imprisonment of not more than twelve years or a fine of the fifth category.
2. The offence referred to in the first paragraph shall not be punishable if it has been committed by a physician who has met the requirements of due care as referred to in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act and who informs the municipal autopsy of this in accordance with Article 7 second paragraph of the Burials and Cremation Act.

Article 294 which deals with assisted suicide is in similar terms. Having set out the offence of assisting suicide and the punishment thereof, it states that 'Article 293 second paragraph applies *mutatis mutandis*'. In general, therefore, active voluntary euthanasia and physician-assisted suicide remain illegal in the Netherlands, except where these are carried out under the requirements set out in the amended Article 293. Central to this scheme is that the requirements of due care be adhered to, and these would now be set out in statutory form. Under these requirements, the physician would have to:

- hold the conviction that the request by the patient was voluntary and well-considered;
- hold the conviction that the patient's suffering was lasting and unbearable;
- consult at least one other independent physician who has seen the patient and has given his written opinion on the requirement of due care;
- inform the patient about the situation he was in and about his prospects;
- and the patient must hold the conviction that there was no other reasonable solution for the situation he was in.

The Bill is not restricted in its operation to adults. Children of 16 and 17 could make their own decision regarding termination of life on request or assisted suicide. The minor must be deemed to have a 'reasonable understanding of his interests' and his or her parents/guardian must be involved in the decision process. However, there is no requirement that either parents and/or a guardian agree with the minor's decision. On the other hand, for children aged between 12 and 16 the approval of parents and/or a guardian is required.⁷¹ The requirements of due care apply in any event.⁷²

⁷¹ Article 2 (4) of the Termination of Life on Request and Assisted Suicide (Review Procedures) Bill. This provides 'If the minor patient is aged between 12 and 16 years and may be deemed to have a reasonable understanding of his interests, the physician may carry out the patient's request, provided always that the parents exercising parental authority and/or his guardian agree with the termination of life or the assisted suicide'.

Moreover, under the Bill the regional assessment committees would be given a formal legislative basis and the reporting of euthanasia would be mandatory (at present it is only an offence to report it as a 'natural death').⁷³

At this stage, the Bill is yet to be passed by the Dutch upper house, although as the Coalition Government has a majority in that house one can expect it to do so in the near future. On one view the Bill merely formalises the present arrangements, making *de jure* what is at present *de facto*. Yet, as one would expect, it has proved to be highly controversial. It is reported that, in its original form, the Bill would have given 12 to 16 year olds the right to end their lives without parental consent. Opposition to this proposal was said to have come from political, religious and medical quarters.⁷⁴ When the amended Bill passed the lower house by 104 votes to 40 on 28 November 2000, it was said to have 'polarised opinion in the country, with opponents of euthanasia, especially in the Calvinist churches and hospice movement, fearing the new law will open the floodgates to thousands more deaths'.⁷⁵ A Vatican spokesman, Joaquin Navarro Valls, said the Bill was contrary 'the natural law of human conscience'.⁷⁶ On the other hand, both the Voluntary Euthanasia Society and the Royal Dutch Medical Association were reported to support reform, on the basis that it would remove a 'legal grey area'.⁷⁷

6. THREE OVERSEAS REPORTS – UK, NEW YORK STATE AND CANADA

(i) House of Lords Select Committee Report on Medical Ethics (Session 1993-94)

The report recommended against the legislation of either euthanasia or assisted suicide. Rejecting the proposal to legalise euthanasia, the report stated:

we do not believe that these arguments [for legalising euthanasia] are sufficient reasons to weaken society's prohibition of intentional killing. That prohibition is the cornerstone of law and social relationships. It protects each of us impartially, embodying the belief that all are equal.⁷⁸

⁷² Article 2 (2).

⁷³ M Otlowski, n 13, p xv.

⁷⁴ P Jacobsen, 'Child euthanasia plan sparks Dutch fury', *Electronic Telegraph*, 14 November 1999.

⁷⁵ J Clements, 'MPs back euthanasia law but Dutch public are bitterly divided', *Electronic Telegraph*, 29 November 2000.

⁷⁶ J Walker, 'Netherlands first to legalise mercy killing', *The Australian*, 30 November 2000.

⁷⁷ K Iley, 'Plan to legalise euthanasia will include children', *The Sydney Morning Herald*, 12 August 1999.

⁷⁸ House of Lords, Report of the Select Committee on Medical Ethics, Session 1993-1\94, HL Paper 21-1, para 237.

Consistent with this emphasis on intentional killing, it also recommended against the creation of a new offence of ‘mercy killing’, stating that:

To distinguish between murder and ‘mercy killing’ would be to cross the line which prohibits any intentional killing, a line which we think is essential to preserve. Nor do we believe that ‘mercy killing’ could be adequately defined, since it would involve determining precisely what constituted a compassionate motive.⁷⁹

On the other hand, the report recommended that a non-statutory code of practice on advanced directives be developed. It did not favour the introduction of natural death legislation, stating:

We suggest that it could well be impossible to give advance directives in general greater legal force without depriving patients of the benefit of the doctor’s professional expertise and of new treatments and procedures which may have become available since the advanced directive was signed.⁸⁰

The report went on to say that, ‘Whilst the idea of the patient-appointed proxy is in many ways attractive, it is vulnerable to the same problems as advanced directives, and indeed to a greater degree’.⁸¹

(ii) The New York State Task Force on Life and the Law (1994, plus 1997 Supplement)

The Task Force acknowledged that its members held different views about the ethical acceptability of euthanasia and assisted suicide. However, despite these differences, the Task Force recommended unanimously that existing laws should not be changed to permit these practices. The three ways by which the Task Force members arrived at this common conclusion were set out as follows:

Some of the Task Force members believe that assisted suicide and euthanasia are inherently wrong, because the practices violate society’s long-standing prohibition against ending human life. These members believe that one person should not assist another’s death or kill another person, even for benevolent motives.

Other Task Force members are most troubled by the prospect of medicalizing the practices. They believe that physician-assisted suicide and euthanasia violate values that are fundamental to the practice of medicine and the

⁷⁹ Ibid, para 260

⁸⁰ Ibid, para 264

⁸¹ Ibid, para 268

patient-physician relationship.

Some Task Force members do not believe that assisted suicide is inherently unethical or incompatible with medical practice. On the contrary, they believe that providing a quick, less prolonged death for some patients can respect the autonomy of patients and demonstrate care and commitment on the part of physicians or other health care professionals. Nonetheless, these members have concluded that legalising assisted suicide would be unwise and dangerous public policy.⁸²

Among the ‘social risks’ of legalisation, some of which may be peculiar to the United States, the Task Force noted:

No matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practices through the prism of social inequality and bias that characterises the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.⁸³

In April 1997 the New York State Task Force on Life and the Law produced a Supplement to its earlier report, responding to issues raised in the *Glucksberg* and *Quill* cases prior to their final determination in the Supreme Court. The Task Force outlined its opposition to physician-assisted suicide and the risks associated with its legalisation as follows:⁸⁴

- *Undiagnosed or untreated mental illness.* Many individuals who contemplate suicide – including those who are terminally ill – suffer from treatable mental disorders, most commonly clinical depression. Yet, physicians routinely fail to diagnose and treat these disorders, particularly among patients at the end of life. As such, if assisted suicide is legalized, many requests based on mental illness are likely to be granted, even though they do not reflect a competent, settled decision to die.
- *Improperly managed physical symptoms.* Requests for assisted suicide are also highly correlated with unrelieved pain and other discomfort associated with physical illness. Despite significant advances in palliative care, the pain and discomfort that accompanies many physical illnesses are often grossly under treated in current clinical practice. If assisted suicide is legalized, physicians are likely to grant requests for assisted suicide from patients in pain before all available options to relieve the patient’s pain have thoroughly been explored.

⁸² The New York Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, May 1994, p xii.

⁸³ Ibid, p xiii

⁸⁴ New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, Supplementary Report, April 1997, pp 4-5.

- *Insufficient attention to the suffering and fears of dying patients.* For some individuals with terminal or incurable diseases, suicide may appear to be the only solution to profound existential suffering, feelings of abandonment, or fears about the process of dying. While the provision of psychological, spiritual, and social supports – particularly, comprehensive hospice services – can often address these concerns, many individuals do not receive these interventions. If physician-assisted suicide is legalized, many individuals are likely to seek the option because their suffering and fears have not adequately been addressed.
- *Vulnerability of socially marginalized groups.* No matter how carefully any guidelines for physician-assisted suicide are framed, the practice will be implemented through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risk to those who are poor, elderly, isolated, members of a minority group, or who lack access to good medical care.
- *Devaluation of the lives of the disabled.* A physician's reaction to a patient's request for suicide assistance is likely to depend heavily on the physician's perception of the patient's quality of life. Physicians, like the rest of society, may often devalue the quality of life of individuals with disabilities, and may therefore be particularly inclined to grant requests for suicide assistance from disabled patients.
- *Sense of obligation.* The legalization of assisted suicide would itself send a message that suicide is a socially acceptable response to terminal or incurable disease. Some patients are likely to feel pressured to take this option, particularly those who feel obligated to relieve their loved ones of the burden of care. Those patients who do not want to commit suicide may feel obliged to justify their decision to continue living.
- *Patient defence to physician recommendations.* Physicians typically make recommendations about treatment options, and patients generally do what physicians recommend. Once a physician states or implies that assisted suicide would be 'medically appropriate', some patients will feel that they have few, if any, alternatives but to accept the recommendation.
- *Increasing financial incentives to limit care.* Physician-assisted suicide is far less expensive than palliative and supportive care at the end of life. As medical care shifts to a system of capitation, financial incentives to limit treatment may influence the way that the option of physician-assisted suicide is presented to patients, as well as the range of alternatives patients are able to obtain.
- *Arbitrariness of proposed limits.* Once society authorizes physician-assisted suicide for competent, terminally ill patients experiencing unrelievable suffering, it will be difficult, if not impossible, to contain the option to such a limited group. Individuals who are not competent, who are not terminally ill, or who cannot self-administer lethal drugs will also seek the option of physician-assisted death, and no principled basis will exist to deny them this right.

- *Impossibility of developing effective regulation.* The clinical safeguards that have been proposed to prevent abuse and errors are unlikely to be realized in everyday medical practice. Moreover, the private nature of these decisions would undermine efforts to monitor physicians' behaviour to prevent mistakes and abuse.

The Task Force concluded that the various distinctions which are made between assisted suicide, the refusal of treatment, and the use of high doses of opioids for the relief of pain, are 'essential to a coherent policy of end-of-life medical care'. The Supplementary Report added, 'Conflating these issues may be rhetorically powerful for those who wish to legalize assisted suicide, but it will ultimately weaken the autonomy of patients at the end of life'.⁸⁵ As discussed, that view was later endorsed by the US Supreme Court in the decisions it handed down in June 1997 in *Quill* and *Glucksberg*.

(iii) Canadian Special Senate Committee Report on Medical Ethics (1995)

By majority, the Canadian Senate Report did not favour the legalisation of either assisted suicide or voluntary euthanasia. It was unanimous in recommending that non-voluntary euthanasia remain a criminal offence. On the other hand, it did recommend the creation of an offence of mercy killing in relation to both voluntary and non-voluntary euthanasia, which would take the form of a less severe penalty in cases where there is the essential element of compassion or mercy.

Committee members opposed to the legislation of voluntary euthanasia said, among other things, that 'the common good could be endangered if the law is changed to accommodate the few cases where pain control is ineffective'. They added:

there is a moral difference between euthanasia and the legitimate practice of withholding and withdrawing of life sustaining treatment and providing treatment aimed at alleviating suffering that may hasten death. In acts of euthanasia, the *intention* is to cause death, whereas in other end of life decisions the *intention* is to alleviate suffering.⁸⁶

In contrast, those members of the Committee in favour of voluntary euthanasia said they believed that:

the principle of autonomy that justifies allowing the withholding and withdrawing of life sustaining treatment also justifies permitting voluntary euthanasia...the provision of treatment aimed at the alleviation of suffering that may hasten death is also similar to voluntary euthanasia. The death of the patient in all these activities is a foreseeable consequence.⁸⁷

⁸⁵ Ibid, p 17.

⁸⁶ Senate of Canada, Report of the Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death*, June 1995, p 86.

⁸⁷ Ibid, p 87.

The Committee unanimously recommended amending the Criminal Code to clarify where the withdrawal or withholding of life-sustaining treatment is legally acceptable; as well as legislation for the making of advanced directives in those Provinces where this does not exist.⁸⁸

7. THREE AUSTRALIAN REPORTS – THE SENATE, TASMANIA AND SOUTH AUSTRALIA

(i) The Senate Legal and Constitutional Legislation Committee (1997)

This report arose directly from the introduction in the Federal Parliament of a Private Member's Bill – the Euthanasia Laws Bill 1996 (the Andrews Bill) – which was intended to override the Northern Territory's *Rights of the Terminally Ill Act 1995*. The Senate Selection of Bills Committee nominated four specific areas of inquiry, namely: the desirability of the enactment of the provisions; the constitutional implications for the Territories; the impact of the Bill on the Northern Territory's criminal code; and the impact on, and attitudes of, the Aboriginal community. In the event, the Committee made no recommendation to the Senate on the Bill because it was a private Member's Bill and

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Instead, appended to the report were seven separate responses from Senators who were either members or participating members of the Committee during the inquiry. In favour of the Andrews Bill was the response endorsed by 13 Senators, among them Brian Harradine, which takes the form of an 'Advice to the Senate'. In relation to the specific terms of reference, this advice argued that: the Andrews Bill should be passed without amendment; that there were no constitutional implications for the Territories; that there would be no adverse impact on the Northern Territory's criminal code; and that the Rights of the Terminally Ill Act 1995 'has had, and will continue to have, an unacceptable impact on the attitudes of the Aboriginal community to health services'.⁹⁰ As to the more general moral and other issues raised by the euthanasia debate, it advised:

We share the views expressed by members of the House of Lords Select Committee, the Canadian Special Select Committee and the New York State task Force that laws relating to euthanasia are unwise and dangerous public policy. Such laws pose profound risks to many individuals who are ill and vulnerable.⁹¹

⁸⁸ For a more detailed discussion of the legal position in Canada see – M Dunsmuir et al, *Euthanasia and Assisted Suicide*, Canadian Library of Parliament, Parliamentary Research Branch, 1998; M Stingl, 'Euthanasia and Health Reform in Canada' (1998) 7 *Cambridge Quarterly of Healthcare Ethics* 348-370.

⁸⁹ Senate Legal and Constitutional Legislation Committee, n 68, p 114.

⁹⁰ Ibid, pp 129-130.

⁹¹ Ibid, p 123.

As to the issue of individual rights and choice, the 13 Senators advised:

The individual rights and autonomy argument is at first glance persuasive. However even if one supports the principle of euthanasia the question needs to be asked: 'Can we sufficiently codify the circumstances in which we would allow euthanasia?' We are of the view that it is impossible.⁹²

As to the argument that the euthanasia debate is bedevilled by conceptual difficulties and distinctions which cannot be sustained, the 13 Senators advised:

We join the long established view that there are strong intuitive moral and clinical distinctions between stopping futile treatment and giving a lethal injection. To try to equate the two is disingenuous. As is the blurring of the concepts of not prolonging the life of, and killing, a patient.

Dying is a natural process and all people have a right to refuse treatment. But that is not euthanasia. Nor is the administration of substances intended to alleviate pain and discomfort which may have the 'double effect' of hastening death. The 'intention' is the key factor.⁹³

The 13 Senators took the view that this was an occasion where the legislature was called upon to provide leadership over a question of profound moral significance, arguing that 'The view that Australia is a pluralist society with diverging values within its citizenry is no justification to uproot a foundation stone of our notions of civilisation and the value we place on human life'.⁹⁴

Of the six other separate responses, two supported the Andrews Bill; in another Senator Coonan declined to state her own conclusions on the Bill, preferring to do so in the forthcoming parliamentary debate; while the other three responses all opposed the Bill, albeit for different reasons. The response of the Northern Territory Senators, Tambling and Collins, focused on constitutional matters, as well as on the process of the Committee's inquiry, of which they were highly critical. Senators Bolkus and McKiernan responded stating it was their intention not to support the Andrews Bill for a variety of reasons. These included considerations based on the rights of individuals and their argument that funds for palliative care were cut by 10% in the previous year's budget. However, the most detailed case against the Andrews Bill, as well as against the advice of the 13 Senators, was presented by Dr Bob Brown, the Australian Greens Senator for Tasmania. In an 'overview'

⁹² Ibid, p 124.

⁹³ Ibid, p 128.

⁹⁴ Ibid.

of his position, Senator Brown said:

As a medical practitioner I was deeply impressed by the plight of those people who died with prolonged and unassailable suffering. That experience led me to support every citizen's right to choose or reject voluntary euthanasia if faced with such personal suffering.

The submissions to the Committee have strengthened that impression. Those who do not want voluntary euthanasia already have the absolute right to reject it. Those who want the option of voluntary euthanasia should no longer be denied their equal right.

Every year, some thousands of Australians spend the last days, weeks or months before they die forced to endure disgustingly painful or otherwise undignified circumstances because outmoded laws, against the wishes of a large majority of Australians, leave them no option.

While a much expanded investment in a national palliative care program would reduce this load of suffering, it cannot and will not eliminate it.⁹⁵

Among Senator Brown's many criticisms of the Committee's report was that its 'analysis of the key issues fails to be the adequate basis upon which conclusions could be safely made'.⁹⁶

(ii) Tasmanian Community Development Committee Report (1998)

The Community Development Committee of the Parliament of Tasmania initiated an inquiry on the need for legislation on voluntary euthanasia in response to the level of public debate prompted by the enactment of the Northern Territory's *Rights of the Terminally Ill Act 1995* and the subsequent repealing legislation, the Federal *Euthanasia Laws Act 1996*. Among other things, the Committee found that:

- Although many of the moral arguments put by both sides of the debate were persuasive, a determination of the need for legislation on active voluntary euthanasia cannot be made on the basis of a subjective moral choice;
- The polarised character of the moral debate for and against active voluntary euthanasia limited its utility as a determinant for legal reform. Euthanasia legislation would have to be based on a general principle that treated all individuals equally;

⁹⁵ Ibid, p 146.

⁹⁶ Ibid, p 177.

- Although individual cases may present a strong argument for change, the obligation of the State to protect the right to life of all individuals equally could not be delivered by legislation based on subjective principles;
- The codification of voluntary euthanasia legislation could not adequately provide the necessary safeguards against abuse;
- Legalisation of voluntary euthanasia would pose a serious threat to the more vulnerable members of society, and that the obligation of the State to protect all its members equally outweighs the individual's freedom to choose voluntary euthanasia;
- In the majority of cases palliative care was able to provide optimum care for suffering patients.
- In a small percentage of cases palliative care is ineffective in relieving all pain, however, whilst regrettable this is not sufficient cause to legalise voluntary euthanasia;
- There is a need for greater resources to expand and improve the quality of palliative care services.⁹⁷

(iii) South Australian Social Development Committee Report (1999)

On 25 March 1998 the Social Development Committee of the South Australian Parliament was given a reference to inquire into the Voluntary Euthanasia Bill 1996, a Private Member's Bill sponsored by the MLC, JAW Levy. The report dealt with the domestic and international law on the subject and canvassed the moral and other arguments for and against active voluntary euthanasia. In relation to the Bill, four of the six members of the Committee recommended that it not be re-introduced and that active voluntary euthanasia and physician-assisted suicide remain criminal offences. The report commented: 'They believed the *Consent to Medical Treatment and Palliative Care Act 1995* not only covered most people's needs, but that South Australia was at the forefront of legislation in this

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In a dissenting report, two members of the Committee recommended that the 1996 Bill be re-introduced and debated; as well, they recommended that 'The criminal status of active voluntary euthanasia and physician-assisted suicide be removed and that these practices be regarded as the ultimate steps in palliative care, steps which a minority of people might wish to access'.⁹⁹

The Committee unanimously recommended that palliative care programs be expanded and that national guidelines and standards on palliative care be developed and implemented. As well, in relation to advance directives, it was recommended that the States and

⁹⁷ Parliament of Tasmania, n 8, pp 5-6.

⁹⁸ Parliament of South Australia, n 7, p xiv.

⁹⁹ Ibid.

Territories establish a protocol to recognise advance requests, such as those permitted under the South Australian legislation.

8. KEY QUESTIONS

John Keown, Lecturer in the Law and Ethics of Medicine at the University of Cambridge, comments that the euthanasia debate raises the following questions:

- is it always wrong for a doctor intentionally to kill a patient, even if the patient is suffering and asking for death?
- does respect for the patient's autonomy not require that his or her request be carried out?
- do patients enjoy a 'right to die' and, if so, what does it mean?
- are only some lives 'worthwhile' and, if so, which and why?
- is there a moral difference between intending to hasten death and foreseeing that life will be shortened, or between killing and letting die, or between euthanasia and assisted suicide?
- can voluntary euthanasia be distinguished in principle from euthanasia without request?
- can voluntary euthanasia be safely regulated or is the 'slippery slope' to euthanasia without request unavoidable?
- is life a benefit for those in a 'persistent vegetative state' or should their feeding and treatment be stopped?
- are 'living wills' or advance directives a desirable mechanism for facilitating treatment decisions in relation to incompetent patients or are they a 'back door' to euthanasia?¹⁰⁰

Keown is, in fact, a well-known opponent of legalising active voluntary euthanasia and, as such, his formulation of the key questions of the euthanasia debate may not be exactly 'value free'. As with every aspect of the contested euthanasia debate they can only be offered as 'one account' of the key questions concerned.

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Keown J, n 15, p 1

9. KEY ISSUES¹⁰¹

If nothing else, the above questions illustrate the fact that the euthanasia debate operates at different levels. It raises issues which belong to moral philosophy, questions relating to legal and practical ethics, as well as considerations of an administrative and procedural kind.

(i) Issues of moral philosophy

Autonomy, self-determination and dignity: Often the case in favour of euthanasia is put in terms of preserving human dignity and respecting the right of individuals to make self-governing choices. This combination of ideas found expression in the judgment of Hoffman 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 of 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 of his value as a person.¹⁰²

One argument is that, due to advances in modern medicine, some individuals find themselves facing a prolonged disintegration of their self-integrity, physically and psychologically, without any hope of cure. The Canadian Supreme Court head such a matter in the *Rodriquez* case, in which the patient asserted ‘that it is a principle of fundamental justice that the human dignity and autonomy of individuals be respected and that to subject her to needless suffering in this manner is to rob her of her dignity’.¹⁰³ The Court did not agree, based primarily on the countervailing duty of the state to protect the sanctity of all human life. An alternative view is presented by Dr Helga Kuhse who addresses the ‘fundamental issue’ of dignity in the following terms:

A dignified death is one which accords with the patient’s values and beliefs, a death that does not contradict the patient’s own view of what it means to lead a good human life and die a dignified death. A mode of dying that is prescribed by the imposition of the

¹⁰¹ These issues are discussed in more detail in the Parliamentary Library’s Background Paper No.3/1995 at pages 10-23.

¹⁰² [1993] AC 789 at 826

¹⁰³ [1993] 3 SCR 519 AT 592 (Sopinka J)

moral or religious beliefs of others is not a dignified death – even if it is relatively pain free.¹⁰⁴

One argument against the case for autonomy is that the informed decisions of competent persons 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. The concern is that euthanasia laws may send the wrong message to the vulnerable and disadvantaged. Former AMA President Dr Brendan Nelson said that: ‘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’.¹⁰⁵ Taking up this theme, Mirko Bagaric, Lecturer in Law at Deakin University, argues that:

The extent to which euthanasia will actually advance patient autonomy has been over-stated. Due to the vulnerability of the patient it is almost impossible to ascertain the level of freedom and rationality associated with a decision to die. Even in the unlikely scenario that some degree of meaningful true autonomy could be guaranteed the probable adverse consequences accompanying the practice are so serious that a decision to nevertheless decriminalise euthanasia would be misguided and irresponsible.¹⁰⁶

The sanctity of life: Fundamental to the argument against euthanasia in all its forms is that it contradicts the principle of the sanctity of human life. 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. From this standpoint *being alive is in itself intrinsically valuable* (irrespective of the quality of that life). As Dr A Fisher of the Australian Catholic University has argued: ‘We have strong feelings that there is an intrinsic value in human life, irrespective of whether it is valuable to the person concerned or indeed to anyone else’. According to Dr Fisher, these beliefs form part of ‘almost everyone’s intuitive values’; it was further contended that ‘No law which ignores them can possibly hope to be acceptable’.¹⁰⁷

Of course, belief in the special worth of human life transcends religious commitment. It 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

¹⁰⁴ Submission to Senate Legal and Constitutional Legislation Committee, n 68, p 61.

¹⁰⁵ D van Gend, ‘Painful arguments in favour of euthanasia’, *Australian Doctor*, 23 June 1995.

¹⁰⁶ M Bagaric, ‘Euthanasia: patient autonomy versus the public good’ (1999) 18 *University of Tasmania Law Review* 146 at 166-167.

¹⁰⁷ Submission to the Parliament of Tasmania, n 8, p 21.

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.¹⁰⁸

A commitment to the value of human life is expressed 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’.

Proponents of euthanasia legislation might argue that a properly formulated law would not deprive a person of his or her life arbitrarily. Also, it can be said that the principle of the sanctity of life is not absolute in nature. Reflecting a secular viewpoint on this issue, Sopinka J in the *Rodriguez* case 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: ‘The principle of the 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’.¹⁰⁹ It is said in this respect that the ‘very sacredness of human life is a crucial argument for rather than against euthanasia’. Explaining the viewpoint held by Professor Ronald Dworkin, Dr Margaret Otlowski submits:

The essence of Dworkin’s thesis is that in order to respect individual patients’ dignity and the intrinsic value of their lives, we must allow individuals freedom of conscience to make mortal decisions for themselves; that ultimate respect for life is shown by respecting individual choice.¹¹⁰

The individual and the common good: 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. Professor Peter Baume summarised this viewpoint when he wrote:

Voluntary euthanasia is justified because it is a self-regarding victimless action arising from an individual decision in a matter which affects individuals alone.¹¹¹

Opposing this, the concern is that the legislation of euthanasia, in any form, will seriously compromise the state’s interest in protecting the right to life (in particular, of vulnerable

¹⁰⁸ [1993] 1 NZLR 235 at 244

¹⁰⁹ [1993] 3 SCR 519 at 595

¹¹⁰ Submission to the Parliament of Tasmania, n 8, p 23.

¹¹¹ Submission to Senate Legal and Constitutional Legislation Committee, n 68, p 58.

members of society). The Northern Territory Select Committee on Euthanasia reported in 1995 that the dichotomy between the rights of the individual, on one side, and the interests of the collectivity, on the other, was the most common theme in the submissions it received.¹¹² Likewise, the South Australian Social Development Committee reported in 1999 that 'A significant number of witnesses argued that active voluntary euthanasia would result in more harm than good. They believed it was imperative that the interests of the minority should be sacrificed for the overall good'.¹¹³ According to the South Australian Committee:

Opponents of legalising active voluntary euthanasia argue that it would compromise the state's interest in protecting the right to life of members of society, particularly of vulnerable members of society such as the frail elderly, the sick, the disabled and the young on behalf of the common good.¹¹⁴

(ii) Issues of legal ethics

Killing and letting die: The question is asked whether there is a real moral difference between intending to hasten death and foreseeing that life will be shortened, or between killing and letting die. This gives rise to some difficult questions of legal ethics.

The conundrum at issue was discussed in an editorial comment in the June 1995 number of the *Criminal Law Journal*. There it was suggested that passive euthanasia, which involves the withdrawal or withholding of life-supporting treatment in certain circumstances, is 'condoned' while active euthanasia is not. The editorial described this distinction as 'highly suspect'. It went on to say:

the criminal law treats an omission to act in the same way as a positive action, if a legal duty to act exists [as it does in the doctor-patient relationship]. Is there really a difference between withholding active support of a terminally ill patient and actively extinguishing his or her life? It is very difficult to appreciate why these options do not amount to the same thing.¹¹⁵

It would seem, on this basis, to be a distinction without a difference. This view was echoed by Lord Browne-Wilkinson (who expressed the hope that Parliament would review the law) in the *Bland* case:

¹¹² Legislative Assembly of the Northern Territory, *Report of the Inquiry by the Select Committee on Euthanasia, Volume Three – Written Submissions*, May 1995.

¹¹³ Parliament of South Australia, n 7, p vi.

¹¹⁴ Parliament of South Australia, n 7, p 75.

¹¹⁵ 'Decriminalising euthanasia' (1995) 19 *Criminal Law Journal* 125

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 the question.¹¹⁶

In the same case Lord Goff of Chievely said that the rationale behind the distinction between killing and letting die was to be found in public policy considerations and not in the precepts of legal reasoning, stating:

in the end the reason for that difference is that, whereas the law considers the discontinuance of life support may be consistent with the doctor's duty to care for his patient, it does not, for the 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.¹¹⁷

In Catholic teaching there is a fundamental distinction between 'ordinary' and non-obligatory 'extraordinary' means of prolonging life. For a doctor to withhold or withdraw the latter is both morally and legally acceptable, for it is tantamount to simply letting nature take its course. A similar view is expressed by the Australian academic, Danuta Mendelson, when she writes:

To require the continuation of a life-support system when it serves no other purpose than to prolong a patient's non-cognitive biological life, is to act contrary to the primary purpose of medicine, which is to preserve and promote health, and to alleviate suffering. In such circumstances, the continuation of artificial means of life support may be lawful, but this does not make the termination of the support systems unlawful, providing the discontinuance accords with good medical practice.¹¹⁸

The doctrine of best interests: In the *Bland* case, the House of Lords authorised the withdrawal of artificial feeding, upon the consent of his parents, from a 17-year-old boy who was in a persistent vegetative state as a result of injuries suffered in a soccer riot. Persistence in this stage was found not to be beneficial to the patient. The principle of the sanctity of life, which was found not to be absolute, was held not to be violated by the withdrawal of treatment. Thus, such withdrawal was found to be in the best interests (as determined by medical judgment) of the patient. A similar approach was adopted in *Auckland Area Health Board v AG*, where it was held that a doctor, acting in good faith and

¹¹⁶ [1993] AC 789 at 866

¹¹⁷ [1993] AC 789 at 866

¹¹⁸ D Mendelson, 'Jurisprudential aspects of withdrawal of life support systems from incompetent patients in Australia' (1995) 69 *The Australian Law Journal* 259 at 271.

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.

This ‘best interests’ doctrine differs to that adopted in the US under the *Cruzan*¹¹⁹ case where the Supreme Court’s approach is based more on the concept of patient autonomy. It was held that, where a patient was unconscious and thus unable to express his or her own views, life-sustaining treatment could only be withdrawn (in the absence of a living will) where there was compelling evidence that the patient would have requested such withdrawal had he or she been competent.

(iii) Practical Issues

Among the many practical issues at stake, four arguments are noted here, two in favour and two opposing the case for voluntary euthanasia.¹²⁰

Euthanasia is practised now: The NSW Voluntary Euthanasia Society told the Senate Legal and Constitutional Legislation Committee that ‘no one knows how many assisted deaths already occur in Australia’ but ‘in one form or another they are said to be notoriously’¹²¹ The Society argued that it would be better to bring the whole question into the open and have honest records kept. The Senate Committee’s survey of research into the practice of euthanasia in Australia is set out at Appendix C.

Predictably, this research is the subject of conflicting interpretations. One example, is the research of Helga Kuhse and others, published in the *Medical Journal of Australia* in February 1997, which, as the Senate Committee pointed out, has been criticised on many grounds from the anti-euthanasia standpoint. One criticism is that the response rate of 64% to the survey, a postal questionnaire sent to 3,000 doctors, suggests that its results may not be representative of Australian doctors, ‘as it is likely that non-respondents may have predominantly been doctors opposed to euthanasia and particularly non-voluntary euthanasia’.¹²² On the other hand, from a pro-euthanasia standpoint Margaret Otlowksi uses the Kuhse survey to argue the case that ‘the practice of bringing about death without explicit request is much more widespread in Australia – a country where the practice of active voluntary euthanasia is prohibited – than it is in the Netherlands where the practice has been quasi-legalized and regulated’.¹²³ Comparing the findings of Kuhse et al with the research undertaken in the Netherlands in 1990 and 1995, Otlowski argues:

¹¹⁹ 110 S CT 2841 (1990)

¹²⁰ These and other arguments for and against voluntary euthanasia are discussed in more detail in the Parliamentary Library’s Background Paper No.3/1995 at pages 54-64.

¹²¹ Senate Legal and Constitutional Legislation Committee, n 68, p 62.

¹²² Ibid, p 88.

¹²³ M Otlowski, n 13, p xiv.

The Australian study, involving a sample of 3,000 doctors from all Australian States and Territories, revealed a much higher incidence in Australia of unrequested active euthanasia than for active voluntary euthanasia (3.5% of all deaths compared with 1.8% for active voluntary euthanasia) and far in excess of the figure for the same category in the Netherlands (0.7% according to the 1995 study). This appears to be largely attributable to the illegality of the practice and the lack of openness on the issues with the consequence that doctors are often taking this decision upon themselves...The substantially higher incidence of non-requested euthanasia in Australia strongly suggests that there are greater risks inherent in the current laws which hold active euthanasia to be illegal, but which are in practice flouted, than exist when genuine attempts are made to control and regulate the practice as has occurred in the Netherlands.¹²⁴

In his submission to the Parliament of Tasmania's Community Development Committee, Senator Abetz said he found the claim that existing practice justifies a change in the prohibition of intentional killing illogical:

This argument is logically weak. Whether euthanasia is a 'common practice' is widely disputed. Even if it were it would not of itself provide a justification. Indeed, if it is widely practised, although it is against the law, it highlights the real concerns of many opponents of euthanasia who argue that the illegal excesses of a minority of doctors will simply become commensurately worse with pro-euthanasia legislation.¹²⁵

Public support for change: Public opinion surveys, it is claimed, show that a sizeable proportion of the community favours some kind of euthanasia legislation. Again, the Senate Committee's overview of these surveys is set out at Appendix C. This included the 1995 poll carried out by the Roy Morgan Research Centre which found that support for voluntary euthanasia stood at 78%. Dr Bob Brown, in his response to the Senate Committee's report commented on the apparent dissonance between the prevailing opinion of the vocal minorities and that of the usually silent majority on this issue, stating:

The preponderant number of submissions to the Committee supporting the [Andrews] Bill, like the vote in the House of Representatives, stands starkly at odds with a consistently large majority of Australians which, according to every opinion poll since the 1950s, supports voluntary euthanasia.¹²⁶

¹²⁴ M Otłowski, n 13, pp xiii-xiv.

¹²⁵ Parliament of Tasmania, n 8, p 34.

¹²⁶ Senate Legal and Constitutional Legislation Committee, n 68, p 147. Senator Brown also criticised the discussion of these opinion poll results in the Committee's report as

Absent from the Senate Committee's overview was the last poll carried out by the Roy Morgan Research Centre, published on 17 September 1996. For this 611 people aged 14 and over were interviewed by telephone. They were first asked whether doctors should let patients die when they are experiencing unrelievable suffering and have no chance of recovery. Two out of three (66%) said the patient should be allowed to die; 16% said doctors should try to keep the patient alive; and 18% were undecided. Three out of four respondents (76%) were in favour of doctors being able to give a lethal dose if requested by a hopelessly ill patient in great pain; 17% were opposed; and 7% were undecided. Moreover, 70% of respondents believed that the other States and Territories should adopt similar laws to the Northern Territory's *Rights of the Terminally Ill Act 1995*.¹²⁷

Opponents of legalisation contend that such poll results should not be accepted at face value, due to confusion as to the terms used, or the methods by which the poll was conducted. Doubts are also expressed about the specific nature of the questions that are asked in this context. Appearing for the group Euthanasia No, Dr Brian Pollard told the Senate Committee that opinion polls on complex ethical matters 'are for political purposes really'. He continued: 'It is not the sort of thing that you can canvass an opinion about, and make decisive responses to, when the understanding of the people polled is not known. In fact, it is unknowable'.¹²⁸

The slippery slope: The argument states that if voluntary euthanasia is accepted then we will invariably be pushed to accept the legalisation of those forms of non-voluntary euthanasia as well. The House of Lords Select Committee on Medical Ethics concluded that it is not possible to secure limits on voluntary euthanasia, stating:

Issues of life and death do not lend themselves to clear definition, and without 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.¹²⁹

The New York State Task Force on Life and Law contended that if voluntary euthanasia were legalised:

incomplete and slanted. The Committee infers, he says, that ordinary Australians do not really understand the issues surrounding active voluntary euthanasia, something he rejects as 'incorrect, patronising and offensive' (page 150).

¹²⁷ The poll findings were published in *The Bulletin*, 17 September 1996.

¹²⁸ Senate Legal and Constitutional Legislation Committee, n 68, p 82.

¹²⁹ House of Lords, *Report of the Select Committee on Medical Ethics*, Session 1993-1\94, HL Paper 21-1, p 49.

[T]he potential for abuse would be profound. This risk does not presume that physicians will act malevolently. On the contrary, this risk is substantial precisely because physicians will act with benevolent motives. Once euthanasia is an establishment as a 'therapeutic' alternative, the line between patients competent to consent and those who are not will seem arbitrary to some doctors. To others, it will seem outright discriminatory or unjust to deny a therapy because of the patient's incapacity to consent.¹³⁰

In effect, the concern is that one cannot quarantine non-voluntary euthanasia from voluntary euthanasia. Various aspects of the Dutch experiment with the decriminalisation of voluntary euthanasia are cited as empirical evidence for this contention. On the other side, proponents of the legalisation of active voluntary euthanasia question the validity of much of this evidence. Otłowski deals with the issue in some detail before concluding:

In order to substantiate a 'slippery slope' argument, it would need to be shown that cases of non-voluntary euthanasia occur more frequently now than they did prior to the quasi-legalization of active voluntary euthanasia in the Netherlands. There is, however, no evidence to suggest that the incidence of such cases is increasing. The Rummelink report [of 1990] is the first extensive study of its kind so no such figures are available.¹³¹

Problems of procedure and complexity: Commentators often point to the difficulties in devising satisfactory procedural safeguards if active euthanasia were legalised. Much of the debate concerning the Northern Territory's *Rights of the Terminally Ill Act 1995* was in these terms, with various claims and counter-claims being made about the adequacy or otherwise of its procedural safeguards. Reflecting on these issues, the Premier of NSW told the Legislative Assembly on 16 October 1996:

I wonder whether we as a Legislature are confident in making a value judgment about what the cooling off period should be for the taking of a human life. The legislative cooling off period for a person who has bought a set of encyclopedias from a door-to-door salesperson is 10 days. Are we happy to have a 48-hour cooling off period for the taking of a human life.¹³²

Responding to the critics of the Northern Territory legislation, the former Chief Minister and instigator of the Act, Marshall Perron, has rejected claims that there could never be a guarantee of effective checks and balances in regulating active voluntary euthanasia and

¹³⁰ The New York State Task Force on Life and Law, *When Death is Sought*, 1994, p 133.

¹³¹ M Otłowski, n13, p 439.

¹³² NSWPD, 16 October 1996, p 4855.

physician-assisted suicide. He told the Parliament of South Australia's Social Development Committee that safeguards could be enacted which would ensure that 'only competent, hopelessly-ill adults, acting voluntarily, were able to access medical assistance to die'. He added, 'Drafting proper safeguards is a matter of striking a sensible balance between preventing non-genuine cases and making the process itself tortuous for the genuinely-motivated suffering patient'.¹³³ The further point made from the pro-euthanasia standpoint is that arguments which assert that euthanasia legislation is unsafe fail to confront the risks inherent in the current legal situation where euthanasia occurs in a hidden and unregulated manner.

On the other side, in his submission to the Parliament of Tasmania's Community Development Committee, Dr Brendan Nelson put the case that end-of-life issues were too complex to be encapsulated in a statutory form. His articulation of that case suggests some of the dilemmas which are found in the euthanasia debate:

I...feel that there are some exceptional circumstances in which it might not be an unreasonable course for a doctor to assist a person to die but I find it impossible to define them...It is very difficult, if not impossible, to get even a set of principles, a code of ethics and certainly not a piece of legislation that will cover all the situations in which we inevitably find ourselves...I have found that the law is a blunt instrument; it does not have the finesse to deal with issues in relation to decision-making that doctors and nurses and family members make with a person who is dying.¹³⁴

¹³³ Parliament of South Australia, n 7, p 66.

¹³⁴ Parliament of Tasmania, n 8, p 30.

APPENDIX A:
THE SOUTH AUSTRALIAN DIGNITY IN DYING BILL 2001

[BIL099-B.HAL]

HOUSE OF ASSEMBLY—No. 79



[As laid on the table and read a first time, 15 March 2001]

South Australia

[Prepared by the Parliamentary Counsel on the instructions of the Hon. R. Such, M.P.]

DIGNITY IN DYING BILL 2001

A BILL FOR

An Act to provide for the administration of medical procedures to assist the death of patients who are hopelessly ill, and who have expressed a desire for the procedures subject to appropriate safeguards.

[OPC-HAS]

Dignity in Dying Bill 2001**SUMMARY OF PROVISIONS**

1. Short title
2. Commencement
3. Objects
4. Definitions
5. Who may request voluntary euthanasia
6. Kinds of request
7. Information to be given before formal request is made
8. Form of request for voluntary euthanasia
9. Procedures to be observed in the making and witnessing of requests
10. Appointment of trustees
11. Revocation of request
12. Register of requests for voluntary euthanasia
13. Registrar's powers of inquiry
14. Administration of voluntary euthanasia
15. Person may decline to administer or assist the administration of voluntary euthanasia
16. Protection from liability
17. Restriction on publication
18. Report to coroner
19. Cause of death
20. Insurance
21. Offences
22. Dignity in Dying Act Monitoring Committee
23. Annual report to Parliament
24. Regulations

SCHEDULE 1*Current Request for Voluntary Euthanasia***SCHEDULE 2***Advance Request for Voluntary Euthanasia***SCHEDULE 3***Certificate of Confirmation***SCHEDULE 4***Report to State Coroner*

Dignity in Dying Bill 2001

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The Parliament of South Australia enacts as follows:

Short title

1. This Act may be cited as the *Dignity in Dying Act 2001*.

Commencement

2. This Act will come into operation 6 months after the date of assent or on an earlier date fixed by proclamation.

Objects

3. The objects of this Act are—

- (a) to give competent adults the right to make informed choices about the time and manner of their death should they become hopelessly ill;
- 10 (b) to ensure that hopelessly ill people who have voluntarily requested euthanasia can obtain appropriate and humane medical assistance to hasten death;
- (c) to ensure that people who may want to request euthanasia are given adequate information before making their request (including information about palliative care) and are not subject to duress or other undue pressure to make a request;
- 15 (d) to ensure that the administration of euthanasia is subject to other appropriate safeguards and supervision;
- (e) to recognise the right of medical practitioners and other persons to refuse to participate in the administration of euthanasia.

Definitions

- 20 4. In this Act—

"adult" means of or above the age of 18 years;

"advance request"—see section 6(1);

"current request"—see section 6(1);

"hopelessly ill"—a person is hopelessly ill if the person has an injury or illness—

- (a) that will result, or has resulted, in serious mental impairment or permanent deprivation of consciousness; or
- (b) that seriously and irreversibly impairs the person's quality of life so that life has become intolerable to that person;

30 "medical practitioner" means a person registered as a medical practitioner under the *Medical Practitioners Act 1983*;

"palliative care specialist" means a medical practitioner who is registered on the specialist register under the *Medical Practitioners Act 1983* and whose principal area of practice is the provision of palliative care;

"Registrar"—see section 12(2);

"voluntary euthanasia" means the administration of medical procedures, in accordance with this Act, to assist the death of a hopelessly ill person in a humane way.

Who may request voluntary euthanasia

5. An adult person who is of sound mind may make a formal request for voluntary euthanasia.

Kinds of request

6. (1) A formal request for voluntary euthanasia must be of one of the following kinds—

- (a) a request (a "current request") by a hopelessly ill person that is intended to be effective without further deterioration of the person's condition; or
- (b) a request (an "advance request") by a person who is not hopelessly ill that is intended to take effect when the person who makes the request becomes hopelessly ill or after the person becomes hopelessly ill and the person's condition deteriorates to a point described in the request.

(2) A formal request for voluntary euthanasia overrides an earlier formal request and, in particular, a current request for voluntary euthanasia overrides an earlier advance request.

Information to be given before formal request is made

7. (1) If a person proposes to make a current request or an advance request for voluntary euthanasia, a medical practitioner must, before the formal request is made, ensure that the person is fully informed—

- (a) if the person is hopelessly ill or suffering from an illness that may develop into a hopeless illness—
 - (i) of the diagnosis and prognosis of the person's illness; and
 - (ii) of the forms of treatment that may be available and their respective risks, side effects and likely outcomes; and
 - (iii) of the extent to which the effects of the illness could be mitigated by appropriate palliative care; and
- (b) if the proposed request is a current request—of the proposed voluntary euthanasia procedure, risks associated with the procedure and feasible alternatives to the procedure (including the possibility of providing appropriate palliative care until death ensues without administration of voluntary euthanasia); and
- (c) if the proposed request is an advance request—of feasible voluntary euthanasia procedures and the risks associated with each of them.

(2) If a medical practitioner providing a person with information in accordance with subsection (1)(a)(iii) is not a palliative care specialist, the medical practitioner must, if reasonably practicable, consult a palliative care specialist about the person's illness and the extent to which its effects would be mitigated by appropriate palliative care before giving the person this information.

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Form of request for voluntary euthanasia

8. (1) A formal request for voluntary euthanasia must be made in writing—

- (a) in the case of a current request—in the form prescribed by Schedule 1; or
- (b) in the case of an advance request—in the form prescribed by Schedule 2.

(2) However, if the person making the request is unable to write, the person may make the request orally in which case the appropriate form—

- (a) must be completed by the witnesses on behalf of the person in accordance with the person's expressed wishes; and
- (b) must, instead of the person's signature, bear an endorsement signed by each witness to the effect that the form has been completed by the witnesses in accordance with the person's expressed wishes.

(3) If practicable, a request for voluntary euthanasia that has been made orally must be recorded on videotape.

Procedures to be observed in the making and witnessing of requests

9. (1) A formal request for voluntary euthanasia must be made in the presence of a medical practitioner and two adult witnesses.

(2) The medical practitioner and both of the witnesses must certify that the person who made the request—

- (a) appeared to be of sound mind; and
- (b) appeared to understand the nature and implications of the request; and
- (c) did not appear to be acting under duress.

(3) The medical practitioner must also certify—

- (a) that the medical practitioner gave the person requesting voluntary euthanasia the information required under this Act¹ before the formal request was made; and
- (b) in the case of a current request—that the medical practitioner, after examining the person for symptoms of depression—
 - (i) has no reason to suppose that the person is suffering from treatable clinical depression; or
 - (ii) if the person does exhibit symptoms of depression—is of the opinion that treatment for depression, or further treatment for depression, is unlikely to influence the person's decision to request voluntary euthanasia.

¹ See section 7.

Appointment of trustees

10. (1) A person who makes an advance request for voluntary euthanasia may, in the instrument of request, appoint one or more persons to be trustees of the request.

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(2) A person is only eligible for appointment as a trustee of a request for voluntary euthanasia if the person is an adult.

(3) The functions of a trustee of the request are—

- (a) to satisfy herself or himself that the preconditions for administration of voluntary euthanasia have been satisfied; and
- (b) to make any necessary arrangements to ensure, as far as practicable, that voluntary euthanasia is administered in accordance with the wishes of the person who requested it.

(4) If a person appoints two or more persons as trustees of a request for voluntary euthanasia, the instrument of request must indicate the order of appointment and, in that case, if the person designated first in order of appointment is unavailable, the person designated second in order of appointment is to act as trustee of the request, if the first and the second are not available, the person designated third in order of appointment is to act as trustee of the request, and so on, but the instrument of request may not provide for two or more persons to act jointly as trustees of the request.

Revocation of request

11. (1) A person may revoke a request for voluntary euthanasia at any time.

(2) A written, oral, or other indication of withdrawal of consent to voluntary euthanasia is sufficient to revoke the request even though the person may not be mentally competent when the indication is given.

(3) A person who, knowing of the revocation of a request for voluntary euthanasia, deliberately or recklessly fails to communicate that knowledge to the Registrar is guilty of an offence.

Maximum penalty: Imprisonment for 10 years.

Register of requests for voluntary euthanasia

12. (1) The Minister must maintain a register of requests for voluntary euthanasia (the "Register").

(2) The Register will be administered by a suitable person (the "Registrar") assigned to administer the Register by the Minister.

(3) If a person who has made a formal request for voluntary euthanasia applies to the Registrar for registration of the request, the Registrar must, on receipt of a copy of the request, register the request in the Register.

(4) If the Registrar is satisfied that a request for voluntary euthanasia has been revoked, the Registrar must register the revocation in the Register.

(5) The Registrar must, at the request of a medical practitioner who is attending a hopelessly ill patient—

- (a) inform the medical practitioner whether a request by the patient for voluntary euthanasia is registered in the Register; and

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- (b) inform the medical practitioner whether any revocation of the patient's request for voluntary euthanasia is registered in the Register; and
- (c) if a request by the patient for voluntary euthanasia is registered in the Register and no revocation of that request is registered in the Register—give the medical practitioner a copy of the registered request.
- (6) No fee may be charged in respect of a duty of the Registrar under this section.
- (7) The regulations may prescribe conditions for access to the Register.

Registrar's powers of inquiry

13. (1) The Registrar may conduct an inquiry to determine whether information recorded, or proposed to be recorded, in the Register is reliable.

(2) The Registrar may, by notice given to a person who may be able to provide information relevant to an inquiry under this section, require the person to answer specified questions or to provide other information within a time and in a way specified in the notice.

(3) A person who fails, without reasonable excuse, to comply with a notice under subsection (2) is guilty of an offence.

Maximum penalty: \$1 250.

Administration of voluntary euthanasia

14. (1) A medical practitioner may administer voluntary euthanasia to a patient if—

- (a) the patient is hopelessly ill; and
- (b) the patient has made a request for voluntary euthanasia under this Act and there is no reason to believe that the request has been revoked; and
- (c) the patient has not expressed a desire to postpone the administration of voluntary euthanasia; and
- (d) the medical practitioner, after examining the patient—
 - (i) has no reason to suppose that the patient is suffering from treatable clinical depression; or
 - (ii) if the patient does exhibit symptoms of depression—is of the opinion that treatment for depression, or further treatment for depression, is unlikely to influence the patient's decision to request voluntary euthanasia; and
- (e) if the patient is mentally incompetent but has appointed a trustee of the request for voluntary euthanasia, the trustee is satisfied that the preconditions for administration of voluntary euthanasia have been satisfied; and
- (f) since the time of the patient's request for voluntary euthanasia, another medical practitioner who is not involved in the day to day treatment or care of the patient has personally examined the patient and has given a certificate in the form prescribed by Schedule 3 (the "certificate of confirmation") certifying—

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(i) that the patient is hopelessly ill; and

(ii) that—

(A) there is no reason to suppose that the patient is suffering from treatable clinical depression; or

(B) if the patient does exhibit symptoms of depression—the practitioner is of the opinion that treatment for depression, or further treatment for depression, is unlikely to influence the patient's decision to request voluntary euthanasia; and

(g) at least 48 hours have elapsed since the time of the examination referred to in paragraph (f).

(2) A medical practitioner may only administer voluntary euthanasia as follows—

(a) by administering drugs in appropriate concentrations to end life painlessly and humanely; or

(b) by prescribing drugs for self administration by a patient to allow the patient to die painlessly and humanely; or

(c) by withholding or withdrawing medical treatment in circumstances that will result in a painless and humane end to life.

(3) In administering voluntary euthanasia, a medical practitioner must give effect, as far as practicable, to—

(a) the expressed wishes of the patient; or

(b) if the patient is mentally incompetent, but has appointed a trustee of the request who is available to be consulted—the expressed wishes of the trustee (so far as they are consistent with the patient's expressed wishes).

Person may decline to administer or assist the administration of voluntary euthanasia

15. (1) A medical practitioner may decline to carry out a request for the administration of voluntary euthanasia on any grounds.

(2) However, if a patient who has requested voluntary euthanasia is hopelessly ill and the medical practitioner who has the care of the patient declines to administer voluntary euthanasia, the medical practitioner must inform the patient or the trustee of the patient's request that another medical practitioner may be prepared to consider the request.

(3) A person may decline to assist a medical practitioner to administer voluntary euthanasia on any grounds without prejudice to the person's employment or other forms of adverse discrimination.

(4) The administering authority of a hospital, hospice, nursing home or other institution for the care of the sick or infirm may refuse to permit voluntary euthanasia within the institution but, if it does so, must take reasonable steps to ensure that the refusal is brought to the attention of patients entering the institution.

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Protection from liability

16. A medical practitioner who administers voluntary euthanasia in accordance with this Act, or a person who assists a medical practitioner to administer voluntary euthanasia in accordance with this Act, incurs no civil or criminal liability by doing so.

Restriction on publication

17. A person must not publish by newspaper, radio, television or in any other way, a report tending to identify a person as being involved in the administration of voluntary euthanasia under this Act, unless—

(a) the person consents to the publication; or

(b) the person has been charged with an offence in relation to the administration or alleged administration of voluntary euthanasia.

Maximum penalty: \$5 000 or imprisonment for one year.

Report to coroner

18. (1) A medical practitioner who administers voluntary euthanasia must make a report to the State Coroner within 48 hours after doing so.

Maximum penalty: \$5 000.

(2) The report—

(a) must be in the form prescribed by Schedule 4; and

(b) must be accompanied by—

(i) the request for voluntary euthanasia or, if the request is registered under this Act, a copy of the request; and

(ii) the certificate of confirmation given by another medical practitioner¹.

¹ See section 14(1)(f).

(3) The State Coroner must forward to the Minister copies of the reports made under this section and the accompanying materials.

Cause of death

19. (1) Death resulting from the administration of voluntary euthanasia in accordance with this Act is not suicide or homicide.

(2) If voluntary euthanasia is administered in accordance with this Act, death is taken to have been caused by the patient's illness.

Insurance

20. (1) An insurer is not entitled to refuse to make a payment that is payable under a life insurance policy on death of the insured on the ground that the death resulted from the administration of voluntary euthanasia in accordance with this Act.

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(2) A person is not obliged to disclose an advance request for voluntary euthanasia to an insurer, and an insurer must not ask a person to disclose whether the person has made an advance request for voluntary euthanasia.

Maximum penalty: \$10 000.

(3) This section applies notwithstanding an agreement between a person and an insurer to the contrary.

Offences

21. (1) A person who makes a false or misleading representation in a formal request for voluntary euthanasia or other document under this Act, knowing it to be false or misleading, is guilty of an offence.

Maximum penalty: Imprisonment for 10 years.

(2) A person who, by dishonesty or undue influence, induces another to make a formal request for voluntary euthanasia is guilty of an offence.

Maximum penalty: Imprisonment for 10 years.

(3) A person convicted or found guilty of an offence against this section forfeits any interest that the person might otherwise have had in the estate of the person who has made the request for voluntary euthanasia.

Dignity in Dying Act Monitoring Committee

22. (1) The Minister must establish a committee to be called the *Dignity in Dying Act Monitoring Committee* (the "Committee").

(2) The Committee will consist of no more than eight members appointed by the Minister of whom—

(a) one must be a person nominated by the South Australian Branch of the Australian Medical Association Inc.; and

(b) one must be a person nominated by The Law Society of South Australia; and

(c) one must be a person nominated by the Palliative Care Council of South Australia Inc.; and

(d) one must be a person nominated by the South Australian Voluntary Euthanasia Society Inc.; and

(e) one must be a person nominated by the South Australian Council of Churches Inc..

(3) The functions of the Committee are—

(a) to monitor and keep under constant review the operation and administration of this Act; and

(b) to report to the Minister, on the Committee's own initiative or at the request of the Minister, on any matter relating to the operation or administration of this Act; and

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(c) to make recommendations to the Minister regarding possible—

(i) amendments to this Act; or

(ii) improvements to the administration of this Act,

which, in the opinion of the Committee, would further the objects of this Act.

(4) The Minister must provide the Committee with a copy of each report received from the Coroner under section 18(3).

(5) A member of the Committee holds office on such conditions and for such term as the Minister determines.

(6) A member of the Committee is entitled to such allowances and expenses as the Minister may determine.

(7) Subject to directions of the Minister, the Committee may conduct its business in such manner as it thinks fit.

Annual report to Parliament

23. On or before 30 September in each year, the Minister must make a report to Parliament on the administration and operation of this Act during the year that ended on the preceding 30 June.

Regulations

24. The Governor may make regulations for the purposes of this Act.

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Dignity in Dying Bill 2001**SCHEDULE 1***Current Request for Voluntary Euthanasia*

1. I *[here set out full name and residential address of the person making the request]* make a request for voluntary euthanasia.

2. I believe that I am presently hopelessly ill and intend the request to be carried out in accordance with the directions given below.

3. I am not acting under duress.

4. I have received the information required under section 7 of the *Dignity in Dying Act 2001*¹.

5. I give the following directions about the timing, place and method of voluntary euthanasia:

[Here set out directions. If any of these matters are to be left to the discretion of a medical practitioner, there should be a statement to that effect.]

.....
(signature)

Date:

Witnesses' certificate

We *[here set out the names and addresses of the two adult witnesses to the request]* certify that—

- (a) the above request for voluntary euthanasia was made in our presence; and
- (b) the person who made the request appeared to be of sound mind and appeared to understand the nature and implications of the request; and
- (c) the person who made the request did not appear to be acting under duress.

.....
(signature)

.....
(signature)

Medical practitioner's certificate

I *[here set out the name and address of the medical practitioner in whose presence the request is made]* certify that—

- (a) the above request for voluntary euthanasia was made in my presence; and
- (b) the person who made the request appeared to be of sound mind and appeared to understand the nature and implications of the request; and
- (c) the person who made the request did not appear to be acting under duress; and
- (d) before the above request was made I provided the person making the request with the information required under section 7 of the *Dignity in Dying Act 2001*¹; and

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(e) after examining the person making the above request—

- I have no reason to suppose that the person is suffering from treatable clinical depression
 - or
 - I have found that the person does exhibit symptoms of depression but I am of the opinion that treatment for depression, or further treatment for depression, is unlikely to influence the person's decision to request voluntary euthanasia.
- [Medical practitioner must delete the statement that is inapplicable]

.....
(signature)

Notes

¹ Section 7 of the *Dignity in Dying Act 2001* provides as follows:

Information to be given before formal request is made

7.(1) If a person proposes to make a current request or an advance request for voluntary euthanasia, a medical practitioner must, before the formal request is made, ensure that the person is fully informed—

- (a) if the person is hopelessly ill or suffering from an illness that may develop into a hopeless illness—
 - (i) of the diagnosis and prognosis of the person's illness; and
 - (ii) of the forms of treatment that may be available and their respective risks, side effects and likely outcomes; and
 - (iii) of the extent to which the effects of the illness could be mitigated by appropriate palliative care; and
- (b) if the proposed request is a current request—of the proposed voluntary euthanasia procedure, risks associated with the procedure and feasible alternatives to the procedure (including the possibility of providing appropriate palliative care until death ensues without administration of voluntary euthanasia); and
- (c) if the proposed request is an advance request—of feasible voluntary euthanasia procedures and the risks associated with each of them.

(2) If a medical practitioner providing a person with information in accordance with subsection (1)(a)(iii) is not a palliative care specialist, the medical practitioner must, if reasonably practicable, consult a palliative care specialist in relation to the person's illness before giving the person this information.

² If the person making the request is unable to sign the request, the request must, instead of the signature, bear an endorsement signed by the two adult witnesses to the effect that the form has been completed by the witnesses in accordance with the person's expressed wishes.

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Dignity in Dying Bill 2001**SCHEDULE 2*****Advance Request for Voluntary Euthanasia***

1. I *[here set out full name and residential address of the person making the request]* make a request for voluntary euthanasia.

2. This is an advance request which I make in anticipation of becoming at some future time hopelessly ill and incompetent to make the request and I ask that the request be carried out, in that event, in accordance with the directions given below.

3. I am not acting under duress.

4. I appoint *[here set out name and address of trustee or trustees]* as trustees of this request¹.

5. I have received the information required under section 7 of the *Dignity in Dying Act 2001*².

6. I give the following directions about the timing, place and method of voluntary euthanasia:

[Here set out directions. If any matters are to be left to the discretion of a trustee of the request or a medical practitioner, there should be a statement to that effect.]

.....
(signature³)

Date:

Witnesses' certificate

We *[here set out the names and addresses of the two adult witnesses to the request]* certify that—

- (a) the above request for voluntary euthanasia was made in our presence; and
- (b) the person who made the request appeared to be of sound mind and appeared to understand the nature and implications of the request; and
- (c) the person who made the request did not appear to be acting under duress.

.....
(signature)

.....
(signature)

Medical practitioner's certificate

I *[here set out the name and address of the medical practitioner in whose presence the request is made]* certify that—

- (a) the above request for voluntary euthanasia was made in my presence; and
- (b) the person who made the request appeared to be of sound mind and appeared to understand the nature and implications of the request; and
- (c) the person who made the request did not appear to be acting under duress; and
- (d) before the above request was made I provided the person making the request with the information required under section 7 of the *Dignity in Dying Act 2001*²; and

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(e) after examining the person making the above request—

- I have no reason to suppose that the person is suffering from treatable clinical depression
 - or
 - I have found that the person does exhibit symptoms of depression but I am of the opinion that treatment for depression, or further treatment for depression, is unlikely to influence the person's decision to request voluntary euthanasia.
- [Medical practitioner must delete the statement that is inapplicable]*

.....
(signature)

Certificate of trustee of the request¹

I [here set out the name and address of the trustee] certify that—

- (a) I am willing to undertake the responsibilities of a trustee of the above request for voluntary euthanasia under the *Dignity in Dying Act 2001*; and
- (b) I will act in that capacity in accordance with the desires of the person who makes the request (so far as they are known to me) and, subject to that, in what I genuinely believe to be that person's best interests.

.....
(signature)

Notes

¹ The appointment of a trustee (or trustees) of the request is optional (and if a trustee is not to be appointed the provisions for appointment should be struck from the form). If two or more trustees are appointed the order of appointment must be indicated by placing the numbers 1, 2, 3.... beside each name. This indicates that if the first is not available, the second is to act as trustee of the request, if the first and second are not available, the third is to act, and so on. It should be noted that the instrument of request cannot provide for two or more persons to act jointly as trustees of the request. (See section 10(4) of the *Dignity in Dying Act 2001*.)

² Section 7 of the *Dignity in Dying Act 2001* provides as follows:

Information to be given before formal request is made

7.(1) If a person proposes to make a current request or an advance request for voluntary euthanasia, a medical practitioner must, before the formal request is made, ensure that the person is fully informed—

- (a) if the person is hopelessly ill or suffering from an illness that may develop into a hopeless illness—
 - (i) of the diagnosis and prognosis of the person's illness; and
 - (ii) of the forms of treatment that may be available and their respective risks, side effects and likely outcomes; and
 - (iii) of the extent to which the effects of the illness could be mitigated by appropriate palliative care; and

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- (b) if the proposed request is a current request—of the proposed voluntary euthanasia procedure, risks associated with the procedure and feasible alternatives to the procedure (including the possibility of providing appropriate palliative care until death ensues without administration of voluntary euthanasia); and
- 5 (c) if the proposed request is an advance request—of feasible voluntary euthanasia procedures and the risks associated with each of them.
- (2) If a medical practitioner providing a person with information in accordance with subsection (1)(a)(iii) is not a palliative care specialist, the medical practitioner must, if reasonably practicable,
- 10 consult a palliative care specialist in relation to the person's illness before giving the person this information.
- ³. If the person making the request is unable to sign the request, the request must, instead of the signature, bear an endorsement to the effect that it has been completed by the two adult witnesses in accordance with the person's expressed wishes.

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SCHEDULE 3

Certificate of Confirmation

I [here set out full name and address of the medical practitioner who gives the certificate of confirmation] certify as follows:

1. I personally examined [here set out full name and residential address of the patient] at [here set out place of examination] at [here set out time of examination] on [here set out date of examination].

2. I am not involved in the day to day treatment or care of the patient.

3. I find the patient to be suffering from the following illness:

[here set out description of the patient's illness]

4. In my opinion the patient is hopelessly ill for the following reasons:

[here set out reasons for believing the patient to be hopelessly ill]

5. After examining the patient—

• I have no reason to suppose that the patient is suffering from treatable clinical depression

or

• I find that the patient did exhibit symptoms of depression but I am of the opinion that treatment for depression, or further treatment for depression, is unlikely to influence the patient's decision to request voluntary euthanasia.

[delete the statement that is inapplicable]

.....
(signature)

Date.

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Dignity in Dying Bill 2001**SCHEDULE 4****Report to State Coroner¹**

I [here set out full name and address of the medical practitioner who administered voluntary euthanasia] administered voluntary euthanasia to [here set out full name and residential address of the patient] at [here set out place of administration] on [here set out date of administration].

1. The patient had been in my care for [here set out the period].

2. The nature of the patient's illness was as follows:

[here set out description of the patient's illness]

3. In my opinion the patient was hopelessly ill for the following reasons:

[here set out reasons for believing the patient to be hopelessly ill]

4. After examining the patient—

• I had no reason to suppose that the patient was suffering from treatable clinical depression or

• I found that the patient did exhibit symptoms of depression but I am of the opinion that treatment for depression, or further treatment for depression, was unlikely to influence the patient's decision to request voluntary euthanasia.

[delete the statement that is inapplicable]

5. Voluntary euthanasia was administered as described below:

[here set out time, place and method of administration]

6. The death ensued as follows:

[here state time, place and manner of death]

.....
(signature)

Date:

Notes

¹ This report must be accompanied by—

- (a) the request for voluntary euthanasia or, if the request is registered under the *Dignity in Dying Act 2001*, a copy of the request; and
- (b) the certificate of confirmation given by another medical practitioner under section 14(1)(f) of the *Dignity in Dying Act 2001*.

APPENDIX B:
LEGISLATION IN AUSTRALIA PROVIDING FOR ADVANCE DIRECTIVES,
MEDICAL JOURNAL OF AUSTRALIA VOL. 172, 5 JUNE 2000.

1: Legislation in Australia providing for advance directives

Victoria

Act: Medical Treatment Act 1988 (Vic).

Type of advance directive: Refusal of treatment certificate (RTC). Treatment refused must relate to a current condition ("current condition" is not defined by the Act but presumably refers to a condition that the person has at the time of completing the RTC). The document must be in the form prescribed by the Act ("in the form" is also not defined, but presumably means in language consistent with that used in the Act).

Legally valid if completed voluntarily by a person of sound mind over 18 years who is informed about their condition. Must be signed by a registered medical practitioner and another person who attest to these matters. The patient does not need to sign.

Revoked by patient clearly indicating this wish to another person.

Palliative care: The RTC does not cover refusal of palliative care, which is defined as "the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or the reasonable provision of food and water".

Physicians' liability: Under the Act, a doctor who treats a patient despite a valid certificate may commit the statutory offence of medical trespass. This offence would arise in addition to common law claims of battery. Doctors who comply with an RTC are granted immunity from civil claims, criminal charges or professional misconduct proceedings, provided the doctor acts in good faith and with reasonable care.

South Australia

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

Type of advance directive: An "anticipatory grant" refusing consent to medical treatment. The directive is only effective for patients in the terminal stages of a terminal illness or in a persistent vegetative state, who are not competent to make treatment decisions. "Terminal illness" is defined as "an illness or condition that is likely to result in death" and terminal stage as "the phase of the illness reached when there is no real prospect of recovery or remission of symptoms".

Legally valid if made by a patient of sound mind over the age of 18 years. Must be in the prescribed form, signed by the patient and witnessed by one person, who need not be a medical practitioner.

Revoked by patient orally or in writing (not stipulated in the Act).

Physicians' liability: Physicians honouring directives under the Act are granted immunity from civil and criminal liability if they act in good faith, without negligence and in accordance with proper standards of professional practice.

Australian Capital Territory

Act: Medical Treatment Act 1994 (ACT), based on the Medical Treatment Act 1988 (Vic).

Type of advance directive: "Direction" refusing treatment generally or treatment of a particular kind. Treatment does not have to relate to a current condition, as it does in Victoria.

Legally valid if patients are of sound mind over 18 years. Direction must be in the prescribed form and witnessed by two people, neither of whom needs to be a medical

practitioner. It can be signed by the patient or by another person at the patient's direction, but it does not have to be signed to be valid.

Revoked by patient clearly indicating his or her wish to another person.

Palliative care: Does not cover refusal of palliative care.

Physicians' liability: A physician honouring a certificate in good faith is protected from civil and criminal liability, as well as claims of professional misconduct.

Queensland

Act: Powers of Attorney Act 1998 (Qld)

Type of advance directive: "Advance health directives." Directions to withhold or withdraw life-sustaining measures cannot operate unless:

- the patient has a terminal illness or an incurable condition and is not expected to live more than a year, or is in a persistent vegetative state, or is permanently unconscious, or has a severe illness with no reasonable prospect of being able to live without the continued application of life-sustaining measures; and
- (if the direction concerns artificial hydration or nutrition) the life-sustaining measure would be contrary to good medical practice; and
- the patient has no reasonable prospect of regaining capacity for health matters.

Legally valid if the directive is in the prescribed form, signed by the patient or another person at the patient's direction and witnessed by two people, one of whom must be a medical practitioner. The witnesses must certify that the patient had the capacity to make the treatment decision at the time of completing the directive.

Revoked by patient indicating his or her wish in writing.

Physicians' liability: Physicians are protected from criminal and civil liability if they honour the directive in good faith.

Northern Territory

Act: Natural Death Act 1988 (NT).

Type of advance directive: "Directives" refusing treatment are only effective in the case of terminal illness, which is defined as "Such an illness, injury or degeneration of mental or physical faculties that death would, if extraordinary measures were not undertaken, be imminent; and from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken". Extraordinary measures are defined in the Act 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".

Legally valid if made by patients of sound mind who are over 18 years. Must be in the prescribed form, signed by the patient and witnessed by two people, who need not be medical practitioners. The treating doctor cannot be a witness.

Revoked by patient orally or in writing (not stipulated by the Act).

Palliative care: Does not cover refusal of palliative care.

Physicians' liability: Physicians complying with directives in good faith are protected from criminal and civil liability.

APPENDIX C:
SURVEYS IN AUSTRALIA ON EUTHANASIA, THE PARLIAMENT OF THE
COMMONWEALTH OF AUSTRALIA, SENATE LEGAL AND CONSTITUTIONAL
LEGISLATION COMMITTEE, REPORT ON EUTHANASIA LAWS BILL 1996.

CHAPTER 7

SURVEYS IN AUSTRALIA ON EUTHANASIA

Introduction

7.1 Those for and against euthanasia drew the Committee's attention to various surveys conducted in Australia in order to support their views on the Euthanasia Laws Bill 1996.

7.2 These surveys fall broadly into the following three categories:

- attitudes of the general public to euthanasia;
- attitudes and practices of the medical profession;
- extent of support in the Northern Territory for the *Rights of the Terminally Ill Act*.

General Public Attitudes

7.3 Many submissions and several witnesses referred the Committee to opinion polls conducted by Morgan and Newspoll showing a high level of general public support for euthanasia. The results of these polls are as follows:

The Morgan Polls

7.4 Since 1962 a Morgan Poll has asked:

"If a hopelessly ill patient, in great pain, with absolutely no chance of recovering, asks for a lethal dose, so as not to wake again, should a doctor be allowed to give a lethal dose, or not?"

7.5 In October 1962, the response to this question was that 47 per cent responded that the doctor should give a lethal dose; 39 per cent responded that the doctor should not give a lethal dose and 14 per cent were undecided.

7.6 By June 1995 the figures were 78 per cent; 14 per cent and 8 per cent respectively, with support for the doctor giving a lethal dose having risen steadily in the interim.¹

7.7 The Committee questioned representatives of the Voluntary Euthanasia Societies on what weight the Committee should give to these results. Mr John Greenwell responded:

The first issue is what I might call democratic principle: to what extent should the parliament give effect to that poll, assuming it to

¹ *Morgan Poll*, Finding No. 2768, p. 3.

be accurate? The second issue, which is of equal importance, is that, even if you take a view that the parliament is not in any way constrained by that kind of majority in the attitude it takes as a matter of democracy, nevertheless it does reflect a change of values in the community. The importance of it is ... not just the one poll you have mentioned but is the succession of polls over 40 years. It was 40 per cent in 1940, it reached 60 per cent in about the 1970s and it climbed to about 75 per cent - the same question. No doubt there is a lot of ignorance in the community. I am not going to say that the polls are an absolutely perfect reflection of a considered view on the part of every member of the community. But it is very difficult to say, in the face of that poll, that the community as a whole no longer accepts that the preservation of life should be an absolute. Rather, what the community's value is now is that in certain circumstances, in the case of great suffering and a person wanting to die, that person should be allowed to do so.²

7.8 Dr Brian Pollard, appearing on behalf of Euthanasia NO, questioned the weight that should be given to public opinion polls on the ground that the public may not be fully informed about the euthanasia issue. He said:

Euthanasia is an extremely complex subject, as everybody knows, and the understandings of different people vary across a very wide range of opinion. For some, emotional argument prevails, but for anybody the question of taking an innocent human life involves an ethical content. So an opinion poll of members of the public about an ethical issue - is it right, or is it not right - I do not think is an appropriate use of an opinion poll. They are for political purposes really. It is not the sort of thing that you can canvas an opinion about, and make decisive responses to, when the understanding of the people being polled is not known. In fact, it is unknowable. Their understanding of the issue is not known and is not knowable. You do not know what they know about it. So you think, 'Now where did they get their information from?' Most likely, most people get their information from the media. The media presentations generally are emotional, they are ratings driven, very often superficial and that is about the extent of the understanding of a lot of people about euthanasia. So an opinion poll is finding what the media have wanted people to know.³

7.9 In relation to the Morgan Poll Dr Pollard has contended that "it would be hard for an uninformed person to answer no to the question without feeling negligent, dogmatic or insensitive."⁴ Dr Pollard has suggested that the question should be rephrased as follows:

2 *Evidence*. Voluntary Euthanasia Societies, p. 229.

3 *Evidence*. Euthanasia NO, p. 217.

4 *Submission No. 4038*. Dr C. Hassed, p. 18.

If a doctor is so negligent as to leave a terminally ill patient in severe pain, for whatever reason, severe enough to drive that person to ask to be killed, should the doctor then be able to compound his negligence by killing his patient, instead of seeking help?⁵

Newspoll

7.10 A Newspoll conducted between July 5 and 7 1996 asked the following question:

"Thinking now about euthanasia where a doctor complies with the wishes of a dying patient to have his or her life ended. Are you personally in favour or against changing the law to allow doctors to comply with the wishes of a dying patient to end his or her life?

7.11 The Poll recorded 53 per cent strongly in favour; 22 per cent partly in favour (making a sub-total of 75 per cent in favour); 6 per cent partly against; 12 per cent strongly against (making a total of 18 per cent against) and 7 per cent uncommitted.⁶

7.12 The Newspoll also asked the following question:

And are you personally in favour or against changing the law to allow doctors to perform active euthanasia, for example, by giving a patient a lethal injection? If in favour - is that strongly in favour or partly in favour? If against - is that strongly against or partly against?

7.13 The Poll recorded 39 per cent strongly in favour; 24 per cent partly in favour (making a sub-total of 63 per cent in favour); 11 per cent partly against; 17 per cent strongly against (making a total of 28 per cent against) and 9 per cent uncommitted.⁷

Practices and Attitudes of the Medical Profession

7.14 A number of surveys have also been carried out to gauge the practices and attitudes of Australian medical practitioners to voluntary euthanasia.

7.15 These surveys cover a number of issues, including the extent to which "medical end-of-life decisions" are already carried out in Australia, the extent to which they would be practiced as an alternative to palliative care, and the degree to which doctors would change their practices with regard to end-of-life decisions if euthanasia were legalised.

5 Submission No. 4038, Dr C. Hassed, p. 19; Evidence, Dr B Pollard, p. 217.

6 The Australian, 9 July 1996.

7 The Australian, 9 July 1996.

Kuhse & Singer, 1987 and Baume & O'Malley, 1994

7.16 In 1987, Professors Helga Kuhse and Peter Singer conducted a survey of doctors in Victoria which found that:

- 48 per cent had been asked by a patient to hasten his or her death;
- 29 per cent had taken active steps to bring about the death of a patient who had asked them to do so;
- of these, 80 per cent had done so more than once;
- 98 per cent still thought they had done the right thing; and
- 60 per cent thought that the law should be changed to permit active voluntary euthanasia.⁸

7.17 A similar survey relating to the practices of New South Wales and Australian Capital Territory doctors conducted by Professor Peter Baume and Emma O'Malley⁹ found that:

- 47 per cent had been asked by a patient to hasten his or her death;
- 28 per cent had taken active steps to bring about the death of a patient who had asked them to do so;
- of these, 81 per cent had done so more than once;
- 93 per cent still thought they had done the right thing;
- 58 per cent thought that the law should be changed to permit active voluntary euthanasia; and
- 46 per cent thought that the law should be changed to permit physician-assisted suicide.¹⁰

7.18 Professor Baume claimed in a subsequent article that the Kuhse & Singer and Baume & O'Malley surveys established that about 14 per cent of medical practitioners practice voluntary euthanasia.¹¹

7.19 The discussion of the survey also suggested that half of all practitioner respondents would practice active voluntary euthanasia if it was legal.¹²

8 Baume P and O'Malley E, "Euthanasia: attitudes and practices of medical practitioners", *The Medical Journal of Australia*, Vol. 161, 18 July 1994, pp. 140 and 142.

9 Baume and O'Malley determined that of 2000 questionnaires sent, 1667 had been seen by the medical practitioners to whom they were addressed, of whom 1268 responded, giving a final response rate of 76.1 per cent.

10 Baume P and O'Malley E, "Euthanasia: attitudes and practices of medical practitioners", *The Medical Journal of Australia*, Vol. 161, 18 July 1994, pp. 140 and 142.

11 Baume P, "Voluntary euthanasia", *Australian Quadrant*, Vol. 68, No. 3 1996, p. 17.

7.20 The Australia and New Zealand Society of Palliative Medicine has contended that the Kuhse & Singer and Baume & O'Malley studies were flawed because the questions asked were not specific and so were open to interpretation.¹³

Waddell et al., 1996

7.21 A survey conducted in September and November 1995¹⁴ put *inter alia* the following hypothetical clinical case scenario to a random sample of Australian doctors in all States and Territories:

A 56 year old man; competent, with a progressively debilitating, although not imminently terminal, condition (motor neurone disease with dysphagia), requesting physician-assisted death.¹⁵

7.22 The doctors were asked how they would treat this patient, with the following results:

- 87.4 per cent of interns, 86.1 per cent of general practitioners, 94.8 per cent palliative care practitioners and 84.1 per cent of specialists responded that they would provide good palliative care only;
- 6.3 per cent of interns, 8.3 per cent of general practitioners, 1.3 per cent of palliative care practitioners and 11.2 per cent of specialists said that they would assist death by providing the means; and
- 6.3 per cent of interns, 5.6 per cent of general practitioners, 3.9 per cent of palliative-care practitioners and 4.7 per cent of specialists responded that they would assist death by active intervention.¹⁶

7.23 The authors of the study concluded that that:

- doctors did not make consistent decisions with regard to the end of life;
- they generally followed patient and family wishes when known;
- they did not generally adhere to a patient's request for assisted death.¹⁷

12 Baume P and O'Malley E. "Euthanasia: attitudes and practices of medical practitioners". *The Medical Journal of Australia*. Vol. 161, 18 July 1994. p. 144.

13 *Submission No. 4538*. Council of the Australian and New Zealand Society of Palliative Medicine. p. 39.

14 This was a postal survey of self-administered questionnaires to a random sample of 2172 Australian doctors in all States and Territories. Hospital trainees, general practitioners, palliative care practitioners and surgeons were surveyed. The response rate was 73 per cent.

15 Waddell C et al. "Treatment decision-making at the end of life: a survey of Australian doctors' attitudes towards patients' wishes and euthanasia". *The Medical Journal of Australia*, Vol. 165, 18 November 1996, p. 541.

16 Waddell C et al. "Treatment decision-making at the end of life: a survey of Australian doctors' attitudes towards patients' wishes and euthanasia". *The Medical Journal of Australia*, Vol. 165, 18 November 1996, p. 542.

7.24 The authors of the survey commented:

With respect to euthanasia, this study showed that few doctors would have complied with the wish of the patient who requested assisted death. Baume & O'Malley speculated that such reluctance was a function of the illegality of the action. Our data does not support this speculation. While patient's wishes, and ethical and religious factors for doctors (as with Baume et al.), seem to be more efficient predictors than legal factors, even the three former factors explain little of the variance in doctors' responses to this request for assisted death ...¹⁸

Flinders University, 1996

7.25 A study of 298 South Australian doctors, including 131 general practitioners, reproduced in the *Australian Doctor* is reported to have found that:

- 33 per cent had received requests from patients to perform active euthanasia;
- 22 per cent had received a request from a patient's family;
- 19 per cent had taken steps to bring about the death of a patient;
- 68 per cent believed that guidelines should be established for withholding or withdrawing treatment;
- 49 per cent of doctors who had helped a patient to die had received no request from the patient;
- 54 per cent of doctors who had helped a patient to die had received no request from the patient's family;
- of the doctors who had practiced euthanasia, 50 per cent considered it to be right and 32 per cent felt it was right when requested by the patient;
- of those who had practiced euthanasia, 85 per cent felt they had "done the right thing", 13 per cent said they had not and the remainder were unsure.¹⁹

17 Waddell C et al. "Treatment decision-making at the end of life: a survey of Australian doctors' attitudes towards patients' wishes and euthanasia", *The Medical Journal of Australia*, Vol. 165, 18 November 1996, p. 540.

18 Waddell C et al. "Treatment decision-making at the end of life: a survey of Australian doctors' attitudes towards patients' wishes and euthanasia", *The Medical Journal of Australia*, Vol. 165, 18 November 1996, p. 544.

19 Hoey F. "Euthanasia study finds belief split in doctors". *Australian Doctor*, 15 November 1996.

Kuhse, Singer and Baume 1997

7.26 The Kuhse, Singer and Baume survey was published in *The Medical Journal of Australia* on 17 February 1997.²⁰ The survey took the form of a postal questionnaire sent to 3,000 doctors between May and July 1996. The questionnaire was based on a translation of a Dutch questionnaire used by Professor P.J. van der Maas to determine the frequency of medical end-of-life decisions in Holland during 1995

7.27 This was done in order to gauge Australian practices relating to medical end-of-life decisions and to compare the incidence of euthanasia and other medical end-of-life decisions in Australia with the position in The Netherlands where euthanasia is practiced openly.

7.28 The findings of the Kuhse, Singer and Baume survey are set out below;²¹

<i>Total deaths (all causes) Australia 1995-96</i>	<i>125,771</i>
1. Active voluntary euthanasia	1.8%
2. Physician-Assisted suicide	0.1%
3. Intentional life-terminating acts without explicit concurrent request	3.5%
4. Opioids in large doses	30.9%
5. Withdrawing/with-holding potentially life-prolonging treatment	28.6%
6. Total of 1 - 5	64.8%

7.29 The Kuhse, Singer and Baume survey also reported that:

- of the 28.6 per cent of Australian deaths that involved a decision to withdraw or withhold treatment:
 - in 3.9 per cent of cases there was no intention to hasten death; and
 - in 24.7 per cent of cases the decision was explicitly intended to hasten death or not prolong life.²²
- Of the 30.9 per cent of Australian deaths in the period that resulted from a decision to alleviate pain and suffering thorough the administration of opioids in sufficient doses to hasten death:
 - in 24.4 per cent of cases there was no intention to hasten death;
 - in 6.5 per cent of cases the decision was partly intended to hasten death.²³

20 Kuhse H et al., "End-of-life decisions in Australian medical practice", *The Medical Journal of Australia* Vol. 166, 17 February 1997, p. 191.

21 Kuhse H et al., "End-of-life decisions in Australian medical practice", *The Medical Journal of Australia* Vol. 166, 17 February 1997, p. 196 (Table 5).

22 Kuhse H et al., "End-of-life decisions in Australian medical practice", *The Medical Journal of Australia* Vol. 166, 17 February 1997, p. 195 (Table 4).

23 Kuhse H et al., "End-of-life decisions in Australian medical practice", *The Medical Journal of Australia* Vol. 166, 17 February 1997, p. 191 at p. 195 (Table 4).

- the rates of intentionally ending life without an explicit request from the patient were significantly higher in Australia than in the Netherlands: it was claimed that 22.5 per cent of all Australian deaths involved the doctor withholding or withdrawing treatment from patients without the patient's explicit request and with the explicit intention of ending life. While no comparable 1995 figure was available for the Netherlands, the 1991 figure was 5.3 per cent, and the 1991 figure for *all* decisions to forgo treatment with an explicit intention of causing death or not prolonging life in the Netherlands was 13.3 per cent.²⁴

7.30 A number of criticisms or allegations have been made of the Kuhse, Singer and Baume survey, the most detailed of which was in the form of a supplementary submission to the Committee from Mr Nicholas Tonti-Filippini and his colleagues, Dr John Fleming, Dr Anthony Fisher and Ms Anna Krohn. The criticisms included the following:

- although it used a similar questionnaire to the two van der Maas surveys, the van der Maas surveys involved lengthy face-to-face interviews with doctors; the Kuhse, Singer and Baume questionnaire was sent by post and self-administered;²⁵
- the 1991 Dutch survey employed a prospective study (together with a retrospective study and a death certificate study); the Kuhse, Singer and Baume survey only employed a retrospective questionnaire. The prospective study carried out in the Dutch study involved doctors filling out a questionnaire each time they made a medical decisions relating to the end of life; being contemporaneous it was arguably more accurate than a retrospective study;²⁶
- similarly, the follow-up Dutch survey relating to deaths in 1995 employed a death certificate study as well as a retrospective study with interviews;²⁷
- the response rate to the Kuhse, Singer and Baume survey was 64 per cent. It has been argued their results are not representative as it is likely that non-respondents may have predominantly been doctors opposed to euthanasia and particularly non-voluntary euthanasia.²⁸ (However, Professor Singer has suggested that the main reason for non-response by doctors was that they were

24 Kuhse H et al., "End-of-life decisions in Australian medical practice", *The Medical Journal of Australia* Vol. 166, 17 February 1997, p. 195.

25 Dr R Manne, *Late Night Live*, ABC Radio National, 18 February 1997.

26 Dr R Manne, *Late Night Live*, ABC Radio National, 18 February 1997.

27 *Submission No. 4040a*, Mr N Tonti-Filippini et al., p. 9.

28 Compare Baume P and O'Malley E, "Euthanasia: attitudes and practices of medical practitioners", *The Medical Journal of Australia*, Vol. 161, 18 July 1994, p. 140 referring to their 1994 survey:

The telephone follow-up of non-respondents [to the survey] allowed comparison of the general opinions of respondents and non-respondents towards AVE [active voluntary euthanasia] The non-respondents were less likely to agree that it is sometimes right for a doctor to take (active) steps to bring about a patient's death ...

too busy and that even if all non-respondents were opposed to non-voluntary euthanasia the incidence would still be higher in Australia than Holland.²⁹⁾

- question 5 in the Kuhse, Singer and Baume survey regarding medical decisions to withdraw or withhold treatment asked about such decisions when they were taken with the explicit intention of *not prolonging life* or hastening the end of life. In this respect it arguably differs from the equivalent question in the Dutch survey relating to deaths in 1995.³⁰ It has been argued that there is a difference between not prolonging life and hastening death and that the Kuhse, Singer and Baume survey should have distinguished between the two.³¹
- the use of the expression "explicit intention of not prolonging life" in this question oversimplifies an act in which the primary concern or direct intention of the doctor is not to impose excessive burdens of the treatment itself.³²
- it has been argued that the majority of Australian non-consent cases revealed the Kuhse, Singer and Baume survey, comprised withholding or withdrawing of treatment cases deriving from the different question used³³, and that in any event there is no obligation on the medical practitioner to offer treatments which medical judgement considers not be reasonable care because the treatment is overly burdensome and the likely benefit decreasing.³⁴

7.31 Professor Kuhse responded in detail to the critique from Mr Tonti-Filippini. She said that the critique could not establish its central claims: "as a consequence, our study ... remains unscathed".³⁵ Her response elicited a further reply from Mr Nicholas Tonti-Filippini and colleagues in which they maintained the validity of their main criticisms.³⁶

AMA Questions - 1997

7.32 By agreement with the Australian Medical Association, the authors of the Kuhse, Singer and Baume survey added two questions devised by the AMA to the questionnaire. These questions went to the issue of whether doctors felt that their current practices relating to end-of-life decisions were inhibited by the law, and whether there was a need for a change in the law.

29 Professor P Singer, *Late Night Live*, ABC Radio National, 17 February 1997.

30 *Submission No. 4040a*, Mr N Tonti-Filippini et al., pp. 11-12.

31 Dr D van Gend, *Late Night Live*, ABC Radio National, 18 February 1997; *Submission No. 4040a*, Mr N Tonti-Filippini et al., p. 7.

32 *Submission No. 4040a*, Mr N Tonti-Filippini et al., p. 7.

33 Dr D van Gend, *Late Night Live*, ABC Radio National, 18 February 1997; *Submission No. 4040a*, Mr N Tonti-Filippini et al., pp. 7-8.

34 *Submission No. 4040a*, Mr N Tonti-Filippini et al., p. 8.

35 *Submission No. 4037b*, Prof H Kuhse, p. 1.

36 *Submission No. 4040b*, Mr N Tonti-Filippini et al.

7.33 The first issue had been touched on in the 1994 Baume & O'Malley study, suggesting that the law was a major inhibition and also the 1995 Waddell study, suggesting that the law was not.

7.34 The questions and results (raw data) are set out below:

Question 24

Did your perception of the law, as it applies your State and Territory, inhibit or interfere with your preferred management of the patient and end of life decision?

yes - go to Question 25

no - go to Question 26

Yes 92

No 1008

No answer 12

Question 25

Would enactment of the laws providing defined circumstances in which a drug may be prescribed and/or administered to patients with terminal illness, with the explicit purpose of hastening the end of life, have enabled your patient to receive better and more appropriate care?

Yes 96

No 467

No answer 549³⁷

7.35 The President of the AMA, Dr Keith Woollard, has written that these results tend to indicate that legalising euthanasia or physician-assisted suicide is unlikely to help medical practitioners in the management of severely or terminally ill patients.³⁸

Steinberg et al., 1997 (Queensland)

7.36 This study comprised two surveys; one of the general public and one of medical practitioners.³⁹ The authors found that:

... lay members of the Queensland community were significantly more likely to support a change in the law to allow active voluntary euthanasia and physician-assisted suicide, and less likely to think that such requests would still be made if pain control were available, than medical practitioners.⁴⁰

37 Letter dated 19 February 1997 from Dr Keith Woollard, President of the Australian Medical Association, to Senator Jeannie Ferris, p. 1.

38 Letter dated 19 February 1997 from Dr Keith Woollard, President of the Australian Medical Association, to Senator Jeannie Ferris, p. 2.

39 The participants were 387 general practitioners and 910 community members from the Queensland electoral roll. The response rate for medical practitioners was 67 per cent; the response rate for community members was 53 per cent.

40 Steinberg M A, "End-of-life decision-making: community and medical practitioners' perspectives". *The Medical Journal of Australia* Vol. 166, 3 February 1997, p. 134.

7.37 Five questions formed the basis of the study:

1. If good palliative care were freely available to everyone who needed it, do you think anyone would ever ask for assistance to end their lives?
 - 79 per cent of doctors and 68 per cent of community respondents responded "yes".
 - 21 per cent of doctors and 32 per cent of community respondents responded "no".
2. If it were always possible to control a person's pain, in a terminal care situation, do you think anyone would ask for euthanasia?
 - 68 per cent of doctors and 45 per cent of community respondents responded "yes".
 - 16 per cent of doctors and 25 per cent of community respondents responded "not sure".
 - 16 per cent of doctors and 30 per cent of community respondents responded "no".
3. If a terminally ill patient has decided that his/her life is of such poor quality that he/she would rather not continue living, do you think a doctor should be allowed by law to assist a terminally ill person to die?
 - 36 per cent of doctors and 60 per cent of community respondents responded "yes".
 - 24 per cent of doctors and 17 per cent of community respondents responded "not sure".
 - 40 per cent of doctors and 23 per cent of community respondents responded "no".
4. If a person is being kept alive by a life-support system (such as a respirator) and that person asks for the machine to be turned off, do you think the doctor should comply with that request?
 - 54 per cent of doctors and 72 per cent of community respondents responded "yes".
 - 34 per cent of doctors and 18 per cent of community respondents responded "not sure".
 - 12 per cent of doctors and 10 per cent of community respondents responded "no".
5. Do you think the law should be changed to allow active voluntary euthanasia for terminally ill people who decide that they no longer wish to live?
 - 33 per cent of doctors and 65 per cent of community respondents responded "yes".
 - 20 per cent of doctors and 16 per cent of community respondents responded "not sure".
 - 47 per cent of doctors and 19 per cent of community respondents responded "no".⁴¹

Extent of Support for the Northern Territory Legislation

Steinberg et al., 1997 (Northern Territory)⁴²

7.38 This survey sought to establish the extent of approval in the Northern Territory for the *Rights of the Terminally Ill Act*. The authors of survey polled nurses, medical practitioners and members of the general community.

7.39 The following question was put:

⁴¹ Steinberg M A, "End-of-life decision-making: community and medical practitioners' perspectives", *Medical Journal of Australia* Vol. 166, 3 February 1997, p. 132.

⁴² Prepared for publication in *The Lancet*, 22 February 1997.

To what extent do you approve of the law that was recently passed in the Northern Territory which allows a terminally ill person to request physician-assisted suicide or euthanasia?

7.40 The survey results are set out below:

Sample	Number Responding	SA	A	NAD	D	SD
Community	530	46.8%	32.5%	7.1%	6.1%	7.6%
Nurses	243	33.7%	31.7%	14.4%	4.9%	15.2%
Doctors	172	14%	20.9%	17.4%	19.8%	27.9%

SA = strongly approve; A = approve; NAD = neither approve nor disapprove;

D = disapprove; SD = strongly disapprove

7.41 It is worth noting that there was a 50 per cent response rate in relation to members of the general community, a 51 per cent response rate from medical practitioners and a 59 per cent response rate from nurses.

7.42 The authors of the survey noted in a letter to the editor of *The Lancet* for publication on 22 February 1997 (supplied in advance to the Committee) that the sampling frame resulted in under-representation of the indigenous and mobile sectors of the Northern Territory population.

7.43 As noted in Chapter 5, the Committee received evidence suggesting a high level of indigenous opposition to the *Rights of the Terminally Ill Act*.

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