

# THE FUTURE OF THE EUTHANASIA DEBATE IN AUSTRALIA

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*[This article considers the likely future direction of euthanasia law reform Australia wide, arguing that renewed interest in euthanasia in the 1990s is the culmination of a steady retreat from the sanctity of life ethic. The article discusses various developments in case law and legislation which illustrate this retreat which is observable in Australian, British Commonwealth and United States jurisprudence. The author argues that, increasingly, the social factors which have given birth to voluntary euthanasia movements around the world, combined with the need to fashion a logically sustainable jurisprudence, will lead to a legally recognised right to die. Regardless of the fate of the Rights of the Terminally Ill Act 1995 (NT), legal developments and social trends suggest the inevitability of legalised euthanasia in Australia.]*

At 3.15am on 25 May 1995, the Rights of the Terminally Ill Act 1995 (NT) was passed by a 15 to 10 majority of the Northern Territory Legislative Assembly. On 1 July 1996, the Act came into operation.<sup>1</sup> At the time of writing, however, its future is far from certain. On 24 July 1996, a two to one majority of the Supreme Court of the Northern Territory rejected a legal challenge brought by an Aboriginal Uniting Church minister, and the head of the Northern Territory Branch of the Australian Medical Association ('AMA'), claiming that the Act was unconstitutional.<sup>2</sup> However, a High Court challenge is planned. More importantly, a Catholic backbencher's private member's Bill introduced into federal Parliament in October 1996 would override the Territory legislation, relying upon s 122 of the Australian Constitution, which gives the federal Parliament power to make laws for the territories.<sup>3</sup> The Bill, which will attract a conscience vote, is likely to pass in the House of Representatives, although its success in the Senate (the States' House) is less certain. Despite earlier threats of retrospectivity, and tightened guidelines regulating the qualifications of special-

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<sup>1</sup> Rights of the Terminally Ill Act 1995 (NT) ('the Act'), as amended by the Rights of the Terminally Ill Amendment Act 1996 (NT). A draft on-line consolidation can be found at: <http://www.nt.gov.au/lant/rotti/amend.html>.

<sup>2</sup> Maria Ceresa, Bernard Lane and Amanda Meade, 'Supreme Court Rejects Challenge on Euthanasia', *The Australian* (Sydney), 25 July 1996, 7; *Wake v Northern Territory* (Supreme Court of the Northern Territory, Martin CJ, Angel and Mildren JJ, 24 July 1996).

<sup>3</sup> Gabrielle Chan and Maria Ceresa, 'Leaders in United Bid to Outlaw Euthanasia', *The Australian* (Sydney), 10 September 1996, 3. The backbencher, Kevin Andrews, was a former barrister and advisor to Melbourne's Catholic St Vincent's hospital.

ists giving second opinions,<sup>4</sup> on 22 September 1996, the first case of legalised euthanasia occurred under the Act.<sup>5</sup>

The Rights of the Terminally Ill Act, which originated as a private member's Bill introduced by former Chief Minister Marshall Perron, puts Australia at the forefront of euthanasia law reform around the world. The Act ushers in a bold social experiment in the legalised killing of patients who are terminally ill and who are experiencing pain or suffering to an extent considered unacceptable by the patient. The Act provides that the treating doctor's prognosis must be confirmed by a second doctor, and a third doctor (who must be a qualified psychiatrist) must certify that the patient is not suffering a treatable clinical depression. Prior to choosing death, the patient must be counselled about palliative care options by a doctor who satisfies legislative criteria ensuring specialist knowledge. The termination of life in accordance with the Act carries immunity from civil or criminal liability, and professional disciplinary action.<sup>6</sup>

In view of the public debate which has accompanied the Northern Territory initiative, this article will consider the likely future direction of law reform Australia wide, arguing that renewed interest in euthanasia in the 1990s is the culmination of a steady retreat from the sanctity of life ethic evident in case law and legislation. This is a phenomenon observable in Australian, British Commonwealth and United States jurisprudence. Increasingly, the social factors which have given birth to voluntary euthanasia movements around the world, combined with the need to fashion a logically sustainable jurisprudence, will lead to a legally recognised right to die. Within a generation, the suggestion that a terminally ill patient should be denied the right to die with medical assistance will appear primitive, if not absurd.<sup>7</sup> Whether this is good social policy remains to be seen. Regardless of the fate of the Northern Territory's legislation, however, there can be little doubt about the future direction which the law will take.

Although there is no one legal terminology for talking about end-of-life decision-making, there is nevertheless wide consensus about the terms used below. For the purposes of this article, *assisted suicide* will be understood to occur when a doctor knowingly and intentionally gives a patient the means, or otherwise

<sup>4</sup> Gay Alcorn, 'Waiting to Go', *The Sydney Morning Herald* (Sydney), 6 July 1996, 30.

<sup>5</sup> Gay Alcorn, 'First Death Under NT Mercy Law', *The Age* (Melbourne), 26 September 1996, 1; 'Euthanasia Splits Nation', *The Australian* (Sydney), 27 September 1996, 1. Sixty-six year old Robert Dent, a former carpenter and pilot, who had suffered from prostate cancer for five years, died following a lethal injection supervised by Darwin doctor Philip Nitschke: Gay Alcorn, 'Now More Want to Die', *The Age* (Melbourne), 27 September 1995, 1. The death occurred using Nitschke's computer-controlled, Kevorkian-style, self-administering 'death machine', which runs using software (entitled 'Final Exit') written by collaborator Des Carne. Patients move through three computer screens, the last of which says 'If you press "Yes", you will cause a lethal injection to be given within 30 seconds, and will die. Do you wish to proceed? "YES/NO"': Gay Alcorn, 'Press 'Yes' to Die Now' *The Age* (Melbourne), 17 April 1996, A13. Early prototypes of the machine had a range of CD music to choose from, and ended with the farewell: 'Good-bye and good luck'.

<sup>6</sup> Rights of the Terminally Ill Act 1995 (NT) s 20.

<sup>7</sup> Former Chief Minister of the Northern Territory, Marshall Perron, has compared the Northern Territory's euthanasia Act to legislation passed in 1894 by the (former) British colony of South Australia, which became the second jurisdiction in the world (after New Zealand) to give women the right to vote, and the first to allow women to stand for Parliament.

assists a patient who takes his or her own life. *Active voluntary euthanasia*, on the other hand, occurs when a doctor intentionally and directly causes the death of a terminally ill patient, in accordance with that patient's wishes, in order to relieve the burden of disease or injury. Active voluntary euthanasia is sometimes distinguished from *passive euthanasia*, the latter referring to death following the withdrawal of life-prolonging medical treatment. The use of the term 'euthanasia' in this context underscores the flimsiness of the act/omission distinction, which is discussed in detail below. *Involuntary euthanasia* occurs when a patient is killed against his or her wishes, although where the patient's wishes are unknown, or where there has been no request for euthanasia, the term *non-voluntary euthanasia* is sometimes used.

### I WHY ARE WE HAVING THE EUTHANASIA DEBATE NOW?

On 25 March 1995, seven Melbourne doctors went public on the front page of *The Age* newspaper in an open letter to the Victorian Premier, admitting to having performed euthanasia, and calling for the introduction of the assisted suicide legislation advocated by the Voluntary Euthanasia Society of Victoria ('VESV').<sup>8</sup> Despite being accused of 'making heroes of themselves',<sup>9</sup> and despite calls for their prosecution by groups such as 'Right to Life',<sup>10</sup> investigations by the Victoria Police and the Medical Practitioners' Board of Victoria were abandoned for lack of evidence.<sup>11</sup> The seven won the VESV's 1995 community service award, and there seems little doubt that they will continue, discretely, to practise euthanasia.<sup>12</sup>

The action taken by the 'Melbourne seven', and the debate precipitated by (what became) the Rights of the Terminally Ill Act 1995 (NT), has re-invigorated the euthanasia debate in Victoria, and throughout Australia generally. The issue has been debated before; for example, in the late 1980s when the Victorian Parliament's Social Development Committee rejected legalised euthanasia in its report on *Options for Dying with Dignity*.<sup>13</sup> But now, in the 1990s, despite legislative initiatives such as the Medical Treatment Act 1988 (Vic), which recognises a patient's right to forego life-preserving treatment, the debate has

<sup>8</sup> Nick Davies, 'Helping Patients to Die', *The Age* (Melbourne), 25 March 1995, 1.

<sup>9</sup> Mark Forbes, 'Fury Over Assisted Deaths', *The Sunday Age* (Melbourne), 26 March 1995, 3.

<sup>10</sup> Rachel Buchanan, 'Charge Euthanasia Doctors, Says Right to Life', *The Age* (Melbourne), 27 March 1995, 1.

<sup>11</sup> Rachel Gibson, 'Suicide Doctors Face Probe', *The Age* (Melbourne), 1 April 1995, 1; Rachel Buchanan and AAP, 'Board Abandons Probe into Euthanasia Doctors', *The Age* (Melbourne), 21 June 1995, 3; Rachel Buchanan, 'Police Probe on Euthanasia', *The Age* (Melbourne), 22 June 1995, 3; Rachel Buchanan, 'Police Drop Euthanasia Inquiry', *The Age* (Melbourne), 10 August 1995, 3.

<sup>12</sup> One of the seven, respected urologist Rodney Syme, confirmed to newspaper reporters a quiet history of euthanasia spanning over 20 years: Nick Davies, 'A Matter of Life & Death', *The Age* (Melbourne), 25 March 1995, B1, B6.

<sup>13</sup> Victorian Social Development Committee, *Inquiry into Options for Dying with Dignity* (1987) 128-42.

returned, stronger than ever. In the media, in books,<sup>14</sup> on the internet,<sup>15</sup> euthanasia is a recurrent theme.

Why is society debating euthanasia so fervently *now*, when the Hippocratic injunction against the taking of life has been a central feature of medical ethics since 400 BC? One contributor to *The Age* newspaper has suggested that:

The debate is about the limits of individual freedoms and the political power of the Baby Boomers, now at the age when they are beginning to contemplate their mortality. It's about an ageing population and a limited health dollar. It's about an increasingly educated population losing its awe of the medical profession. And it provides an intriguing look at religion in a secular society.<sup>16</sup>

Central to the mindset or personal philosophy which fuels euthanasia advocacy is the emerging ethic of what might be called 'liberal individualism'. According to Professor Margaret Somerville:

We are now societies based on intense individualism — possibly individualism to the exclusion of any real sense of community, including in situations facing death and bereavement ... Matters such as euthanasia, that would have been largely the subject of moral or religious discourse are now explored in our courts and legislatures, particularly through the concepts of individual human rights, civil rights and constitutional rights.<sup>17</sup>

Combined with this, one might mention the declining influence of the churches in shaping social policy. Fundamentalist churches, and those with a tradition of hierarchical religious authority, argue that euthanasia, like suicide, is 'a rejection of God's absolute sovereignty over life and death'.<sup>18</sup> The philosophy underlying euthanasia, by contrast, is atomistic and relativistic: an affirmation of individual moral freedom in a world lacking moral absolutes. Of course, not all opponents of legalised euthanasia are religious, many are simply more 'communitarian' in outlook, believing that individual freedoms and interests should be tempered by communal values, social goals, and traditional constraints.<sup>19</sup>

The euthanasia debate can also be seen as a reaction to the technological determinism and medical bureaucracy which characterises modern medicine. While drugs and medical machinery can prolong the dying process, many feel that the life thereby 'saved', frequently endured without privacy in the goldfish bowl of

<sup>14</sup> Recent titles include: Helga Kuhse (ed), *Willing to Listen — Wanting to Die* (1994); Peter Singer, *Re-Thinking Life & Death: The Collapse of Our Traditional Ethics* (1994); Simon Chapman and Steven Leeder, *The Last Right? Australians Take Sides on the Right to Die* (1995); John Keown (ed), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (1995); Ian Parsons and Christopher Newell, *Managing Mortality: Euthanasia on Trial* (1996).

<sup>15</sup> For example, on-line sites such as *Deathnet*: <http://www.islandnet.com/~deathnet/>, which provides on-line news reports, access to government reports, space for both advocates and opponents of euthanasia to post materials, as well as links to other on-line resources, including the Canada-based *Last Rights Information Centre*, and Derek Humphry's *Euthanasia Research & Guidance Organisation* (ERGO).

<sup>16</sup> Gay Alcorn, 'Marshall Law', *The Age* (Melbourne), 24 May 1995, 13.

<sup>17</sup> Margaret Somerville, 'Sentencing Society to Ethical Death', *The Age* (Melbourne), 13 November 1995, 13.

<sup>18</sup> Pope John Paul II, *Evangelium Vitae: On the Value and Inviolability of Human Life* (1995), para 66.

<sup>19</sup> See Tom Beauchamp, 'Reversing the Protections' (1994) 24 *Hastings Center Report* 18.

the hospital ward, undermines the dignity and the values which have characterised their life or the lives of loved ones. Margaret Battin notes that, increasingly this century, and for the first time in human history, the majority of people in western societies are dying from diseases which are characterised by an 'extended deteriorative decline'. The predictability of this downhill road is having an important cultural effect, focusing attention onto the *manner* of dying, and challenging assumptions about the norms of dying.<sup>20</sup>

This is particularly true, for example, of AIDS, which shares the 'deteriorative decline', yet is unique amongst twentieth century diseases in its capacity to decimate young and healthy populations (mostly men) in a way not seen since medicine arrested the typical killers of past centuries: typhoid, tuberculosis, smallpox, and so on. In this way, AIDS challenges the assumption of 'medical control' over disease, and so undermines traditional norms of medical management.

Not everyone, of course, accepts that euthanasia advocacy is a response to declining church influence, an expression of personal autonomy or rising individualism, a reaction against the impersonal, biology-driven achievements of modern medicine, or the epidemiology of death in the twentieth century. Some see the push for euthanasia as a symptom of the failure of doctors to communicate with their patients, their failure to respect patient choice and to discontinue treatment when it is futile, and their failure to practice good palliative care.<sup>21</sup> Others point to the ageing population, and economic pressures to free up hospital beds.<sup>22</sup>

## II THE DECLINE OF THE SANCTITY OF LIFE ETHIC IN LAW

The current euthanasia debate did not arrive in a freak windstorm. The signs have been appearing on the walls progressively over the past three or so decades. Challenging society's traditional prohibition on the killing of terminally ill consenting patients is the logical next step in a legal and ethical retreat from the sanctity of life ethic of the Judeo-Christian tradition. Within law, this retreat is reflected in the changing definition of death, in the growth of a legally-supported right to self-determination extending to the withdrawal of life-support, and in the recognition by courts that — in limited circumstances — life-support may be withdrawn *without consent* because life is considered to be *futile*. The decline of the sanctity of life ethic in law has thus created the conditions under which direct confrontation with society's prohibition of euthanasia, is now possible.

<sup>20</sup> Margaret Battin, *Ethical Issues in Suicide* (1995) 201, 225.

<sup>21</sup> See, eg, Brian Pollard and Ronald Winton, 'Why Doctors and Nurses Must Not Kill Patients' (1993) 158 *Medical Journal of Australia* 426.

<sup>22</sup> See, eg, Bob Santamaria, 'Tacit Consent to Euthanasia', *The Weekend Australian* (Sydney), 1-2 April 1995, 28; Bob Santamaria, 'Euthanasia's Bell Tolls for Thee', *The Weekend Australian* (Sydney), 13-14 July 1996, 22.

### A The Changing Definition of Death

In the 1990s, death is usually defined either in terms of the permanent cessation of heart-beat, blood circulation and breathing (heart/lung death), or as the irreversible cessation of the functions of the entire brain, including the brain stem (brain death). The concept of brain death emerged from the work of the Harvard Brain Death Committee, which reported in the *Journal of the American Medical Association* in 1968 that 'responsible medical opinion' was ready to adopt new criteria for pronouncing death in circumstances where an individual had suffered 'irreversible coma as a result of permanent brain damage'.<sup>23</sup> Importantly, the Committee made it clear that its criteria only applied to patients who had irreversibly lost all brain function, including brain-stem function. However, by re-labelling someone as a 'ventilated corpse', who might otherwise have been thought of as alive, the Committee successfully avoided the ethical injunction to 'prolong life at all costs'.

In the decades following the Harvard Committee's report, the concept of brain-death has been accepted into the law of most western countries.<sup>24</sup> In 1977, the Australian Law Reform Commission recommended the introduction of a statutory definition of death which included the concept of whole-brain death,<sup>25</sup> and all states except Western Australia have now enacted such legislation.<sup>26</sup>

In the 1990s, the push is on for a further re-definition of death to include 'higher-brain death'. Interest in the concept of higher-brain death has accompanied the growing number of patients who can now be sustained indefinitely, despite being in a permanent coma, or a persistent vegetative state ('PVS').<sup>27</sup> A PVS may arise following irreversible damage to the cerebrum, which — whether alone or in interrelationship with the brain-stem — is thought to control 'higher-brain' functions including consciousness, thought, feeling and memory. A prognosis of PVS implies, however, the permanent loss of consciousness, cognitive function and sensory capacity, although the patient may breath without

<sup>23</sup> Ad Hoc Committee of the Harvard Medical School, 'A Definition of Irreversible Coma' (1968) 205(6) *Journal of American Medical Association* 85, 87.

<sup>24</sup> In 1981, for example, the President's Commission in the United States recommended uniform legislation embodying both heart/lung and whole brain criteria: President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Defining Death: A Report on the Medical, Legal and Ethical Issues in the Determination of Death*, (1981) 2. By 1995, 33 states had adopted the Uniform Determination of Death Act which gives effect to this recommendation (Uniform Determination of Death Act 12 ULA 443 (1995 Supp)).

<sup>25</sup> Australian Law Reform Commission, *Human Tissue Transplants*, Report No 7 (1977), paras 133-7.

<sup>26</sup> See, eg, Human Tissue Act 1983 (NSW) s 33; Human Tissue Act 1982 (Vic) s 41.

<sup>27</sup> A persistent vegetative state which is regarded as irreversible is called a permanent vegetative state ('PVS'). The prognosis of PVS patients is linked to the cause of the coma. Some patients may regain awareness after four months in a persistent vegetative state, although few will ever reach full independence: see Keith Andrews, 'Recovery of Patients after Four Months or More in the Persistent Vegetative State' (1993) 306 *British Medical Journal* 1597. A 1994 review estimated that there are between 10,000 and 25,000 adults in the United States in a persistent vegetative state, and between 4,000 and 10,000 children: The Multi-Society Task Force on PVS, 'Medical Aspects of the Persistent Vegetative State: Part 1' (1994) 330(21) *New England Journal of Medicine* 1499, 1503. In Britain the estimate is 1,000 to 1,500: *Airedale NHS Trust v Bland* [1993] AC 789, 879 ('Bland').

assistance, retain some reflexes, respond to some stimuli, and may 'live' for years and even decades with artificial feeding and hydration.<sup>28</sup>

A 'higher-brain' definition of death remains controversial because of its creeping infringement upon the sanctity of life ethic, and the judgment it conveys about the moral status of human beings. A well-known American advocate of the concept of higher-brain death, Professor Robert Veatch, candidly admits that his preference is based on the view that the essence of personhood or 'being human' is the integrated functioning of mind and body. As Justice Stevens of the United States Supreme Court stated in his dissenting opinion in the well-known *Cruzan* case, which concerned a PVS patient:

[F]or patients like Nancy Cruzan, who have no consciousness and no chance of recovery, there is a serious question as to whether the mere persistence of their bodies is "life" as that word is commonly understood ... Life, particularly human life, is not commonly thought of as a merely physiological condition or function. Its sanctity is often thought to derive from the impossibility of any such reduction.<sup>29</sup>

Accordingly, Veatch advocates defining higher-brain death in terms of the 'irreversible cessation of the capacity for consciousness'.<sup>30</sup> Catholic bioethicists disagree. Dr Norman Ford, Director of the Caroline Chisholm Centre for Health Ethics in Melbourne, writes that 'permanently unconscious patients and new-born babies, including anencephalic infants, are human subjects with personal dignity whose lives are morally inviolable'.<sup>31</sup> Professor Peter Singer of the Monash University Centre for Human Bioethics, has taken a third view. Writing about anencephalic infants (who are born with only a brain stem and who — like PVS patients — are permanently unconscious, insensate and unknowing), Singer agrees that it is counter-intuitive to call such an infant 'dead'. He argues, however, that it is morally acceptable to remove organs for transplantation from infants whose lack of a cerebral cortex permanently precludes any capacity for consciousness and feeling.<sup>32</sup>

The simplistic distinction between life and death which Singer wishes to avoid perpetuating could perhaps be overcome by recognising that death is not so much an event, as a *process* which can occur at different levels of organisation within

<sup>28</sup> See Robyn Howard and David Miller, 'The Persistent Vegetative State' (1995) 310 *British Medical Journal* 341; The Multi-Society Task Force on PVS, above n 27; The Multi-Society Task Force on PVS, 'Medical Aspects of the Persistent Vegetative State: Part 2' (1994) 330(22) *New England Journal of Medicine* 1572.

<sup>29</sup> *Cruzan v Director, Missouri Department of Health* 497 US 261 (1990), 345-6 ('*Cruzan*').

<sup>30</sup> Robert Veatch, 'The Impending Collapse of the Whole-Brain Definition of Death' (1993) 23 *Hastings Center Report* 18, 23.

<sup>31</sup> Norman Ford, 'Killing and Caring Don't Mix', *The Sunday Age* (Melbourne), 29 October 1995, 14.

<sup>32</sup> Singer, above n 14, 46-56. Singer's views on euthanasia and the morality of killing infants have generated heated debate. See, eg, Jenny Teichman, 'Humanism and Personism: The False Philosophy of Peter Singer' (1992) 12 *Quadrant* 26; Herlinde Pauer-Studer, 'Peter Singer on Euthanasia' (1993) 76 *The Monist* 135; P Sundström, 'Peter Singer and 'Lives Not Worth Living' — Comments on a Flawed Argument from Analogy' (1995) 21 *Journal of Medical Ethics* 25.

the human body, each of which may follow an independent trajectory.<sup>33</sup> Nevertheless, a simple, precise and uniform definition of death is crucial in areas of law concerned, for example, with homicide, succession, and tissue and organ transplantation. Proposals for a 'high brain' definition of death have been further muddied by the fact that many advocates believe such a definition should be implemented with a conscience clause so that people can elect in advance the criteria of death they wish to apply to them.

The debate over 'higher-brain death', following on from the acceptance of 'whole brain death', is the logical next step in a process of re-evaluating the moral value of life in circumstances where a patient lacks the capacity for consciousness and self-awareness. The law's evolving definition of death represents a significant, although perhaps a subversive means of undermining the sanctity of life ethic. It is subversive because it prevents the real issue — the sacredness or moral value of life — from ever being faced head-on. The concept of 'higher-brain death', in particular, remains significant because it is slowly being absorbed into the law in other ways: if not as a basis for a new legal definition of death, then certainly as a justification for withdrawing life-preserving medical treatment.

### B 'Futile Lives' and the Withdrawal of Life-Support

In England, the phenomenon of the permanent vegetative state was brought into the public arena through the case of 17 year old Anthony Bland, whose lungs were crushed and perforated in the fatal crush at the Hillsborough football stadium on 15 April 1989. Through prolonged oxygen deprivation, Bland's cerebral cortex had 'resolved into a watery mass'.<sup>34</sup> Bland had lain in what doctors concluded was an irreversible vegetative state for nearly four years when the House of Lords handed down its declaratory judgment in February 1993 on the legality of withdrawing artificial hydration.

The Law Lords were unanimous that where, in accordance with a responsible body of medical opinion, a doctor concludes that further medical treatment will be of no benefit to a permanently unconscious patient, there is no duty to provide it, and such treatment may legally be withdrawn.<sup>35</sup> As both advocates<sup>36</sup> and opponents<sup>37</sup> of legalised euthanasia have recognised, this decision represents a significant retreat from the sanctity of life ethic.

It is fundamental that in their provision of medical treatment to incompetent patients, doctors owe a duty to act in the patient's best interests. When a patient is dying, the patient's best interests may only require sedation or pain relief, to

<sup>33</sup> See Linda Emanuel, 'Re-examining Death: The Asymptotic Model and a Bounded Zone Definition' (1995) 4 *Hastings Center Report* 27.

<sup>34</sup> *Airedale NHS Trust v Bland* [1993] AC 789, 856 (Lord Keith).

<sup>35</sup> *Ibid* 858-9 (Lord Keith), 867-9 (Lord Goff), 876-7 (Lord Lowry), 883-4 (Lord Browne-Wilkinson), 897-9 (Lord Mustill).

<sup>36</sup> Singer, above n 14, 57-80; Peter Singer, 'Presidential Address: Is the Sanctity of Life Ethic Terminally Ill?' (1995) 9 *Bioethics* 327, 337-42.

<sup>37</sup> See, eg, John Finnis, 'Bland: Crossing the Rubicon?' (1993) 109 *Law Quarterly Review* 329, 335; John Finnis, 'A Philosophical Case Against Euthanasia', in Keown, above n 14, 30-4.

permit the patient to die with dignity.<sup>38</sup> It is well accepted that there is no duty to continue medical heroics when death is imminent and inevitable. But what about a patient who is permanently unconscious, although not terminally ill — what are the best interests of such a person?

According to Lord Mustill, Anthony Bland had ‘no best interests of any kind’.<sup>39</sup> Thus, while the termination of Anthony’s life might not have been in his best interests, Anthony’s best interests in being kept alive had also disappeared, together with the justification for the indefinite continuation of life support.<sup>40</sup> In a similar vein, Lord Keith observed that where a person has no cognitive capacity whatever, and no prospect of recovery, ‘it must be a matter of complete indifference whether he lives or dies’.<sup>41</sup>

These remarks obviously reflect moral judgments about the value of Anthony’s life. According to Lord Mustill, the withdrawal of medical treatment was both ethical and legally permissible because ‘the continued treatment of Anthony Bland can no longer serve to maintain that combination of manifold characteristics which we call a personality.’<sup>42</sup> While not turning his mind to a higher-brain definition of death, Lord Mustill was adopting the same criterion as a basis for withdrawing treatment in circumstances where death would certainly follow. Each of the other Law Lords’ speeches reflected, or were consistent with, Lord Mustill’s reasoning.<sup>43</sup> Lord Goff said:

for my part I cannot see that medical treatment is appropriate or requisite simply to prolong a patient’s life, when such treatment has no therapeutic purpose of any kind, as where it is futile because the patient is unconscious and there is no prospect of any improvement in his condition .... But in the end, in such a case as the present, it is the futility of the treatment which justifies its termination.<sup>44</sup>

The essence of their Lordships’ decision was thus that Anthony Bland’s life was ‘futile’, and pointless, and that this justified the withdrawal of the medical treatment which was keeping him alive.<sup>45</sup> Bland, it should be remembered, died from dehydration following the removal of feeding and hydration in accordance with their Lordships’ decision. It is clear, therefore, that English law, at least, does not protect the sanctity of life of patients who are permanently unconscious.

<sup>38</sup> See, eg, *Bland* [1993] AC 789, 867 (Lord Goff). See also Devlin J’s summing up to the jury in the famous trial of Dr Adams, that where ‘the purpose of medicine — the restoration of health — could no longer be achieved, there was still much for the doctor to do, and he was entitled to do all that was proper and necessary to relieve pain and suffering even if the measures he took might incidentally shorten life by hours or perhaps even longer’: quoted in Henry Palmer, ‘Dr Adams’ Trial for Murder’ [1957] *Criminal Law Review* 365, 375.

<sup>39</sup> *Bland* [1993] AC 789, 897.

<sup>40</sup> *Ibid.*

<sup>41</sup> *Ibid* 858.

<sup>42</sup> *Ibid* 899.

<sup>43</sup> *Ibid* 869 (Lord Goff), 858 (Lord Keith).

<sup>44</sup> *Ibid* 869.

<sup>45</sup> Indeed, two of their Lordships went further and held that where treatment can no longer be said to be in the patient’s best interests, there is a *duty* to stop treatment: *ibid* 876-7 (Lord Lowry), 883 (Lord Browne-Wilkinson).

By putting *Bland* into practice, doctors not only ensure that such patients will die, but their actions bespeak the view that such patients would be better off dead.<sup>46</sup>

It is worth emphasising that the *Bland* decision was not concerned with the concept of patient self-determination. In America, a variety of approaches to cases of acquired incapacity have developed in different states, unified by their general preference for 'substituted judgment'. A substituted judgment approach requires the decision-maker (or the court) to second-guess whether an incompetent patient *would have wanted* treatment withdrawn under the circumstances, if he or she could have foreseen the injury which was sustained. English courts, by contrast, have focused on what is in the patient's best interests.<sup>47</sup> The recognition that Anthony Bland's life was 'futile', and that he had *no best interests* in continuing to live his life thus involved a paternalistic judgment about the moral value of life imposed upon the patient from outside.

There are preliminary indications that English courts may be prepared to take this paternalistic, quality of life model of decision-making even further as a basis for hastening the deaths of incompetent patients. Even in circumstances where the patient is not permanently unconscious, courts have not accepted that the sanctity of life ethic will always dictate that the patient's best interests require the prolongation of life. In one recent case, the court accepted that where the deformities of a newly born, yet non-terminally ill baby, viewed from the perspective of a person able to make a sound judgment, were such that life would be intolerable, then life-preserving ventilation could lawfully be withdrawn.<sup>48</sup> As Taylor LJ stated, 'I consider the court is entitled in the best interests of the child to say that deliberate steps should not be taken artificially to prolong its miserable life span.'<sup>49</sup>

A central feature of the *Bland* decision was its reliance upon the increasingly discredited 'act/omission distinction'. While authorising the withdrawal of Anthony's life-preserving treatment, their Lordships affirmed that euthanasia is unlawful,<sup>50</sup> thus requiring a distinction to be drawn between the two. Lord Mustill, Lord Goff and (apparently) Lord Keith reasoned that the lawful withdrawal of treatment could be regarded as an omission to provide treatment which there was no duty to provide, and could therefore be distinguished from direct or active intervention, such as a lethal injection, which amounted to murder under current law. Thus, when a patient died following the withdrawal of life-support,

<sup>46</sup> For a subsequent example of this approach in action, see *Frenchay Healthcare National Health Service Trust v S* [1994] 1 WLR 601.

<sup>47</sup> In *Bland*, their Lordships held that the decision to withdraw treatment from a permanently unconscious patient was a medical decision for the doctor, although it required scrutiny by a court, until a sufficient body of experience and practice had grown which obviated this need: *Bland* [1993] AC 789, 859 (Lord Keith), 871 (Lord Goff), 875 (Lord Lowry), 885 (Lord Browne-Wilkinson). Implicit in this approach was a rejection of the American, 'substituted judgment' approach: *ibid* 864-5, 871-4 (Lord Goff), 895 (Lord Mustill).

<sup>48</sup> *In re J (Wardship: Medical Treatment)* [1991] Fam 33, 46-7, 55.

<sup>49</sup> *Ibid* 55.

<sup>50</sup> *Bland* [1993] AC 789, 859 (Lord Keith), 865 (Lord Goff), 892-3 (Lord Mustill).

the doctor could not, in law, be regarded as legally responsible under the law of homicide.<sup>51</sup>

This creative interpretation of causation has attracted some notable academic support.<sup>52</sup> However, not only does it require the willing suspension of disbelief, but it also directs attention away from the central issue. Significantly, Lord Mustill admitted that to absolve doctors from causing the death of a patient who, quite literally, would die from the withdrawal of fluids, on the basis that withdrawing intravenous hydration and nourishment was an omission, and not an act, was 'morally and intellectually dubious',<sup>53</sup> 'illogical',<sup>54</sup> and served only to emphasise 'the distortions of a legal structure which is already both morally and intellectually misshapen.'<sup>55</sup> Similarly, Lord Goff conceded that the distinction could lead to a 'charge of hypocrisy'.<sup>56</sup>

In an area of law as important as that which regulates decision-making at the end-of-life, it is important to avoid splitting hairs. In view of the known reality that unconscious patients dependent upon life-support *will die* if life-support is withdrawn, any attempt to avoid liability for killing based upon intention is immediately suspect.<sup>57</sup> As far as *actus reus* is concerned, it is surely the case that since doctors have the ability to prolong life, the withdrawal of life-preserving treatment from an unconscious patient shortens life, thereby causing death. As Justice Scalia recognised in the *Cruzan* case,<sup>58</sup> an 'omission' or 'withdrawal' of treatment would not be ignored if a nurse turned off a ventilator without permission, or if a parent starved an infant: this could well be manslaughter, or even murder. The fact that the doctor has no *duty* to keep administering treatment, because the patient's life is considered 'futile', should not lead one to think that the doctor has not caused the patient's death. In their eagerness to distinguish euthanasia, the Law Lords camouflaged the central issue: whether withdrawing life-support and so ending a patient's life was *justified* in the circumstances. It is better to see the withdrawal of life-preserving treatment for what it is: *a form of non-voluntary euthanasia*, and to justify it on ethical or policy grounds, than to pretend that doctors are not, by withdrawing life-support from an incompetent patient dependent upon it, engaged in the killing business.<sup>59</sup> Nevertheless, a majority of the Canadian Supreme Court upheld the integrity of the distinction in *Rodriguez v British Columbia (Attorney-General)*.<sup>60</sup>

<sup>51</sup> Ibid 858-9 (Lord Keith), 865-6, 873 (Lord Goff), 887, 897-8 (Lord Mustill).

<sup>52</sup> See, eg, Glanville Williams, *Textbook of Criminal Law* (2nd ed, 1983) 282-3.

<sup>53</sup> *Bland* [1993] AC 789, 898.

<sup>54</sup> Ibid 895.

<sup>55</sup> Ibid 887.

<sup>56</sup> Ibid 865.

<sup>57</sup> Despite this, some Catholic commentators still argue that there is a distinction between 'intending' the patient to die and 'willing' or 'permitting' the patient to die: Moira McQueen and James Walsh, 'The House of Lords and the Discontinuation of Artificial Nutrition and Hydration: An Ethical Analysis of the Tony Bland Case' 35 (4) *Catholic Lawyer* 363, 370, 377.

<sup>58</sup> *Cruzan* 497 US 261 (1990), 297.

<sup>59</sup> Lord Lowry, in fact, did recognise that the *Bland* case might be seen as an example of 'euthanasia in action': *Bland* [1993] AC 789, 877.

<sup>60</sup> [1993] 3 SCR 519, 605-7 ('*Rodriguez*'). Sopinka J, writing for five justices, noted that:

A more honest approach is evident in a recent New Zealand case which concerned the withdrawal of ventilation from a patient with Guillain-Barré syndrome, a disease which destroys the conductivity of the nerves between the brain and body, leaving the patient unable to move or communicate; entirely and permanently disengaged from the body in a kind of 'living death'. Justice Thomas said:

In my view, doctors have a *lawful excuse* to discontinue ventilation when there is no medical justification for continuing that form of medical assistance. To require the administration of a life-support system when such a system has no further medical function or purpose and serves only to defer the death of the patient is to confound the purpose of medicine.<sup>61</sup>

If one recognises, therefore, the problems that the act/omission distinction causes in this context, but also believes that doctors should be entitled to withdraw life-preserving treatment from permanently unconscious patients, then what moral or legal basis is there for forbidding doctors from hastening death by lethal injection, instead of subjecting the patient's family and carers to the stress of watching the patient's (albeit unconscious) body die from acute dehydration or malnutrition?<sup>62</sup> English law provides no satisfying answer to this question. In *Bland* their Lordships simply affirmed that euthanasia was illegal, that legalisation was a question for Parliament, and that under the current law, 'the interest of the state in preserving life overrides the otherwise all-powerful interest of patient autonomy.'<sup>63</sup>

But for the discredited act/omission distinction, therefore, the *Bland* case authorises, in effect, the non-voluntary euthanasia of patients who are irreversibly comatose. If the *Bland* approach is followed in Australia, as it appears to have already been in New Zealand,<sup>64</sup> then only the distorted logic of the act/omission distinction will prevent the practice of legalised non-voluntary euthanasia of PVS

[w]hether or not one agrees that the active versus passive distinction is maintainable, ... the fact remains that under our common law, the physician has no choice but to accept the patient's instructions to discontinue treatment. To continue to treat the patient when the patient has withdrawn consent to that treatment constitutes battery. The doctor is therefore not required to make a choice which will result in the patient's death as he would be if he chose to assist a suicide or to perform active euthanasia.

<sup>61</sup> *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235, 250 (Thomas J) (emphasis added); see also 253-4. Admittedly, these remarks were made within the context of the Crimes Act 1961 (NZ) s 151, which imposes on health carers a duty to 'provide the necessities of life', except where there is a 'lawful excuse'. For a full discussion of this case, see P Skegg, 'Omissions to Provide Life-Prolonging Treatment' (1994) 8 *Otago Law Review* 205.

<sup>62</sup> Dr Keith Andrews, who gave evidence in the *Bland* case, notes paradoxically that '[w]e seem to be progressing down the road of accepting involuntary euthanasia before voluntary euthanasia has been accepted legally. It is unlikely that starvation would be regarded as an acceptable way of assisting dying in voluntary euthanasia, so should we even consider this method for involuntary euthanasia?': Andrews, above n 27, 1602.

<sup>63</sup> *Bland* [1993] AC 789, 893 (Lord Mustill). See also: 866 (Lord Goff). While *Bland* itself involved no question of patient consent, it nevertheless raised the broader issue of legal justification for causing death. These remarks were made within the context of patient consent to death: 893 (Lord Goff).

<sup>64</sup> *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235 in fact preceded *Bland*, and was recognised as having been influential in their Lordships' deliberations: see *Bland* [1993] AC 789, 867, 872 and 896.

and irreversibly comatosed patients. Once the act/omission distinction is rejected in this context, of course, it will only be a matter of time until it will be rejected within the context of *competent patients* who already (as discussed below) have the right to have life-preserving treatment withdrawn.

Recent American decisions suggest that the act/omission distinction will not survive intact for very long. In *Compassion in Dying v State of Washington*,<sup>65</sup> the United States Court of Appeal for the Ninth Circuit held that a Washington statute prohibiting assisted suicide was unconstitutional on the basis that it infringed the Due Process Clause of the Fourteenth Amendment. Reinhardt J, delivering the court's opinion, stated that:

[W]e see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient's life. Similarly, we see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life.<sup>66</sup>

Similarly, in *Quill v Vacco*,<sup>67</sup> the Second Circuit regarded the disparity between New York State law, which permitted a competent patient to hasten death by withdrawing life-support, yet prohibited a person from hastening their death by self-administering prescribed drugs, as evidence that the latter provisions, which prohibited assisted suicide, violated the Equal Protection Clause of the Fourteenth Amendment.<sup>68</sup> It is implicit in this conclusion that there is no relevant legal or moral difference between the omission and the positive act, at least where the positive act consists of prescribing lethal drugs for self-injection by a terminally ill patient.

### C *Personal Autonomy and the Withdrawal of Life-Support*

In January 1985, former Australian water-ski champion John McEwan dived into the Murray river at Echuca (a town on the New South Wales — Victorian border), and suffered spinal injuries which rendered him quadriplegic. A year later, when he asked for the withdrawal of the ventilator which was keeping him alive, his doctor's insurers refused, fearing litigation.<sup>69</sup> When McEwan subsequently went on a hunger strike in a Melbourne hospital, he was certified as insane. That certification was not revoked until he agreed to accept food, take anti-depressant drugs and undergo counselling.<sup>70</sup>

<sup>65</sup> *Compassion in Dying v State of Washington* 79 F 3d 790 (1996) ('*Compassion in Dying*').

<sup>66</sup> *Ibid* 824 (Reinhardt J).

<sup>67</sup> *Quill v Vacco* 80 F 3d 716 (1996).

<sup>68</sup> *Ibid* 40-1 (Miner J). In *Rodriguez v British Columbia (Attorney General)* [1993] 3 SCR 519, 543-5, 549-50, Lamer CJC (dissenting), reached a similar conclusion, considering the prohibition on assisted suicide in s 241(b) of the Criminal Code, and the right to equality in s 15(1) of the Canadian Charter of Rights and Freedoms.

<sup>69</sup> Nicholas Tonti-Filippini, 'Some Refusals of Medical Treatment which Changed the Law of Victoria' (1992) 157 *Medical Journal of Australia* 277, 277-8.

<sup>70</sup> Peter Ward, 'New Life in the Death-with-Dignity Debate' *The Australian* (Sydney), 14 October 1987, 11.

The community debate in Victoria which followed the McEwan case led to the enactment of the Medical Treatment Act 1988 (Vic) which gives competent adult patients a statutory right to refuse medical treatment generally, or particular kinds of medical treatment. This right of refusal operates, however, only in respect of a 'current condition'. Nor does it extend to the refusal of palliative care, which includes the provision of reasonable procedures to relieve pain, and the reasonable provision of food and water. Refusals are recorded in a 'refusal of treatment certificate', and a doctor who ignores the certificate and treats a patient may be guilty of medical trespass.<sup>71</sup>

Victoria's Medical Treatment Act is one of several models for patient self-determination which operate in various Australian states, following acquired incapacity. South Australia and the Northern Territory have enacted 'living will' statutes, which enable competent persons to make a formal direction refusing 'extraordinary measures' in the event that the person becomes incompetent in future and suffers from a terminal illness.<sup>72</sup> 'Extraordinary measures' would include artificial ventilation, intravenous hydration and feeding, dialysis, transplants of vital organs, and other procedures which prolong life by 'supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation'.<sup>73</sup>

In addition to advance directives, there are also several models for proxy decision-making. Usually, when a patient becomes incompetent, decisions regarding his or her medical treatment are made by the legal guardian, in accordance with the patient's best interests. The appointment of the guardian requires an application to the relevant Guardianship and Administration Board, and the guardian's authority is usually limited to those decisions a parent would be authorised to make on behalf of a child.<sup>74</sup> Several states have followed their American counterparts by enacting legislation which authorises a spouse, carer, friend or relative to consent to medical treatment on a patient's behalf, a power which would not otherwise exist unless that person was the incompetent patient's legal guardian.<sup>75</sup> Several states provide for the appointment of an enduring (medical) power of attorney, which authorises the attorney to consent to medical

<sup>71</sup> Similar legislation operates in the Australian Capital Territory: Medical Treatment Act 1994 (ACT) ss 6-12.

<sup>72</sup> Natural Death Act 1983 (SA); Natural Death Act 1988 (NT).

<sup>73</sup> Natural Death Act 1983 (SA) s 3; Natural Death Act 1988 (NT) s 3. For further discussion, see Dr Danuta Mendelson, 'Medico-Legal Aspects of the "Right to Die" Legislation in Australia' (1993) 19 *Melbourne University Law Review* 112; David Lanham and Belinda Fehlberg, 'Living Wills and the Right to Die with Dignity' (1991) 18 *Melbourne University Law Review* 329.

<sup>74</sup> Consent to certain prescribed, or major medical procedures may still require the consent of the Board: eg Guardianship and Administration Board Act 1986 (Vic) ss 24, 36-42. Under Australian common law, court approval is also required for the sterilisation of an incompetent person: *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

<sup>75</sup> Guardianship Act 1987 (NSW) ss 35-7; Guardianship and Administration Act 1993 (SA) s 59; Guardianship and Administration Act 1995 (Tas) ss 4, 39, 43. For a United States example, see California Probate Code §§ 3200-11.

treatment on behalf of an incompetent person.<sup>76</sup> However, broader legislation exists in Victoria and the Australian Capital Territory which specifically authorises a patient to confer an enduring medical power of attorney upon an agent. The agent has authority to *refuse* medical treatment on the patient's behalf in circumstances where the patient later becomes incapacitated.<sup>77</sup>

The Australian legislation thus includes a variety of mechanisms (advance directives, including 'living wills', and proxy decision-making under a court appointed guardian or pursuant to an enduring medical power of attorney), which enable patients to exercise — to varying degrees — a right of bodily self-determination encompassing a right to hasten death by refusing life-preserving medical treatment. In the United States, the right to refuse unwanted medical treatment is an aspect of the 'liberty' which citizens enjoy under the Fourteenth Amendment to the United States Constitution.<sup>78</sup> In New Zealand, it is a statutory right under the New Zealand Bill of Rights Act 1990<sup>79</sup> which has an evolving 'quasi-constitutional' status.

Such a right also exists under common law. Courts in the industrialised common law democracies have increasingly affirmed the general principle that competent adult patients have the right to decide for themselves whether to undergo medical treatment.<sup>80</sup> British Commonwealth and American courts have recognised that, provided the patient is competent to make the decision, and provided his or her wishes have been properly ascertained, the law will respect this right, even if it is regarded as unreasonable and even if it will have fatal consequences for the patient.<sup>81</sup> As Lord Browne-Wilkinson said in the *Bland* case, '[a] mentally competent patient can at any time put an end to life support systems by refusing his consent to their continuation.'<sup>82</sup> In January 1996, for example, an anorexic woman was permitted to die in an English hospital, despite

<sup>76</sup> However this legislation does not on its face authorise the refusal of life-preserving treatment by the person entrusted with the power of attorney on behalf of the patient: see *Guardianship and Administration Act 1993 (SA) s 25* (referring to refusal, although it is unclear whether this extends to withdrawal of life-preserving treatment); *Guardianship and Administration Act 1995 (Tas) ss 4, 32, 36-46*; *Powers of Attorney Act 1956 (ACT) s 13*.

<sup>77</sup> *Medical Treatment Act 1988 (Vic) s 5A*; *Medical Treatment Act 1994 (ACT) ss 13-18*.

<sup>78</sup> See *Cruzan* 497 US 261 (1990), 278-9. While this interest is not unqualified, it was assumed in the *Cruzan* court opinion that 'the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.' See also 287-9 (O'Connor J).

<sup>79</sup> *New Zealand Bill of Rights Act 1990 (NZ) s 11*.

<sup>80</sup> See, eg, United States: *Schloendorff v Society of New York Hospital* 105 NE 92 (1914) 93; *Cruzan* 497 US 261 (1990), 277; Australia: *F v R* (1983) 33 SASR 189, 193; *Rogers v Whitaker* (1992) 175 CLR 479, 486-7; England: *Sidaway v Board of Governors of Bethlehem Royal Hospital* [1985] AC 871, 882, 888; Canada: *Rodriguez v British Columbia (Attorney-General)* [1993] 3 SCR 519, 598-9; New Zealand: *Smith v Auckland Hospital Board* [1965] NZLR 191, 219; *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235, 245.

<sup>81</sup> United States: *Bouvia v Superior Court (Glenchur)* 225 Cal Rptr 297 (1986); *Fosmire v Nicoleau* 551 NYS 2d 876 (1990); *State v McAfee* 385 SE 2d 651 (1989). England: *In re T (Adult: Refusal of Treatment)* [1993] Fam 95, 115, 116-17, 121; *In re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290, 294-5; *Bland* [1993] AC 789, 857, 859, 864, 882, 892; *Secretary of State for the Home Department v Robb* [1995] 1 All ER 677 (competent adult's right to self-determination prevails over any countervailing state interest). Canada: *Nancy B v Hôtel-Dieu de Québec* (1992) 86 DLR (4th) 385.

<sup>82</sup> *Bland* [1993] AC 789, 882.

the wishes of her family that she receive nourishment through a drip.<sup>83</sup> Similarly, in one Canadian case,<sup>84</sup> a doctor who administered blood to an unconscious Jehovah's Witness, ignoring the card in her purse which stated that she did not want blood to be administered under any circumstances, was held to be guilty of battery. Damages of \$20,000 were awarded for mental distress.

The basis for the right to refuse medical treatment is the fact that such treatment involves the intentional infliction of physical force upon the body. Subject to emergencies and other exceptions, therefore, medical treatment administered by a doctor is only lawful when the patient consents to it. The right to refuse medical treatment is thus an expression of the right not to be subjected to unlawful assault.<sup>85</sup>

The extent of the common law right in Australia appears to be somewhat less clear than in England. In Australia, aiding and abetting suicide remains a crime,<sup>86</sup> and a person is permitted to use reasonable force to prevent another person from committing suicide.<sup>87</sup> This creates potential problems when it is clear to the doctor that the patient intends to achieve their death by refusing treatment, yet has not made a statutory declaration under one of the legislative mechanisms described above. In 1983, a New South Wales court refused to grant an injunction which would have prevented prison authorities from force-feeding a prisoner who had been on a hunger strike. The Court refused the injunction both because the legislation permitted force-feeding in the prison, but also because any such injunction would have amounted to aiding and abetting the prisoner's attempt to commit suicide.<sup>88</sup> Similarly, in 1989 a Victorian judge refused to grant an injunction which would have prevented hospital doctors from operating on an unconscious man to discover the source of bleeding in his throat. The man's wife said he wanted to die and he had taken a drug overdose. However, under the circumstances, an injunction preventing the operation would have aided and abetted the man's suicide.<sup>89</sup> One can speculate on whether the judge would have decided differently if the man had previously made an advance directive refusing medical treatment under the Medical Treatment Act 1988 (Vic). As they stand, however, these cases are examples of how an otherwise established, legal right of

<sup>83</sup> 'Woman Suffering from Anorexia Insists on Being Allowed to Die' (1996) 15(1) *Monash Bioethics Review* 4, 4-5.

<sup>84</sup> *Malette v Shulman* (1987) 47 DLR (4th) 18.

<sup>85</sup> See, eg, *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, 309-10.

<sup>86</sup> See, eg, Crimes Act 1958 (Vic) s 6B(2); Crimes Act 1900 (NSW) s 31C.

<sup>87</sup> See, eg, Crimes Act 1958 (Vic) s 463B; Crimes Act 1900 (NSW) s 574B.

<sup>88</sup> *Schneidas v Corrective Services Commission* (1983) 7 *Criminal Law Journal* 353, 354. Recent English cases, by contrast, indicate that the right of self-determination will prevail, and will permit a patient (or prisoner) to refuse food and water for so long as they retain mental capacity to do so: *Secretary of State for the Home Department v Robb* [1995] 1 All ER 677. To resolve this issue, legislation authorising the force-feeding of a patient against his or her will has sometimes been enacted, for example, where the patient is suffering a mental disorder (see, eg, *B v Croydon Health Authority* [1995] 1 All ER 683) or is under detention (see, eg, *Secretary, Department of Immigration, Local Government and Ethnic Affairs v Mok* (Supreme Court of New South Wales, Powell J, 30 September 1992)).

<sup>89</sup> *In re Kinney* (Supreme Court of Victoria, Fullagar J, 23 December 1988); Loane Skene, 'The Fullagar Judgment' (1989) 14 *Legal Service Bulletin* 42.

self-determination was curtailed because of the underlying intention with which the act was done.

Despite the potential ambiguity in the Australian position, enough has been said to show that legal recognition of a right of bodily self-determination through legislation and under common law, extending as it does to the withdrawal of life-preserving treatment, significantly undermines the sanctity of life ethic. Patients are legally entitled to end their lives by rejecting life-preserving treatment. While the exercise of such a right is complicated if the patient becomes incompetent, legislative mechanisms such as living wills and medical powers of attorney all attempt to ensure compliance with the patient's previously expressed values and wishes.

The increasing recognition of the importance of personal autonomy in the law is creating pressure for further reform. If patients are able to end their lives by withdrawing ventilation (so that they asphyxiate, albeit under sedation), or by withdrawing hydration and nourishment (so that they die from kidney failure, or slowly starve to death), what rock of principle should prevent them from ending their lives more directly and humanely? Although Lord Goff spoke of 'the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia — actively causing [a patient's] death to avoid or to end his suffering',<sup>90</sup> it seems clear that the Rubicon has already been crossed, in deed if not in word.

The anomalies can be multiplied. Putting the exception embodied in the Rights of the Terminally Ill Act 1995 to one side, suicide is a crime in the Northern Territory, although not elsewhere in Australia.<sup>91</sup> Assisted suicide, however, is a crime in all Australian states.<sup>92</sup> Able bodied individuals may therefore lawfully commit suicide, but physically disabled individuals may not: the ethics of the sanctity of life prevent an individual from receiving assistance or assisting others, whereas the ethics of personal autonomy allow individuals to kill themselves. As noted above, in April 1996, in *Quill v Vacco*,<sup>93</sup> the United States Court of Appeal for the Second Circuit held that this disparity violated the Equal Protection Clause of the Fourteenth Amendment.<sup>94</sup>

The current logic of the law regulating end-of-life decisions may therefore be summarised as follows. On the one hand, the law has undermined the sanctity of life ethic by permitting health care workers to hasten death by terminating life-support systems, provided that the patient is irreversibly comatosed so that life has become 'futile', or provided that the patient has exercised personal autonomy by rejecting the treatment on which their life depends. Active intervention to kill a patient, however, is precluded by the fact that courts believe there is a relevant

<sup>90</sup> *Bland* [1993] AC 789, 865 (Lord Goff).

<sup>91</sup> See, eg, Crimes Act 1958 (Vic) s 6A; Crimes Act 1900 (NSW) s 31A. In the United States, suicide and attempted suicide have not been criminal offences for at least 10 years: *Compassion in Dying* 79 F 3d 790 (1996), 809-10. A majority of states retain laws prohibiting assisted suicide.

<sup>92</sup> See, eg, Crimes Act 1958 (Vic) s 6B(2); Crimes Act 1900 (NSW) s 31C; See also above n 86.

<sup>93</sup> 80 F 3d 716 (1996).

<sup>94</sup> *Ibid* 40-1 (Miner J).

moral or legal difference between 'passive' euthanasia, following the withdrawal of life-support, and 'active' euthanasia, following, for example, a lethal injection.

On the other hand, the law has undermined the sanctity of life ethic by permitting health care workers to hasten death by actively giving treatment, provided that treatment is given for a lawful medical purpose. The administration of drug overdoses (euphemistically called 'pain relief'), which have the effect of hastening death, is legally permissible, provided the doctor can point to the concomitant purpose of providing relief from pain and suffering. This is the well-established principle of 'double effect',<sup>95</sup> recognised by Justice Devlin in Dr Adams' trial.<sup>96</sup> It is now widely relied upon in hospitals and palliative care settings to justify humane treatment which also shortens life. The dividing line between intending to relieve the pain of an exhausted and dying patient, and intending to expedite their inevitable death is, however, as thin as onion skin. As one Oregon physician has commented:

Dying patients are given larger and larger doses of morphine. We talk about the 'double effect', and know jolly well we are sedating them into oblivion, providing pain relief but also providing permanent relief, and we don't tell them.<sup>97</sup>

While the doctor's intention is the distinguishing characteristic, it is probably safe to assume that many people would have difficulty understanding the moral and legal difference between 10 to 30 semi-lethal injections causing death over three to seven days (perfectly legal pain relief), and death within an hour after one lethal injection (euthanasia, murder).<sup>98</sup>

#### D *Paternalism, Personal Autonomy and the Sanctity of Life Ethic*

The retreat from the sanctity of life ethic embodied in the developments discussed above reflects two quite distinct philosophical approaches to end-of-life decision-making. The first approach centres on personal autonomy. Seen through libertarian lenses, the conflict generated by the euthanasia debate is between a 'communitarian' world view where social goals and values circumscribe aspects

<sup>95</sup> This principle has been accepted as part of the common law of the United Kingdom: *Bland* [1993] AC 789, 867 (Lord Goff); the United States: *Compassion in Dying* 79 F 3d 790 (1996), 822; and New Zealand: *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235, 252, 253 (Thomas J).

<sup>96</sup> See Palmer, above n 38, 375. Dr John Adams was an English family practitioner who was tried at the Old Bailey in the 1950s for the murder of an 81 year old patient whom he had injected with 2.6 grams of heroin and 2.6 grams of morphine during the last days of her life. Although eventually acquitted, Dr Adams was fined heavily for a variety of offences which included making false statements (by claiming he was not a beneficiary under his patient's will), attempting to conceal phials of morphine, and obstructing police. The General Medical Council later barred him from practicing for three years: Clifford Hawkins, *Mishap or Malpractice* (1985) 64-5. Devlin J, the presiding judge (later Lord Devlin), wrote a book about the case after Adams' death: Patrick Devlin, *Easing the Passing: The Trial of Dr John Bodkin Adams* (1985).

<sup>97</sup> Paul Cotton, 'Medicine's Position is Both Pivotal and Precarious in Assisted-Suicide Debate' (1995) 273 *Journal of the American Medical Association* 363, 363. As Grimley Evans, Professor of Geriatric Medicine at Oxford University, is reported to have said 'doctors shrink from active euthanasia because they are trained to kill only by accident': Raymond Tallis, 'Is There a Slippery Slope?', *Times Literary Supplement* (London), 12 January 1996, 3.

<sup>98</sup> Rodney Syme, 'A Patient's Right to a Good Death' (1991) 154 *Medical Journal of Australia* 203, 204.

of individual freedom, and a more individualistic world view where personal choice within the personal sphere trumps social values.

Society's increasing moral commitment to personal autonomy is reflected in case law and legislation recognising a right to refuse medical treatment, including life-support where death will inevitably follow. Although assisted suicide and active voluntary euthanasia are frequently 'marketed' as merciful relief for terminally ill patients in unbearable pain, 'personal autonomy' as a philosophical justification for euthanasia provides no logical basis for limiting euthanasia either to those in unbearable pain or those who are terminally ill. If personal autonomy is the only relevant value, the logical conclusion is a right to assisted suicide *simpliciter*. If personal autonomy is the only underlying justification for assisted suicide/euthanasia reform, then the deep implications of this should be frankly acknowledged and debated in a way which has not occurred to date.

Personal autonomy does not, however, explain all the legal developments which have undermined the sanctity of life ethic. The re-definition of death to include 'whole-brain death', and the legal permission to withdraw life-support from PVS patients whose 'higher brains' are dead reflect moral judgments about the quality of life imposed upon the individual from outside. These developments reflect paternalistic assessments about the point at which life becomes futile, or the point at which life becomes so attenuated that further existence would serve no purpose. It is important to recognise the existence and potential impact of this approach to end-of-life decision-making as we briefly review the current state of euthanasia law reform.

### III THE CURRENT STATE OF EUTHANASIA LAW REFORM

#### A Australia

In Westminster-style democracies whose Constitutions largely lack substantive rights guarantees, such as Australia or Britain, the prospect of euthanasia law reform is remote in the absence of legislative change. This is in contrast to the United States, where law reform has emerged through court litigation challenging the constitutionality of legislation criminalising physician-assisted suicide, or through citizen-initiated referenda.

Within a parliamentary context, the reform process ultimately relies not only upon broad public support; and successful advocacy by major players in the political debate; but also upon parliamentary facilitators. This creates problems, since euthanasia is not a party-political issue, and would therefore ordinarily, only attract a conscience vote. In the Northern Territory, the passage of the Rights of the Terminally Ill Act 1995 was largely due to the hard work and personal commitment of the former Chief Minister, whose private member's Bill was backed by his own power and influence.

In Victoria, by contrast, the inability of the Voluntary Euthanasia Society to find a private member to sponsor a reform Bill is one reason why the euthanasia debate has not gotten beyond the press, and why advocates such as the

'Melbourne seven' have resorted to increasingly high profile (some would say exhibitionist tactics) to get the issue onto the political agenda. Following the admissions of the 'Melbourne seven', an Opposition call for a Parliamentary inquiry into euthanasia was rejected,<sup>99</sup> although the Premier expressed personal support for legalised voluntary euthanasia, and, following the enactment of the Rights of the Terminally Ill Act 1995 (NT), foreshadowed that Parliament would consider the issue during 1996.<sup>100</sup> Subsequently, however, in response to an appeal by 70 Victorian doctors, he indicated that his government would not be considering euthanasia in the 'foreseeable future'.<sup>101</sup> More recently still, he has described the Andrews Bill (which would repeal the Rights of the Terminally Ill Act 1995 (NT)) as 'absolutely immoral' and 'an insult to humanity', yet confirmed that while Victoria will monitor developments in the Northern Territory, there are no plans to change state laws 'within the next four years'.<sup>102</sup>

It is hardly surprising that politicians should seek to avoid a divisive issue like euthanasia. A former Australian Governor-General's support for euthanasia had politicians from both sides of politics running for cover.<sup>103</sup> Nevertheless, a legislative approach to euthanasia law reform is preferable if reform is to occur: Parliaments are democratic, and able to fashion an appropriately detailed framework incorporating safeguards. The major safeguards embodied in the Rights of the Terminally Ill Act 1995 are summarised in Table 1. The philosophical basis for the Act is clearly the exercise of personal autonomy. The decision to die is one made by the patient; it is not a judgment imposed from outside. On the other hand, social judgments about the moral value of life restrict the exercise of this right to a narrow context where a patient is terminally ill, not suffering a treatable depression, and is suffering pain or distress at an unacceptable level. Elsewhere in Australia, private members' Bills introduced in South Australia and the Australian Capital Territory have failed.<sup>104</sup> Reform is unlikely in New South Wales following a Parliamentary debate revealing four-to-one opposition to legislation.<sup>105</sup> An Australia-wide response to the regulation of euthanasia is highly unlikely: a proposal by a former federal Health Minister for a national

<sup>99</sup> Shane Green, 'Kennett Rejects Euthanasia Inquiry', *The Age* (Melbourne), 4 April 1995, 5.

<sup>100</sup> Gay Alcorn, Gareth Boreham and Nicole Brady, 'Kennett: I Support Euthanasia', *The Age* (Melbourne), 26 May 1995, 1; Shane Green and Steve Dow, 'Premier Signals State Euthanasia Debate', *The Age* (Melbourne), 27 May 1995, 3.

<sup>101</sup> Steve Dow, 'No Euthanasia Change, Says Kennett', *The Age* (Melbourne), 3 November 1995, 9; Terry Brown, 'Euthanasia Appeal Rejected', *Herald-Sun* (Melbourne), 3 November 1995, 39.

<sup>102</sup> Ewin Hannan and David Nason, 'Kennett Attacks 'Immoral' Attempt to Override NT Law', *The Australian* (Sydney), 27 September 1996, 6.

<sup>103</sup> Bill Hayden, 'A Right to Live, and Die, Without Intervention', *The Australian* (Sydney), 23 June 1995, 17; Paul Chamberlain, Rachel Buchanan and Claire Kermond, 'PM Ducks in Hayden Uproar', *The Age* (Melbourne), 23 June 1995, 4.

<sup>104</sup> The SA Bill: Andrew Ramsay, and Ebru Yaman, 'MPs Put Brake on Right-to-Die Push', *The Australian* (Sydney), 27 July 1995, 1. The ACT Bill: Maria Ceresa and John Ellicott, 'ALP Pair Cross Floor to Oppose Euthanasia' *The Australian* (Sydney), 23 November 1995, 3.

<sup>105</sup> David Nason, 'Open House Slams Door on Euthanasia', *The Australian* (Sydney), 17 October 1996, 1; Trudy Harris, 'Historic Debate Full of Emotion', *The Australian* (Sydney), 17 October 1996, 4.

taskforce to assess the Northern Territory's legislation and to ensure uniform state laws was defeated by state health ministers.<sup>106</sup>

**Table 1**  
Safeguards Embodied in the Rights of the Terminally Ill Act 1995

- Only adult patients suffering terminal illnesses can be assisted: s 7(1)(a);
- The treating doctor must be satisfied on reasonable grounds that the patient is experiencing pain, suffering or distress to an extent unacceptable to the patient, with no treatment reasonably available to the patient, other than palliative care: ss 4, 7(1)(b).
- A second doctor must confirm the treating doctor's prognosis: s 7(1)(c)(iii).
- A third doctor, who must be a qualified psychiatrist, must certify that the patient is not suffering a treatable clinical depression: s 7(1)(c)(iv).
- The treating doctor must counsel the patient as to treatment options, including palliation, counselling and psychiatric support; must be satisfied that the patient has considered the effect of the decision upon family, and that the decision is freely and voluntarily made. Information about palliative care options must be given either by the treating doctor or another doctor who satisfies legislative criteria ensuring specialist knowledge in palliative care. Following the counselling, the patient must reaffirm his or her decision: s 7(1)(e)-(h).
- A cooling off period of 48 hours applies, the treating doctor must provide the assistance personally and remain until the patient has died: s 7(1)(n)-(p).
- Prior to this, the patient's request to die must be documented, signed, witnessed and countersigned by the second doctor in accordance with statutory requirements: s 7(1)(i)-(k).
- A request may be rescinded at any time: s 10.
- The Act requires the treating doctor to document in the patient's medical record all aspects of the process, including the paperwork demonstrating compliance with the legislative procedure as it relates to each of the three doctors involved in the process, noting the drugs used to bring about death, certifying death, and reporting to the Coroner, who in turn reports to the Attorney-General: ss 12-15.
- The Act requires the use of interpreters holding prescribed qualifications where the patient and any of the three doctors involved in the process do not share the same first language: s 7(4). The interpreter must be present at the signing of a request for assistance, and must not stand to gain anything from the patient's death: s 7(1)(l)-(m).
- Doctors giving assistance may not receive any reward for their services above a normal fee: s 6.

<sup>106</sup> Gareth Boreham, 'Tehan in Clash Over Inquiry on Euthanasia Law', *The Australian* (Sydney), 15 June 1995, 4; Tim Stevens, 'Euthanasia: Nat MPs will Follow Conscience', *The Australian* (Sydney), 19 June 1995, 3.

### B *The British Commonwealth*

Australia is the only member of the British Commonwealth yet to experiment with euthanasia law reform. On 16 August 1995, the New Zealand Parliament rejected by a 61:29 majority a private member's Death With Dignity Bill, which would have legalised voluntary euthanasia for the terminally ill.<sup>107</sup> In England, a 1994 House of Lords Select Committee report opposed legalising euthanasia.<sup>108</sup> This conclusion was shared by the majority of the Canadian Special Senate Committee on Euthanasia and Assisted Suicide which presented its report to the Canadian Parliament on 6 June 1995.<sup>109</sup> The Canadian Supreme Court had already determined in the *Rodriguez* case that the prohibition of assisted suicide does not violate the Canadian Charter of Rights and Freedoms.<sup>110</sup> The European Commission on Human Rights reached a similar decision, holding that English legislation criminalising assisted suicide does not violate the right to 'respect for private and family life' in Article 8 of the European Convention on Human Rights.<sup>111</sup>

### C *The Netherlands*

In the Netherlands, euthanasia remains a crime on the statute books,<sup>112</sup> although since 1973, case law has established that a doctor who terminates a patient's life in accordance with certain criteria and who reports the procedure, will not be guilty of any offence and is unlikely to be charged. To remain unprosecuted, the termination must follow a persistent, voluntary and well-informed request from a patient experiencing unbearable pain or suffering, with no treatment or other options for relief available, and the doctor must consult with a colleague.<sup>113</sup> If these criteria are satisfied, the doctor may rely successfully upon the defence of necessity or *force majeure*. The basis of this defence is that the doctor's duty to preserve life comes into conflict with the duty to relieve unbearable suffering.<sup>114</sup>

<sup>107</sup> Graeme Speden 'Choice Key to Law's Death Bill' *The Dominion* (Wellington), 16 August 1995, 10; Graeme Speden 'MPs Throw out Euthanasia Bill' *The Dominion* (Wellington), 17 August 1995, 1.

<sup>108</sup> 'Their Lordships on Euthanasia' (1994) 343 *The Lancet* 430.

<sup>109</sup> Randall Palmer 'Canada May Cut Euthanasia Penalties' *The Australian* (Sydney), 8 June 1995, 9; Canada, *Special Senate Committee on Euthanasia and Assisted Suicide: Final Report* (1995): internet address: <http://www.rights.org/~deathnet/senate.html>.

<sup>110</sup> *Rodriguez v British Columbia (Attorney-General)* [1993] 3 SCR 519.

<sup>111</sup> *App No 10083/82 v United Kingdom* (1984) 6 EHRR 140.

<sup>112</sup> Dutch Criminal Code ss 293-4.

<sup>113</sup> John Keown, 'Euthanasia in the Netherlands: Sliding Down the Slippery Slope?' in Keown, above n 14, 264.

<sup>114</sup> See Netherlands Ministry of Foreign Affairs, *The Termination of Life by a Doctor in the Netherlands* (Press Release on the Regulation of Euthanasia and Assisted Suicide in the Netherlands), May 1995; J Rummelink, 'The Legal Position on Euthanasia in the Netherlands', paper given to the 6th Annual Australasian Society for HIV Medicine (ASHM) Conference, Sydney, 4 November 1994 (English translation kindly provided by the author); Barney Sneiderman and Marja Verhoff, 'Patient Autonomy and the Defence of Medical Necessity: Five Dutch Euthanasia Cases' (1996) 34 *Alberta Law Review* 374.

A good deal of debate over the wisdom of legalising euthanasia has centred around the 'Rommelink Report', a study commissioned by the Dutch government in 1990 to quantify the practice of euthanasia, and to investigate end-of-life decisions generally. Journal articles detailing the findings of the Rommelink Committee indicate that in 1990, the estimated incidence of active voluntary euthanasia, as a percentage of all annual deaths (~130,000 deaths), was 1.8% (~2,300 cases). Similarly, an estimated 0.3% of annual deaths were the result of assisted suicide (~400 cases). The Committee also estimated an annual figure of 1000 deaths (0.8% of annual deaths) which fell into neither of the preceding categories, where life was terminated without the patient's explicit request. Referring to these cases of non-voluntary euthanasia, the authors of the study stated that the patients were 'close to death and were suffering grievously', and that in more than half of cases the decision was discussed with the patient or the patient had indicated in a previous phase of their illness a desire for euthanasia if suffering became unbearable.<sup>115</sup> The admission of cases of non-consensual euthanasia has resulted in vehement criticism of the Dutch policy of decriminalisation. What should be remembered, however, is that non-consensual euthanasia also occurs in countries where euthanasia is illegal. Until the extent of illegal euthanasia is known, it seems premature to condemn the euthanasia policy of the one country which has opened itself up to inspection.

Partly as a result of the Rommelink report, the Dutch government decided not to introduce legislation which would have explicitly legalised euthanasia.<sup>116</sup> Nevertheless, effective from 1 June 1994, a statutory notification procedure came into operation in the Netherlands embodying 50 criteria which act as guidelines for assessing the decision of a doctor to terminate the life of a terminally ill patient for whom no prospect of improvement exists. Doctors' reports are verified by the municipal pathologist and assessed by the public prosecutor, who also determines whether the doctor can rely upon the *force majeure* defence.<sup>117</sup>

In the recent, highly publicised *Chabot* case, the Dutch Supreme Court affirmed that a doctor could successfully rely upon the *force majeure* defence in circumstances where the patient's suffering was not caused by a somatic disease.<sup>118</sup> The patient in this case wanted to die after her marriage had broken down, and her two sons and father had died. She persistently refused treatment, and was described by the Court as suffering a 'depression in a narrower sense

<sup>115</sup> Paul van der Maas, Johannes van Delden, Loes Pijnenborg and Casper Looman, 'Euthanasia and Other Medical Decisions Concerning the End of Life' (1991) 338 *The Lancet* 669, 672. See also Johannes van Delden, Loes Pijnenborg and Paul van der Maas, 'The Rommelink Study: Two Years Later' (1993) 23 *Hastings Center Report* 24.

<sup>116</sup> Rommelink, above n 114.

<sup>117</sup> Netherlands Ministry of Foreign Affairs, above n 114.

<sup>118</sup> *Office of Public Prosecutions v Chabot*, Supreme Court of the Netherlands, Criminal Chamber, 21 June 1994, nr 96.972; see Marjanke Spanjer, 'Assisted Suicide for Mental Distress' (1995) 345 *The Lancet* 246. For an English-language translation of the Court's decision, see John Griffiths, 'Assisted Suicide in the Netherlands: The *Chabot* Case' (1995) 58 *Modern Law Review* 232; see also Sneiderman and Verhoff, above n 114, 398-405.

without psychotic characteristics, in the context of a complicated grieving process'.<sup>119</sup>

The *Chabot* decision, while consistent with an approach to euthanasia focused upon the moral value of 'personal autonomy', provides fuel for those who argue that legalised euthanasia is a 'slippery slope' leading to the wholesale abuse of vulnerable patients. As noted above, once society accepts that an individual's right to self-determination justifies medical assistance in dying, what logic limits euthanasia to terminally ill patients? Where the line should be drawn between personal autonomy, and paternalistic judgments about the moral value of life 'imposed' upon the individual by society, is a matter for each society, although it would be foolish to assume that there will be no 'subtle transformation of ethical sensibility', once society becomes accustomed to euthanasia.<sup>120</sup> In the Netherlands, the fact that euthanasia has evolved through court decisions which lack the precision of a detailed legislative framework, may perhaps have encouraged a certain 'drift'. John Keown, a leading English critic of Dutch euthanasia policy, has argued that:

[I]t is not even possible precisely to identify the legal criteria, let alone define them: the Supreme Court omitted to lay down a precise list and lower courts have issued sets of criteria which are far from congruent .... In short, the Guidelines are simply incapable, because of their vagueness and the fact that they entrust the decision-making to the individual practitioner, of ensuring that euthanasia is carried out only in accordance with the criteria they specify'.<sup>121</sup>

If Keown's analysis is right, it is clear that euthanasia reform should only occur through Parliaments, and only then in accordance with a systematic and precise set of legislative criteria, perhaps subject to 'administrative supervision' by the judiciary.<sup>122</sup>

Opponents of euthanasia also point to the recent *Prins* case, where a gynaecologist was convicted of murder for killing a brain damaged spina bifida baby described as 'a sleeping plant', after consulting with family and colleagues.

<sup>119</sup> John Keown, 'Physician-Assisted Suicide and the Dutch Supreme Court' (1995) 111 *Law Quarterly Review* 394, 395. Dr Chabot was convicted in this case, but on the basis that since the patient was not suffering a somatic illness, he could not establish the necessity defence without ensuring that a second doctor had examined the patient. This had not occurred. However, the Supreme Court imposed no punishment.

<sup>120</sup> See Robert Manne, 'The Slippery Slope is a Life and Death Argument' *The Age* (Melbourne), 14 June 1995, 18. Keown cites the case of a leading Dutch practitioner of euthanasia who would not rule out performing euthanasia on an elderly patient who felt he was a 'nuisance to his relatives who wanted him dead so they could enjoy his estate': John Keown, 'Euthanasia in the Netherlands: Sliding Down the Slippery Slope?' in Keown, above n 14, 265.

<sup>121</sup> Keown, above n 120, 265-6.

<sup>122</sup> In the writer's view, if euthanasia were to be legalised, such 'administrative supervision' should only relate to ensuring procedural compliance with relevant safeguards. In this context, an interesting analogy may be drawn with the judiciary's role in authorising search warrants, or telephone taps. The writer would not, however, support a model of legalisation which required, as of course, a substantive judicial hearing as a pre-requisite to euthanasia, thereby clogging the courts and negating the central role of the patient's doctors. The requirement for institutional ethics approval as a pre-requisite to the termination of life-support in *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235, has been criticised on the same basis: see Skegg, above n 61. I am grateful to Associate Professor Geoff Lindell, Faculty of Law, University of Melbourne, for a broad-ranging discussion on these matters.

However, the Court said the decision could 'reasonably be considered as justifiable', and no punishment was imposed.<sup>123</sup> While the law was formally upheld, this result does suggest the influence of paternalistic judgments about the moral value of life similar to those which contributed to the acceptance of 'whole-brain death', the debate over 'higher-brain death', and the withdrawal of life-support from PVS patients in the *Bland* decision. In view of the fact that the law has already been substantially influenced by judgments about the moral value of life which are paternalistic or 'imposed-from-without', it would be foolish to ignore future pressures towards non-voluntary euthanasia based upon social, legislative or judicial perceptions that 'a life like that is not worth living'. Indeed, such issues already lie latent within existing law.

#### D The United States

Like the Netherlands, but unlike Australia, the right to die in the United States has emerged through court decisions, albeit decisions admitting previously-unrecognised constitutional rights to physician-assisted suicide. In March 1996, the Ninth Circuit held that the right to commit suicide with the assistance of physician-prescribed, lethal medication was an aspect of the 'liberty' that citizens enjoy under the Due Process Clause of the Fourteenth Amendment.<sup>124</sup> In April 1996, as noted above,<sup>125</sup> the Second Circuit held that this right does not exist under the Due Process Clause, but under the Equal Protection Clause of the Fourteenth Amendment.<sup>126</sup>

Although the effect of the Ninth Circuit ruling has been temporarily blocked by a Supreme Court injunction pending an application for Supreme Court review,<sup>127</sup> both decisions confirm the power of the United States' courts to effect important social policy changes through constitutional review. These decisions have sparked a challenge to a 1995 Oregon District court decision<sup>128</sup> which struck

<sup>123</sup> Tony Sheldon, 'Dutch Court Convicts Doctor of Murder' (1995) 310 *British Medical Journal* 1028, 1028; 'Dutch Doctor Convicted but not Punished for Euthanasia of Infant' (1995) 14(3) *Monash Bioethics Review* 5, 5-6. See also Jennifer Chao, 'Baby Poses Sad Test for Dutch Euthanasia Law', *The Age* (Melbourne), 14 April 1995, 8.

<sup>124</sup> *Compassion in Dying* 79 F 3d 790 (1996). The Due Process Clause of the Fourteenth Amendment provides that no state shall 'deprive any person of life, liberty, or property, without due process of law': United States Constitution amendment XIV, § 1. The Ninth Circuit covers the States of Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon and Washington.

<sup>125</sup> See above n 93.

<sup>126</sup> The Equal Protection Clause provides that no State shall 'deny to any person within its jurisdiction the equal protection of the laws': United States Constitution amendment XIV, § 1. The Second Circuit covers the States of Connecticut, New York and Vermont. This paper will not discuss the legal basis for these decisions in detail; see, however, Roger Magnusson, 'The Sanctity of Life and the Right to Die: Social and Jurisprudential Aspects of the Euthanasia Debate in Australia and the United States' (1996) *Pacific Rim Law & Policy Journal* (forthcoming).

<sup>127</sup> 'Courts Play 'Green Light — Red Light' with Assisted Suicide Rulings' *ERGO! U.S. News Bulletins*, 1 May 1996, *ERGO's News Archives*: <http://www.islandnet.com/~deathnet/ergo.html>.

<sup>128</sup> *Lee v State of Oregon* 891 F Supp 1429 (1995).

down the Oregon Death with Dignity Act<sup>129</sup> on the ground that it offended the Equal Protection Clause of the Fourteenth Amendment. An unfortunate consequence of both decisions, however, was that they created a regulatory vacuum: invalidating Washington State and New York State laws, which prohibited assisted suicide, but providing no mechanism through which to address issues such as patient depression, the meaning of 'terminally ill', the desirability of second opinions, conflict of interest between doctor and patient, and the issue of 'duress' from relatives. While constitutional rights can defeat state legislation and also force reluctant states to 'handle the hot potato' of assisted suicide/euthanasia, they may also facilitate the premature 'birth' of emerging rights in the absence of an appropriate regulatory framework. If courts were to erect a comprehensive framework themselves, they would, of course, attract criticism for usurping the legislative role.

In view of their conflicting rationales, the Supreme Court has agreed to hear appeals against both the Ninth and Second Circuit decisions during the current term.<sup>130</sup> Physician-assisted suicide through prescription of lethal drugs would, of course, only be the beginning. To British Commonwealth lawyers, it is interesting to note that much of the debate in the United States appears to have focused rather narrowly upon physician-assisted suicide ('PAS'), rather than active voluntary euthanasia. Medico-legal specialists,<sup>131</sup> and physicians<sup>132</sup> advocating law reform have advocated the legalisation of PAS, although not, curiously, active voluntary euthanasia. Even Jack Kevorkian appears to have limited his activities to assisting patients to suicide.

Once legalised, however, it is unlikely that this distinction could be maintained for very long. The recognised importance of autonomy in medical decision-making supports a right to direct euthanasia at the doctor's hand, as much as a right to assisted suicide. Indeed, advocates would argue that a prohibition upon the former discriminates against those who are unable, physically, to do what is

<sup>129</sup> This Act, which was narrowly voted into law in November 1994 in a citizen-initiated referendum, was the first successful attempt by an American State to legalise physician-assisted suicide. Similar citizen-initiated laws were voted down in Washington State in 1991 and in California in 1992. For further discussion, see Melinda Lee and Susan Tolle, 'Oregon's Plans to Legalise Suicide Assisted by a Doctor' (1995) 310 *British Medical Journal* 613; Ann Alpers and Bernard Lo, 'Physician-Assisted Suicide in Oregon: A Bold Experiment' (1995) 274 *Journal of the American Medical Association* 483.

<sup>130</sup> 'Supreme Court to Rule on Euthanasia', *The Age* (Melbourne), 4 October 1996, A8. American constitutionalist Professor Yale Kamisar has argued that the Supreme Court has already intimated that laws against assisted suicide are examples of conduct between consenting adults which are not beyond state regulation: *Paris Adult Theatre I v Slaton* 413 US 49 (1973), 68; Yale Kamisar, 'Physician-Assisted Suicide: the Last Bridge to Active Voluntary Euthanasia' in Keown, above n 14, 227. For further debate, see Robert Sedler, 'Are Absolute Bans on Assisted Suicide Constitutional? I Say No' (1995) 72 *University of Detroit Mercy Law Review* 535; Yale Kamisar, 'Against Assisted Suicide — Even a Very Limited Form' (1995) 72 *University of Detroit Mercy Law Review* 735.

<sup>131</sup> See, eg, Lawrence Gostin, 'Drawing a Line Between Killing and Letting Die: The Law, and Law Reform — On Medically Assisted Dying' (1993) 21 *Journal of Law, Medicine & Ethics* 94.

<sup>132</sup> See, eg, Timothy Quill, Christine Cassel and Diane Meier, 'Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide' (1992) 327 *New England Journal of Medicine* 1380, 1381.

necessary to achieve their own death, thus providing the grounds for a further Equal Protection Clause challenge.

#### IV SOCIAL FACTORS PRECIPITATING EUTHANASIA LAW REFORM

The revival of the euthanasia debate provides a timely opportunity to re-assess the general direction of the law as it regulates end-of-life decisions. This paper has argued that the law has already retreated significantly from the sanctity of life ethic. Legal developments were categorised into two different 'moral' categories: (i) those enabling the patient to make his or her own decision about the moral value of life, and to hasten the dying process as an exercise of personal autonomy; and (ii) those permitting death to be hastened following paternalistic judgments about 'futility' and lack of quality of life imposed upon the patient by doctors authorised to act (regardless of any knowledge about the patient's beliefs or wishes).

For those who see longevity as an absolute moral value, the decline of the sanctity of life ethic in law presents an alarming picture. After all, the idea that all human life is equally and intrinsically precious, and should never be taken, regardless of its value as perceived by others, has been central to the moral foundations of society for many centuries. In the words of one New Zealand judge, the preservation of life is an ideal 'which not only is of inherent merit in commanding respect for the worth and dignity of the individual but [it] also exemplifies all the finer virtues which are the mark of a civilised order.'<sup>133</sup>

Nevertheless, as the factors precipitating the euthanasia debate suggest, times are changing. Having come this far, the law can now only refuse to admit a legal right to die by relying on distinctions such as the discredited act/omission distinction in *Bland*. While some groups remain fiercely opposed to legalised euthanasia, euthanasia law reform in Australia's more populous states appears, on balance, inevitable within the next decade, once the current state of the law is understood within its wider social context.

Australian opinion polls have repeatedly confirmed broad community support for voluntary euthanasia legislation. A July 1996 poll showed 75% support for legalised euthanasia, although there was less support for lethal injections (63%).<sup>134</sup> Similar levels of support exist in the United States.<sup>135</sup>

Although levels of support for legalised euthanasia within the medical profession do not approach those of the general community, Australian studies nevertheless show majority support. For example, Baume and O'Malley's 1994 study

<sup>133</sup> *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235, 244 (Thomas J).

<sup>134</sup> Mike Stekete, 'Three in Four Back Euthanasia — Newspoll', *The Australian* (Sydney), 9 July 1996, 1. See also: Steve Dow and Elissa Blake, 'Most Back Euthanasia: Poll', *The Age* (Melbourne), 7 June 1995, 1 (which reported 74% (male) and 76% (female) support for a law protecting doctors who perform euthanasia).

<sup>135</sup> See, eg, 'Public Support Rising for Assisted Suicide' *ERGO! U.S. News Bulletins*, 15 April 1996, *ERGO's News Archives*, above n 127 (1996 Gallup poll reporting 75% in favour of lawful, medically assisted death). See also: Harvard Program on Public Opinion and Health Care, 'Should Physicians Aid their Patients in Dying? The Public Perspective' (1992) 267 *Journal of the American Medical Association* 2658.

of 1268 doctors in New South Wales and the Australian Capital Territory reported that 46% of respondents had been asked by a patient to hasten his or her death. Twenty-eight percent (12.3% of all respondents) had complied with the request. Fifty-nine percent agreed in principle that active euthanasia is sometimes right, and 58% called for legal change.<sup>136</sup> Data from other Australian studies are summarised in Table 2.<sup>137</sup> These studies are not unique. A growing body of international research confirms the fragmentation of attitudes towards euthanasia within the medical profession.<sup>138</sup>

It is significant that the high levels of doctor support for euthanasia law reform in Australia have been obscured by the conservative response of Australia's largest professional medical body, the politically powerful Australian Medical Association ('AMA').<sup>139</sup> The participation of medical bodies is important to the process of national law reform, in view of the 'sovereignty' or 'ownership' such bodies seek to exercise over questions of health policy and ethics. The current conservatism of the AMA also provides a convenient shield for politicians who are reluctant to handle a 'hot potato'. The opposition of the Victorian Branch of the AMA, for example, is well known, and the Victorian Premier has indicated to the writer that he will not consider euthanasia law reform until the medical community shows overwhelming support for it.<sup>140</sup>

Since the process of legalised euthanasia requires doctors to play a central role, legislation introduced over the protest of significant sections of the medical profession could hardly command public confidence. This may explain the reluctance of bodies such as the Victorian Branch of the AMA to survey its own membership:<sup>141</sup> a pro-euthanasia result could only fuel the reform process.

<sup>136</sup> Peter Baume and Emma O'Malley, 'Euthanasia: Attitudes and Practices of Medical Practitioners' (1994) 161 *Medical Journal of Australia* 137.

<sup>137</sup> The references to these studies are: Helga Kuhse and Peter Singer, 'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia' (1988) 148 *Medical Journal of Australia* 623; Helga Kuhse and Peter Singer, 'Euthanasia: A Survey of Nurses' Attitudes and Practices' (1992) 21(8) *Australian Nurses Journal* 21; Christine Stevens and Riaz Hassan, 'Management of Death, Dying and Euthanasia: Attitudes and Practices of Medical Practitioners in South Australia' (1994) 20 *Journal of Medical Ethics* 41.

<sup>138</sup> See, eg, Melinda Lee, Heidi Nelson and Virginia Tilden, 'Legalising Assisted Suicide — Views of Physicians in Oregon' (1996) 334 *New England Journal of Medicine* 310. This survey used a sample of 2761 doctors. It found that 66% regarded physician-assisted suicide as ethical in some cases; 60% supported legalisation in some cases; 46% indicated they might be willing to prescribe a lethal drug dose for a terminally ill patient if this was legal, although 52% had moral objections; 21% (570) had been asked by a patient for a prescription for a lethal dose and 7% had complied). See also Jerald Bachman, Kirsten Alcer and David Doukas, 'Attitudes of Michigan Physicians and the Public Toward Legalising Physician-Assisted Suicide and Voluntary Euthanasia' (1996) 334 *New England Journal of Medicine* 303; B Ward and P Tate, 'Attitudes Among NHS Doctors to Requests for Euthanasia' (1994) 308 *British Medical Journal* 1332.

<sup>139</sup> See, eg, Andrew Darby, Elissa Blake and Steve Dow, 'AMA Push for States to Reject Euthanasia', *The Age* (Melbourne), 26 May 1995, 5.

<sup>140</sup> Telephone discussion with the Honourable Jeffrey Kennett, Premier of the State of Victoria, Australia, 8 April 1995.

<sup>141</sup> Rachel Gibson, 'Euthanasia Survey Idea Rejected', *The Age* (Melbourne), 31 March 1995, 5.

<b>Table 2</b>			
<b>Health Care Workers' Attitudes to Active Voluntary Euthanasia: Australian Studies</b>			
Study	In-principle Support	Compliance with Patient Requests	Law Reform
<b>Kuhse &amp; Singer:</b> 869 Victorian doctors (1988)  *Sample: 1893 (46% response rate)	It is sometimes right for a doctor to take active steps to end a patient's life at the patient's request: 62% : 34% in favour	*40% of doctors (354) asked by patient to hasten death;  *29% (107) of 369 doctors had taken active steps to end a patient's life	60% : 37% in favour of pro-euthanasia law reform
<b>Kuhse &amp; Singer:</b> 951 Victorian nurses (1992)  *Sample: 1942 (49% response rate)	75% : 25% support in favour of Australia adopting the Netherlands situation permitting active voluntary euthanasia in certain circumstances	*55% of nurses (502) asked by patient to hasten death, 333 nurses received requests for direct assistance;  *5% (of 333) took active steps to hasten death without a doctor's request; 25% (of 502) were requested by a doctor to take active measures to end a patient's life and 85% of this number complied	78% of respondents in favour of pro-euthanasia law reform
<b>Stevens &amp; Hassan:</b> 298 South Australian doctors (1994)  *Sample: 494 (60% usable returns)	Is it ever right to bring about the death of a patient by active steps? 18% said yes, 26% said yes, but only if requested by the patient	*33% of doctors asked by patient to hasten death by taking active steps; 19% (56) had complied with the request	45% in favour of legalisation of active euthanasia (39% opposed)
<b>Baume &amp; O'Malley:</b> 1268 New South Wales and ACT doctors (1994)  *Sample: 1667 (76% response rate)	59% agreement that it is sometimes right for a doctor to take active steps to bring about a patient's death	*46.4% of doctors asked by patient to hasten death; of those asked, 28% had complied with the request (12.3% overall); 7% had provided the means for suicide	58% in favour of changing the law to permit active voluntary euthanasia

The opposition of the churches is another obvious factor which could slow the process of euthanasia reform. The Rights of the Terminally Ill Act 1995 (NT) has been stridently criticised both by the Vatican<sup>142</sup> and the Australian Catholic Bishops Conference, the latter reminding Catholics in a pastoral letter that humans must not play God, and that while 'there is no virtue in suffering for its own sake ... the experience of death is a profoundly Christian experience when we go to meet God at the moment when God chooses to call us'.<sup>143</sup> Catholic opposition to euthanasia reaches beyond theological reasons to include the effect of euthanasia upon the provision and development of palliative care, and the danger of the 'slippery slope' caused by the weakening of the sanctity of life ethic.

In their 1988 study of Victorian doctors, Kuhse and Singer found that of the 62% of respondents supporting, in principle, active voluntary euthanasia, Roman Catholics were the only group not to give majority support.<sup>144</sup> Baume and O'Malley's 1994 replication of this study found Catholic practitioners were most opposed to active voluntary euthanasia and physician-assisted suicide, agnostic/atheist practitioners were most sympathetic, and Protestant practitioners were midway between.<sup>145</sup> While Catholic practitioners were significantly different from others in the strength of their opposition to euthanasia, Baume and O'Malley did find a small minority of Catholic doctors prepared to perform euthanasia (18% of those asked by patients to hasten death).<sup>146</sup>

American research confirms that individual attitudes towards active voluntary euthanasia correlate with religious affiliation. In a 1995 study, Caddell and Newton found conservative Protestants and Catholics to be least supportive of active euthanasia, with higher levels of support amongst liberal Protestants, Jews and those with no religious affiliation (63% support overall).<sup>147</sup> In a 1992 Australian study, however, Ho and Penney argued that while highly religious people were less approving of euthanasia than non-religious people, this correlation reflected underlying differences in conservatism and that 'when respondents' level of conservatism was controlled, religiosity failed to relate significantly to either passive or active euthanasia'.<sup>148</sup> This is an interesting finding in the Australian context, since Australian society is considerably more secular than

<sup>142</sup> Gino Concette, 'Life is not Ours to Choose', *The Age* (Melbourne), 5 July 1996, A13; Gay Alcorn, 'Vatican Condemns Territory Euthanasia Law', *The Age* (Melbourne), 4 July 1996, A9; Belinda Hickman, Katherine Glascock and Jodie Scott, 'Ethical Dilemma: Churches Unite in Condemnation', *The Australian* (Sydney), 27 September 1996, 6.

<sup>143</sup> Australian Catholic Bishops Conference, Pastoral Letter to the Catholic People of Australia, May 1995.

<sup>144</sup> Helga Kuhse and Peter Singer, above n 137, 624-5.

<sup>145</sup> Peter Baume, Emma O'Malley and Adrian Bauman, 'Professed Religious Affiliation and the Practice of Euthanasia' (1995) 21 *Journal of Medical Ethics* 49, 50.

<sup>146</sup> *Ibid* 52.

<sup>147</sup> See David Caddell and Rae Newton, 'Euthanasia: American Attitudes Toward the Physician's Role' (1995) 40 *Social Science & Medicine* 1671.

<sup>148</sup> Robert Ho and Ronald Penney, 'Euthanasia and Abortion: Personality Correlates for the Decision to Terminate Life' (1992) 132 *The Journal of Social Psychology* 77, 84 where the authors conclude that '[t]his finding suggests that the observed relationship between religiosity and attitudes toward euthanasia may be due to their common relationship to conservatism.'

American society, with fewer Australians having religious affiliations or attending church.

While the conservative churches continue to express their views, in the writer's view, it is unlikely that they alone will successfully prevent the legalisation of euthanasia. The perception that churches are attempting to enforce their own doctrinal beliefs upon a pluralist society remains a source of criticism.<sup>149</sup> The influence of churches upon social policy has declined this century: their influence in this debate has probably been assisted by the convergence of their interests with those of the AMA and other conservatives, and by their articulation of a broad range of conservative, non-religious arguments.

The media are playing an important and continuing role in hastening euthanasia reform, by promoting debate and mobilising the attitudes which are fuelling calls for change. Somerville notes that:

[w]e are ... media societies. We are the first age in which our collective storytelling takes place through television. A terminally ill person, begging for euthanasia, makes emotionally gripping television.<sup>150</sup>

Few people could have remained unaffected by a 1995 Dutch documentary, screened in England, North America, Australia, and other countries, which showed Dutchman Kees van Wendel de Joode, who suffered from a degenerative muscular disease, being put to death by his family doctor.

Another important feature of the euthanasia debate is the massive media attention given to those doctors who have achieved notoriety or celebrity status either by openly admitting to assisted suicide and euthanasia, or by being 'found out' and prosecuted for homicide. The admissions made by the 'Melbourne seven', while premature in so far as they were intended to force either a 'show-trial', or legislative reform within Victoria, are typical of an increasing unwillingness amongst sections of the medical profession to 'play dumb' about their involvement in euthanasia. Doctors such as Jack Kevorkian<sup>151</sup> and Timothy Quill<sup>152</sup> in

<sup>149</sup> See, eg, Padraic McGuinness, 'Democracy and the Right to Die', *The Sydney Morning Herald* (Sydney), 6 July 1996, 33. See also Archbishop Sir Frank Little, 'There is Nothing Compassionate in a Doctor's "Mercy" Killing', *The Age* (Melbourne), 17 April 1995, 9; cf Rodney Syme, 'Assisted Suicide is not a Synonym for Homicide', *The Age* (Melbourne), 17 May 1995, 15.

<sup>150</sup> Somerville, above n 17.

<sup>151</sup> On 23 August 1996, for example, 68 year old retired pathologist Jack Kevorkian assisted in his third and fourth suicides for the week, about nine hours apart. After dropping off a corpse at a local hospital, Kevorkian was stopped by police, and was arrested after calling them Nazis. On 7 September 1996, he assisted in his fortieth suicide, hours after police raided the motel where he was providing counselling: 'Kevorkian Assists Isabel Correa', *ERGO! U.S. News Bulletins*, 7 September 1996, *ERGO's News Archives*, above n 127. Kevorkian has been acquitted three times by Michigan juries on assisted suicide charges. During the course of the third trial, Kevorkian assisted another patient to die in between sessions in the witness stand.

<sup>152</sup> See Timothy Quill, 'Death and Dignity: A Case of Individualised Decision Making' (1991) 324 *New England Journal of Medicine* 691, in which Quill details a case of physician-assisted suicide; 'Jury Declines to Indict a Doctor Who Said He Aided in a Suicide' *The New York Times* (New York) 27 July 1991, A1; Timothy Quill, Christine Cassel and D Meier, 'Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide' (1992) 327 *New England Journal of Medicine* 138. Quill was a plaintiff in the Second Circuit Court of Appeal litigation partially overturning the New York State prohibition of assisted suicide. See also *Quill v Vacco* 80 F 3d 716 (1996).

the United States, and Nigel Cox<sup>153</sup> in England, have come to represent a growing protest against the laws which prohibit assisted suicide and euthanasia of the terminally ill. In Australia, doctors such as Darren Russell and Norm Roth in Melbourne, and Philip Nitschke in Darwin, have appeared regularly in the media, promoting the right to die with medical assistance.<sup>154</sup>

The 'right to die' movement has itself become a highly organised machine, consisting of voluntary euthanasia societies in all Australian jurisdictions, operating beneath the umbrella of an international federation consisting of over 40 similar societies. These societies promote their viewpoint tirelessly through the media, funding research,<sup>155</sup> and by funding and bringing lawsuits.<sup>156</sup>

The euthanasia option is supported by some patient groups. In a 1993 Sydney study, 90% of a cohort of men with either AIDS or ARC (AIDS-related complex) indicated that they would personally wish to have the option of euthanasia if a life-threatening diagnosis were made. Interestingly, 86% of the 105 subjects stated that they were afraid of suffering, but only 19% feared death itself.<sup>157</sup> Studies suggest significant levels of euthanasia within the HIV/AIDS community.<sup>158</sup> In one highly controversial publication, four Sydney doctors released a leaflet containing a 'euthanasia recipe' as part of a series on HIV/AIDS treatments.<sup>159</sup> In the 1990s, AIDS has become, within the public mind, the disease which most justifies the right to die.

Support for the legalisation of euthanasia within the medical profession and in society generally does not, of course, automatically translate into law reform. Euthanasia policy is a delicate matter, and legislators are understandably cautious. As a non-party issue, euthanasia depends upon 'parliamentary facilitators', and the kind of widespread consensus which delivers success in a conscience vote. Of the many arguments against euthanasia reform, perhaps the most important are the debates about palliative care, and the 'slippery slope'.

<sup>153</sup> See D Brahmans, 'Euthanasia: Doctor Convicted of Attempted Murder' (1992) 340 *The Lancet* 782; Claire Dyer, 'Rheumatologist Convicted of Attempted Murder' (1992) 305 *British Medical Journal* 731; The Honourable Mr Justice Ognall, 'A Right to Die? Some Medico-Legal Reflection' (1994) 62(4) *Medico-Legal Journal* 165.

<sup>154</sup> Philip Nitschke and Julie-Anne Davies, 'I Would Do the Same Thing Again', *The Sunday Age* (Melbourne) 29 September 1996, 5.

<sup>155</sup> See, eg, Baume and O'Malley, above n 136.

<sup>156</sup> Eg *Compassion in Dying* 79 F 3d 790 (1996).

<sup>157</sup> Brett Tindall, Sally Forde and Andrew Carr, 'Attitudes to Euthanasia and Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease' (1993) 6 *Journal of Acquired Immune Deficiency Syndrome* 1069.

<sup>158</sup> P Bindels, A Krol, and E van Ameijden, 'Euthanasia and Physician-Assisted Suicide in Homosexual Men with AIDS' (1996) 347 *The Lancet* 499. This Dutch study of homosexual men with AIDS carried out between 1985 and 1992 found that 22% of men (n = 131) died as a result of assisted suicide or euthanasia. This was 12 times the national euthanasia rate of 2.1% as estimated in the Rummelink study (above n 114 and accompanying text). An interview-based study by Canadian social worker Russel Ogden has also revealed evidence of euthanasia within the HIV community in Vancouver: Russel Ogden, *Euthanasia, Assisted Suicide & AIDS* (1994); Douglas Todd, 'Mercy Killing Secret World Revealed', *The Weekend Sun* (Vancouver), 12 February 1994, A1, A2; Douglas Todd, 'Suicide Study Attracts Continent Wide Attention', *The Vancouver Sun* (Vancouver) 15 February 1994, B6; Clyde Farnsworth, 'Vancouver AIDS Suicides Botched', *The New York Times* (New York), 14 June 1994, C12.

<sup>159</sup> L Chan, L Johnson, K Machon, *This Way Out: AIDS X — Information Sheet No 8* (December 1994).

The 'slippery slope' or 'thin end of the wedge' argument embodies the concern that 'if voluntary euthanasia [were] permitted, it would not stay voluntary for very long'.<sup>160</sup> Robert Manne argues, for example, that:

[f]or anyone who understands social process the expansion of the circle of those who can be killed will come as no surprise. For once we agree to the principle of doctors performing voluntary euthanasia by what effort of societal will, on what rock of ethical principle, can we resist its extension to ever new categories of sufferers? There is no such will: no such fixed and reliable principle .... The slippery slope ... involves a subtle transformation of ethical sensibility. Over time we become blind to how we once thought.<sup>161</sup>

In the writer's view, the importance of this argument has not been fully appreciated by many advocates of legalisation. Euthanasia has largely been marketed through the media as 'merciful pain relief for terminally ill patients'. However, as noted previously, the logic of personal autonomy indicates a wider right. Furthermore, certain forms of non-voluntary euthanasia already lie latent within the law, kept invisible by the act/omission distinction. In the writer's view, legalised euthanasia *will* change norms and values. While this hardly demonstrates the preconditions for Auschwitz,<sup>162</sup> it is inevitable that the retreat from the sanctity of life ethic already evident through the recognition of 'personal autonomy' and paternalistic judgments will push the limits of any future euthanasia law. More attention needs to be given, therefore, to articulating stable boundaries for euthanasia, once society has approved of it in principle.

A second argument levelled against euthanasia law reform is that palliative care can adequately relieve pain and distress, thereby obviating the need for a 'euthanasia escape route'. Baume and O'Malley, reflecting on the implications of their 1994 survey study, conclude that the levels of participation in illegal euthanasia suggest 'a substantial level of need among patients for symptom relief which current arrangements do not provide'.<sup>163</sup> Palliative care physicians, on the other hand, chide their colleagues who support law reform for their ignorance of multi-disciplinary management techniques.<sup>164</sup> The problem, however, goes beyond pain, as studies considering the reasons for requests for euthanasia by patients confirm.<sup>165</sup> Adelaide palliative specialist Roger Hunt, who has broken ranks with his speciality, writes:

But what can be done for those patients who have unresolvable pain? And what about common problems such as weakness, loss of independence, incontinence, loss of dignity and a sense of meaninglessness due to a progressively dimin-

<sup>160</sup> Robert Goff, 'A Matter of Life and Death' (1995) 3 *Medical Law Review* 1, 17.

<sup>161</sup> Manne, above n 120, 18.

<sup>162</sup> See, generally, with respect to the 'slippery slope' argument: J Burgess, 'The Great Slippery-Slope Argument' (1993) 19 *Journal of Medical Ethics* 169.

<sup>163</sup> Baume and O'Malley, above n 136, 142.

<sup>164</sup> See, eg, Brian Pollard, Letter to the Editor, (1994) 161 *Medical Journal of Australia* 572; Dr Rodger Woodruff, 'Facts Needed to Balance Doctors' Euthanasia Push', *The Age* (Melbourne), 30 March 1995, 12.

<sup>165</sup> See Clive Seale and Julia Addington-Hall, 'Euthanasia: Why People Want to Die Earlier' (1994) 39 *Social Science & Medicine* 647.

ishing quality of life? Such problems cannot be eliminated by palliative care teams.<sup>166</sup>

Conceding that palliative care has its limitations, other specialists nevertheless argue that '[k]illing the failures of medical or social care would be negative, in that it would not contribute to finding solutions to their problems'.<sup>167</sup> On this view, the re-definition of the doctor's role to include killing, will eventually undermine medical skills and retard medical progress.

## V CONCLUSION

This paper has argued that if social trends and legal developments over recent decades are any guide, then legalised euthanasia is an inevitable development for Australia's more populous states, certainly within the next 5 to 10 years. Social factors bearing this out include high levels of popular and medical support for legalised euthanasia, the effect of on going community debate through the media, the absence of sufficiently powerful religious influences in Australian public life, and the fact that law enforcement authorities appear reluctant to investigate and charge doctors who have admitted to involvement. Legal factors bearing this out include the growing importance of personal autonomy within the law, extending to the refusal of life-support, as well as the emergence of certain paternalistic judgments about quality of life as a justification for hastening death; for example, the acceptance of 'higher brain death' as a basis for withdrawing life-support.

Underlying the euthanasia debate is an ideological struggle between competing world views. Opposition to legalised euthanasia reflects a perspective which is essentially conservative and communitarian, and which is more likely to be informed by the teachings of an authoritarian church. Advocacy for the legalised killing of consenting, terminally ill patients, on the other hand, reflects a perspective which is essentially liberal, individualistic, and more likely secular.

As with other delicate social policy issues, it is appropriate to hasten slowly. Attempts to repeal the Rights of the Terminally Ill Act 1995 (NT) may not, ultimately, be in the public interest, as they may rob society of the chance to closely monitor a policy of legalisation in a small environment, and to learn from this experience, before the legal and social tide precipitates reform in the more populous States.

More research is needed on the current practice of euthanasia, both legal and illegal, in order to generate deeper understanding of the respective advantages and disadvantages of a prohibitionist policy. While Australian and American surveys<sup>168</sup> have pointed to trends in attitudes and behaviour within the medical profession, there remains little understanding of the complexity of attitudes towards euthanasia generated by close involvement in end-of-life decisions, the conditions under which illegal euthanasia is currently practiced, how it is carried out, and its impact upon health care workers. There is a critical need for more

<sup>166</sup> Roger Hunt, 'Legislative Reform is Needed', *The Age* (Melbourne), 7 April 1995, 16.

<sup>167</sup> Pollard and Winton, above n 21, 428.

<sup>168</sup> See above nn 136-8.

research in drawing out the implications of current illegal practices for euthanasia policy generally, and a responsible regulatory regime in particular.

Finally, if euthanasia is to be legalised, the appropriate vehicle for achieving this change is, in the writer's view, the legislature. Such a controversial change in the moral and legal fabric of society as legalised euthanasia entails deserves nothing less than *democratic* reform. It has been argued that for an issue as sensitive as euthanasia, this should require more than 50% plus one,<sup>169</sup> although given the direction of social and jurisprudential developments in Australia in recent years, to a more widespread consensus about the rights of the terminally ill to die with medical assistance is likely to be achieved soon, if it has not been already.

<sup>169</sup> F Brennan, 'Federalism Calls the Shots When a Territory Goes it Alone', *The Australian* (Sydney), 12 July 1996, 15.