

LEGALISED EUTHANASIA IN AUSTRALIA

Australia is the only country in the world where euthanasia has been formally legalised by statute. The Act, known as the *Rights of the Terminally Ill Act* (ROTI) of the Northern Territory, had a relatively brief history, and its development is of interest.

In February 1995, the then Chief Minister of the Northern Territory, Marshall Perron, announced his intention to introduce a bill for voluntary euthanasia into the parliament. As time went on, he was forced to make several changes to the bill and to establish a parliamentary inquiry, which was only given limited terms of reference.

The parliament was evenly divided, but in the final, exhausting all-night sitting, the bill passed by a narrow margin on 25 May, 1995. History, of several kinds, had been made. While it was a legal world first, it had taken place in a small, provincial parliament with no house of review, for a community with limited radiotherapy services, no palliative care specialist, an inadequately resourced domiciliary palliative care program and not a single hospice.

For over a year, no use could be made of the Act because some of its provisions were found to be unworkable. Eventually, after a failed legal challenge to its validity, the necessary official approval was finally given and it passed into law on July 1, 1996. It contained no local residential requirements, so all Australians had access to it, but neither doctors nor lawyers seemed to be sure of its limits.

Meanwhile, in the State of New South Wales, a member of the Labor Party was given leave by his party to introduce a private member's bill for the legalisation of voluntary euthanasia in that State. A low-key organisation, called 'Euthanasia NO', to oppose the moves for euthanasia in NSW, was set up with a young lawyer, Tony Burke, at its head.

The then Premier of NSW, Bob Carr, had been an open supporter of euthanasia, but, after further consideration, he gradually changed his view. When the original mover of the bill resigned from parliament, other members of his party wanted to adopt the bill, but were denied. Some other parliamentarians expressed interest in fostering another bill, but nothing came of them. The leaders of both major political parties in NSW publicly declared themselves against legalised euthanasia. In October 1996, two non-parliamentarians with opposing views were invited to address the parliament, a thing that had not occurred in living memory. Tony Burke was one of these. He not only won the debate, he received a standing ovation for what was considered one of the best speeches ever heard in the House. Euthanasia became a dead issue in New South Wales, for the time being.

Meanwhile, in the national parliament in Canberra, a young lawyer MP, Kevin Andrews, had become appalled at the news that the dormant NT Act was to be put into effect at last. As a lawyer, he knew that the national parliament could override certain laws in the Territories, but not in the States. After some discussions within his party, he was given approval to try to do that.

Andrews and Burke met and decided to pool their resources in the national arena. By the time Andrews introduced his bill to overturn the NT Act into the federal parliament on October 28, 1996, the organisation was ready to go. In a newspaper article in June of that year, Andrews had written:

'For more than a decade I have been professionally concerned with death. Through my involvement with the Victorian parliamentary inquiry into dying with dignity in the 1980s and the subsequent debates about appropriate legislation, I came to consider carefully the appropriate balance between rights and responsibilities.

The Victorian legislation, which I helped to draft, draws a clear distinction between recognising the right of a person to refuse futile, burdensome or unwanted treatment, and the deliberate active bringing about the death of another person.

It was on this basis that I was confident in advising a hospital that it could ethically accede to a patient's request to turn off a ventilator because she found it burdensome. This led to my drafting protocols for hospitals to establish procedures for when a patient should not be resuscitated. The work shaped my personal conviction that the active taking of another's life is unethical...'

Andrews gave as the main reasons for his bill that the NT Act had been passed by 'a small territory, with the population of a suburban municipality in Melbourne or Sydney, by one vote, without any house of review, without attempting to say why a law rejected by every major inquiry in the world was proper, and in the face of universal opposition from its Aboriginal population', and that it was 'poorly drafted, had inadequate safeguards and a law that fails to protect innocent people will always be a bad law'. Lawyers everywhere were prominent among those who supported the NT Act, claiming it was not only safe, but a model of safety.

The Andrews bill easily passed in the lower House on December 9, 1996, and just three days later, was sent to the Senate, where members of all parties were allowed a conscience vote. There was a short delay while a Senate Committee reviewed the situation, then, when put to the vote in March 1997, the Bill passed by 38 votes to 33, and with that, the life of the NT statute, which had lasted only eight months, was brought to an end.

The Bill's passage was at once followed by an intense and acrimonious outburst of public dismay and criticism. Some accused the politicians of cowardice, of bowing to the religious lobby (though only one sixth of submissions to the Committee had mentioned religious morality), but the most common accusation was that the politicians had either ignored or betrayed the clear wishes of the majority, because public opinion polls were generally believed to reflect mature, reasoned community views on euthanasia. In fact, the Committee had simply reached the same conclusion as every previous similar government-sponsored committee of inquiry into the consequences of legalising euthanasia, anywhere in the world, namely that it was an unsafe law.

By contrast, one who had observed the Committee in action said 'I can express my surprise and relief at the conscientious way in which many of the politicians went about their task of understanding and evaluating the issues, about which, like the community itself, they were at first largely ignorant'. Despite the intensity of the outcries against the apparent betrayal, the furore quickly subsided and has not been heard since, though the underlying mindset of many is of course unchanged and will undoubtedly surface again.

In an article written by three Australian authors, published in an English medical journal in 1998, the actual workings of the *ROTI* Act during the 8 month period of its life were analysed. One of the authors, Philip Nitschke, who was the practitioner who had carried out all four of the acts of euthanasia during that time, supplied all the information about the patients, which could not

otherwise have been known. In addition to the three patients, another four possible candidates did not avail themselves of the law. Nitschke subsequently repudiated the conclusions of the article, claiming they were unwarranted.

Among the article's findings were:

- one patient who received euthanasia did not meet the requirements of the Act
- differences of opinion arose between doctors over one patient's medical future. It was resolved by a doctor with no expertise in terminal care.
- in one case, relevant psychiatric evidence had been withheld.
- all seven patients had symptoms of depression.
- the requirement of the Act that each patient be seen by a psychiatrist was intended to be a 'gate-keeper' against the unacceptable possibility that some patients who wanted euthanasia could be successfully treated so that this wish could be overcome. Analysis of the cases showed that depression is difficult to diagnose in the terminally ill (see relevant section of the paper in this series on *The Legalisation of Euthanasia*), and that the critical function of the psychiatrist and other specialists as 'gate-keepers' against possible abuse was 'clearly limited'.

In short, the *ROTI* was not the model of safety that some lawyers had predicted. It was a tragedy that this outcome, that had been foreseen and warned against by numerous committees of inquiry, were not heeded. A critique of the *ROTI* (drafted before its enactment) is included at the end of this paper as an Appendix, to enable readers to understand better what was actually rejected by the Australian parliament. It is inconceivable that such a law could have survived scrutiny in any other Australian State.

Some other developments regarding euthanasia in Australia

- Altogether, Australian parliaments have, over the years, been presented with many proposals to legislate for euthanasia. None have succeeded.
- The South Australian parliament has already rejected one law to allow euthanasia, and is expected to report soon on a further attempt, following the holding of an extensive inquiry.
- The Australian Capital Territory parliament has in recent years rejected a bill for euthanasia.
- In 1996, the Tasmanian parliament appointed a committee of five MPs to examine the legalisation of euthanasia in that State. Of the five members, four were in favour of euthanasia. After holding a public inquiry, which took written and oral submissions, and after a lengthy period of deliberation, the Chairperson of the committee released its final unanimous report against legalisation in 1998. She said the Committee had found that 'it would be impossible to frame a law that included all the safeguards to protect the vulnerable, the weak and disabled', and that 'introducing legislation to legalise killing another human being would be overstepping society's moral boundaries'. The committee called for more spending on palliative care and promotion of existing laws which allow the dying to refuse life-prolonging treatment.

Appendix

A critique of the Voluntary Euthanasia Bill 1996, N T

(drafted before its enactment)

Minimal requirements for safety in any part of the criminal law are:

- clear and accurate definitions of key concepts,
- provisions set out in terms that can be interpreted in the same way by all who read them, and
- a certainty, or at least a high degree of probability, that any requisite safeguards are capable of being observed.

Section 3. A person is defined as 'hopelessly ill' if the person has 'an injury or illness that

(i) results in permanent deprivation of consciousness or

(ii) seriously and irreversibly impairs the person's quality of life so that life has become intolerable to that person'.

A medical definition of 'hopeless' illness would be something like: 'illness with a known capacity to shorten life and which, by medical consensus, has entered its final phase'. This Bill's definition omits both those objectively verifiable elements, and indeed defines nothing. It relies heavily on the claimed subjective psychological response of an individual to his/her illness, a claim that does not have to be explained or examined, and the illness itself does not have to be hopeless in the medical sense.

Under its terms, some people whose illness posed no present or foreseeable threat to life and carried the prospect of an indefinite length of life ahead, could have their lives ended on request. A simple case might be that of a person with advanced arthritis, with poor mobility and inadequately relieved joint pain, whose social supports were few or absent, causing isolation, frustration, loss of self-esteem and depression. If euthanasia then took place, it may be for reasons that were amenable to much improvement, but without any obligation to seek or provide that improvement.

The existing common law right of a patient to refuse medical treatment does not confer a right to any further action. This Bill would entitle the holder of a personal view about intolerability, which is not a matter for objective testing, to the further right to be killed on request. This would override one of the basic principles of criminal law thought necessary to protect all innocent human life without exception, the same principle found in the statutes of every country. Such profound disregard for the provision of equal justice and for the presumption of the equal value and inviolability of all innocent human life is staggering.

Section 6. Provides that the medical practitioner must give the patient certain information, to ensure that consent is informed. The idea that inserting 'must' in a clause will guarantee that a particular thing actually happens is naive and dangerous.

Unless an informed observer was present on every occasion, and unless a written record of the conversation was made and kept, it could never be known whether the information was in fact adequate, correct, unbiased or non-coercive. If anyone later wished to check, the only other witness would not be available.

In the last clause of this section, the doctor is required to inform the patient of 'the risks associated with each' form of euthanasia. It would seem, in an unfamiliar new world of lawful medical killing, that the risk being referred to could only be the risk of not being killed. While it is macabre to regard not being killed as a risk, it may be quite likely, both because it is reported as having sometimes happened in the USA and because doctors have no training in killing.

Since this Bill would also exempt doctors from civil and criminal liability in Section 14, it is illogical that doctors, who must bear due responsibility for all their other actions, may incur no penalty for any negligence in this matter. Where would be the protection for a patient who may have been left, for example, permanently brain damaged, by an action permitted by an unsafe law, but for which the doctor was professionally unprepared?

Doctors are not taught how to kill patients because Australian criminal law and Australian medical ethical codes of practice forbid them to do so, in conformity with equivalent laws and codes throughout the world.

Section 8. When a request for euthanasia is made in the presence of two witnesses and one medical practitioner, all must certify that the person

(i) 'appeared to be of sound mind' (but no-one is required to establish whether the person was actually of sound mind),

(ii) did not appear to be acting under duress, (see earlier comments on the impossibility of ensuring that) and

(iii) the doctor must certify that he/she had no reason to suppose that the person was suffering from treatable clinical depression (but again, is not required to establish that fact).

Section 12. A doctor may administer euthanasia if

- 'at least 48 hours have elapsed since the request'. (This clause shows a near total disregard for the safety of psychologically disturbed persons, far less protective than that required for the purchaser of a set of encyclopaedias).

- 'the person is incompetent but has appointed a trustee...who is satisfied that the preconditions for...euthanasia have been satisfied'. Since the trustee could never be sure that these conditions had been met because some are impossible to guarantee, and since a trustee could not always, if ever, be sure what the person would find 'intolerable' in the circumstances, this provision could amount to the legalisation of life-taking without valid request, or non-voluntary euthanasia, better described as murder.

Whatever reasons the doctor gave for agreeing to end life, they would be related inevitably to his/her personal values, and would differ from what other doctors may decide, in the same circumstances. Being arbitrary and randomly met, that could not be just.

Section 16. Death by euthanasia, carried out as provided in this Bill,

- 'is not homicide'. Since homicide is defined as 'the killing by one person of another', what could be the purpose of this clause, other than to try to obscure the reality of what was done? However one misused words, legalised euthanasia would always remain legalised homicide.

- 'is taken to have been caused by the patient's illness', which may not have been life-threatening. Since the illness was obviously NOT the cause of death, deceit is now added to illogic, and presumably the doctor will be allowed, if not encouraged, to be deceitful also in a statutory document, by falsifying the death certificate. At present, that is a criminal offence with an appropriate penalty. Will that also be changed to accommodate deceit?

Comment

Like every such Bill before it, but to a more dangerous degree, this Bill is found to be highly protective of the doctor's actions, even when they may have been negligent, and to deny vulnerable patients, driven to ask for death by unrelieved pain, anxiety, depression or despair, any effective protection in law.

By its terms, the doctor alone:

- has the last and critical decision on whether euthanasia takes place,

- is not required to reveal to medical experts any aspects of the illness and its treatment, before euthanasia is carried out. In that case, it could never be known whether such killing was medically justifiable, if indeed it could ever be justified. Medical certificates are matters of opinion, not of fact.

- is not required to keep, and produce to experts when required, such comprehensive documentation as would reveal the full medical facts of what occurred,

- chooses the consulting doctor,

- is not required to have or to seek any particular medical expertise, as is often known to be necessary, in these circumstances

- alone composes the reports to the authorities on the basis of which his/her actions are judged.

Taken together with the other failings discussed in this commentary, these provisions leave ample scope for the virtually unfettered abuse of seriously ill patients when they are at their most vulnerable.

Although every major inquiry into the legalisation of euthanasia has independently concluded that such law could never be made safe, and has published its reasons for this conclusion, this Bill contains no evidence of any awareness of that information. It re-cycles most of the principal known defects.

An untested assumption behind any euthanasia law is that arbitrary medical killing has lately become acceptable for doctors, despite a long universal tradition to the contrary. The World Medical Association (WMA) and every national medical association in the world, with one

exception, hold it to be unethical practice for doctors. That is, it is considered morally wrong, a reference to secular, not religious, morality. The WMA has issued separate declarations for both euthanasia and assisted suicide, indicating specifically that they are unethical. If a matter is agreed to be morally wrong, it cannot be made morally right simply by passing a law. To make such a law without examining this ethical basis would be to mock the serious protective intent of law, since this Bill would be, in effect, an inducement to doctors to behave unethically.

Governments in each State have established tribunals to review medical practices and, where they find unethical behaviour, to take whatever corrective or punitive action seems necessary. It is one thing for individuals to behave unethically - it is another for a government with no mandate and no consent or request from the medical body to offer unbidden its approval of unethical medical conduct. Is it conceivable that any Australian community would be better served by having unethical doctors?

This is the most unsatisfactory and unsafe proposal for euthanasia yet put forward in Australia.