

the circumstances in which a person may apply to be released on licence should be limited to 'exceptional circumstances'. The consequences of revocation of a licence should be the same as the consequences of revocation of parole.

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the right to refuse medical treatment

Such as be sick of incurable diseases they comfort with sitting by them, with talking with them, and, to be short, with all manner of helps that may be. But if the disease be not only incurable, but also full of continual pain and anguish, then the priests and the magistrates exhort the man, seeing he is not able to do any duty of life, but by overliving his own death is noisome and irksome to others and greivous to himself, that he will determine with himself no longer to cherish that pestilent and painful disease. And seeing his life is to him but a torment, that will not be unwilling to die, but rather take a good hope to him, and either dispatch himself out of that painful life, as out of a prison, or a rack of torment, or else suffer himself willingly to be rid out of it by others. And in so doing they tell him he shall do wisely, seeing by his death he shall lose no commodity but end his pain.

St Thomas More, *Utopia*, 1516

legislation opposed in victoria. The Victorian government's 'dying with dignity' legislation appears to face certain defeat with the Opposition's announcement that it would not support it. Without that support the Bill would be brought down in the State's Upper House. Under the Bill it would

be an offence for a medical practitioner to provide medical treatment knowing that the patient had refused it. The refusal by the patient must be 'clearly expressed or indicated'. A medical practitioner and another person must be satisfied as to that. They must be satisfied also and certify that the patient's decision is made voluntarily and without inducement or compulsion. The patient must have been sufficiently informed about his or her condition and be able to make a decision. However a person may provide for decisions about medical treatment to be made after he or she becomes incompetent by appointing another person as his or her agent.

The Bill states that it is desirable 'to encourage community and professional understanding of the changing forms of treatment from cure to pain relief for terminally ill patients and to ensure that dying patients receive maximum relief from pain and suffering.'

The Opposition legal affairs spokesman, Mr Bruce Chamberlain, explained that 'the legislation was a step into the unknown'. He criticised the Bill on the following grounds:

- There were static definitions in the Bill for conditions which were continually changing.
- The Bill applied not only to intrinsically terminal illnesses but also to conditions that could be lethal if left untreated but were reversible with treatment. (*Canberra Times* 14 April 1988.)

The Australian Medical Association was reported to have warned that a refusal of medical treatment

certificate could be issued by relatives of an incompetent patient even where treatment had a good chance of success. (*Canberra Times* 14 April 1988.)

The Bill had received wide support crossing traditional religious boundaries. Both the Catholic Archbishop, Sir Frank Little, and the Anglican Archbishop of Melbourne, Dr David Penman, had spoken in favour of it. Dr Penman was reported in the *Melbourne Sun* (14 April 1988) as having expressed disappointment at the Opposition's change in attitude towards the Bill.

liberal party faces criticism. On 20 April 1988 the *Melbourne Sun* reported that 'unprecedented pressure' is being placed on Victorian State Liberal MP's over their about face on the Bill. According to that newspaper, some of Victoria's 'most respected academics and church leaders' have called on the parliamentarians to ignore the party decision and vote with their conscience to pass the Bill. The group is reported to include Melbourne University's Vice-Chancellor, Professor David Pennington; the University's Dean of Medicine, Professor Graeme Ryan; and the Dean of Humanities at Deakin University, Professor Max Charlesworth.

The issue has been one of controversy since 1976 when the Karen Quinlan case received considerable publicity. Karen was in a coma following a drug and alcohol overdose. Her condition was classified neurologically as a 'persistent vegetative state'. The New Jersey Supreme Court ruled that the Quinlan family's right to privacy allowed removal of Karen's respirator. She lived for nine years after the respirator was removed.

The Quinlan family had arrived at the decision to request removal of

the respirator after considerable discussion with their parish priest, who brought to their attention the *allocutio* of Pope Pius XII. That religious statement arose out of an interview with the Pope by anaesthetists and dealt with the moral consequences of withdrawing medical machinery from terminal patients. The Pope stated that it was not morally sinful to cease such 'extraordinary' treatment to a terminal patient and that such a patient need only be given 'ordinary' treatment.

In 1986 a New Jersey Superior Court judge ruled that the respirator could be removed from a 37 year-old woman suffering from ALS or Lou Gehrig's disease.

The *New York Times* (29 June 1986) reported that Mrs Farrell's case 'is typical of the growing number of 'right-to-die' cases across the nation. A terminally ill patient asks to have life-support systems removed to be allowed to die. The doctor, fearful of criminal or civil liability, refuses.'

The New York Times article continues:

This was never a question 40 years ago, when technology did not exist to reinflate lungs, restart hearts, fight many infections and move organs from one human into another. A majority of Americans died at home in their own beds, surrounded by family and the family doctor, who provided comfort and solace, including at times an extra dose of morphine to ease the pain and perhaps bring death sooner.

Today, 80 percent of the more than two million deaths in the United States each year occur in institutions. Thus, allowing someone to die naturally now involves a whole team of professionals who must consciously decide not to do what they can do. Few know the patient or family well but all have their

own fiercely held views of professionalism and ethics as well as fears of litigation.

Mr Paul Armstrong, [the new Jersey lawyer who represented the family of Karen Quinlan] among others, finds the Farrell case particularly disturbing because it involves the court in ruling on private decisions within the family home, where Mrs Farrell is maintained. 'It's a sad day when the decision of a competent, terminally ill patient at home somehow needs to be decided by an American court,' he said. 'If the legacy of Karen Quinlan has any meaning, it clearly established the constitutional right for each of us to make those decisions for ourselves.'

Mrs Farrell's doctor is understood to have feared liability. And her husband sought the ruling to protect himself from any legal action, too. AJ Levinson, executive director of Concern for Dying, a right-to-die group in New York City, sees this as a typical pattern. 'It's coercion through fear,' she says. 'Coercion of family and patients by doctors, hospital lawyers and administrators suggesting their is some criminality to exerting the constitutional rights they hold under existing law.'

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public hearings on ivf

Who shall decide when doctors disagree?

Alexander Pope, *Moral Essays*

The New South Wales Law Reform Commission recently conducted a public hearing on in vitro fertilisation (IVF). This followed the issue of a discussion paper in July 1987. (See [1987] *Reform* 189 for an article on its contents.)

The hearing was conducted on Friday 15 April 1988 at the University of

Sydney Law School. Its purpose was to provide a forum in which members of the public could express views and make a direct contribution to the process of law reform.

Present at the hearing were members of the Artificial Conception Division of the NSWLRC. They are

- Ms Helen Gamble, Chairman of the NSWLRC
- Mr Russell Scott, Deputy Chairman of the Commission and Commissioner in charge of the Artificial Conception reference
- Dr Susan Fleming, Obstetrician and Gynaecologist
- Ms Eva Learner, Social Worker
- Mr Keith Mason, QC, Solicitor General for New South Wales.

A large number of people attended the hearings and many made submissions. Submissions were made on behalf of organisations and by private individuals. Among those who made submissions were:

- The Council for Civil Liberties
- The Presbyterian Womens' Association
- The Maternity Alliance
- The St Thomas More Society
- The Catholic Church — Sydney Archdiocese
- The Right to Life Organisation

Submissions were also made by a number of parents who have taken part in the in vitro fertilisation program.

Some of the key questions the NSWLRC must now answer and which were addressed at the hearing are