purpose. The same vetting proceedures should apply to step-parents as to unrelated adoptive parents.

intercountry adoption. Couples who have been unable to adopt Australian children have turned to overseas countries to meet their needs. Reforms recommended by the committee are designed to deal with concerns expressed by individuals and agencies that overseas families may be coerced into relinquishing children or otherwise exploited. As a result of a study of research literature, the committees concluded that children placed with families of a different race or culture were at greater risk of experienceing difficulties with identity and self-esteem. The report therefore recommends that every child placed for adoption should be placed with adoptive parents of the same broad ethnic and cultural background as the child, thus ensuring the child's cultural and ethnic identity is not lost as a consequence of the adoption. In addition, it proposes that arrangements should only be made for children living in overseas countries to be adopted in Australia where the prospective adoptive parents share the same broad ethnic and cultural background as the child. Foreign adoption orders will only be recognized when adoptive parents have at least 12 months genuine residence or domicile in the country in which the order was made.

adoption of aboriginal children. To bring WA into line with other States and Territories with large aboriginal populations, the committee recommends that the aboriginal placement principle be incorporated into the adoption legislation. The committee considered that this was necessary to ensure that policy is put into practice. ■

the suicide machine

> Just before she pressed the button she looked at me and said 'Thank you, thank you, thank you'.
>
> Dr Jack Kevorkian,

In April 1990, the Victorian Parliament passed the Medical Treatment (Enduring Power of Attorney) Bill (*St Vincents Bioethics Centre Newsletter*, March 1990). The Bill extends the provisions of the Medical Treatment Act 1988 (Vic) by permitting a patient's agent or guardian to make a decision to refuse medical treatment (See *Reform*, April 1988). The Bill also contains a number of safeguards to ensure that agents or guardians do not use their powers to refuse medical treatment in a way which would promote the suicide of a patient. Thus, it remains an offence to incite or aid or abet a person to commit suicide. The operation of other laws, such as those relating to homicide, is also preserved.

In the recent book entitled *You, Your Doctor and the Law*, by Loane Skene (Oxford University Press 1990), the most recent developments on the law relating to euthanasia are discussed (pp 193-8). The author notes that legislation similar to that in Victoria also exists in South Australia (Natural Death Act 1983 (SA)) and the Northern Territory (Natural Death Act 1988 (NT), not yet operative). The Western Australian Law Reform Commission is also considering the question.

changing attitude. Ms Skene cites two Victorian cases which, she asserts, may illustrate a changing attitude to patients who want to be allowed to die. In one case a quadriplegic was refused his wish to be allowed to die, while in the other case, a patient with motor neurone disease was, at her request, removed from a respirator. She died soon thereafter. It is to deal with such cases that the above legislation was thought necessary.

the suicide machine. The question of euthanasia, which was last discussed in the October 1986 and April 1988 issues of *Reform*, was taken to a new extreme recently when an American doctor allowed someone to use a machine which he had designed to make it easy for persons to commit suicide (*Sydney Morning Herald* 7 June 1990).

The machine consists of an intravenous needle connected to three separate solutions. The needle is implanted by a person assisting the intended suicide, and a harmless saline drip is initiated. When a button is pressed by the patient, the other solutions are introduced into the drip, causing first unconciousness and then painless death within six minutes. From the point of view of the person assisting, it is crucial that the patient be the one to set into motion the final drip, because otherwise criminal charges were likely. The first, and so far only, user of the machine was a 54-year-old American woman suffering from Alzheimer's disease. (*Sun-Herald* 1 July 1990)

legal implications. Dr Jack Kevorkian, the machine's inventor and an advocate of voluntary euthanasia, recently visited Australia to explain his views, as well as the circumstances in which the machine had been used. He said that one of the most difficult problems he had faced in arranging the suicide had been the search for a place in which it could be done. Assisting a suicide is an offence in most American States and Dr Kevorkian had determined that Michigan was the only State in which it was legal for his machine to be used. It had been necessary for the woman to travel 2 000 kilometres from her home in Oregon to Michigan to enable her to use the machine.

reluctance. There was also great reluctance on the part of property owners to allow their premises to be used for the intended purpose and it became necessary for the procedure to be carried out in a van at a public park. Michigan prosecutors are still considering whether Dr Kevorkian should be charged with an offence, and the machine itself has been impounded.

responsibility. Dr Kevorkian believes that the medical profession is avoiding its responsibility to its patients by leaving decisions about switching off life support systems to the courts.

> These are the hardest decisions in medicine, but who can do it if not the doctors?

He asked. Dr Kevorkian said that as a general rule, doctors should not use his machine. Instead, he envisages suicide clinics administered by non-medical workers. As for the Hippocratic oath, he says that it does not mean that doctors should save lives at all costs. According to Dr Kevorkian, Hippocrates regarded it as normal practice to help terminally ill patients die painlessly and in peace. Dr Kevorkian sees his views as merely re-establishing the true medical tradition that was subverted by religious taboos (*Sydney Morning Herald* 7 June 1990). ■

the death penalty

> Must we kill to prevent there being any wicked? This is to make both parties wicked instead of one.
>
> Pascale, *Pensees*, 1670

There have been different developments in legislation governing the death penalty in our region.

In New Zealand the Abolition of the Death Penalty Act, 1989 abolished the death penalty for treachery and treason, which were the only two offences for which it applied in New Zealand (*Bulletin of Legal Developments*, 1990, quoting the *Commonwealth Law Bulletin* April, 1990). The death penalty for murder had been abolished in 1961 and the last civilian executed in New Zealand was hanged in 1957 (Amnesty International Report, 1989, *When the State Kills*, p 184).

The Papua New Guinean Government is currently contemplating re-introducing the death penalty. In PNG the death penalty has been abolished for ordinary crimes since the country became independent in 1975. In 1980 a bill to restore the death penalty as a discretionary punishment for wilful murder was defeated. A 1985 move to introduce the death penalty for gang-rape and murder was also unsuccessful (When the State Kills, p 189).