



Senate Legal and Constitutional Legislation Committee

**Consideration of Legislation Referred
to the Committee**

Euthanasia Laws Bill 1996

March 1997

The Parliament of the Commonwealth of Australia

Senate Legal and Constitutional Legislation Committee

**Consideration of Legislation Referred
to the Committee**

Euthanasia Laws Bill 1996

March 1997

© Commonwealth of Australia 1997
ISSN 1326-9364

This document was produced from camera-ready copy prepared by the Senate Legal and Constitutional Legislation Committee, and printed by the Senate Printing Unit, Department of the Senate, Parliament House, Canberra.

Members of the Legislation Committee

Members

Senator E Abetz, Tasmania, *Chair* (Chair from 3 March 1997)
Senator J McKiernan, Western Australia, *Deputy Chair*
Senator the Hon N Bolkus, South Australia
Senator H Coonan, New South Wales (from 26 February 1997: previously a Participating Member)
Senator V Bourne, New South Wales (to 3 March 1997)
Senator A Murray, Western Australia (from 3 March 1997)
Senator W O'Chee, Queensland

Participating Members

All members of the Opposition: and
Senator B Brown, Tasmania
Senator M Colston, Queensland
Senator the Hon C Ellison, Western Australia (from 26 February 1997: previously the Chair)
Senator J Ferris, South Australia
Senator B Harradine, Tasmania
Senator W Heffernan, New South Wales
Senator D Margetts, Western Australia
Senator J McGauran, Victoria
Senator the Hon N Minchin, South Australia
Senator the Hon G Tambling, Northern Territory
Senator J Woodley, Queensland

Secretariat

Mr Neil Bessell (Secretary to the Committee)
Mr Steve Curran (Principal Research Officer)
Mr Simon Taylor (Principal Research Officer)

The Senate
Parliament House
CANBERRA ACT 2600

Tel: (06) 277 3560
Fax: (06) 277 5794

TABLE OF CONTENTS

Members of the Committee	iii
PREFACE	
Introduction	ix
Senate Selection of Bills Committee	ix
“Terms of Reference”	ix
Conduct of the inquiry	x
Submissions	x
Public Hearings	x
Structure of the Report	x
Terminology	xi
Acknowledgments	xii
CHAPTER 1	
THE BILL	
What the Bill does	1
The History of the Bill	1
Senate Scrutiny of Bills Committee	3
CHAPTER 2	
THE RIGHTS OF THE TERMINALLY ILL ACT	
The Rights of the Terminally Ill Act (the RTI Act)	5
What the Rights of the Terminally Ill Act does	5
The enactment of the legislation	6
Further attempts to repeal and amend the legislation	8
Legal challenges to the RTI Act	8
Effect of the legal challenges on the scope of the Committee's report	10
The use made of the RTI Act	10
CHAPTER 3	
CONSTITUTIONAL AND RELATED ISSUES	
Constitutional arguments on whether the Commonwealth should exercise its power	13
Arguments supporting the Bill	13
Arguments opposing the Bill	17
The possibility of national legislation	22
CHAPTER 4	
LEGAL ISSUES	
Introduction	25
Claims that the Bill would produce uncertainty	25
The basis of the claims	25
An assessment of the extent of the uncertainty	27
Assessment of the practical impact of the uncertainty	33
Should the Bill be amended to reduce the uncertainty?	35

Operation of the "for avoidance of doubt clause"	37
--	----

CHAPTER 5

ABORIGINAL ISSUES	39
Introduction	39
Aborigines and the Rights of the Terminally Ill Act	39
Consultation with Aborigines during the legislative process	40
Education campaign	41
Possible misinformation	44
The application of the Act to Aborigines	46
Aboriginal Attitudes to Euthanasia	47
Impact on Aborigines - Willingness to Access Medical Services	50
Other Considerations	53
Fear of Genocide	53
Sorcery	53
Payback	54

CHAPTER 6

EUTHANASIA LAWS BILL – FOR AND AGAINST	57
Introduction	57
Arguments for Euthanasia	57
Individual Rights and Autonomy	57
Choice	59
Compassion and Death with Dignity	61
Legalising what in reality is already common practice	62
Moral Equivalence	63
Arguments against euthanasia	65
Sanctity of life	65
Religious beliefs	67
The slippery slope	69
Erosion of medical ethics and the doctor - patient relationship	72
Palliative Care	74

CHAPTER 7

SURVEYS IN AUSTRALIA ON EUTHANASIA	81
Introduction	81
General Public Attitudes	81
The Morgan Polls	81
Newspoll	83
Practices and Attitudes of the Medical Profession	83
Kuhse & Singer, 1987 and Baume & O'Malley, 1994	84
Waddell et al., 1996	85
Flinders University, 1996	86
Kuhse, Singer and Baume 1997	87
AMA Questions - 1997	89
Steinberg et al., 1997 (Queensland)	90
Extent of Support for the Northern Territory Legislation	91
Steinberg et al., 1997 (Northern Territory)	91

CHAPTER 8

INTERNATIONAL DEVELOPMENTS	93
-----------------------------------	----

Introduction	93
House of Lords Select Committee	93
Canadian Special Senate Select Committee	95
New York State Task Force	95
The Netherlands	96
The Dutch Penal Code	97
Court Decisions	97
Guidelines	100
The 1991 and 1995 Studies	101
The Slippery Slope? - Differing Interpretations	102
Switzerland	106
Oregon's Death with Dignity Act	108
CHAPTER 9	
SUMMARY	111
Introduction	111
The "Territory rights" issue	111
Legal issues – uncertainty	112
Aboriginal issues	113
General moral, philosophical, ethical and social issues	114
ADVICE TO THE SENATE by Senators Abetz, Bishop, J. Collins, Conroy, Ellison, Ferris, Harradine, Heffernan, Hogg, McGauran, Minchin, O'Chee and Woodley	115
ADDITIONAL COMMENT by Senators Bolkus and McKiernan	131
ADDITIONAL STATEMENT by Senator Coonan	141
VOLUNTARY EUTHANASIA: A CRITICISM of the REPORT of the SENATE LEGAL and CONSTITUTIONAL COMMITTEE on the EUTHANASIA LAWS BILL 1996 by Senator Brown	145
ADDITIONAL COMMENTS BY THE NORTHERN TERRITORY SENATORS Senators B Collins and Tambling	179
COMMENTS by Senator Cooney	181
ADDITIONAL COMMENTS by Senator Ellison	187
APPENDIX 1	
ANALYSIS OF SUBMISSIONS	189
APPENDIX 2	
WITNESSES WHO APPEARED BEFORE THE COMMITTEE	193

APPENDIX 3

"HOSPITAL SERVICES SUPPLIED TO ABORIGINAL PEOPLE IN THE NT, 1993-96"

197

PREFACE

Introduction

In May 1995, the Legislative Assembly of the Northern Territory enacted the *Rights of the Terminally Ill Act 1995* and the Act came into force on 1 July 1996. The Act allows a doctor in defined circumstances to comply with a request from a patient that the doctor end the patient's life or assist the patient to end his or her own life. The legislation has no precedent in Australia or overseas. It has proved to be highly controversial.

In late June 1996, Mr Kevin Andrews, Member for Menzies in the House of Representatives, announced his intention to introduce a private member's Bill to override the Rights of the Terminally Ill Act. On 9 September 1996, he introduced the Bill entitled Euthanasia Laws Bill 1996 (the Bill) in the House. On 9 December 1996, the House of Representatives agreed to the Bill with amendments.

Senate Selection of Bills Committee

On 7 November 1996, while debate on the Bill continued in the House of Representatives, the Senate Selection of Bills Committee recommended and the Senate agreed that the provisions of the Bill be referred to the Senate Legal and Constitutional Legislation Committee for inquiry and report on or before 24 February 1997. This reporting date was subsequently extended to 6 March 1997.

“Terms of Reference”

A reference relating to the provisions of a Bill allows a Legislation Committee to undertake a wide ranging inquiry into the broad aspects of proposed legislation as well as specific technical matters arising from the Bill itself.

It should be noted that, in its recommendation to refer the provisions of the Bill to the Legal and Constitutional Legislation Committee, the Selection of Bills Committee nominated four specific areas of inquiry, namely:

- the desirability of the enactment of the provisions;
- the constitutional implications for the Territories of the enactment of the provisions;
- the impact of the enactment of the provisions on the Northern Territory criminal code; and
- the impact on, and attitudes of, the Aboriginal community.

Conduct of the inquiry

On 16 November 1996, the Committee advertised the reference in *The Australian*, *The Northern Territory Leader* and *The Canberra Times*, inviting interested organisations and individuals to lodge submissions to the inquiry. A similar advertisement was placed in the *Norfolk Island Islander*. The Committee also formally invited approximately 200 individuals and groups to lodge submissions or to bring the inquiry to the attention of colleagues. The Committee requested that submissions be lodged by 12 December 1996.

Submissions

In response to this invitation, the Committee received 12,577 submissions from every State and Territory in Australia and from several overseas countries. Details of the submissions are available in volume 2 of this report.

The response to this parliamentary inquiry has been unprecedented. The Committee understands that previous topical inquiries such as *Aircraft Noise in Sydney* and *Child Support* received 5,000 and 6,000 submissions respectively. A statistical analysis of the 12,577 submissions appears in Appendix 1.

Public Hearings

Public hearings were convened as follows:

- Darwin 24 January 1997
- Canberra 13 February 1997
- Canberra 14 February 1997

A list of organisations and individuals who gave evidence at these hearings appears at Appendix 2.

Two participating members of the Committee organised an open public forum on the Bill in Darwin on 23 January 1997. Other members of the Committee attended and a transcript was taken. The Committee subsequently resolved to incorporate this transcript as part of the oral evidence it received.

Structure of the Report

The Committee's approach to the inquiry and the structure of its report reflects the fact that the Senate referred the Bill to a committee having legal and constitutional matters as its focus. The report recognises, however, that these issues are part of a broader debate that embraces moral, philosophical, ethical and social issues.

In Chapters 1 and 2, the Committee sets out what the Bill does, its history, and the main features and history of the Northern Territory law, the *Rights of the Terminally Ill Act 1995*, which gave rise to the Bill.

In the remainder of the report the Committee addresses different aspects of the question whether the Commonwealth should exercise its constitutional power to enact the Bill. In Chapters 3, 4 and 5 respectively, the Committee considers three specific matters mentioned by the Selection of Bills Committee: the constitutional implications for the Territories; the claims that the Bill will have unintended or uncertain impacts on other Territory laws and powers to legislate; and the impact of the *Rights of the Terminally Ill Act 1995* and the Bill on, and the attitudes of, the Aboriginal community.

In Chapters 6 to 8, the Committee considers whether the Commonwealth should exercise its power having regard to the general arguments for and against euthanasia.

In Chapters 1 to 8, the Committee identifies the various issues and summarises the competing arguments put to it on those issues.

In Chapter 9 the Committee summarises the contentions.

Terminology

Literally, "euthanasia" refers to a good death or a gentle and easy death. However, euthanasia and related terms have come to mean different things to different people. This was reflected in the variety of ways the terms were used in submissions.

The Committee notes that the Parliamentary Research Service in a series of papers on euthanasia considers that "euthanasia" can be divided into four categories. These are:

- Active voluntary euthanasia: where medical intervention takes place, at a patient's request, in order to end the patient's life.¹
- Passive voluntary euthanasia: where medical treatment is withdrawn or withheld from a patient, at the patient's request, in order to end the patient's life.²
- Passive in/non-voluntary euthanasia: where medical treatment or life-support is withdrawn or withheld from a patient, without the patient's request, in order to end the patient's life.³

1 Cica N, *Euthanasia - the Australian Law in an International Context: Part 1: Passive Voluntary Euthanasia*, Research Paper No. 3 1996-97, Parliamentary Research Service, p. iv.

2 The House of Lords Select Committee on Medical Ethics preferred to speak of "withdrawing or not initiating treatment" than using the term "passive euthanasia", arguing that there "is plenty of scope for argument over the ethical equivalence of killing and letting die in certain circumstances": House of Lords, *Report of the Select Committee on Medical Ethics*, 1994, Vol. 1, p. 10. In practice the distinction between active and passive euthanasia may be difficult to maintain. For example, it could be argued that the discontinuance of mechanically sustained medical treatment such as ventilation is active euthanasia.

3 Cica N, *Euthanasia - the Australian Law in an International Context: Part 1: Passive Voluntary Euthanasia*, Research Paper No. 3 1996-97, Parliamentary Research Service, p. iv. The House of Lords distinguishes between non-voluntary euthanasia (which it defines as the killing of a patient who does not have the capacity to understand what euthanasia means and cannot therefore form a request or withhold consent) and involuntary euthanasia (where the patient is competent to make a request, but does not do so): House of Lords, *Report of the Select Committee on Medical Ethics*, 1994, Vol. 1, p. 11

- Active in/non-voluntary euthanasia: where medical intervention takes place, without the patient's request, in order to end the patient's life.⁴

Other important terms include:

- Physician-assisted suicide: suicide using a lethal substance prescribed and/or prepared and/or given to a patient by a doctor for self-administration for the purpose of assisting the patient to commit suicide.⁵
- Double Effect: the administration of drugs (eg large doses of opioids) with the intention of relieving pain, but foreseeing that this might hasten death even though the hastening of death is not actually intended.⁶

Acknowledgments

The Committee expresses its appreciation of all those who lodged submissions and gave oral evidence.

The Committee thanks those who assisted it with the complex legal issues discussed in Chapter 4. In particular, the Committee records its thanks to Mr Geoffrey Dabb, First Assistant Secretary, Criminal Law Division, Attorney-General's Department.

The Committee also thanks the secretariat support staff who had the task of processing an unprecedented number of submissions: Ms Joy Brogan, Ms Lara Crew, Ms Jacquie Hawkins, Ms Julie Hunter, Mrs Della McCay, Mr John McAvoy, Ms Debbie McMahon, and also temporary assistance from officers in other parts of the Department of the Senate.

Senator Eric Abetz
Chairman

4 Cica N, *Euthanasia - the Australian Law in an International Context: Part 1: Passive Voluntary Euthanasia*, Research Paper No. 3 1996-97, Parliamentary Research Service, p. iv.

5 See *Rights of the Terminally Ill Act 1995 (NT)*, s. 3 (definition of assist); the House of Lords add the rider that the patient should be competent: House of Lords, *Report of the Select Committee on Medical Ethics*, 1994, Vol. 1, p. 11.

6 House of Lords, *Report of the Select Committee on Medical Ethics*, 1994, Vol. 1, pp. 10 and 11.

CHAPTER 1

THE BILL

What the Bill does

1.1 In this Chapter the Committee examines what the Euthanasia Laws Bill 1996 (the Bill) does. It also sets out the history of the Bill and the view expressed on it by the Senate Standing Committee for the Scrutiny of Bills.

1.2 The Bill removes the power under the Self-Government Acts of the three Territories to enact laws:

which permit or have the effect of permitting (whether subject to conditions or not) the form of intentional killing of another called euthanasia (which includes mercy killing) or the assisting of a person to terminate his or her life.

1.3 The Bill then provides that each Legislative Assembly does have the power to make laws with respect to:

(a) the withdrawal or withholding of medical or surgical measures for prolonging the life of a patient but not so as to permit the intentional killing of the patient; and

(b) medical treatment in the provision of palliative care to a dying patient, but not so as to permit the intentional killing of the patient.

(c) the appointment of an agent by a patient who is authorised to make decisions about the withdrawal or withholding of treatment; and

(d) the repealing of legal sanctions against attempted suicide.¹

1.4 The Bill also contains a clause that provides that the Northern Territory's *Rights of the Terminally Ill Act 1995* "has no force or effect as a law of the Territory". The same clause provides that the Bill will not operate retrospectively to render unlawful or invalid anything done under the Rights of the Terminally Ill Act (the RTI Act) prior to the date the Bill comes into force.

1.5 The Bill does not define the terminology it uses.

The History of the Bill

1.6 The second reading debate on the Bill commenced on 28 October 1996. In his second reading speech, Mr Andrews set out the case for the Bill. He said the Commonwealth had the

¹ Paragraphs (c) and (d) were introduced as amendments in the House of Representatives: see para. 1.8 below.

power to override the RTI Act and the responsibility to do so, as it affected all Australians. The 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 state why a law rejected by every major inquiry in the world was proper, and in the face of universal opposition from its Aboriginal population ...".²

1.7 Mr Andrews also said the Act was poorly drafted and had inadequate safeguards. He said that the people who are most at risk under the Act were the most vulnerable, and "a law which fails to protect vulnerable people will always be a bad law".³ He rejected the view that the Act facilitated personal autonomy: "A lethal injection is not an autonomous action, even with the use of a machine".⁴ He also rejected the view that there was no difference between turning off a life-support machine or refusing treatment and the giving of lethal injections. He said that if the Act was not overridden, there would be pressures to extend euthanasia to persons who were not terminally ill or who had not consented.

1.8 In the debate in the House, the Rt Hon Ian Sinclair MP sought unsuccessfully to move a motion that:

the House is of the opinion that, because of the discriminatory nature of the provisions of the Euthanasia Laws Bill 1996, it should not proceed to consider the measure further; and calls on the Attorney-General and Minister for Justice to have an alternative bill prepared and presented to the House in a form which does not discriminate against the people of any part of Australia and which would enable Members to vote according to their views on the issue of euthanasia on the basis of a possible uniform, national approach to the issue.⁵

1.9 During the Committee stage, an amendment to the Bill was successfully moved on behalf of the Hon Barry Jones MP. This added two further matters on which the Territories were expressly to have power to make laws, that is, sub-clauses (c) and (d) as set out in paragraph 1.3 above⁶

1.10 Mr Andrews said that he was willing to accept the amendments. He noted that nothing in the Bill would have precluded the Territories legislating in the ways set out in these two clauses anyway, and that the intention behind the amendments was simply to offer encouragement to the Territories to actually legislate in these ways.⁷ The *Medical Treatment Act 1988 (Vic)* and the *Consent to Medical Treatment and Palliative Care Act 1995 (SA)*

2 House of Representatives, *Hansard*, 28 October 1996, p. 5905.

3 House of Representatives, *Hansard*, 28 October 1996, p. 5908.

4 House of Representatives, *Hansard*, 28 October 1996, p. 5906.

5 House of Representatives, *Hansard*, 9 December 1996, p. 7976, 8036.

6 House of Representatives, *Hansard*, 9 December 1996, p. 8062.

7 House of Representatives, *Hansard*, 5 December 1996, p. 7379; 9 December 1996, pp. 8063, 8071-72.

were referred to as examples of the sort of legislation being encouraged by paragraph (c).⁸ The Australian Capital Territory in fact has already enacted legislation of this type.⁹

1.11 The Bill as amended was passed by the House on 9 December by a vote of 88 to 35 on the third reading.¹⁰ The debate and votes on the Bill were not conducted on party lines but were treated as matters on which individual members were free to determine their positions, known as "conscience votes". These votes usually relate to moral or ethical matters on which the established political parties choose not to adopt a policy.

1.12 The Bill was introduced into the Senate on 12 December 1996.

Senate Scrutiny of Bills Committee

1.13 The Senate's Scrutiny of Bills Committee has a watching brief to alert the Senate to the possibility that Bills coming before the Senate may by express words or otherwise breach certain defined principles. In reporting to the Senate, the Scrutiny of Bills Committee "expresses no concluded view on whether any provisions offend against its principles or should be amended. These are regarded as matters for the Senate to decide."¹¹

1.14 One of the principles against which the Scrutiny of Bills Committee assesses Bills is whether they "trespass unduly on personal rights and liberties".¹² The Scrutiny of Bills Committee considered the Euthanasia Laws Bill and reported on it in September 1996. It stated that the provisions of the Bill "may be considered" to breach this principle.¹³ It did so on the basis of five related points that it said were raised by the Bill and which it identified under the heading of "self-government rights":

- The Commonwealth Parliament having given the Legislative Assembly of each Territory the power 'to make laws for the peace, order and good government' of each Territory, would, by this bill, negate the valid exercise of that legislative power by one of them.
- The Commonwealth Parliament, by this bill, proposes to intrude on the law-making function of the Territories not in accordance with a general principle but on an ad hoc basis. This threatens the certainty which ought exist for its citizens when any one or more of the Territories passes a valid law.
- The Commonwealth Parliament, while undoubtedly having the power to pass this bill, would, by so doing, create a situation where some Australians are treated in a way different from other citizens because it curtails their present right to self-government in circumstances where, were they to live in the States, it could not do so.

8 House of Representatives, *Hansard*, 21 November 1996, p. 7327, 9 December 1996, p. 8063.

9 See *Medical Treatment Act 1994 (ACT)*.

10 House of Representatives, *Hansard*, 9 December 1996, p. 8078-79.

11 H Evans (ed.), *Odgers' Australian Senate Practice*, 7th edn, 1995, p. 375.

12 Senate, *Standing Orders*, SO 24(1)(a)(i).

13 Senate Standing Committee for the Scrutiny of Bills, *Alert Digest*, No. 7/96, 18 September 1996, p. 6.

- *The Northern Territory (Self-Government) Act 1978* has now been in operation for a number of years and, up to the time this bill was introduced, people living there had the reasonable expectation that the statute would not be amended to deprive their Assembly of a power it had held for over a decade and a half. This bill now puts that reasonable expectation at risk.
- This bill, if passed, would override the decision of the democratically elected government of the Northern Territory when it appears that there would be no head of power or international convention by which it could override the same or similar legislation enacted by the States.¹⁴

14 Senate Standing Committee for the Scrutiny of Bills, *Alert Digest*, No. 7/96, 18 September 1996, pp. 5-6.

CHAPTER 2

THE RIGHTS OF THE TERMINALLY ILL ACT

The Rights of the Terminally Ill Act (the RTI Act)

2.1 The Committee received some submissions containing detailed criticisms of the provisions of the RTI Act. The description that follows does not set out to canvass these criticisms. The RTI Act was not referred to the Committee and the aim of its inquiry was not to fine-tune its provisions. It was clear from the evidence received that those supporting and opposing the Bill overwhelmingly did so because they supported or opposed the general thrust of the Act. If the Senate decides not to pass the Bill, the question of fine-tuning the Act is one to be considered by the Northern Territory. If the Senate decides to pass the Bill, this question will not arise.

What the Rights of the Terminally Ill Act does

2.2 The RTI Act is the first legislation of its kind to come into operation anywhere in the world.¹ It provides for a procedure under which a mentally competent adult may request assistance to voluntarily terminate his or her own life. Section 4 of the Act provides:

A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life.

2.3 The assistance provided may include the provision of a substance to the patient for self administration, or administration by the medical practitioner.

2.4 The Act provides that those participating in the process shall not be subject to civil or criminal action or professional disciplinary action for anything done in good faith and without negligence in compliance with the Act.² Without this provision, the medical practitioner involved could be charged with either abetting a suicide or with murder, depending on the form the assistance takes in the particular case.

2.5 The Act contains a large number of provisions intended to ensure that the patient, all the medical personnel and any hospital or nursing home involved are all voluntary participants in the termination of that patient's life. The Act also requires that a broad range of factors must have been considered before reaching and implementing the decision to terminate the patient's life. It requires the participation of at least three medical practitioners. It also requires that the patient be given information on the palliative care that might be available.

1 *Submission No. 3345*, NT Government, p. 26.

2 RTI Act, s. 20.

2.6 The Act does not impose any requirement that the patient be a Northern Territory resident or have any substantial family or other connection with the Territory.

The enactment of the legislation

2.7 In considering whether the Commonwealth should exercise its power to override the RTI Act, issues were raised whether the Northern Territory Legislative Assembly had given due consideration to the Act, and whether it had consulted sufficiently widely on it. A brief sketch of how the legislation was enacted and came into operation is therefore relevant.

2.8 On 1 February 1995, Mr Marshall Perron MLA, who was then Chief Minister of the Northern Territory, announced that he would introduce a private member's bill into the Territory's Legislative Assembly to provide for a form of active voluntary euthanasia. He introduced the Rights of the Terminally Ill Bill, on 22 February 1995.³ On the same day, the Legislative Assembly established a Select Committee on Euthanasia to examine it.⁴ Throughout the Assembly's consideration of the Bill, its members were not bound by party discipline and were free to vote according to their individual views.

2.9 The Select Committee received 1126 submissions. Of these, 255 were from Northern Territory residents, with 122 in favour of the Bill, 123 against and 10 not indicating a position.⁵ Overall, 72 per cent of submissions were in favour of euthanasia or the right of choice, with 27 per cent opposed to the issue or the Bill itself.⁶ The Select Committee held hearings on twelve days in March and April 1995. Its report was tabled and debated in the Legislative Assembly on 16 May 1995.⁷

2.10 The Select Committee's terms of reference required it to take evidence and submissions on the Bill. However, it took the view that it "did not have a specific charter to make recommendations for or against euthanasia",⁸ and its report did not do so. The report made thirteen recommendations for changes to the Bill in the event that the Assembly decided that the Bill should proceed, and seven recommendations relating to ancillary matters.

2.11 On 24 May 1995, the second reading debate on the RTI Bill resumed. Following debate, the motion that the Bill be read a second time was agreed to by thirteen votes to twelve.⁹ Some forty-nine amendments were made at the Committee stage,¹⁰ and the Bill

3 NT, *Parliamentary Record (Debates)*, 22 February 1995, p. 2496.

4 NT, *Parliamentary Record (Debates)*, 22 February 1995, p. 2528.

5 NT Legislative Assembly, *The Right of the Individual or the Common Good?: Report of the Inquiry by the Select Committee on Euthanasia*, May 1995, vol. 1, p. 31.

6 NT Legislative Assembly, *The Right of the Individual or the Common Good?: Report of the Inquiry by the Select Committee on Euthanasia*, May 1995, vol. 1, p. 31.

7 NT, *Parliamentary Record (Debates)*, 16 May 1995, pp. 3108-54.

8 NT Legislative Assembly, *The Right of the Individual or the Common Good?: Report of the Inquiry by the Select Committee on Euthanasia*, May 1995, vol. 1, p. 1.

9 NT, *Parliamentary Record (Debates)*, 24 May 1996, p. 3734.

10 *Submission No. 3345*, NT Government, p. 27.

passed the third reading stage by fifteen votes to ten.¹¹ One of the amendments let the Government delay the Act's coming into force in order to allow time for regulations to be prepared, and training, education and information-gathering to occur.¹²

2.12 The Administrator of the Northern Territory assented to the Bill on 16 June 1995.¹³

2.13 The *Northern Territory (Self Government) Act 1978*, s. 9 provides that the Commonwealth Government may, within six months of the Administrator's assent, disallow a proposed law in whole or in part, or may recommend amendments to it. None of these actions were taken in relation to the Bill.¹⁴ The office of the then Prime Minister, the Hon Paul Keating MP, "advised that the legislation was within power and not a matter for disallowance".¹⁵

2.14 The Committee was told that the power to disallow has never been used since self government was granted to the Territory in 1978.¹⁶ The Commonwealth Parliament, as distinct from the Executive, has not reserved to itself any power to disallow Territory legislation.

2.15 Following the assent to the Bill, the Northern Territory Government set up a working party of officers from the Attorney-General's Department and Territory Health Services to advise it on the implementation of the Act and the preparation of regulations under the Act. The working party met over a period of fourteen months.¹⁷ Arising from its work, community and Aboriginal education programs on the Act were developed. The Committee was told that all formal components of the community education program were completed in November 1996, with the Aboriginal program scheduled to be completed by April 1997.¹⁸

2.16 The working party engaged in extensive consultations and in the course of these identified technical aspects of the Act requiring amendment. As a result, the Attorney-General, Mr Steve Hatton MLA, introduced the Rights of the Terminally Ill Amendment Bill on 23 November 1995.¹⁹ The amending Bill was debated and passed on 20 February 1996.²⁰ An attempt during the debate to introduce a further amendment that would have had the effect of repealing the principal Act was not successful.²¹ The attempt to add a sunset clause to the

11 NT, *Parliamentary Record (Debates)*, 24 May 1996, p. 3782.

12 NT, *Parliamentary Record (Debates)*, 24 May 1996, p. 3735 (Mr Perron).

13 NT, *Government Gazette*, No. G26, 28 June 1995, p. 5.

14 *Submission No. 3345*, NT Government, p. 18.

15 NT, *Parliamentary Record (Debates)*, 8 October 1996, p. 9115 (Mr Stone, Chief Minister).

16 *Submission No. 3345*, NT Government, p. 17. See also Commonwealth Parliamentary Library, Legislative Research Service (N Cica), *Euthanasia – the Australian Law in an International Context: Part 2: Active Voluntary Euthanasia*, Research Paper No. 4 1996-97, September 1996, p. 58, note 102.

17 *Submission No. 3345*, NT Government, p. 31.

18 *Submission No. 3345*, NT Government, p. 32.

19 NT, *Parliamentary Record (Debates)*, 23 November 1995, p. 5863.

20 NT, *Parliamentary Record (Debates)*, 20 February 1996, pp. 6375-6442.

21 NT, *Parliamentary Record (Debates)*, 20 February 1996, pp. 6423-25.

principal Act, under which it would have ceased to operate on 1 July 1999, was also unsuccessful.²²

2.17 On 6 June 1996, the Northern Territory Administrator fixed 1 July 1996 as the day on which the Act, as amended, would come into operation.²³

2.18 As noted above, a working party of officers consulted widely in drawing up regulations to apply under the Act. The working party's report was tabled and debated in the Legislative Assembly on 23 May 1996.²⁴ On 5 June 1996, the proposed regulations were released in draft form for public comment.²⁵ They were made as regulations on 28 June 1996.

Further attempts to repeal and amend the legislation

2.19 On 15 May 1996 a private member's bill was introduced in the Legislative Assembly by Mr Neil Bell MLA to repeal the RTI Act. When the Bill came on for debate on 21 August, it was rejected by a vote of fourteen to eleven at the second reading stage.²⁶

2.20 On 21 August 1996, a bill was introduced by Mr Eric Poole MLA which sought to amend the RTI Act to make it unlawful for public hospitals and health clinics to provide assistance under the Act. The aim was to reassure those, particularly remote Aboriginal communities, who were said to fear, incorrectly, that they were at some risk of involuntary euthanasia by going to public health facilities.²⁷ This bill was also rejected, in this case by a vote of fifteen to ten.²⁸

Legal challenges to the RTI Act

2.21 On 17 June 1996, Dr Chris Wake and the Rev Djiniyini Gondarra began proceedings in the Northern Territory Supreme Court seeking an injunction to prevent the proclamation of the RTI Act, and the making of regulations under the Act. The matter was heard on 21 June by Chief Justice Martin. He declined to grant the injunction. He referred the matter to the Full Court of the Supreme Court, which heard the case on 1 and 2 July, and gave its decision on 24 July 1996.

2.22 Two broad arguments were put to the Full Court. First, it was argued that the Northern Territory Legislative Assembly lacked the power to enact the RTI Act. In support of this argument, the plaintiffs asked the Court to find that there was an inalienable right to life, and that the Act violated that right and was therefore invalid. A related argument was that, as the Territory had not achieved complete self-government, its Assembly's powers should be

22 NT, *Parliamentary Record (Debates)*, 20 February 1996, pp. 6425-27.

23 NT, *Government Gazette*, No. S15, 13 June 1996.

24 NT, *Parliamentary Record (Debates)*, 23 May 1996, pp. 7655-72.

25 Mr Steve Hatton MLA, Attorney-General, Media Release, 5 June 1996.

26 NT, *Parliamentary Record (Debates)*, 21 August 1996, p. 8373.

27 NT, *Parliamentary Record (Debates)*, 21 August 1996, p. 8271.

28 NT, *Parliamentary Record (Debates)*, 21 August 1996, p. 8293.

read down so as not to empower it to make laws abolishing the suggested fundamental right. Secondly, it was argued that the Administrator had not validly given his assent to the Act.

2.23 The Full Court rejected both these arguments by a majority (Martin CJ and Mildren J, with Angel J dissenting) and held that the RTI Act was a valid law of the Territory. In regard to the first argument, the majority did not need to decide if the Act infringed any fundamental right because they held that a State can clearly override any such right by explicit legislation. The majority found that there was no basis to treat the Territory differently to a State in this respect, and that the Act in question was explicit.²⁹

2.24 The second argument arose from the provision in s. 7(2) of the *Northern Territory (Self Government) Act 1978* for two alternatives by which the Administrator may deal with a proposed law presented for his assent. Both allow the Administrator to either assent or withhold assent. But one gives the Administrator the further option of reserving the proposed law for the Governor-General's pleasure. If this option is exercised, the Commonwealth has the opportunity to intervene and impose its views before the proposal becomes law. However, if either method of assent is used, the Commonwealth still has the right to disallow the resulting law within six months under s. 9 of the Self Government Act, as described above.

2.25 For the RTI Act, the Administrator used the form of assent which does not include the option of reservation for the Governor-General's pleasure. This form of assent can only be used where the proposed law makes provision solely in relation to a matter specified in s. 35 of the Self Government Act. Section 35 refers to matters in which Ministers of the Territory are to have executive authority. A long list of these matters is set out in regulation 4(1) of the Northern Territory (Self Government) Regulations.

2.26 The plaintiffs argued for a narrow reading of the language used to describe these matters and then argued that the RTI Act did not relate to any of them. As a result, they argued, the Administrator's assent was not validly given. The majority found that the substance of the Act related to three of the matters listed in regulation 4(1): maintenance of law and order and the administration of justice, private law, and the regulation of businesses and professions.³⁰ The majority therefore held that the assent was validly given.

2.27 The dissenting judge, Justice Angel, took the view that the RTI Act had "no relevant substantial connection with any or any combination of the heads of power in reg 4".³¹ He characterised the Act as unique; as one that institutionalised intentional killing which would otherwise be murder; and as one that institutionalised aiding suicide which would otherwise be a crime. In his view, nothing in regulation 4(1), whether read liberally or restrictively, gave any warrant to the legislative establishment of institutional termination of human life other than as a punishment.³² As a result, Justice Angel found that the purported assent to the Act was not valid and that the Act had not passed into law.

2.28 Because in his view no valid assent had been given, Justice Angel did not need to decide whether the Act was also beyond the legislative power of the Northern Territory. He

29 *Wake v Northern Territory* (1996) 124 FLR 298, 306 (Martin CJ and Mildren J).

30 *Wake v Northern Territory* (1996) 124 FLR 298, 310 (Martin CJ and Mildren J).

31 *Wake v Northern Territory* (1996) 124 FLR 298, 314 (Angel J).

32 *Wake v Northern Territory* (1996) 124 FLR 298, 314 (Angel J).

did, nonetheless, canvass the question whether a legislature had an unfettered power to override a fundamental right such as the suggested right to life. He referred to a wide range of legal and philosophical writings. However, he did not express any final view on the point.³³

2.29 The plaintiffs lodged with the High Court an application for special leave to appeal the decision of the Northern Territory Full Court. When the High Court considered the application on 15 November 1996, it decided to adjourn the matter until the Parliament had completed its deliberations on the Euthanasia Laws Bill 1996. Chief Justice Brennan explained:³⁴

The preliminary issue for our decision is whether this Court should entertain an application to consider a challenge to the Northern Territory Act on constitutional grounds before the Parliament has completed its deliberations on the Bill and, if special leave be granted, to list that challenge for hearing contemporaneously with the debate in the Parliament, or whether the application should be adjourned until after the Parliament's deliberations are completed. The latter course is preferable. It avoids any possibility of embarrassing or complicating the political process without prejudicing the merits or demerits of the constitutional challenge.

Effect of the legal challenges on the scope of the Committee's report

2.30 The various arguments on the invalidity of the RTI Act that were put to the Northern Territory Supreme Court were also put to the Committee.³⁵ If these arguments are correct in law, there is no need for the Parliament to consider enacting a Bill to override the RTI Act.

2.31 The Committee has not addressed these arguments in its report. They are essentially questions of law. As such, only a court can give an authoritative answer to them. The Committee notes that the arguments were not accepted by the Northern Territory Supreme Court. It also notes that the matter has been taken to the High Court, which has deferred the question whether to hear it until the Parliament has completed its consideration of the Bill.

2.32 For the purposes of this report, the Committee has assumed, without deciding the matter, that the Territories possess the power to enact legislation like the RTI Act, and that Act has itself been validly enacted.

The use made of the RTI Act

2.33 There is no obligation under the RTI Act for the patient, medical practitioners or any hospital involved in a death under the Act to publicise the fact that it is occurring or has occurred. The only reporting required to be made public is the annual report by the Coroner to

33 *Wake v Northern Territory* (1996) 124 FLR 298, 327 (Angel J).

34 *Wake v Northern Territory*, High Court of Australia, No. D10 of 1996, transcript of proceedings, 15 November 1996, p. 4.

35 *Submission No. 3237*, NT Branch of the AMA, p. 7; *Submission No. 3193*, NT Coalition Against Euthanasia (Mr M Hardie), pp. 4-5; *Submission No. 3501a*, NT Coalition Against Euthanasia, pp. 7, 8, 18; *Submission No. 4031*, St Thomas More Society, p. 6.

the Attorney-General, and the latter in turn has to report to the Legislative Assembly.³⁶ The following information made on the use of the Act is based on information put into the public domain by participants.

2.34 In one highly publicised case, Mr Max Bell, a 66-year-old suffering from terminal stomach cancer, came to Darwin from New South Wales with the aim of using the Act in July 1996. According to media reports, he was unable to find a specialist who was prepared to be one of the three doctors required under the Act.³⁷ He returned to his home town, where he died on 2 August.³⁸

2.35 On 22 September, Mr Bob Dent, a 66-year-old Darwin resident suffering from terminal prostate cancer, became the first person known to have died under the RTI Act. He self-administered the fatal drugs in his home, using a computer-controlled device provided by Dr Philip Nitschke.³⁹

2.36 On 2 January 1997 in a rented Darwin room, Mrs Janet Mills ended her own life in accordance with the RTI Act, also by using Dr Nitschke's device.⁴⁰ She was 52 years old and was suffering from a rare form of cancer. She had come from her home in South Australia in late November 1996 in order to use the Act.

2.37 On 22 January 1997, Dr Nitschke announced that two days earlier he had assisted another patient to die under the Act. The patient was a 69-year-old Darwin man suffering from terminal stomach cancer.⁴¹ The death by self-administered injection occurred in the patient's home.⁴²

2.38 On 1 March 1997, a 70-year-old Sydney woman with cancer died in Darwin following a machine-delivered lethal injection. She was assisted by Dr Nitschke, acting under the RTI Act, and died in the presence of her five adult children.

2.39 At the hearing on 24 January, Dr Nitschke was asked by the Committee if he could estimate the rate at which patients might use the Act. He replied:

... I would estimate that one a month would seem to be perhaps realistic. Given the immense problems for interstate people to access this legislation, it is very hard to see that this will ever represent a significant avenue for people coming from interstate.⁴³

36 RTI Act, s. 14.

37 "Death rekindles euthanasia fight", *Australian*, 5 August 1996, p. 5.

38 "NT death candidate in tragic farewell", *Sunday Age*, 4 August 1996, p. 5.

39 "The fight to end a life", *Sydney Morning Herald*, 27 September 1996, p. 10.

40 "New death enlivens euthanasia debate", *Canberra Times*, 7 January 1997, p. 1; "Suffering ends in peace and privacy", *Australian*, 7 January 1997, p. 1.

41 "NT law's third mercy death", *Sydney Morning Herald*, 23 January 1997, p. 3.

42 *Evidence*, Dr P Nitschke, p. 49.

43 *Evidence*, Dr P Nitschke, p. 52.

CHAPTER 3

CONSTITUTIONAL AND RELATED ISSUES

Constitutional arguments on whether the Commonwealth should exercise its power

3.1 The Commonwealth Parliament has the power under s. 122 of the Constitution to enact the Bill. Even opponents of the Bill conceded this.¹

3.2 The question for the Committee's inquiry was whether the Parliament should exercise this power.

3.3 The Committee recognises that it is logically possible to be an opponent of both the policy embodied in the RTI Act and of Commonwealth legislation to override the Act. For those taking this view and some others, the key issue was not the correctness or otherwise of the policy in the Act, but which level of government in Australia should determine this question – the Commonwealth or the Territories. For example, the Chief Minister of the ACT, Ms Kate Carnell MLA, told the Committee:

I am not going to talk about the merits or otherwise of euthanasia. The critical issue is the attempt by federal parliament to amend the self-government legislation of the territories ...²

3.4 In this Chapter, the Committee reviews arguments for and against the Commonwealth Parliament exercising its power to enact the Bill having regard to the constitutional implications for the Territories. As noted in the Preface, the Committee in this Chapter and those that follow identifies the various issues and summarises the competing arguments.

Arguments supporting the Bill

3.5 Some saw the RTI Act as attacking a basic human right. From this perspective, the need to override the Act came first and any question of Territory rights was secondary. the

1 See for example, *Submission No. 3345*, NT Government, p. 10; *Submission No. 4048*, ACT Government, p. 8; *Submission No. 3117*, Mr M Perron, p. 14; *Submission No. 4503*, NSW Council for Civil Liberties, p. 6; *Submission No. 9536*, Ms M Braham MLA, p. 2; *Submission No. 8745*, Voluntary Euthanasia Society of NSW, p.2; *Evidence*, Ms M Hickey MLA, p. 20. Lawyers supporting the Bill expressed a similar view: see for example, *Submission No. 4021*, Mr M Sneddon, p. 2; *Submission No. 9944*, Prof. G Moens and Mr J Trone, p. 5; *Submission No. 2428*, Mr D Galligan QC, p. 3; *Submission No. 4674*, Mr F Gaffy QC, p. 2; *Submission No. 4976*, Mr K O'Shea, p. 4; *Submission No. 8749*, Mr T Ginnane, p. 3. See also *Evidence*, Attorney-General's Department, pp. 194, 196; Mr G Williams, p. 209.

2 *Evidence*, ACT Government, p. 178.

submission from Calvary Hospital, for example, said: "There is a hierarchy of rights: States Rights cannot over-ride matters of life and death".³

3.6 Against this, Professor Tom Campbell of the Australian National University Law Faculty, argued:

If the intrusion of the Commonwealth Parliament into this matter is justified by the argument made by the Bill's proposer, namely that this is a matter of fundamental rights, then this introduces a novel constitutional basis for the exercise of Commonwealth power. There is nothing in our Constitution to require that fundamental rights are not equally a responsibility of States and by extension of Territories. The Northern Territory has a responsibility and right to determine for itself the implications of human rights in relation to such specific issues as euthanasia.⁴

3.7 Many submissions supported Commonwealth legislation by arguing that the impact of the RTI Act extended outside the Northern Territory. For example, the NT Branch of the Australian Medical Association described the Act as "in essence a bad law that impacts not just on Territorians but on all of humankind".⁵ The NT Coalition Against Euthanasia said: "The Territories do not have an unfettered right to pass laws that affect all Australians given the subordinate nature of the Territory Governments by virtue of the Commonwealth's residual powers".⁶

3.8 One way in which the Act was said to affect all Australians was that patients could travel from other parts of Australia to the Territory to use the Act and interstate medical specialists could have a role under the Act.⁷ The Northern Territory Branch of the Australian Medical Association said that the claim that the Territory had a right to legislate without interference by the Commonwealth "cannot be considered acceptable in view of the fact that the NT has passed a law that allows for the killing of people from all over Australia".⁸ Dr

3 *Submission No. 4051*, Calvary Hospital, p. 1. See also for example, *Submission No. 8248*, Bishop P Power, p. 3; *Submission No. 8252*, Social Issues Committee of the Anglican Church Diocese of Sydney, p. 2; *Submission No. 8337*, Presbyterian Church of Victoria, p. 1; *Submission No. 8734*, Mrs D Easton, p. 4; *Submission No. 3194*, Fr E Ahern, p. 8; *Submission No. 3121*, Mr M McAuley, p. 17; *Submission No. 4057*, Adelaide Justice Coalition, p. 2; *Submission No. 4730*, Archbishop B Hickey, p. 2.

4 *Submission No. 3617*, Prof T Campbell, p. 1.

5 *Submission No. 3237*, NT Branch of the Australian Medical Association, p. 6. See also *Submission No. 4032*, Mr C Francis QC, p. 3.

6 *Submission No. 3501*, NT Coalition Against Euthanasia, p. 2. See also for example, *Submission No. 3510*, Australian Federation of Right to Life Associations, pp. 11-12; *Submission No. 4019*, Australian Family Association, Tas. Branch, p. 2; *Submission No. 3105*, Dr J Santamaria, pp. 4-5.

7 See for example, *Submission No. 4004*, Knights of the Southern Cross (Essendon Branch), p. 5; *Submission No. 4003*, Salt Shakers, p. 5; *Submission No. 4012*, Victorian Association for Hospice and Palliative Care, p. 4; *Submission No. 4522*, Caritas Christi Hospice, p. 2; *Submission No. 8750*, Dr N Muirden, p. 5; *Submission No. 11,852*, Mr G Hodges, p. 1.

8 *Submission No. 3237*, NT Branch of the AMA, p. 7. See also for example, *Submission No. 11,852*, Mr G Hodges, p. 1; *Submission No. 8750*, Dr N Muirden, p. 5.

Anthony Fisher referred to the Northern Territory becoming "a 'haven' for 'death tourism' for Australia and the world" due to the RTI Act.⁹

3.9 Against this, it was said that the RTI Act was no different to many other Territory laws that would affect someone who chose to travel to the Territory. For example, Ms Dawn Lawrie argued: "If people come to the Northern Territory seeking to take advantage of our euthanasia legislation, they approve of that legislation – they are exercising free will and no impediment should be placed in their way".¹⁰

3.10 It was claimed that the fact that euthanasia was the subject of intense interest and debate in all parts of Australia made it a national issue requiring national resolution.¹¹ Some saw the RTI Act as having moral implications for the whole of Australia. The NSW Council of Churches, for example, referred to the RTI Act as a law "which will dictate the moral ethic to the entire nation of Australia".¹² The Caroline Chisolm Centre for Health Ethics referred to the "inevitable flow-on effect for all Australians because life is devalued right across the country".¹³ Dr Anthony Fisher believed that "the practice of euthanasia in the Territory may well have a corrupting effect on public attitudes and upon healthcare practice elsewhere in the country".¹⁴

3.11 The Committee notes concerns that all Australian taxpayers will be asked to fund the use of the RTI Act through Medicare and insurance rebates and through the funding of the education and employment of health workers participating in the use of the Act. In relation to the payment of Medicare benefits, the Committee notes the statement of the Minister for Health, the Hon Dr Michael Wooldridge, in June 1996 in which he said that the Government "will not make available, regardless of the legality of the procedure, the payment of Medicare benefits for euthanasia-related services".¹⁵ Dr Philip Nitschke gave evidence that preliminary consultations with the patients he has assisted to use the RTI Act are covered by Medicare: "The final event, as you might call it – when the person actually does ask for the lethal injection – is specifically excluded from remuneration from Medicare".¹⁶

9 *Submission No. 4563*, Dr A Fisher, p. 18. See also *Submission No. 3230*, Coalition for the Defence of Human Life, p. 4 ("euthanasia tourism").

10 *Submission No. 4501*, Ms D Lawrie, p. 2. See also for example, *Submission No. 2390a*, Mr B Howard, p. 4; *Submission No. 4053*, Mr C Friel, p. 2.

11 See for example, *Submission No. 4012*, Victorian Association for Hospice and Palliative Care, p. 4; *Submission No. 4021*, Mr M Sneddon, p. 3.

12 *Submission No. 3129*, NSW Council of Churches, p. 1.

13 *Submission No. 4026*, Caroline Chisolm Centre for Health Ethics, p. 2. See also for example *Submission No. 4556*, Queensland Advocacy Inc, p. 4 ("significant impact on the social value structure of the whole country").

14 *Submission No. 4563*, Dr A Fisher, p. 18.

15 House of Representatives, *Hansard*, 27 June 1996, p. 3013. Under the legislation, the payment of Medicare benefits is dependent on that benefit being clinically relevant. The basis of the exclusion of euthanasia from benefits is the Government's assessment, supported by advice from the Australian Medical Association, that euthanasia is not clinically relevant.

16 *Evidence*, Dr P Nitschke, pp. 58-59.

3.12 Some also said that enactment of the RTI Act affected Australia's international reputation,¹⁷ or was a matter of international interest,¹⁸ or, by acting as a precedent, would have impacts overseas.¹⁹ It was therefore seen as a proper matter for the Commonwealth to legislate on.

3.13 In addition to the arguments based on the extra-Territorial impacts of the Act, some focused on the uniqueness of the RTI Act. They made the point that proposals for similar legislation had been rejected elsewhere in Australia and by major studies overseas. A number of grounds were then put as to why the Territory should not be allowed to enact a law that was both unique and seen to have extra-Territorial impacts. These included the smallness of the Territory's population, that the Territory is dependent financially on the Commonwealth, that its Legislative Assembly has only a small number of members, that the legislation was enacted with undue haste and insufficient consultation, and that the Act was passed by only a single vote, thirteen to twelve.²⁰ On the last point for example, Mrs Christine Glass argued: "This kind of legislation has been rejected everywhere else in the world, so how can 13 people know better".²¹

3.14 It was also said that the lack of a house of review in the Northern Territory parliament made it "entirely appropriate that the Commonwealth Parliament act as a house of review for controversial legislation such as the Northern Territory euthanasia law which affects all Australians ...".²²

3.15 The Committee was told that analogies based on "States rights" were not relevant because the Territories were not States.²³ As Mr Mark Sneddon, a senior lecturer in law at Monash University, put it: "Consistent with the lesser autonomy of the Territories and the plenary grant of power in s. 122 of the Constitution is a greater responsibility on the part of the Commonwealth for the laws and government of the Territories".²⁴ Mr Vincent Vandeleur expressed the view that the Commonwealth's possession of the power to intervene carried with it an obligation to do so: "By not taking action to overrule the Act, the Federal Parliament will be seen to be approving the radical social change which the Act brings

17 See for example, *Submission No. 1665*, Prof G Phillips, p. 3; *Submission No. 3062*, Mr E Roberts, p. 10; *Submission No. 3230*, Coalition for the Defence of Human Life, p. 4.

18 See for example, *Submission No. 4021*, Mr M Sneddon, p. 3.

19 *Submission No. 3507*, Queensland Right to Life, p. 3. See also for example, *Submission No. 4009*, Assemblies of God in Australia, p. 18 (the NT "is setting the agenda, not only for Australia but for much of the world"); *Submission No. 4529*, Mrs E Lewis, p. 5.

20 See for examples in which some of these points were raised, *Submission No. 789*, Christian Medical & Dental Fellowship of Australia, p. 1; *Submission No. 3122*, Dr P Markey, p. 3; *Submission No. 4030*, Right to Life Australia, p. 10; *Submission No. 4153*, Mr P Kamsma, p. 2; *Submission No. 8742*, Archbishop K Rayner, p. 4.

21 *Submission No. 3144*, Mrs C Glass, p. 1.

22 *Submission No. 3235*, Festival of Light (SA), p. 10.

23 See for example, *Submission No. 4674*, Mr F Gaffy QC, p. 2; *Submission No. 4976*, Mr K O'Shea, p. 3; *Submission No. 9944*, Prof. G Moens and Mr J Trone, pp. 1-2; *Submission No. 4005*, TRUST, p. 12.

24 *Submission No. 4021*, Mr M Sneddon, pp. 2-3.

about".²⁵ Mr Philip Temple, who said he was a long-time Northern Territory resident, argued that the states rights argument had no substance and "is really a back-door attempt to garner support for voluntary euthanasia by avoiding the real issues involved in that debate and appealing instead to emotions of territorial patriotism".²⁶

3.16 Some supporters of Commonwealth legislation relied on a legal view of the status of Territories, and as a result gave little weight to the argument that conventions and political practices should inhibit the Commonwealth from legislating. Even those prepared to give greater weight to this argument nonetheless considered that it had to give way in the special circumstances of the RTI Act. For example, Fr Frank Brennan noted in his submission that the Parliament:

does have the power to overrule a Territory law. Should it ever exercise that power? Only in very rare circumstances: where no State has similarly legislated; where the Territory law is a grave departure from the law in all equivalent countries; where the Territory law impacts on the national social fabric outside the Territory; and where the Territory law has been enacted without sufficient regard for the risks and added burdens to its own more vulnerable citizens, especially Aborigines. This is such a circumstance.²⁷

3.17 The Committee was also told that it was impossible to have a law permitting euthanasia that contained adequate safeguards against its abuse: the Parliament had a responsibility to prevent the Northern Territory from attempting the impossible.²⁸

Arguments opposing the Bill

3.18 The Committee notes that the Bill was opposed by the Governments and the Legislative Assemblies of the three Territories affected.²⁹ The opposition of the members of Northern Territory Legislative Assembly was unanimous, although, as noted in the previous Chapter, votes in the Assembly related to the RTI Act have been far from unanimous. Similarly, in the ACT Legislative Assembly the members were unanimously opposed to the

25 *Submission No. 4534*, Mr V Vandeleur, p. 2. See also for example, *Submission No. 3062*, Mr E Roberts, p. 10; *Submission No. 4026*, Caroline Chisolm Centre for Health Ethics, p. 2; *Submission No. 8744*, Maj-Gen D Francis, p. 3; *Submission No. 4529*, Mrs E Lewis, p. 5; *Submission No. 4561*, L Young, p. 2.

26 *Submission No. 3504*, Mr P Temple, p. 2.

27 *Submission No. 7399*, Fr F Brennan, p. 11. See also *Evidence*, Fr F Brennan, pp. 208, 212.

28 *Submission No. 8615*, Mr B Sutherland, pp. 2, 20. See also for example *Submission No. 4826*, Mr F Lee, p. 9; *Submission No. 7357*, Mr P Limbers and others, p. 2.

29 See the Remonstrance from the Northern Territory Legislative Assembly and the resolution of the Legislative Assembly of Norfolk Island presented to the Parliament on 27 October 1996: Senate *Hansard*, 28 October 1996, pp. 4576-79. See also *Submission No. 3345*, NT Government; *Submission No. 4048*, ACT Government; *Submission No. 7577*, Norfolk Is. Government; and *Evidence*, ACT Government, p. 177.

Bill (with one abstention), despite the fact that its members are far from unanimous on the merits of their Territory enacting legislation like the RTI Act.³⁰

3.19 The Committee also notes that at the 27 September 1996 Leaders' Forum, the Premiers of all the States supported the Territories' view that the Commonwealth should not legislate.³¹ Again, those present were not supporting the policy of the RTI Act, but were expressing a view on which level of government in Australia should decide on the policy.

3.20 It was put to the Committee that Commonwealth legislation would be an unprecedented breach of the conventions and practices underpinning self-government. According to these, the Commonwealth did not and should not interfere in matters over which it had transferred legislative power to the Territories.³² On this view, Territory residents had a reasonable expectation that such interference would not occur, and enactment of the Bill would put this expectation at risk.³³ The ACT Chief Minister, Ms Kate Carnell MLA, told the Committee:

In a democratic society, conventions stabilise the distribution of power and give citizens an expectation of what may or may not be done within the political process. This bill erodes public respect for the existing distribution of power.³⁴

3.21 Mr Anthony Macmichael, the Chairman of the Darwin Branch of the Country Liberal Party, said at the forum in Darwin on 23 January 1997 that:

the Northern Territory is politically mature and it is our Rights of the Terminally Ill Act. It is in our backyard; we are the people who need to live with it. If we have got it wrong, we should be the ones to correct it. If we do not agree with what our elected members of our Legislative Assembly have done within the convention of the Westminster system then we should show our result at the ballot box and let it all be done within the Territory under the constitutional convention under which we were given self-government 18 years ago.³⁵

3.22 Mr Nicholas Tonti-Filippini responded to the argument that the Bill would undermine the democratic rights of Territorians by saying:

to consider it democratic to withdraw the protection of the law in regard to life itself for a vulnerable minority of citizens is not an action of a genuine democracy. Democracy is not only rule by the

30 *Evidence*, ACT Government, pp. 180, 185.

31 *Submission No. 1100*, Tasmanian Government, p. 1; *Submission No. 4020*, Queensland Government, p. 1; *Submission No. 8740*, Victorian Government, p. 1.

32 *Submission No. 3345*, NT Government, pp. 10-19; *Submission No. 4048*, ACT Government, pp. 7-8; *Submission No. 7577*, Norfolk Is. Government, p. 2.

33 See for example, *Submission No. 3552*, Mrs S Cavanagh, p. 3.

34 *Evidence*, ACT Government, p. 179.

35 *Evidence*, Mr A Macmichael, p. 112.

people but also rule for the people. Respect for the inviolability of each individual member of the human family is a fundamental premise of democracy.³⁶

3.23 A number of submissions referred to the fact that the Commonwealth had made no move to disallow the RTI Act within the six-month period provided for in the Self-Government Act.³⁷ It was suggested that, having failed to use the power provided under the Act, the Commonwealth should not now attempt to achieve the same result by going outside the Act. However, the Northern Territory Government told the Committee it would have opposed any use of the disallowance power, regarding such use as a breach of the conventions relating to self-government.³⁸

3.24 It was contended that the existence of the disallowance provision can be used to support the view that Commonwealth intervention in relation to Territory legislation is an ever-present and valid option.³⁹ On this view, the Bill should be seen as no more than an equivalent intervention, albeit by a different means.

3.25 No-one identified for the Committee any case in which a withdrawal of power to legislate had occurred. Some submissions referred to the *Human Rights (Sexual Conduct) Act 1994* as if it constituted a precedent. However, the Committee notes that Act imposed a uniform national policy on all the States and Territories, not just on the Territories.⁴⁰ Moreover, it did not withdraw powers to legislate by amending the Territory Self-Government Acts.

3.26 The Committee was told that although the Bill was introduced with the stated purpose of preventing euthanasia, it would not achieve this because it did not prohibit euthanasia in the States, where more than 95 per cent of the Australian population live.⁴¹ Mr Joseph Santamaria QC responded to this view:

The purpose of the *Bill* is to prevent euthanasia in those parts of Australia for which the Commonwealth has clear legislative responsibility and authority on that subject. If enacted, the *Bill* will achieve that purpose.⁴²

36 *Submission No. 4040*, Mr N Tonti-Filippini, p. 19.

37 See for example, *Submission No. 4502*, Mr A Macmichael, p. 2; *Submission No. 3101*, NT Voluntary Euthanasia Society, p. 4.

38 See for example *Submission No. 3345*, NT Government, p. 18; *Submission No. 3552*, Mrs S Cavanagh, p. 3. See also *Evidence*, Ms M Hickey MLA, p. 23.

39 See *Submission No. 3501a*, NT Coalition Against Euthanasia, p. 12 which notes that one of the ways in which Northern Territory legislation may be assented to involves a Commonwealth Minister: s. 7(2)(b) of the Self-Government Act. The submission argues that this provides further evidence that the Northern Territory lacks some of the self-government rights possessed by the States.

40 *Submission No. 3345*, NT Government, pp. 2, 15; *Submission No. 4048*, ACT Government, p. 7.

41 *Submission No. 4048*, ACT Government, p. 9. See also for example, *Submission No. 3552*, Mrs S Cavanagh, p. 3.

42 *Submission No. 4054a*, Mr J Santamaria QC, para. 69.

3.27 Because it did not implement a national policy for all parts of Australia, the Bill was seen by its opponents as legislation on a discriminatory and *ad hoc* basis.⁴³ The ACT Attorney-General, Mr Gary Humphries MLA, told the Committee: "If it were part of a national uniform scheme we would be much more sanguine about what is being proposed, but this is discriminatory against just two or three territories".⁴⁴

3.28 The Bill was also criticised on the ground that the Parliament was deciding on it by means of a "conscience vote". Some said this involved the unwarranted assumption that the consciences of Parliamentarians were better than those of the Northern Territory Legislative Assembly.⁴⁵ Others criticised the implication inherent in overriding the RTI Act that federal politicians were more intelligent, knowledgeable or wiser than Territory ones.⁴⁶

3.29 Some opponents of the Bill saw the transfer of legislative powers to the Territories as part of a long-term trend towards giving Territory residents the same democratic rights to control their affairs as those enjoyed by the residents of the States. On this view, enactment of the Bill was seen as an anti-democratic reversal. Because it reduced the powers of the Territories to legislate, the Bill was seen as increasing the gap between the self-government rights enjoyed by residents of the Territories and those of residents of the States.⁴⁷ The Law Council of Australia told the Committee that the Commonwealth should not now seek to derogate from the grant of self-government, and by seeking to do so "was unnecessarily interfering in the internal government of the Northern Territory".⁴⁸

3.30 Some submissions saw enactment of the Bill as anti-democratic in that Members and Senators from outside the Territory were overriding a law enacted by the democratically elected members of the Territory Assembly after extensive debate, consultation and Committee inquiry.⁴⁹ The ACT Government said that enactment of the Bill would produce "the incongruous situation ... that the Representatives and Senators who vote in favour of it will reserve to their own States the power to make laws permitting euthanasia at any time, while denying that power to the Territories – jurisdictions that they do not represent".⁵⁰ The submission from the Northern Territory Government said:

43 See for example, *Submission No. 4048*, ACT Government, pp. 4, 8, 10; *Submission No. 3345*, NT Government, pp. 19-20, 21, 22; *Submission No. 4623*, Mr D Swanton, pp. 8-9; *Submission No. 7482*, Humanist Society of WA, p. 4.

44 *Evidence*, ACT Government, p. 181.

45 *Submission No. 4501*, Ms D Lawrie, p. 2. See also *Submission No. 4015*, Australian Federation of Aids Organisations, p. 5.

46 See for example, *Submission No. 4536*, Mr A Chapman, p. 3; *Submission No. 4623*, Mr D Swanton, p. 9; *Submission No. 7482*, Humanist Society of WA, p. 4.

47 *Submission No. 4048*, ACT Government, pp. 3-6; *Submission No. 3345*, NT Government, p. 20-21; *Submission No. 7577*, Norfolk Is. Government, p. 2; *Submission No. 8756*, Ms M Wallace, p. 6. See also Senate Standing Committee for the Scrutiny of Bills, *Alert Digest*, No. 7/96, 18 September 1996, p. 6.

48 *Submission No. 8751*, Law Council of Australia, p. 1.

49 See for example, *Submission No. 4501*, Ms D Lawrie, pp. 1-2.

50 *Submission No. 4048*, ACT Government, p. 10.

It is not to the point that the members of that national Parliament are elected by the people of Australia to make laws for Australians generally, including territories. Once a grant of self-governing powers to a territory has been made, then the citizens of that territory are entitled to expect that the institutions and elected representatives of that self-governing territory will deal exclusively with matters within the grant of self-government. For the national Parliament to act contrary to this legitimate expectation constitutes a very dangerous precedent. It may well encourage members of the national Parliament, elected from any part of Australia, to think that if they do not like a territory law on any subject, they can freely override it, in total disregard of the grant of power already made to the legislature of the territory and the representative institutions the national Parliament has already established.⁵¹

3.31 The submission from the Norfolk Island Government noted that the Commonwealth had given undertakings to consult wherever possible with it before legislating for the Island. However, its views were not sought on the Bill, nor was it given the opportunity to comment on it.⁵² The Norfolk Island Government said that although it had no intention to legislate on assisted termination of life, the removal of its power to do so was "both paternalistic and patronizing and ... [ran] counter to all notions of effective Federalism".⁵³

3.32 Another argument was that the Bill would prevent the Territories from dealing with the topic in any form in the future, no matter what the emerging needs of the Community may one day be and no matter what laws the States may enact on the topic.⁵⁴ The Board of Social Responsibility of the Uniting Church in Australia referred to the RTI Act and said that the Bill "makes the overly simplistic assumption that legislation on this subject can never have a responsible role or purpose".⁵⁵

3.33 The Northern Territory Government said that the impact of the Bill, if enacted, could not survive the grant of Statehood to the Territory.⁵⁶ Its Solicitor-General explained the reasoning:

The Euthanasia Laws Act would, on its present terms as a Bill, only apply to the existing Legislative Assembly of the Northern Territory established under the Northern Territory (Self-Government) Act 1978. On present proposals, if the Northern Territory was to become a new State, that Legislative Assembly would almost

51 *Submission No. 3345*, NT Government, p. 20. See also *Submission No. 4048*, ACT Government, p. 10 (a "regressive precedent"); *Submission No. 7244*, Law Society of NSW, p. 2 (enactment of the Bill "raises a serious issue of constitutional precedent"); *Submission No. 3145a*, Mrs J Peterson, p. 5.

52 *Submission No. 7577*, Norfolk Is. Government, p. 2.

53 *Submission No. 7577*, Norfolk Is. Government, p. 2.

54 *Submission No. 3345*, NT Government, p. 2; *Evidence*, ACT Government, p. 182.

55 *Submission No. 2217*, Board of Social Responsibility of the Uniting Church in Australia, p. 4.

56 *Submission No. 3345*, NT Government, p. 7. See also *Submission No. 3501a*, NT Coalition Against Euthanasia, p. 7, which agreed that the impact of the Bill would lapse upon the grant of NT statehood.

certainly disappear, to be replaced by a new State Parliament under a new State constitution. In that event, unless the Euthanasia Laws Act was to be amended (perhaps as part of the terms and conditions of the grant of Statehood), such that that Act continued to operate on and from the grant of Statehood in respect of the new State Parliament and its legislative powers, then the Act would cease to have any further effect on the Northern Territory upon the grant of Statehood.⁵⁷

3.34 Several arguments were said to flow from this. First, the impact of the Bill on the Territory could only be transitory. The Northern Territory Government said that achieving this time-limited effect was not worth the damage done to the principles of self-government.⁵⁸ Secondly, the effect would be enduring on the other two Territories, although they had not created the situation giving rise to the Bill.⁵⁹

3.35 Thirdly, some expressed the view that the enactment of the Bill would complicate the granting of statehood to the Northern Territory because consideration would have to be given to whether the Commonwealth should, or under the Constitution could, prevent the new State from having the legislative power to enact legislation like the RTI Act.⁶⁰

The possibility of national legislation

3.36 On 12 December 1996, Senator Bob Collins gave notice in the Senate of his intention to move the following motion:

That the Senate-

(a) is of the opinion that, because of the discriminatory nature of the provisions of the Euthanasia Laws Bill 1996, it should not proceed to consider the measure further; and

(b) calls on the Attorney-General and Minister for Justice (Mr Williams) to have an alternative bill prepared and presented to the Senate in a form which does not discriminate against the people of any part of Australia and which would enable senators to vote according to their views on the issue of euthanasia on the basis of a possible uniform, national approach to the issue.⁶¹

3.37 The Senate has not yet considered this motion.

57 *Evidence*, Northern Territory Solicitor-General, Mr T Pauling QC, p. 257.

58 *Submission No. 3345*, NT Government, p. 21.

59 *Evidence*, ACT Government, p. 182.

60 See for example, *Submission No. 3345*, NT Government, pp. 7, 20-21; *Submission No. 4503*, NSW Council for Civil Liberties, p. 7; *Evidence*, Mr K Enderby QC, p. 225. See also *Evidence*, Northern Territory Solicitor-General, Mr T Pauling QC, pp. 256-59 for a detailed response from a legal perspective to whether the enactment of the Bill will impede progress to statehood.

61 Senate, *Hansard*, 12 December 1996, p. 7256. As noted in the previous Chapter, an attempt to move a similar motion by Rt Hon Ian Sinclair MP in the House of Representatives was unsuccessful.

3.38 The Committee received conflicting evidence on whether the external affairs power, s. 51(29) of the Constitution, empowers the Commonwealth to enact a national euthanasia law.

3.39 Those who believed that the external affairs power would support national legislation referred primarily to article 6(1) of the International Covenant on Civil and Political Rights (ICCPR). This article provides: "Every human being has the inherent right to life. This right shall be protected by law. No one shall arbitrarily deprived of his life."

3.40 Mr George Williams, senior lecturer in law at the Australian National University, referred the Committee to an article in *The Australian* on 22 October 1996 in which he and Ms Natasha Cica wrote: "It seems the Commonwealth could ... rely on articles of the covenant [ICCPR] and use the external affairs power to enact a national euthanasia law".

3.41 When Mr Williams appeared before the Committee, he addressed this issue in his opening statement. He said that:

there are great problems with the Commonwealth seeking to legislate to cover the states as well as the territories. However, in this as well as in many other areas, the constitutional law is untested and the final result is unclear. ... It could ... seek to regulate euthanasia in the states to a limited fashion by relying perhaps on the external affairs power, which is untested in this aspect. I think it is more likely than not that you could not rely on that power but, again, it is untested.⁶²

3.42 The Attorney-General's Department told the Committee:

In our view, the external affairs power would not support an anti-euthanasia measure. As the international law stands at the moment, there is no international customary law which obliges states to enact such anti-euthanasia laws. ... There is no express treaty provision which deals with euthanasia, so any law would have to be argued on the basis of an application of the right to life in article 6 of the International Covenant on Civil and Political Rights. It is clear from the travaux préparatoires, the preparatory works, that it was not intended at the time to cover euthanasia. It was regarded as too hard an issue for the international community to deal with.⁶³

3.43 Father Frank Brennan also commented on the possibility of a national law on euthanasia supported by the external affairs power:

You might raise some esoteric arguments about the external affairs power and whether or not euthanasia is contrary to international law. ... Clearly, to argue that the taking of a person's life at their request is an arbitrary taking of life is a very long bow. Even with

62 *Evidence*, Mr G Williams, p. 210.

63 *Evidence*, Attorney-General's Department, p. 214. See also *Evidence*, Mr G Williams, p. 213-14; *Submission No. 4024*, Ms A Twomey, p. 12-14.

the exigencies of international law, that would be a very big ask. Therefore, I do not think that under the external affairs power such a law could be passed.⁶⁴

3.44 Professor George Zdenkowski prepared a paper for the Human Rights and Equal Opportunity Commission which examined the relevance of international human rights law to euthanasia issues. He considered whether the RTI Act was contrary to article 6(1), and concluded:

it is arguable (but by no means clearcut) that the legislation does not violate article 6(1) ICCPR (or any of its other provisions), given its very limited scope and extensive statutory safeguards.⁶⁵

3.45 The Committee notes, however, that if a State were to enact legislation like the RTI Act, the Commonwealth could attempt to frustrate its operation by piecemeal application of its constitutional powers. The Committee was told that amongst the possibilities that the Commonwealth could explore are: the use of the corporations power to prevent corporations having any role in the State scheme; the use of the appropriations power to limit remuneration to doctors acting under the scheme; and the withdrawal of the Medicare provider number of those doctors.⁶⁶

3.46 The concerns of Aboriginal people about the RTI Act are addressed below. If a State enacted legislation like the RTI Act, the Commonwealth might wish to ensure that it did not impact on Aboriginals. The Committee was told that s. 51(26) of the Constitution, the race power, would enable the Commonwealth to legislate to prevent this impact.⁶⁷

64 *Evidence*, Fr F Brennan, p. 208.

65 G Zdenkowski, *The International Covenant on Civil and Political Rights and Euthanasia: A Report to the Human Rights and Equal Opportunity Commission*, October 1996, p. 27. See also *Submission No. 4524*, Dr M Otlowski, p. 17 ("in order to be meaningful, the right to life must be a right which is capable of being waived").

66 *Evidence*, Mr G Williams, pp. 210-11.

67 *Evidence*, Mr G Williams, p. 210; *Evidence*, Attorney-General's Department, p. 215.

CHAPTER 4

LEGAL ISSUES

Introduction

4.1 In this Chapter the Committee considers legal issues arising from the use of particular terminology in Bill. At the time the Bill was referred to the Committee the concern was with its possible impact on the Northern Territory's Criminal Code. As the Committee gathered evidence it became clear that this was at best a symptom of a more fundamental concern that the Bill might create uncertainties due to the terminology it used.

4.2 In reviewing these matters the Committee was assisted by advice from officers of the Attorney-General's Department whom the Attorney-General made available. They told the Committee that as the Bill was a private member's bill, the Department did not have any role in its preparation.¹ In assisting the Committee, the Department said it was not representing any policy position in relation to the Bill,² and it did not make a submission to the Committee.

Claims that the Bill would produce uncertainty

4.3 The use in the Bill of the phrase "intentional killing" gave rise to claims that legal uncertainty would result from enactment of the Bill. The following sections set out:

- the basis of the claims that the Bill will create legal uncertainty;
- an assessment of the extent of the uncertainty;
- an assessment of the practical impact of the uncertainty created; and
- a consideration of whether the Bill could and should be amended to reduce the uncertainty.

The basis of the claims

4.4 The Bill uses the term "intentional killing" in three places. The Territories are denied the power to make laws which permit "the form of intentional killing of another called euthanasia (which includes mercy killing) ...". However, they are expressly said to have the power to legislate for:

- (a) the withdrawal or withholding of medical or surgical measures for prolonging the life of a patient but not so as to permit the intentional killing of the patient;
- (b) medical treatment in the provision of palliative care to a dying patient, but not so as to permit the intentional killing of the patient;

1 *Evidence*, Attorney-General's Department, p. 197.

2 *Evidence*, Attorney-General's Department, pp. 192, 197.

4.5 Thus the scope of what the Bill denies and what it expressly allows both depend on the meaning given to "intentional killing". It was put to the Committee that the phrase did not have a clear, generally accepted meaning in the law. The phrase is not defined in the Bill.

4.6 The legal arguments that the Committee received became very technical and complex. On one view, that in itself is evidence that enactment of the Bill will produce uncertainty.³ What follows is of necessity a simplified outline of the arguments and the major points of difference.

4.7 In essence, the issue was whether "intentional killing" includes cases where a doctor takes action with the best of intentions (to avoid futile treatment or to optimise pain relief) but knows that the action will cause (or accelerate⁴) the death of the patient.

4.8 Both the Northern Territory's *Natural Death Act 1988* and the ACT's *Medical Treatment Act 1988* permit doctors to withdraw treatment in some circumstances, even though the doctor knows that death will result. In addition, the Medical Treatment Act creates a right for patients to receive relief from pain and suffering to the maximum extent reasonable under the circumstances. This may include cases where the drugs given for pain relief may also hasten death.

4.9 The Committee was given detailed arguments that the Bill would or might affect these Territory laws and create uncertainty over the scope of the Territories power to legislate. For example, the legal analysis annexed to the submission from the ACT Government suggested that, if the Bill were passed in its present form, the ACT Medical Treatment Act "would be invalid in toto".⁵ The ACT Government said:

We believe that the legislation is sufficiently ambiguous as to create uncertainty about the operation of our Medical Treatment Act in the ACT. That is an act designed to reinforce the protocols of the palliative care practices in the territory. Doctors and nurses involved in this area would undoubtedly be uncertain about the application of the law as a result of this legislation and would be, I think, much more likely to be involved in litigation of some sort as a result of the passing of this federal act.⁶

4.10 The Northern Territory Government's submission had opinions from four Queen's Counsel and an officer from its Attorney-General's Department appended. The submission noted that expert views differed on whether the Bill would invalidate provisions in the Territory's *Natural Death Act 1988*.⁷ The Royal College of Nursing, Australia and others also

3 *Evidence*, Royal College of Nursing, Australia, p. 164.

4 Attorney-General's Department, Criminal Law Division, "Briefing note on the Euthanasia Laws Bill 1996", 10 December 1996, para. 27 states: "In relation to palliative care, it should be noted that the accelerating of death is, in the law of homicide in Australia and England, equivalent to the causing of death".

5 *Submission No. 4048*, ACT Government, p. 21.

6 *Evidence*, ACT Government, p. 183.

7 *Submission No. 3345*, NT Government, pp. 24-25.

raised concerns that enactment of the Bill would lead to legal uncertainty over what matters it affected.⁸

4.11 However, the Committee also received legal opinions from Mr Joseph Santamaria QC to the effect that the Bill would not produce the uncertainty claimed by the Territory Governments.⁹ His submissions were similar to the views of Mr Tom Hughes QC.¹⁰

An assessment of the extent of the uncertainty

4.12 A preliminary question is which body of law a court would look to in order to determine the meaning of "intentional killing" in the Bill.

4.13 Mr Santamaria stated:

In my submission, the correct approach to interpretation of the word "intentional" is that, since the *Bill* deals with matters relating to the law of homicide, it is a logical starting point to assume that Parliament intends that the word "intentional" when used in the *Bill* has the same meaning as it does in relation to the law of homicide. When, as my earlier analysis demonstrates, this meaning results in a logical and coherent operation of the *Bill* consistent with the intentions of its Parliamentary proponents, there is no reason to depart from that interpretation.¹¹

4.14 An uncertainty in a provision creating an offence of intentional killing would be resolved by applying the rule that uncertainty in a criminal statute is to be resolved in favour of the accused. However, the Attorney-General's Department noted that the Bill is a part of a constitutive law, not a criminal statute, so there is no presumption that "intentional" should be interpreted narrowly.¹² Mr Santamaria agreed with this.¹³

4.15 If the law of homicide is to be used, the question then arises of which jurisdiction's law of homicide would apply. The Committee put this to Mr Geoffrey Dabb of the Attorney-General's Department who responded:

I think the only fair answer is that it is uncertain. One can imagine many different arguments being brought from different directions

8 *Submission No. 4552*, Royal College of Nursing, Australia, pp. 3-4; *Evidence*, Royal College of Nursing, Australia, pp. 163-64, 169. See also for example, *Submission No. 3617*, Prof T Campbell, p. 1; *Submission No. 3755*, Mr G Williams, p. 1; *Submission No. 4531*, Ms N Cica, p. 2; *Submission No. 7305*, Mr M Eburn, p. 7; *Submission No. 8756*, Ms M Wallace, pp. 3-5.

9 *Submission Nos. 4504 and 4054a*, Mr J Santamaria QC.

10 On 22 October 1996, Mr Hughes QC provided an opinion to the Northern Territory Government, and this was attached to the Government's submission to the Committee.

11 *Submission No. 4054a*, Mr J Santamaria QC, para. 57.

12 Attorney-General's Department, Criminal Law Division, "Briefing note on the Euthanasia Laws Bill 1996", 10 December 1996, para. 31.

13 *Submission No. 4054a*, Mr J Santamaria QC, para. 57.

about the meaning of 'intentional'. If it has a narrow meaning in a particular jurisdiction which serves the purpose of a party in litigation, no doubt they will contend that is the applicable one. But I would think the mere fact that the law of homicide varies considerably as between the jurisdictions concerned is a reasonably strong argument against saying that you simply go to what it means in the law of homicide.

Senator COONAN – Do I take it from that that what you are really saying is that the bill means different things in different territories because homicide laws are different? Is that sensible or defensible – how would you see it?

Mr Dabb – No, I would have difficulty with that proposition. I think the bill must be read as intending to prevent legislators making certain kinds of laws and that that kind of law that cannot be made is the same in all jurisdictions. I think logically you would have to take that view.

Senator COONAN – It is a very difficult area though, isn't it? It is not certain at all.

Mr Dabb – Yes. In other words, if one were to produce a draft provision – I could give examples of provisions that might be valid or not depending on the view taken of intentional killing – they would either be valid or not in the ACT or in the Northern Territory. The result would not be different depending on where they were enacted.¹⁴

4.16 The question of which jurisdiction's homicide law applies is of major significance only if there are differences that are relevant to interpreting the meaning of "intentional killing". In the Northern Territory, the law on homicide is contained in its Criminal Code. The relevant law in the Australian Capital Territory and Norfolk Island is based largely on the common law.

4.17 The Committee received differing views on whether the Northern Territory Criminal Code excluded consideration of common law principles and cases in this area. The view from the Territory's lawyers was that it did.¹⁵ Opinions from Mr Tom Hughes QC and Mr Joseph Santamaria QC argued that a court would look to common law principles to resolve any uncertainties in the Code.¹⁶ They concluded as a result that the law as to "intentional killing" was the same in the Northern Territory as in a jurisdiction relying on common law principles.

4.18 The Attorney-General's Department said: "It is a question of some difficulty whether the law of homicide under the Code is materially different for present purposes from the law of homicide in an Australian common law jurisdiction."¹⁷ However, it said that "it seems likely"

14 *Evidence*, Attorney-General's Department, p. 205.

15 See for example the opinion of the NT Director of Public Prosecutions, Mr Rex Wilde QC, 28 October 1996, p. 2; and the Memorandum of Advice prepared by Mr Jack Karczewski, 28 October 1996, p. 1.

16 Advice of Mr T Hughes QC, 22 October 1996, para. 7; *Submission No. 4504a*, Mr J Santamaria QC, paras 13-18.

17 Attorney-General's Department, Criminal Law Division, "Briefing note on the Euthanasia Laws Bill 1996", 10 December 1996, para. 35.

that the High Court would not regard the Code as excluding all reference to common law principles.¹⁸

4.19 The question of possible differences between the law on "intentional killing" in the different jurisdictions largely reflects the fact that the law in all Australian jurisdictions is uncertain in the context of end-of-life medical decision-making. Mr Dabb of the Attorney-General's Department told the Committee: "in our view there is already a large amount of uncertainty in the law in this area, because cases simply are not brought".¹⁹

4.20 Mr Dabb pointed out that law enforcement authorities have not sought to test the limits of the law and in some respects the law on end-of-life medical decision-making is simply not being enforced.²⁰ As a result there are no decisions of Australian courts to provide direct guidance.²¹ There are a few decisions from overseas common law jurisdictions such as England and New Zealand. It was generally assumed that these would be followed by Australian courts, but some questioned this assumption.²²

4.21 The Attorney-General's Department noted that English cases refer to a rule that a doctor caring for a dying patient may lawfully administer pain-killing drugs despite the fact the he or she knows that an incidental effect of doing so will be to shorten the patient's life. The Department said "it is uncertain whether the rule *as stated* is part of the law in all common law jurisdictions in Australia ... [and a] degree of further uncertainty exists as to Code jurisdictions ...".²³ The Department said if the rule were to be adopted here, "which seems probable as to general principle, if uncertain as to reasoning or detail", many uncertainties would nonetheless remain on matters of significant detail.²⁴

4.22 Against this background of uncertainty, the evidence presented to the Committee indicated that there are two separate ways of categorising "intention" in the law of homicide, a wider and a narrower one. The wider one treats a death that is foreseen as certain as a death that is "intended". The Attorney-General's Department explained: "the intention sufficient for

18 Attorney-General's Department, Criminal Law Division, "Briefing note on the Euthanasia Laws Bill 1996", 10 December 1996, para. 37. See also *Evidence*, Attorney-General's Department, p. 199.

19 *Evidence*, Attorney-General's Department, p. 193 and similarly at pp. 200, 202.

20 *Evidence*, Attorney-General's Department, pp. 203, 206. See also the Opinion of the NT Solicitor-General, Mr T Pauling QC, 16 September 1996, p. 5: "Every inquiry of substance has found a huge "grey area" where now doctors roam unsupervised by the law".

21 Attorney-General's Department, Criminal Law Division, "Briefing note on the Euthanasia Laws Bill 1996", 10 December 1996, paras. 5, 13. See also *Submission No. 4524*, Dr M Otlowski, p. 3: "as a result of the serious discrepancies which exist between the legal principles and the law in practice, there is no established legal precedent with reference to which medical decisions in respect of terminal patients can be made and evaluated".

22 See *Evidence*, Northern Territory Solicitor-General, Mr T Pauling QC, pp. 8, 256 for an example of the view that Australian law is increasingly diverging from English common law principles.

23 Attorney-General's Department, Criminal Law Division, "Second briefing note on the Euthanasia Laws Bill 1996", 14 February 1997, p. 1 (emphasis in original). See also for example *Submission No. 4048*, ACT Government, p 18 which notes that relevant English decisions on doctor-assisted suicide have yet to be followed in Australia and states that they cannot be held to be the law in the ACT.

24 Attorney-General's Department, Criminal Law Division, "Second briefing note on the Euthanasia Laws Bill 1996", 14 February 1997, p. 1.

murder encompasses both an intention to kill *and* an intention to do an act while foreseeing that the death of another will be a probable result".²⁵

4.23 The Department drew the Committee's attention to s. 5.2(3) in the Schedule to the Commonwealth's *Criminal Code Act 1995*, which is not yet in force. This provides: "A person has intention with respect to a result if he or she means to bring it about or is aware that it will occur in the ordinary course of events". Mr Dabb told the Committee that this definition "is the one on which – in relation to Commonwealth statutes, in any event – we assume the courts will interpret intention or intentionally ...".²⁶

4.24 The narrower approach to "intention" argues that there are two distinct categories. As Mr Santamaria QC put it: "the High Court has distinguished two mental states sufficient for murder: (1) intent to kill or cause grievous bodily harm; (2) knowledge of likely consequences".²⁷ Only the former constitutes "intention" on this approach.

4.25 Mr Santamaria did not agree that the definition in the *Criminal Code Act 1995* would be relevant. He pointed out that the Code will not come into general operation until the year 2000,²⁸ and in the meanwhile "the definition of 'intention' that applies for the purposes of most Commonwealth criminal statutes is the common law definition".²⁹ He noted that in the discussions that led to the Code definition it was acknowledged that the definition being adopted was one that was broader than the common law position.³⁰

4.26 Mr Dabb responded to Mr Santamaria on this point:

The purpose of the reference to the *Criminal Code Act 1995* was not to suggest that the definition of 'intention' contained therein governed of its own force the meaning of 'intentional' in the Bill. Rather the purpose was to show the distinction - that had been adopted in Commonwealth legislation because it was a clear and workable distinction - between on the one hand acts done with a

25 Attorney-General's Department, Criminal Law Division, "Briefing note on the Euthanasia Laws Bill 1996", 10 December 1996, para. 27 (emphasis in original).

26 *Evidence*, Attorney-General's Department, p. 201. Mr Dabb also said: "In some of the submissions there has been a confusion between these two notions of intention and recklessness. I do not suggest for a moment that the phrase 'intentional killing' would encompass recklessness. That is something quite different." (p. 201)

27 *Submission No. 4054a*, Mr J Santamaria QC, para. 30.

28 Section 2 of the *Criminal Code Act* provides:

Commencement

2.(1) Subject to subsection (2), this Act commences on a day to be fixed by Proclamation.

(2) If this Act does not commence under subsection (1) within the period of 5 years beginning on the day on which this Act receives the Royal Assent [15 March 1995], it commences on the first day after the end of that period.

29 *Submission No. 4054b*, Mr J Santamaria QC, para. 7.

30 *Submission No. 4054b*, Mr J Santamaria QC, para. 9.

moral certainty that a result will follow and acts done with an awareness of a substantial risk that a result would follow.³¹

4.27 The Bill refers to "intentional killing of another called euthanasia". Given the degree of uncertainty that surrounds the meaning of "euthanasia" it is not clear that its use in the Bill assists in resolving differences over the interpretation of "intentional killing". Mr Dabb referred to the possibility that "euthanasia" did not cover cases in which the doctor's intention was mixed – partly pain relief and partly hastening death.

If euthanasia is defined only as it is in that meaning – which I think it probably does have here where you really desire the death; it is not just a just a mixed kind of thing – then there is an argument that that does help to support the argument that a narrower view is given to intentional killing, but I think it is still very doubtful.

4.28 The two approaches lead to different interpretations of "intentional killing" in the Bill. As Mr Santamaria explained, on the approach he advocated, the Bill:

prevents the legislature of a Territory from making laws which authorize medical practitioners from taking steps which they intend will kill their patients; it does not deprive those legislatures from authorizing such conduct where it is known that one of its likely consequences is the death of the patient. Accordingly, such a legislature is not deprived of power to enact any law which specifies that a medical practitioner may prescribe and administer drugs for the relief of pain notwithstanding that the medical practitioner knows that it is likely (or even certain) that his or her patient will die; however, the legislature is deprived of power to enact a law which provides that a medical practitioner may prescribe drugs in order to kill his or her patient. Withdrawal of treatment on the grounds that it is futile or burdensome is to be similarly analysed.³²

4.29 In contrast, the approach suggested by the Attorney-General's Department envisaged the possibility that the term "intentional killing" might have different meanings in different clauses in the Bill, and focused on the possible uncertainties created by the clauses in the Bill relating to the withholding of treatment and to palliative care.³³ In this context, the Department said that on its approach "it is reasonable to regard ... [the following two cases] as possible cases of intentional killing within the meaning of the Bill":

M administers the treatment to relieve P's pain or distress knowing that the treatment *will* also shorten P's life but not desiring that result (that is to say M would take steps to avoid that secondary

31 Mr G Dabb, Attorney-General's Department, Letter to the Committee, 3 March 1997, p. 2.

32 *Submission No. 4054a*, Mr J Santamaria QC, para. 31.

33 ie. to the proposed s. 50A(2)(a) and (b) of the Northern Territory Self-Government Act as amended by the Bill: see Mr G Dabb, Attorney-General's Department, Letter to the Committee, 3 March 1997, p. 1.

result if any were available but does not believe such are or will be available, given the intention to administer the treatment).

M administers the treatment mainly to relieve P's pain or distress knowing that the treatment *will* also shorten P's life and regarding that result as an acceptable secondary consequence, not being prepared to take steps to avoid it if any presented themselves.³⁴

4.30 The Department also provided examples relating to the withdrawal of treatment.

There may well be cases of withdrawal of life-sustaining measures and of treatment in the course of palliative care where it could reasonably be said that an intentional killing of the patient had occurred. In relation to withdrawal of measures, this is illustrated by the intervenor who turns the system off to end the patient's life because the patient would be 'better off' or the doctor who turns off the system to aid a (competent) suicidal patient. Regardless of whether such conduct should be prosecuted, it is not unreasonable to say the intention was to kill the patient, whether or not others would prefer language such as 'end the patient' s suffering' or 'let nature take its course'.³⁵

4.31 Mr Dabb summed up the views put to the Committee:

Two views have emerged. One is that there is a broad meaning to be given to the expression 'intentional killing', in which case there will be a large area within which the legislatures may not legislate. The other view is that there is a very narrow meaning, in which case there would be quite a small area, and that obviously of itself is going to create uncertainty if the meaning of that expression is not specific.

The view that was put forward by the department and was adopted by some others is that the expression 'intentional killing' probably applies to situations where someone does an act knowing that a result will certainly follow from that act, as well as the situation where the person does the act with the desire or wish to bring about that result. I might call that the broader view. The narrower view is that intentional killing only refers to cases where the person doing the act really wants and desires the result to come about, and of course here we are talking about the death of the patient. So the question is: could a territory law validly say, 'A medical practitioner may administer treatment for the purpose of pain relief even though he or she knows that death will be a certain result of that act?'

Senator COONAN – Sorry to interrupt – or even probable?

34 Attorney-General's Department, Criminal Law Division, "Briefing note on the Euthanasia Laws Bill 1996", 10 December 1996, paras. 32 and 28 (emphasis in original).

35 Attorney-General's Department, Criminal Law Division, "Briefing note on the Euthanasia Laws Bill 1996", 10 December 1996, para. 31 (footnote omitted).

Mr Dabb – This is where confusion arises, and 'probable' raises other issues. I think even under the broad view of intentional killing, we would say that a person who does an act for a certain purpose, knowing that it is foreseeing only a possibility or even a probability, is probably not intentionally killing. That would be an extremely broad view. I think such conduct could be authorised by territory legislature consistently with the terms of this prohibition. But we are left with these two – the narrow compartment and the broad compartment – and which is it?³⁶

4.32 A further factor arises because in some cases where the death was foreseen, the law treats the conduct leading to it as justified. Mr Santamaria drew the Committee's attention to the following High Court observation in *R v Crabbe*:

not every fatal act done with the knowledge that death or grievous bodily harm will probably result is murder. The act may be lawful, that is, justified or excused by law. A surgeon who competently performs a hazardous but necessary operation is not criminally liable if the patient dies, even if the surgeon foresaw that his death was probable.³⁷

4.33 The law may treat some actions in the palliative care and withdrawal of treatment areas as justified, even though in all other respects they would be "intentional killing". However, any attempt to state exactly what actions are justified leads back to the general uncertainties in this area of the law that have already been referred to.

4.34 Analysis of whether the Bill would affect the operation of the Northern Territory's Natural Death Act and the ACT's Medical Treatment Act brought to light uncertainties in the meaning of both Acts.³⁸ It is not proposed to traverse the uncertainties here. It is sufficient to state that the effect of them is to render it impossible to give an unequivocal answer to the question whether enactment of the Bill would affect the operation of either or both of these two Acts.

Assessment of the practical impact of the uncertainty

4.35 In noting the differing legal opinions on the impact of the Bill, the Northern Territory Government argued:

The important point to make is that it is most undesirable that there be any legal doubt as to the validity or lawfulness of acts or

36 *Evidence*, Attorney-General's Department, p. 200.

37 (1985) 156 CLR 464, 470.

38 On the uncertainties in the Natural Death Act, see Attorney-General's Department, Criminal Law Division, "Briefing note on the Euthanasia Laws Bill 1996", 10 December 1996, paras. 44-47. On the Medical Treatment Act, see Attorney-General's Department, Criminal Law Division, "Second briefing note on the Euthanasia Laws Bill 1996", 14 February 1997, pp. 2-3; *Evidence*, Attorney-General's Department p. 200; *Submission No. 4054a*, Mr J Santamaria QC, paras. 38-42.

omissions done in purported compliance with the Natural Death Act. The law on the subject of death and criminal liability as to death is complicated enough, and the addition of any further legal uncertainty, no matter how small, is difficult to justify. It is submitted that the Euthanasia Laws Bill, if enacted, would give rise to considerable legal uncertainty.³⁹

4.36 The ACT Attorney-General, Mr Gary Humphries MLA, made a similar point:

I would simply say to members of this committee that, whatever the committee's views about the legislation, it is essential that they make laws which are precise and understandable from their very outset and not leave the territories in the position of not knowing exactly what the parameters and the effect of the legislation are on them.⁴⁰

4.37 Against this is the fact that there is already a high degree of uncertainty in this area of law. It apparently causes no practical problems, not least due to the fact that the law is not actively enforced. It might readily be argued that the enactment of the Bill will not alter this.

4.38 For example, the Territories are responsible for bringing prosecutions. If the effect of the Bill was thought by a Territory prosecutor to invalidate a provision conferring protection on a doctor acting in a palliative care or treatment withholding case, it would always be open to the prosecutor simply not to prosecute. Conversely, if the Territory wanted to test the law so as to resolve uncertainties, test prosecutions might be brought on admitted facts.⁴¹

4.39 However, it can be argued that the uncertainty that is generated by the Bill is of a different and more significant kind than that currently existing in that it involves powers to legislate, not just uncertain criminal laws. Mr Dabb of the Attorney-General's Department commented on this aspect of the uncertainty caused by the Bill:

I think the main difficulty with it is that it is in a constitutive statute that deals with the powers of legislatures to make laws. If legislatures are going to legislate in this area, the uncertainty of the expression will create doubt about whether those laws are in force or not and how they should be applied. That is the difficulty I see with it.⁴²

4.40 However, at the risk of oversimplification, the effect of uncertainty about Territory powers to legislate is to allow the (admittedly somewhat uncertain) common law principles to

39 *Submission No. 3345*, NT Government, p. 25.

40 *Evidence*, ACT Government, p. 185.

41 Attorney-General's Department, Criminal Law Division, "Briefing note on the Euthanasia Laws Bill 1996", 10 December 1996, para. 57. See also *Evidence*, Attorney-General's Department, p. 206.

42 *Evidence*, Attorney-General's Department, p. 203.

prevail, either directly or by using them to assist in interpreting criminal statutes.⁴³ This might be thought acceptable given that New South Wales and Tasmania, for example, continue to operate with these principles.

4.41 On the other hand, the Bill would leave the Territories with uncertain powers to clarify the present law. The course of judicial decisions interpreting this law may create a need to legislate. The Committee notes the point made by Mr Dabb about the present law: "If there are test cases it might demonstrate perhaps surprising, perhaps unwanted, aspects of the law, which might give rise to the need for further legislative amendment".⁴⁴

4.42 The Committee notes that if this happens, there is at least a possibility that it will fall to the Commonwealth Parliament to do the legislating, because the combined effect of the Bill and the judicial decisions might be that the Territories lack the power to do so.

4.43 Alternatively, it may lead to dispute between the Commonwealth and the Territory involved as to whether or not the Territory has the legislative power to remedy the situation. The Attorney-General's Department also pointed out that if, after the Bill comes into operation, Territory authorities expressed a different view about the effect of it from that taken by Commonwealth legislators, community uncertainty could be created about how the law was to be applied.⁴⁵

4.44 The Committee notes that if there are cases of genuine doubt, then Commonwealth legislation will be the only safe solution.

Should the Bill be amended to reduce the uncertainty?

4.45 The Committee considered whether the meaning of "intentional killing" could be clarified in the Bill. As indicated above, Mr Santamaria believed that the meaning was clear. He therefore argued that "any further definition would be superfluous and would risk clouding what is at present a clear position".⁴⁶

4.46 The Attorney-General's Department did not consider the meaning was clear. Accordingly the Committee asked Mr Dabb how the Bill might be improved. He replied:

On the particular point – and I am not making this as a concrete proposal – of the scope of unlawful killing, it would be a little clearer to me if it said 'does not permit conduct for the purpose of killing the patient'. 'Purpose' to me would be a clearer word. That has got an ambiguity, which is here in any event, which is what about multipurpose acts? What if the purpose of the act is mainly to

43 See Attorney-General's Department, Criminal Law Division, "Briefing note on the Euthanasia Laws Bill 1996", 10 December 1996, para. 33 (ACT withdrawal of treatment), para. 34 (ACT palliative care), para. 51 (NT withdrawal of treatment).

44 *Evidence*, Attorney-General's Department, p. 193 and similarly at pp. 200, 202.

45 Attorney-General's Department, Criminal Law Division, "Briefing note on the Euthanasia Laws Bill 1996", 10 December 1996, para. 57.

46 *Submission No. 4054a*, Mr J Santamaria QC, para. 51.

relieve pain, but the person administering the treatment thinks it is also quite a good outcome that this person will not wake up in the morning?

Senator COONAN – Could you say 'sole purpose'?

Mr Dabb – That is clearer, but I think we can all imagine how mixed purposes would be suggested or could not be disproved. How could it ever be proved in a criminal case that a defendant did not have at least a partial purpose of achieving this objective?

Senator COONAN – Maybe it could be 'main purpose'.⁴⁷

4.47 The Committee notes that Mr Dabb said he was not necessarily advocating that the amendment he identified should be made:

Beyond pointing to the particular difficulty – I certainly think there is a difficulty – I would not necessarily suggest that something has to be done about it. There are many areas in legislation where fairly vague and imprecise expressions are used and the courts are left to apply them in a sensible way.⁴⁸

4.48 Mr Dabb later commented:

there may be advantage in trying to make the language more precise – that might improve it – but it would be an exercise of some difficulty and you would need to be precise about the result you wanted to achieve and confident that you were improving the language. If the answer is that the proposer of the bill or the draftsman does not really think they can do much better than this, then maybe they stop at a point where there is a certain amount of uncertainty, and it is a matter for people who consider the bill whether they are prepared to pass the bill on that basis.⁴⁹

4.49 The ACT Attorney-General, Mr Humphries, was asked by the Committee why he thought that the term was not defined in the Bill. He replied: "I suggest it is very difficult to define what 'intentional killing' means".⁵⁰

4.50 Fr Frank Brennan offered an amendment if one were thought to be necessary to avoid uncertainty:

I do not think a law of this sort can dispel all the doubts that exist in all the different jurisdictions about the key elements of criminal law. If there were any real concern about that, I think that could readily be remedied by, for example, adding a clause, 'For the avoidance of

47 *Evidence*, Attorney-General's Department, p. 202.

48 *Evidence*, Attorney-General's Department, p. 204.

49 *Evidence*, Attorney-General's Department, p. 204.

50 *Evidence*, ACT Government, p. 185.

doubt, this act has no effect on various acts,' and you could list them – the Natural Death Act, the Criminal Code Act et cetera.⁵¹

4.51 The Committee notes that the difficulty with this suggestion is that aspects of the Northern Territory's Natural Death Act and the ACT's Medical Treatment Act are simply unclear. This was referred to above. Mr Santamaria examined the ACT Act and noted the uncertainties. He observed:

if the Act does allow directions made with the intention of bringing about death, eg, directions to withdraw treatment which is neither futile nor burdensome from incompetent patients *in order to kill them*, then the *Bill* would invalidate the use of such directions. In my submission, this would be a desirable and welcome operation of the *Bill*; moreover, it would be consistent with its objective of prohibiting the legalisation of euthanasia by Territory legislatures.⁵²

4.52 The Committee notes that if the Bill were amended so as to preserve the Medical Treatment Act it would risk preserving something that permitted actions contrary to the main aim of the Bill. Furthermore, it might add further uncertainty to the meaning of "intentional killing". A court might assume that what the preserved Acts allowed was not within the meaning of the phrase. As a result of the drafting deficiencies in the Acts, this might generate confusion rather than add certainty to the interpretation of the Bill.

Operation of the "for avoidance of doubt clause"

4.53 The amendments that the Bill would make to the Northern Territory Self-Government Act include a clause headed "application" (Schedule 1, clause 2). This provides that "for the avoidance of doubt" the RTI Act "has no force or effect as a law of the Territory" except as regards things done before the Bill comes into force.

4.54 The Committee assumes that the doubt the drafter of the Bill was addressing was whether the removal of a power to legislate voided laws already enacted under that power with retrospective effect or only from the date the power was removed.

4.55 The Committee had two concerns about this clause. The first was whether it was effective to achieve its stated aim. The second was due to the fact that it referred only to the RTI Act.

4.56 In relation to the first concern, the Committee noted a comment made by the majority of the High Court in the *Capital Duplicators Case* in 1992 that the Parliament

has no power under the [ACT] Self-Government Act to disallow any [excise] duty imposed by [an enactment of] the Legislative Assembly; the Parliament must, if it wishes to override the

51 *Evidence*, Fr F Brennan, pp. 211-12.

52 *Submission No. 4054a*, Mr J Santamaria QC, para. 41 (emphasis in original).

enactment, pass a new law to achieve that result. It cannot repeal or amend the enactment.⁵³

4.57 This can be read as saying that the Commonwealth does not have the power to directly repeal a Territory law. The Committee asked if the bare statement in clause 2 of Schedule 1 of the Bill that a Territory law has "no force or effect" might be construed as an attempt to repeal that law, and as such therefore ineffective. The Attorney-General's Department said that the clause would be effective.⁵⁴

4.58 The result of enactment of the Bill would therefore seem to be to leave the RTI Act lying dormant on the NT statute book. It would revive if the Bill were to be repealed. It might also revive were the Northern Territory to become a State. This would depend on, amongst other things, the precise legal method used to make the laws of the Territory continue in force as the laws of the new State.

4.59 On the second concern, the Committee notes that the provision avoids doubt only with respect to the RTI Act. Earlier in this Chapter, the Committee noted that there was uncertainty whether enactment of the Bill would affect other legislation.

53 *Capital Duplicators Pty Ltd v Australian Capital Territory* (1992) 177 CLR 248, p. 283 Brennan, Deane and Toohey JJ (emphasis added), p. 284 Gaudron J agreeing.

54 *Evidence*, Attorney-General's Department, p. 199.

CHAPTER 5

ABORIGINAL ISSUES

Introduction

5.1 When referring the Euthanasia Laws Bill 1996, the Selection of Bills Committee recommended and the Senate agreed that this Committee inquire into and report on the impact on, and attitudes of, the Aboriginal community to the Rights of the Terminally Ill Act.

5.2 Several submissions maintained that the Euthanasia Laws Bill 1996 should be passed because the Act it seeks to invalidate, the RTI Act, has an adverse impact on the Aboriginal community in the Northern Territory.

5.3 It should be noted that the 1991 census records a Northern Territory Aboriginal population of 39,926, being 23 per cent of the total Northern Territory population of 175,836. Many aborigines live in remote communities.

5.4 In this Chapter the Committee reviews evidence it received on the impact on and attitudes of the Aboriginal community. In particular the Committee will address the following:

- Aborigines and the RTI Act;
- Aboriginal attitudes to euthanasia; and
- impact on Aborigines and in particular their willingness to access medical services.

Aborigines and the Rights of the Terminally Ill Act

5.5 The Committee heard evidence on the development of the legislation in the Northern Territory and the extent of the involvement of Aborigines in this process. Submissions raised concerns about:

- consultation and the legislative process;
- the education campaign conducted following the enactment of the legislation;
- possible misinformation; and
- the application of the legislation to Aborigines.

Consultation with Aborigines during the legislative process

5.6 The process leading to the enactment of the RTI Act was described in Chapter 2. In relation to the question of consultation with Aborigines at this early stage, Mr Perron, the sponsor of the Act, advised the Committee:

I did not seek out Aboriginal spokespersons or elders to discuss the proposal with. I introduced it into parliament as a private member relying on the basis that it would be a hotly debated subject. Having relatively small electorates, as territory MLAs do, I believed that individual members would consult their electorates and bring their electorates' views back.¹

5.7 Debate on the bill was adjourned to May 1995 pending a report by a select committee of the Legislative Assembly (the 'NT Select Committee'). Before the NT Select Committee began its hearings it sent information relating to its inquiry and the RTI Bill to all Aboriginal communities in the Northern Territory. It also offered to visit individual Aboriginal communities.² The NT Select Committee held hearings in Darwin, Alice Springs, Hermannsburg, Tennant Creek, Katherine, Yirrkala, Nhulunbuy, Milingimbi and Ngiuu.³

5.8 The NT Standing Committee heard evidence that:

- (1) concepts of euthanasia and suicide were unfamiliar to Aborigines, and the people of Hermannsburg for instance had no words for them in their language;
- (2) however, old people who are ready to die may stop eating and drinking, at least after consultation with their families;
- (3) the difficulty with a person providing assistance to make a patient die is that, whatever the assister's intentions, they could be viewed as an instrument of sorcery or payback in the larger picture, and possibly as a murderer;
- (4) as a result, euthanasia could result in payback against a person giving assistance or otherwise involved, such as a doctor, relative, interpreter or person signing a prescribed form on behalf of the patient;
- (5) euthanasia was regarded at least by some as morally, ethically and traditionally wrong;
- (6) hospitals were often feared or regarded as culturally alien;
- (7) there was a risk that Aborigines would fear that they could be killed without their consent, which had the potential to deter them from attending hospital;

1 *Evidence*, Mr M Perron, p. 37.

2 NT Legislative Assembly, *The Right of the Individual or the Common Good?*, Report of the Inquiry by the Select Committee on Euthanasia, May 1995, vol. 1, p. 2.

3 NT Legislative Assembly, *The Right of the Individual or the Common Good?*, Report of the Inquiry by the Select Committee on Euthanasia, May 1995, vol. 1, p. 3.

(8) English is a fourth or fifth language for some Aborigines in the bush, giving rise to obvious difficulties with communication and education.⁴

5.9 During the Legislative Assembly's subsequent consideration of the RTI Bill an amendment was agreed to that required a qualified interpreter (with level 3 accreditation from the National Accreditation Authority for Translators and Interpreters) to be present where the medical practitioner and the patient did not share the same language.⁵

5.10 In voting on the RTI Bill, the then Member for Arnhem, a traditional Aborigine, voted in favour of the bill. The Member for Arafura, Mr Rioli, also Aborigine, voted against the bill.

5.11 As noted in Chapter 2, there was a delay from the date the Act was passed on 25 May 1995 until it entered into operation on 1 July 1996. Shortly after the RTI Bill was passed a working party comprising officers of the Northern Territory Attorney-General's Department and Territory Health Services was established. It was required, *inter alia*, to develop and recommend a community education program.⁶

Education campaign

5.12 The submission of the Northern Territory Government advised:

Territory Health Services was given responsibility for the education program [relating to the RTI Act] in February 1996. All formal components of the Rights of the Terminally Ill Community Education program with the exception of the Aboriginal education program were completed at end November 1996. The Aboriginal education program is scheduled to complete on 1 April 1997. A budget of \$297,455 was approved by the Government and, of this amount, \$110,000 was devoted to informing Aboriginal communities and Aboriginal health care workers about the legislation, with particular emphasis on its voluntary nature.⁷

5.13 Two groups were formed to advise on the implementation of the education program: an Advisory Group (with a general community education brief) and an Aboriginal Education Reference Group. The latter was formed in April 1996 and chaired by the Chief Health Officer, with 20 members drawn from the following organisations:

- Green Ant Research, Arts and Publishing
- the Aboriginal Development Unit
- the North Australian Aboriginal Legal Aid Service

4 NT Legislative Assembly, *The Right of the Individual or the Common Good?*, Report of the Inquiry by the Select Committee on Euthanasia, May 1995, vol. 1, p. 22 ff.

5 NT, *Parliamentary Record (Minutes)*, 25 May 1995, p. 275.

6 *Submission No. 3345*, NT Government, p. 27.

7 *Submission No. 3345*, NT Government, p. 32.

- Wurli Wurlinjang Health Service
- the Aboriginal and Islander Medical Support Services
- the Office of Aboriginal Development
- the Faculty of Aboriginal and Islander Studies
- the Tangentyre Council
- the Territory Health Service and
- the Attorney-General's Department.⁸

5.14 Mr Chips Mackinolty of Green Ant Research, Arts and Publishing ('Green Ant') was appointed to devise an Aboriginal education program. Mr Mackinolty told the Committee that he had worked with a number of Aboriginal organisations between 1981 and 1990, including some time as a research officer and journalist with the Northern Land Council; since 1990 he has been self employed, principally as a consultant in relation to Aboriginal issues.⁹

5.15 The primary object of the education program was described by the Chief Health Officer of the Northern Territory, Dr Shirley Hendy, as being to provide unbiased and factual information on euthanasia to Aboriginal communities.¹⁰

5.16 In mid-1996 Green Ant began meeting with Aboriginal community and health organisations in the Territory, and the Northern Territory Government's submission to the Committee advised that information sessions were conducted in 21 locations across the Northern Territory. Mr Mackinolty gave evidence that education sessions were conducted face to face, with a male and female interpreter. Where appropriate, separate sessions were held for males and females.¹¹

5.17 Mr Mackinolty told the Committee that approximately 800 Aborigines attended the education sessions.¹² The Northern Territory Government advised that as at December 1996, the Tiwi Islands, Port Keats and Daly Rivers areas were the main communities not visited by Green Ant; those communities wished to defer education until the fate of the RTI Act had been determined by the Senate and, if relevant, the High Court. As at December 1996 written and audio material was in the process of being translated into 25 Aboriginal languages, with tapes to be distributed to health clinics, community councils and Aboriginal media outlets.¹³

5.18 Mr Mackinolty submitted reports to the Aboriginal Education Reference Group dated 3 June, 28 June, 9 July, 23 July, 19 September and 9 October 1996. The reports stated:

- Aboriginal opposition to the RTI Act was near universal;¹⁴

8 *Submission No. 3345*, NT Government, p. 34.

9 *Evidence*, Mr C Mackinolty, p. 153.

10 *Evidence*, Dr S Hendy, p. 12.

11 *Evidence*, Mr C Mackinolty, p. 152.

12 *Evidence*, Mr C Mackinolty, p. 152.

13 *Submission No. 3345*, NT Government, pp. 37 and 38.

14 Mackinolty C, Report to Aboriginal Education Reference Group dated 28 June 1996: *Rights of the Terminally Ill Act: Education Program*, p. 1.

- Despite continuing education, Mr Mackinolty has been concerned that the availability of euthanasia, taken with the fears it engendered, had the potential to damage the hard-won reputation of the Territory Health Service among the Aboriginal population;¹⁵
- There had been some hostility to the education team from non-Aboriginal clinic staff, and at least one case of ‘active obstructionism’. One central Australian community health service had boycotted a meeting, although it had sent a representative to a subsequent meeting;¹⁶ and
- In later stages of the campaign some previously hostile Aboriginal groups had become more receptive, and there was a genuine interest from health workers and community leaders in finding out exactly what was in the legislation and a widespread community desire ‘to at least know what is in the legislation’, despite a distaste for its content.¹⁷

5.19 Mr Mackinolty gave evidence that he was confident that most of the 800 Aborigines who attended the Green Ant education sessions understood that euthanasia was voluntary.¹⁸ However, even though he personally supported his own right to euthanasia as a non-Aboriginal, his experience in conducting the education campaign had brought him to favour the repeal of the RTI Act because of its potential to deter Aboriginal people from seeking prompt medical attention.¹⁹

5.20 The Committee also received evidence that one Aboriginal organisation chose to say as little as possible to their constituency about euthanasia, fearing that education, rather than clearing up confusion, would only intensify existing fears:

[The Board of the Anyinginyi Congress] decided to have nothing to do with publicising or explaining the bill, because we could not afford to be associated with the bill. There was too much risk of causing people to not turn up to the clinic as regularly.²⁰

5.21 The Committee was also advised that, even where there had been education about the RTI Act, the essentials may not have been fully understood, especially when conveyed in English:

To talk to Aboriginal people, especially Aboriginal bush people, in white man’s language, and to expect us to understand something

15 Mackinolty C, Report to Aboriginal Education Reference Group dated 28 June 1996: *Rights of the Terminally Ill Act: Education Program*, p. 3.

16 Mackinolty C, Report to Aboriginal Education Reference Group dated 23 July 1996: *Rights of the Terminally Ill Act: Education Program*, p. 1; Mackinolty C, Report to Aboriginal Education Reference Group dated 9 July 1996: *Rights of the Terminally Ill Act: Education Program*, p. 2.

17 Mackinolty C, Report to Aboriginal Education Reference Group dated 9 October 1996: *Rights of the Terminally Ill Act: Education Program*, p. 1.

18 *Evidence*, Mr C Mackinolty, p. 150.

19 *Evidence*, Mr C Mackinolty, pp. 147 and 154.

20 *Submission No. 9332*, Ms J Napurrula-Schroeder, p. 1.

like this is very hard. I have quite a bit of understanding of white man's ways but it is still difficult for me to understand this one.²¹

Possible misinformation

5.22 The NT Voluntary Euthanasia Society submitted that it believed that exploitation of the Aboriginal fear of health services was deliberately used as an emotive 'weapon' by the opponents of voluntary euthanasia, particularly the churches which it said exerted great influence in some communities. The Society contended that Aboriginal people are vulnerable to such exploitation, and it takes time for them to talk through the issues, realise that they are being manipulated, and understand the voluntary nature of the Act.²²

5.23 The Northern Territory Government noted in its submission:

One member [of the Aboriginal Education Reference Group] relayed information from a remote Aboriginal community that they wanted to hear the 'full' story about euthanasia, not just the Church story.²³

5.24 Similar allegations were made by a number of witnesses heard by the Committee in Darwin, including the Chief Minister of the Northern Territory, Mr Shane Stone and the former Chief Minister, Mr Marshall Perron.²⁴

5.25 Mr Lovegrove, a former senior Northern Territory public servant with experience in Aboriginal affairs, also suggested that Aboriginal fears of euthanasia may have been deliberately exacerbated and exploited by anti-euthanasia groups:

I express my concern, not at the right of certain ideologists to have their say, but at the misrepresentations some were making to people over whom they have an emotional hold. Where this group happens to be Aboriginal, I believe some of the frightening lies they were told about the subject were a psychological and emotional exploitation of them, as blatant as any that has ever occurred in the Territory. I have been seeing it happen on other matters in the Territory for a long time. eg. The uranium debate, land rights, mining, green issues, self government, statehood.

By way of example in this case, I happened to be recently with a group of mature and influential Aboriginals of my own generation who came from eight different communities in the Territory. They were all tribal people. We were discussing a range of important matters. During morning tea one of the ladies informally raised the matter of euthanasia and said, "We have been talking about that law

21 *Submission No. 4061*, Mr G Ntjalka Williams, Ntaria Council President, p.1.

22 *Submission No. 3101*, NT Voluntary Euthanasia Society, p. 4.

23 *Submission No. 3345*, NT Government, p. 40.

24 *Evidence*, Mr M Reed, pp. 12 and 13; Mr S Stone, p. 15; Mrs M Hickie, p. 21; Mr M Perron, p. 37.

which Marshall Perron is making next week. We are all really frightened."

Another said, "Yes. We heard about it too. They reckon the government is going to round up all the real sick people and those with V.D. and things like that and finish them off. That's not the Aboriginal way. People are frightened to go to hospital now."²⁵

5.26 On the other hand, the Reverend Djiniyini Gondarra, Executive Director of the Northern Territory Council of the Uniting Aboriginal and Islander Christian Congress, said: "We are not frightening people. We are telling them the truth about this legislation."²⁶

5.27 As has been noted, Mr Mackinolty was confident that most of the 800 people who attended the Green Ant education campaigns understood that the procedures under the Act were voluntary.

5.28 The only positive evidence of misinformation which was provided to the Committee was that certain Aboriginal Communities have been told that euthanasia could only occur in Darwin so as to put them at ease in using local health clinics. Evidence was provided from Papunya Community via Alice Springs that these statements had been provided by local doctors:

The doctor here told us it was OK and that the clinic would never have the needle like that available. We were told Alice Springs would not have it either. Only in Darwin. But a lot of people are still a bit scared.²⁷

5.29 It was also stated by Valda Shannon of the Julalikari Council who acted as the interpreter for Chips Mackinolty during the Green Ant Consultations in Tenant Creek:

We had to tell people that at Tenant Creek hospital and at Alice Springs hospital nothing like this could ever happen. Because we did not want people to decide that they were not safe at these hospitals. We had to tell them that it was only available at Darwin.²⁸

5.30 It is appreciated that this misinformation about the operation of the legislation was provided so as to encourage people to feel safe utilising local health services. However, a question arises as to whether this may pose dangers for the future if there is a death in accordance with the RTI Act at Alice Springs.

The application of the Act to Aborigines

25 *Submission No. 3116*, Mr T C Lovegrove, pp. 5 and 6.

26 *Evidence*, Reverend D Gondarra, p. 69.

27 *Submission No. 9314*, Mr S Butcher and 7 other members of the Papunya Community, p. 1.

28 *Submission No. 9344*, Ms V Shannon, Julalikari Council, p. 1.

5.31 On its face, the RTI Act applies to Aborigines and non-Aborigines alike. In practice, however, it may be difficult – perhaps impossible – for many Aborigines to use because of the interpreter provisions contained within the Act.

5.32 Section 7(4) of the Act provides:

A medical practitioner shall not assist a patient under this Act where the medical practitioner or any other medical practitioner or qualified psychiatrist who is required under subsection (1) or (3) to communicate with the patient does not share the *same first language as the patient*, unless there is present at the time of that communication and at the time the certificate of request is signed by or on behalf of the patient, an interpreter who holds a prescribed professional qualification for interpreters in the first language of the patient. (emphasis added)

5.33 Regulation 6 prescribes the professional qualifications for interpreters:

For the purposes of section 7(4) of the Act, the interpreter shall hold one of the following professional qualifications in the first language of the patient:

- (a) accreditation as a Conference Interpreter from the National Accreditation Authority for Translators and Interpreters;
- (b) accreditation as an Interpreter from the National Accreditation Authority for Translators and Interpreters.

5.34 The Committee notes that the 1991 census found that 79 per cent of Northern Territory Aborigines over the age of 5 years (25,753 persons) spoke a language other than English at home.²⁹

5.35 The Committee heard evidence that a scarcity of interpreters with a requisite qualification in Aboriginal languages would limit the ability of Aborigines to use the Act. Indeed, it was submitted that the effect of this was in substance discriminatory because many Aborigines would be denied a right extended to non-Aboriginal people.³⁰

Aboriginal Attitudes to Euthanasia

5.36 The Committee received many submissions from Aboriginal groups objecting to euthanasia on the basis that it was not 'the Aboriginal way' or that it was contrary to Aboriginal Law.

5.37 Some submissions argued that active euthanasia was not practiced by traditional Aboriginal societies and that therefore it was 'not the Aboriginal way'. For example, Mr John Nummar of the Kardu Numida Elders Council submitted:

29 *Australia's Aboriginal and Torres Strait Islander Population*, 1991 census, ABS catalogue no. 2740.0.

30 *Evidence*, Ms D Lawrie, pp. 83-83.

When someone was sick . . . [their relatives] never planned to kill the person. They would not hit the person with a stick. They would never block the person's nose.³¹

5.38 Similarly, Ms Geraldine Liddle of the Tiwi Islands submitted: "I don't believe in euthanasia. I am a descendant of the Gurindgi tribe. Euthanasia is not our way; it is not true for us. I don't want euthanasia."³²

5.39 Others argued that there were positive traditional laws against killing, or at least certain kinds of killing. Mr John Baptist Pupangmirri of Bathurst Island stated:

If a person wants to die it is up to the person to die themselves. But if I am a doctor and I give a person a right to kill themselves, if I support the person in killing themselves, then I am a murderer too. It makes me a murderer too. You cannot agree to this sort of thing. Killing is wrong. It is against the Law.³³

5.40 Similarly, the Reverend Djiniyini Gondarra contended in his submission:

Our ancient Law/Maḍayin [the Maḍayin is a foundation law common to all Aboriginal people³⁴] does not empower our Traditional Nārra/Parliaments, to create Law/Wāyuk, that give an individual the right to take the life of another. The same Law/Maḍayin states, as a principle of law, that death should be by natural causes only, except of course in the case of capital punishment.³⁵

5.41 The Committee also notes the evidence of several Aboriginal communities. For example, members of the Lajamanu Community, Warlpiri Tribe submitted:

We strongly believe that natural death is the best way. Even if the person is suffering and is in pain, the person knows and the family knows that the person will finish soon. The brothers and cousins they have the final conversation with the person who is dying and all other family members sit around the person in a big circle.³⁶

5.42 Ms Valda Shannon of the Julalikari Council also emphasised the importance of Aboriginal people being with their family at the time of death.³⁷

31 *Submission No. 5776*, J Nummar of the Elders Council of Kardu Numida Incorporated, p. 1.

32 *Submission No. 4582*, Ms G Liddle, p. 1.

33 *Submission No. 4059*, J B Pupangmirri, p.1.

34 *Evidence*, Reverend D Gondarra, p. 65.

35 *Submission No. 327*, Reverend D Gondarra, p. 1 (emphasis in original).

36 *Submission No. 9315*, Lajamanu Community, p. 2.

37 *Submission No. 9344*, Ms V Shannon, Julialikari Council, p. 1.

5.43 When questioned on Aboriginal attitudes to the RTI Act, Mr Chips Mackinolty advised that the overwhelming attitude of Northern Territory Aborigines was that they wanted the legislation repealed.³⁸

5.44 However it should be noted that the Committee received evidence suggesting that some Aborigines, at least, were not opposed to non-Aboriginal people having recourse to euthanasia on moral, ethical or traditional grounds. In other words, they did not seek to impose their beliefs on non-Aboriginal people.³⁹ Ms Debra Aloisi submitted:

I work at an aboriginal settlement near Katherine. I have talked to "traditional" aborigines in the community – several asked me to explain the Act. After me explaining the term, all have shrugged their shoulders and said, in effect, "so what". They refer it to "whitefella business" and leave it at that.⁴⁰

5.45 It should also be noted that the Committee received evidence suggesting a danger in assuming that diverse clans and language groups share common traditional practices, although common beliefs and principles may have been transmitted by Christianity.⁴¹

5.46 Other submissions attacked the notion that the sanctity of life was an element in traditional Aboriginal culture. For example, Mr Lovegrove argued that passive euthanasia, infanticide, inter-clan killing, capital punishment and abortion were not alien to traditional Aboriginal culture.⁴² He recounted examples of passive euthanasia (involving the withdrawal of sustenance from an elderly, dying person) and infanticide of which he had direct knowledge. He said that he understood infanticide was accepted under Aboriginal Law because:

... the infant had not become a "person" in the eyes of the Aborigines its death did not bring about "payback". It was also believed by some that the child would be reborn at a more convenient time.⁴³

5.47 Mr Robin Henry and the Northern Territory Country Liberal Party also submitted that traditional Aborigines had practiced infanticide and passive euthanasia.⁴⁴ Mr Mackinolty referred in evidence to cases he knew of where dying Aborigines would stop eating and drinking and walk off into the bush to die. However, he stressed that, while this suggested a functional acceptance of suicide, there was no other person assisting or taking active steps to bring the person's life to an end.⁴⁵

38 *Evidence*, Mr C Mackinolty, p. 148.

39 *Evidence*, Ms H Morris, p. 88; *Submission No. 4506*, D Aloisi, p. 3.

40 *Submission No. 4506*, D Aloisi, p. 3.

41 *Submission No. 3116*, Mr T C Lovegrove, p. 14.

42 *Submission No. 3116*, Mr T C Lovegrove, pp. 16-24.

43 *Submission No. 3116*, Mr T C Lovegrove, p. 21.

44 *Submission No. 2690*, R Henry, p. 6; *Submission No. 3552*, Country Liberal Party, p. 6.

45 *Evidence*, Mr C Mackinolty, p. 152.

5.48 It was not entirely clear whether Aboriginal objections to euthanasia were based on traditional law, or Christianity, or a mixture of both. The 1991 census recorded that 66.6 per cent of the Northern Territory Aboriginal population identified as Christian, compared with 64.5 per cent of the general Northern Territory population. The largest four groups were Catholic (21.3 per cent of Territory Aborigines), Uniting Church (11.2 per cent), Lutheran (10.9 per cent) and Anglican (9.9 per cent). A number live in communities on former missions where there is a continuing church influence.

5.49 Mr Lovegrove generally argued that conceptions of the sanctity of life among Aborigines were a recent event, influenced by Christianity.⁴⁶

5.50 Mr Mackinolty, on the other hand, preferred the view that traditional beliefs, rather than those of the Christian churches, were dominant.

I have observed a number of incidents and listened to discussions among Aboriginal people which convince me that the Christian churches present on many Aboriginal communities were not as influential and successful on this issue as they might have liked. As noted in my reports to the department, rejection of the RTI legislation was just as strong on communities not heavily influenced by the Christian churches. It is my firm view that it is traditional religion and Law that has been the overwhelmingly dominant factor influencing Aboriginal people's rejection and fear of the RTI legislation.⁴⁷

5.51 Some submissions on this point appeared to reflect a perception that in practice euthanasia would involve a hospital death, away from family and traditional country.

5.52 Tiwi elders submitted:

When we die our spirits go back to our fatherland. People in our community are afraid to go to hospital now. Our spirit goes away when we die naturally but it won't if we get the needle.⁴⁸

5.53 Mr Butiman Dhurrkay of the Galiwin'ku Community, Elcho Island, claimed that prior to death:

a sick person would be with the family and we would sing the songs of our ancestors of our history of our creation. That is our way. This law has stood for thousands of years and we cannot break it. This is the law for all of us Yolngu people.⁴⁹

5.54 A number of other submissions from Elcho Island were to similar effect. For example, Theodora Narndu of Karden Numida Incorporated submitted:

46 *Submission No. 3116*, Mr T C Lovegrove, pp. 16-24.

47 *Submission No. 12,592*, Mr C Mackinolty, p. 2.

48 *Submission No. 11,315*, President of the Nguju Community and others, Bathurst Island, p. 1.

49 *Submission No. 4479*, Mr B Dhurrkay, p.1.

We want to pass the tradition on to our young people. We want the right to live just as peacefully as any white Australia citizen. We want to pass the tradition on. This law attacks our tradition. It is not our way.⁵⁰

Impact on Aborigines - Willingness to Access Medical Services

5.55 A number of submissions suggested that the RTI Act would deter Aborigines from seeking medical assistance. For example, the first report by Mr Mackinolty to the Aboriginal Education Reference Group noted: "We have been told of direct cases already where people have been reluctant to present because of the fears of the legislation ...".⁵¹

5.56 Mr Mackinolty also advised that the RTI Act would cause Aborigines to defer medical treatment.⁵² The Committee questioned Mr Mackinolty on these matters at a public hearing in Canberra on 13 February 1997.

Senator HARRADINE - Are you telling us that the very existence of the Northern Territory legislation is a significant threat to Aboriginal health?

Mr Mackinolty – Yes, that is exactly what I am saying.

Senator HARRADINE – And that is one of the reasons you have come to the conclusion that it should be overturned?

Mr Mackinolty – In the Northern Territory, yes. I would just state that the very fact of the legislation, at least anecdotally, is causing people to be reluctant to present, or to present not as soon as one might, to attend clinics or to go to hospital. That delay in presentation, let alone the non-presentation, threatens people's health in suburban Canberra, let alone in areas where health outcomes are already far worse than ours and the expectation of life is 20 years less. If you take north-east Arnhem Land, for example, it has got the highest mortality rate in the country. That is one of the many areas in the territory where, doctors will give you anecdotal stuff about this, people are not presenting. I do not know if there is anyone on this committee with any medical experience, but certainly anecdotally, if you have got the flu going through a community, it does not take very long before everyone has got the flu and it does not take long before, if you do not go to the doctor the first day or the second day, it is pneumonia. If your health is not all that good in the first instance, you are going to die. It is as simple as that. It is not my personal belief, necessarily, that this sort of legislation should get rolled in the territory. I do not think it should be rolled, for example, on the basis of states rights; I do not

50 *Submission No. 3777*, Ms T Narndu of Kardu Numida Incorporated, p. 2.

51 Mackinolty, C, Report to Aboriginal Education Reference Group dated 28 June 1996: *Rights of the Terminally Ill Act: Education Program*, p. 3.

52 *Evidence*, Mr C Mackinolty, p. 147.

think it should get rolled on the basis of other ethical or moral things. I just think it should get rolled because it is going to kill people, if it has not already. It is as simple as that.⁵³

5.57 Similar evidence was presented by some Aboriginal groups. For example, Mr Arthur Ah Chee of Alice Springs submitted:

I know a lot of Aboriginal people are frightened about euthanasia. They really don't understand. The ones that do are like the rest. They are still frightened about not returning from hospital. In Alice Springs a lot of the family, if a family member has to go down South to hospital, people feel really concerned. The majority of the family, because of what has happened in the past, people are very frightened.⁵⁴

5.58 A submission from the Papunya Community stated:

Sometimes the nurses from town ask people to sign bits of paper, but the sick person does not know what they are signing. A lot of people do not read or write, old people especially but some young people too. Many people do not know what they are signing. It is so easy to be tricked.⁵⁵

5.59 The President of the Daguragu Community, who was also in charge of a health clinic, confirmed that people were avoiding the clinic:

They are really worried. Even when we make appointments for them in town, some of them are cancelling their appointments because they do not get the right information, especially with community consulting with Aboriginal people.⁵⁶

5.60 Similarly, a submission by Mr Alan Maroney from the Wurli Wurlinjang Health Service, based in Katherine, said:

Since this law has come in I have seen a lot of my people who won't go to the health clinic anymore. When it's a simple sickness like a cold they won't go. They now wait until they are really sick.⁵⁷

5.61 It is difficult to determine whether Aboriginal fears about the impact of the RTI Act are based on concerns about euthanasia or an historical distrust of western medicine.

5.62 While this concern could derive from a lack of familiarity with the checking procedures in the RTI Act, it may equally suggest a lack of faith in the motives and efficiency of hospitals

53 *Evidence*, Mr C Mackinolty, pp. 153-154.

54 *Submission No. 4829*, Mr A Ah Chee, p. 1.

55 *Submission No. 9314*, Papunya Community via Alice Springs, p. 1.

56 *Evidence*, Ms H Morris, p. 87. See also *Evidence*, Mr R Muhlen-Schulte, p. 90.

57 *Submission No. 3665*, Mr A Maroney, President of the Wurli Wurlinjang Health Service.

and medical practitioners. The Committee received evidence that historically the relationship between Aborigines and western medical care has been troubled by memories of past practices such as the sterilisation of Aboriginal women.⁵⁸

5.63 The NT Voluntary Euthanasia Society appeared to concede a latent Aboriginal fear of western health services; however, it claimed this fear had been exploited as an emotive weapon by opponents of euthanasia.⁵⁹ The possibility of misinformation regarding euthanasia has been considered above.

5.64 There was disagreement as to whether or not the RTI Act had led to, or would in the future lead to, a decrease number so Aborigines seeking health care.

5.65 The Northern Territory Government denied that there had been any decrease in the use of medical facilities by Aborigines, and provided the Committee with statistics in support of this assertion. This information related to hospital separations, emergency evacuations to hospital from remote communities and non-emergency travel to hospital under the Patient Accommodation Travel Scheme. No clear decrease was shown in relation to any of these categories since 1995. These statistics appear in Appendix 3.

5.66 However, Mr Mackinolty argued that these statistics could only measure what had happened in the past, not what would happen in the future.⁶⁰ And, as noted, while not necessarily referring to actual cases of the avoidance of medical care, many submissions predicted that the availability of euthanasia would deter Aborigines from seeking medical assistance,⁶¹ while others gave anecdotal evidence of this having occurred.

5.67 There was some evidence of a change in perceptions being brought about by education. In his submission of 20 November 1996 the Reverend Dr Djiniyini Gondarra claimed to know of people who were refusing to go to hospital because of fear of euthanasia.⁶² But when giving evidence to the Committee on 24 January 1997 the Reverend Gondarra seemed to concede that education had to some extent been effective in overcoming the fear of hospitals initially engendered by the RTI Act.⁶³

Other Considerations

5.68 Three other matters relevant to the impact of euthanasia laws on aborigines were raised in evidence. These relate to the fear of genocide, sorcery and pay-back.

58 *Submission No. 7399* of Fr F Brennan, pp. 9 and 10; *Submission No. 4610*, Father A Corry, p. 3.

59 *Submission No. 3101*, NT Voluntary Euthanasia Society, p. 4.

60 *Submission No. 12,592*, Mr C Mackinolty, p. 5.

61 *Submission No. 9314*, Papunya Community via Alice Springs; *Submission No. 9426*, M E Moreen, Nina Black and R Kantilla, p. 1; *Submission No. 11,315*, President of the Nguiu Community of Bathurst Island and others, p. 1; *Submission No. 3777*, T Narndu of Kardu Numida Incorporated; *Submission No. 9315*, Lajamanu Community Warlipi Tribe, p. 1.

62 *Submission No. 327*, Reverend D Gondarra, p. 2.

63 *Evidence*, Reverend D Gondarra, p. 69.

Fear of Genocide

5.69 Aboriginal attitudes to euthanasia may have been affected by a belief that the western health system was part and parcel of a generally antagonistic culture which, with the additional spectre of euthanasia, could lead to the further demise or even genocide of Australian Aborigines.⁶⁴

Sorcery

5.70 There was evidence that Aboriginal fears and suspicions relating to euthanasia need to be seen against the background of traditional Aboriginal conceptions of cause and effect and sorcery. This issue is related to religious and traditional objections to euthanasia, and the possible relevance of payback. Some Aborigines may not see euthanasia as an exercise of freedom of choice by an individual but, rather, as something wrought by supernatural forces, the mechanics of euthanasia playing a mere agency role.

5.71 Mr Mackinolty argued:

. . . in Aboriginal cosmology the notion of “natural” death applies only, perhaps, to the extremely old person. In all other cases, cause of death lies in a complex interplay of sorcery, payback and/or transgression of the Law. Thus, although the “cause” of death might appear to non-Aboriginal people to result from trauma (eg a road accident) or diseases (eg a heart attack or cancer); Aboriginal people would look beyond such apparent “causes” to determine whether the person died from sorcery attacks, vengeful spirits, from breaking the Law and so on.⁶⁵

5.72 Mr Mackinolty concluded that the voluntary nature of euthanasia was arguably irrelevant, so Aboriginals might decide to avoid medical assistance altogether.⁶⁶

5.73 Similarly, in his report of 23 July 1996 Mr Mackinolty argued that the Northern Territory Government education program would not:

. . . preclude people simultaneously holding different and at times apparently contradictory understandings of euthanasia (for example, that euthanasia is a voluntary action undertaken by people for whom it is culturally acceptable such as a possible agent for sorcery or payback). This has enormous potential to compromise and/or damage the reputations of Territory Health Service Staffers from AHWs to doctors.⁶⁷

64 *Submission No. 3553*, Dr D Ashbridge and others, Appendix 3, p. 5; Mackinolty C, Report of Aboriginal Education Reference Group: *Rights of the Terminally Ill Act* Education Program 28 June 1996.

65 *Submission No. 12,592*, Mr C Mackinolty, p. 3.

66 *Submission No. 12,592*, Mr C Mackinolty, pp. 4, 10.

67 Mackinolty C, Report to Aboriginal Education Reference Group dated 23 July 1996: *Rights of the Terminally Ill Act: Education Program*, p. 2

5.74 The Reverend Gondarra contended:

Since white man came to this land of ours, Yolngu⁶⁸ have been trying to work out if western doctors are Marrngitj (healers) or Galka (sorcerers) . . . Some people have felt that maybe western doctors are Marrngitj. However, when one of our people die, especially in hospital or after a big operation, the majority of our people believe that western doctors are Galka. When this happens it makes our people very sad and frightened of the health system.⁶⁹

5.75 Ms Helen MacCarthy of Daly River put the proposition succinctly: "Killing is like payback. It brings up all sorts of problems. Some people out bush would have all sorts of reactions."⁷⁰

Payback

5.76 Payback is relevant to the issue of euthanasia in two ways. First, Aborigines might regard a death resulting from, or perceived to result from, euthanasia as a case of payback. Secondly, such a death might be seen as murder, thus itself leading to payback or a revenge action of some kind.

5.77 The report of the Northern Territory Select Committee on Euthanasia noted concerns about retribution in the form of payback under Aboriginal law. It noted claims that the patient's close family relations might suffer such retribution for "allowing" the patient to die, as could an interpreter or doctor involved or a person signing a consent form for the patient by proxy.⁷¹

5.78 In his supplementary submission, Mr Lovegrove referred to a killing which may (although it is not clear) have been intended to forestall suffering, as recounted in a story by Grant Ngabidj:

Ngabidj talks about an Aboriginal who climbed a tree to get a sugar-bag and was caught-up in the tree ... Five men of another group came along and found him "hanging up there still alive, perishing, and they knocked him". The dead man's relatives went to Carlton Downs station to call together people to settle the matter. Another mob came up and surrounded the group and apparently lengthy discussion took place. Eventually they all went to sleep. Just before dawn the sleepers were attacked. [Ngabidj] says, "They waited till the whole turnout was sleeping properly and just before

68 Aboriginals of the East Arnhem Land Region.

69 *Submission No. 327*, Reverend D Gondarra, p. 2. See also *Evidence*, Reverend D Gondarra, p. 61.

70 *Submission No. 4469*, Ms H McCarthy, p. 1.

71 NT Legislative Assembly, *The Right of the Individual or the Common Good?*, Report of the Inquiry by the Select Committee on Euthanasia, May 1995, vol. 1, p. 24.

the sun came up they rushed them, every one. No one stopped, they killed those blackfellows with shovel spear or anything.”⁷²

5.79 Mr Lovegrove argued that this and other examples of Aboriginal violence recounted in his submission support his view that tribal Aborigines who have not absorbed Christianity were accustomed to violence and would not be greatly distressed at the idea of an individual being allowed to choose to end his or her life.⁷³ However, as has been noted, the reaction of the family of the first man who was killed in the above story may also be taken to suggest that euthanasia (if indeed that was the motive of the killing recounted by Ngabidj) could invoke retribution in the form of payback.

5.80 The National Aboriginal and Torres Strait Islander Catholic Council’s submission said as much:

To deliberately kill someone can cause a pay back situation. Because of our strong preservation of life, to kill someone is an evil act and therefore that evil must be destroyed. If a doctor helps an individual which causes a death and the community is aware of this, payback may be due and the life of that doctor must be affected so as to destroy the evil. There would be a conflict between western and traditional law and would cause friction between the two groups.⁷⁴

5.81 On the face of it, one might argue that the payback issue is academic because, at least on the evidence of Mr Mackinolty few Aborigines would use the RTI Act.⁷⁵ And a large proportion of Aborigines would be ineligible for euthanasia because of the interpreter provisions until interpreters with the prescribed qualifications become available.

- However, payback issues may still arise if an Aborigine is *perceived* to have died under the RTI Act, even though they actually died from some other cause. The Committee heard evidence that that there were Aboriginal people who had wrongly attributed certain deaths to euthanasia.⁷⁶

72 *Submission No. 3116a*, Mr T C Lovegrove, p. 9 and 10; see M Shaw, *My Country of the Pelican Dreaming: the Life of an Australian Aborigine of the Gadjerong*, Grant Ngabidj, 1904-1977, Australian Institute of Aboriginal Studies (1981), p. 69.

73 *Submission No. 3116a*, Mr T C Lovegrove, p. 11.

74 *Submission No. 4672*, NATSICC Ltd, p. 1.

75 *Evidence*, Mr C Mackinolty, p. 150.

76 *Evidence*, Mr C Mackinolty, p. 151.

CHAPTER 6

EUTHANASIA LAWS BILL – FOR AND AGAINST

Introduction

6.1 In this Chapter, the Committee reviews those arguments advanced for and against euthanasia. These arguments are the basis upon which most submissions expressed views on whether enactment of the provisions of the Euthanasia Laws Bill is desirable.

Arguments for Euthanasia

6.2 Evidence to the inquiry advanced five main reasons in support of euthanasia. These are:

- individual rights and autonomy;
- choice;
- dying with dignity - a merciful response to suffering;
- legalising what in reality is already common practice; and
- no moral difference between voluntary euthanasia and other medical end-of-life decisions

Individual Rights and Autonomy

6.3 Several submissions and witnesses referred the Committee to John Stuart Mill's treatise *On Liberty* in which he wrote:

the only purpose for which power can be rightly exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.¹

6.4 Support for voluntary euthanasia is based on the principle of individual rights and autonomy. Accordingly, a competent individual should have the right to determine how and when to die as long as this does not interfere with the rights of others.

6.5 Professor Peter Baume summarised this viewpoint when he wrote:

1 Quoted in *Submission No. 4623*, Dr D. Swanton, p. 3.

Voluntary euthanasia is justified because it is a self-regarding victimless action arising from an individual decision in a matter which affects individuals alone.²

6.6 At a public hearing of the Committee, Professor Baume elaborated on these views in the following terms:

the real purpose for which society is entitled to restrict the action of people is when the actions impinge on others. So I do not drive on the right-hand side of the road because I might hurt other people by doing so. I do not drive when I am drunk for the same reason. But for other matters which affect me and me alone, I reserve the right to make my own decisions ... and that is very consistent with liberal philosophy that individuals have a right to make decisions for themselves. I reject any efforts of people to impose views which they may hold conscientiously upon other people, if there is no question of third parties being involved.³

6.7 Mr Marshall Perron, the architect of the Northern Territory's Rights of the Terminally Ill Act, emphasised that Australians want the right to be able to make decisions in relation to the timing and nature of their death and explained why, in his view, support for voluntary euthanasia will grow. He told the Committee that in 1900, the average life span in Australia was 51 years and that today it is 75 years for a male and about 80.9 years for a female. According to Mr Perron, "we have never died so slowly and, for a very few, we have never died so agonisingly. The future in medical science is going to be that this scenario becomes more so." He concluded:

the fact is that as time goes by more and more of us are going to die when somebody makes the decision that we can die. What I believe the Australian people are saying is that they want the right at least to be able to make that decision for themselves in advance of being in such a state that they cannot make the decision and others have that responsibility for them.⁴

6.8 Those who support euthanasia reject arguments that they are attempting to impose their ethical values upon others. In his submission, Dr David Swanton argued that "the critical difference is that people who support euthanasia are not demanding that everybody must have euthanasia, but only that those who want euthanasia be given the option".⁵

6.9 Opponents of euthanasia reject this reasoning and in response quote the words of John Donne that:

2 Professor P Baume, "Voluntary euthanasia and law reform", *Australian Quarterly*, Vol. 68, No. 3, 1996, p. 17.

3 *Evidence*, Professor P. Baume, p. 115.

4 *Evidence*, Mr M. Perron, p. 28.

5 *Submission No. 4623*, Dr D. Swanton, p. 4.

No man is an island, entire of itself: every man is a piece of the continent, a part of the main ... Any man's death diminishes me, because I am involved in mankind.⁶

6.10 Ms Mary Sutherland, a private citizen from Darwin, Northern Territory, used this quotation in her address to the Open Public Forum, convened on 23 January 1997 in Darwin by Senator Grant Tambling and Senator Bob Collins and attended by several members of the Committee. Ms Sutherland went on to say:

John Donne knew something about interdependence that we have forgotten. People today seem to ignore that and pretend independence. We are spending megamoney researching youth suicide and black deaths in custody; on the other hand, we are legislating to allow people to kill themselves in certain circumstances. We are confused about the value of the person.⁷

6.11 Indeed, Dr Roger Woodruff, Director of Palliative Care, Austin and Repatriation Medical Centre, Heidelberg Victoria, stated that the concept of absolute individual autonomy is at odds with modern society. Dr Woodruff added that G B Shaw in *Pygmalion* described total individual independence as “Middle class blasphemy. We are all dependent on one another, every soul of us on earth”.⁸

6.12 In its submission, the group Euthanasia NO, questioned arguments based on personal autonomy and the ‘right to die’. The submission noted:

Despite the talk about this being a matter of autonomy no one has ever actually proposed that we all have a right to be killed on request. It is a right which is only offered to those individuals who have been deemed to be in such circumstances as to be considered better off dead.⁹

Choice

6.13 Choice was also advanced as a major reason in support of euthanasia. Ms Pauline Wright, representing the NSW Council of Civil Liberties, summarised the view of many submissions when she told the Committee that voluntary euthanasia is a matter for the individual and that it is a matter of choice. She said:

Voluntariness is the crux of it and we believe that the Northern Territory legislation goes a long way to ensuring voluntariness. Those who are terminally ill, and who wish to, ought to have the choice to terminate their own lives with the assistance of

6 Quoted in *Submission No. 4563*, Dr A. Fisher, p. 9.
Evidence, Northern Territory Council of Churches, p. 67.

7 *Evidence*, Ms M. Sutherland, p. 98.

8 *Submission No. 1620*, Dr R. Woodruff, p. 8.

9 *Submission No. 3503*, Euthanasia NO, p. 6.

medication. Most people will be able to self-administer medication, but for those who cannot, the assistance of a willing doctor in administration of the medication should be available ... The moral argument that is most often advanced is that there is innate value in a human life. That is very hard to argue with. That is, of course, true. But so is the proposition that a person is in such suffering that they can no longer stand their life. Why should they be denied the right to terminate that life in a way that is as easy as possible? It is their choice. If they choose that, we ought not deny it to them. It all comes down to choice. If a person disagrees with voluntary euthanasia for a religious reason, whatever reason it might be, that person does not have to exercise the right, but I don't think they should impose that moral or religious view - whatever their view might be - on those who do wish to die.¹⁰

6.14 Similarly, Mr Bruce Meagher, representing the AIDS Council of NSW, registered the support of many of the members of that organisation for voluntary euthanasia. In particular, he emphasised to the Committee that “people do not make this choice except after a lot of serious thought and consideration”. He observed that many people with HIV and AIDS are “very young - they die in their twenties and their thirties” but they “want to stay alive”. However, Mr Meagher explained that “some individuals get to the point where they decide that they cannot fight anymore, it is not worth their while and the pain and indignity are too much. When they have made that choice, I believe that choice should be respected”.¹¹

6.15 When speaking at the Open Public Forum in Darwin, Mr Eric Poole, the Member for Araluen in the Northern Territory Parliament, told the Committee:

I am sure many of us may want to say goodbye to life on our terms and in our own time. We may want the freedom to weigh the options before us and then make an earlier but more peaceful exit. Surely we should have that choice. There should never be a right or a wrong way to die. One death should not be called dignified because the person swallowed pills or had a lethal injection and another undignified because he or she struggled to the bitter end. Dignity in death is solely to be defined by the individual and his or her own set of values. Undignified deaths are those in which the moral values of others are imposed on the dying individual against the values, judgment and wishes of the patient.¹²

6.16 Similarly, Mr Graeme Everingham commented on the issue of choice. He said;

I am vehemently in favour of the choice embraced in the Northern Territory Rights of the Terminally Ill Act. The right specifically outlined in the Rights of the Terminally Ill Act is the right of choice of the terminally ill individual. The act empowers the terminally ill

10 *Evidence*, Coalition of Organisations for Voluntary Euthanasia, pp. 245-6.

11 *Evidence*, Coalition of Organisations for Voluntary Euthanasia, pp. 248.

12 *Evidence*, Mr E. Poole, p. 108.

individual alone to make their own choice about the appropriate treatment for that individual's terminal illness.¹³

6.17 At the same Forum, Ms Sheila Clarke, expressed a contrary view. She observed:

I am totally against voluntary euthanasia because, as one previous speaker said, we have no choice in entering life and I do not think we should have any choice in leaving it. You are talking about people suffering. Everybody suffers; this is life. If you do not have some suffering, how can you enjoy the better parts? It is by contrast. My big concern is that you have now legalised, or are attempting to legalise, a criminal act. Once you legalise anything - I do not care what it is - if it is against the natural law, the floodgates are open. I believe that it is very easy to forge signatures so anybody, if they thought I was getting in the way, could forge my signature and have me put away. I want to die when my time comes. I do not care when it is or how I go but I will take my risk at how I go and I think everybody else should do the same.¹⁴

6.18 Members of the Committee questioned representatives of Euthanasia NO, a single issue organisation that is opposed to voluntary and non-voluntary euthanasia, on the issue of choice. Mr Tony Burke replied:

That choice is only available by the passage of a law. That law has a very serious impact on vulnerable people and, given that is the only way that choice can be made available, I think it ought not be.¹⁵

Compassion and Death with Dignity

6.19 Proponents of euthanasia also argue that euthanasia is the compassionate and merciful answer to insoluble suffering and indignity, especially in the case of terminal illness.

6.20 Dr Helga Kuhse summarised the views in many submissions when she addressed the “fundamental issue” of dignity in the following terms:

A dignified death is one which accords with the patient's values and beliefs, a death that does not contradict the patient's own view of what it means to lead a good human life and die a dignified death. A mode of dying that is prescribed by the imposition of the moral or religious beliefs of others is not a dignified death - even if it is relatively pain-free.¹⁶

13 *Evidence*, Mr G. Everingham, p. 99.

14 *Evidence*, Ms S. Clarke, p. 101.

15 *Evidence*, Euthanasia NO, p. 221.

16 *Submission No. 4037*, Dr H. Kuhse, p. 11.

6.21 Mrs Rosemary Dewick, a registered nurse who appeared on behalf of the Voluntary Euthanasia Societies, recounted in a most moving way her experience of a particularly “hard death”. She told the Committee that her patient's cries “will be carved into my brain for the remainder of my days”. She concluded that anyone who has heard the cries as she has would support the “pioneering, honest, humane and compassionate Rights of the Terminally Ill Act of the Northern Territory” and oppose the Euthanasia Laws Bill 1996.¹⁷

6.22 Nevertheless, the Committee was reminded by Professor Peter Ravenscroft, the President of the Australian and New Zealand Society of Palliative Medicine, of the following comments by the social commentator, Mr Hugh Mackay:

No question as serious as euthanasia should be settled on individual cases. A general principle must be found which transcends particular cases. As with capital punishment, one principle which could be universally applied is that human life should be valued to the extent which puts it beyond the state.¹⁸

Legalising what in reality is already common practice

6.23 The New South Wales Voluntary Euthanasia Society indicated that “no one knows how many assisted deaths already occur in Australia” but “in one form or another they are said to be notoriously not uncommon”.¹⁹ According to the Society, it would be better to bring the whole question into the open and have honest records kept.²⁰

6.24 Similar views were expressed by Mr Marshall Perron, who stated:

It is surely preferable to have voluntary euthanasia tolerated in particular circumstances with stringent safeguards and a degree of transparency, than to continue to prohibit it officially while allowing it to be carried out in secret without any controls.²¹

6.25 Dr Helga Kuhse, Director of the Centre for Human Bioethics, Monash University, expressed similar sentiments. Dr Kuhse advised that many people now die in hospitals, after a decision has been taken to allow, or help them to die. These “medical end-of life decisions” may include the withdrawal or withholding of life sustaining treatment, the administration of life-shortening pain and symptom control and euthanasia and assisted suicide. According to Dr Kuhse, the high incidence of these decisions flies in the face of the sanctity of life view. Dr Kuhse concluded that the continued prohibition of voluntary euthanasia coupled with its widespread practice does not permit proper control and scrutiny and discourages doctors from

17 *Evidence*, Mrs R. Dewick, p. 228.

18 *Evidence*, Australian and New Zealand Society for Palliative Medicine, p. 135.

19 *Submission No. 8745*, New South Wales Voluntary Euthanasia Society, p. 6.

20 *Submission No. 8745*, New South Wales Voluntary Euthanasia Society, p. 6.

21 *Submission No. 3117*, Mr M. Perron, p. 12.

seeking consent to medical end of life decisions where this consent could, and should, be sought.²²

6.26 Dr Robert Marr, representing the Doctors Reform Society, expressed similar views. He told the Committee that every doctor in Australia knows that “secret euthanasia” is being practiced. He recommended that “we need to bring it out in the open and stop sticking our heads in the sand and saying that this is not going on”. He explained further:

I believe that doctors are acting in a compassionate way in doing this, in helping patients. But we have gone past the day when we can leave things in doctors' hands. Patients have rights, and what greater right should they have than a right to decide what happens to them at the end of their life? ... The key thing ... to consider is that voluntary and involuntary euthanasia is going on in Australia today and, if you are concerned about euthanasia, the best thing you can do is bring it out into the open, bring it under scrutiny, bring in safeguards and have patients having a right to have a say in what happens to them at the end of their life - not leaving it up to doctors.²³

Moral Equivalence

6.27 In her submission and in evidence to the Committee, Dr Helga Kuhse maintained that the continued prohibition of medically assisted suicide and voluntary euthanasia represents a particular moral point of view that has no place in a pluralist and liberal society, such as Australia.

6.28 According to Dr Kuhse, it is neither intrinsically nor absolutely wrong for an incurably ill and suffering patient to choose a course of action that is not only known to lead to death, but that is also intended to lead to death. Nor is it assumed to be intrinsically wrong for doctors to render direct assistance to patients who ask for it - not merely in the knowledge that death will result but also fully intending that death should result.²⁴

6.29 Dr Kuhse elaborated on this view in the following terms:

Laws allowing the refusal of medical treatment, but not direct assistance in dying to those who are terminally ill are unjust. They discriminate between patients on the morally irrelevant grounds of whether or not a patient who wants to die is fortunate enough to require life support, which he or she can then lawfully refuse - thereby bringing about his or her own death with the help of a doctor. Continued focus on the subjective mental states of doctors - on their intentions, rather than the patient's consent - encourages

22 *Submission No. 4037*, Dr H. Kuhse, p. 2.

23 *Evidence*, Coalition of Organisations for Voluntary Euthanasia, p. 247.

24 *Submission No. 4037*, Dr H. Kuhse, p. 5.

hypocrisy and secrecy, and does not provide procedural safeguards that ensure patient consent to medical end-of-life decisions.²⁵

6.30 Dr Kuhse concluded that it is morally proper for doctors to sometimes provide direct medical aid in dying to patients who are terminally or incurably ill, and who request it.²⁶

6.31 Several submissions rejected the “moral equivalence argument” advanced by Dr Kuhse. For example, Professor Michael Ashby, Director of Palliative Care, Monash Medical Centre, Monash University, noted that “whilst a doctor’s intention may not always be easy to validate, evaluation of intention and motive are fundamental to legal analysis, and many would argue that intention is also determinative of the moral character of medical interventions.”²⁷

6.32 According to Professor Ashby, there is still a substantial body of medical opinion which defends the viewpoint that there are strong intuitive moral and clinical distinctions between stopping absolutely or relatively futile medical treatment and giving a lethal injection.²⁸ Professor Ashby concluded:

At present, the law and prevailing codes of medical ethics draw a sharp distinction between these two acts. It is preferable that this continues to be the case for the sake of social solidarity and the practice of palliative care.²⁹

6.33 The Australian Medical Association (AMA) adheres to the declarations of the World Medical Association that euthanasia and doctor assisted suicide are unethical but that a physician should respect the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.³⁰

6.34 In its own *Position Statement on Care of Severely and Terminally Ill Patients - May 1996*, the AMA endorses the right of patients to refuse treatment and the right of a severely and terminally ill patient to have relief of pain and suffering even when such therapy may shorten the patient’s life.³¹

6.35 Dr Michael Smith of the Australian Association of Hospice and Palliative Care told the Committee that the Association holds the view that:

dying is a natural process and all people with a terminal illness currently have the right to refuse futile treatment or have futile treatment withdrawn. This is not euthanasia. In addition, to leave a person in avoidable pain and suffering by not providing them with

25 *Submission No. 4037*, Dr H. Kuhse, p. 15.

26 *Submission No. 4037*, Dr H. Kuhse, p. 7.

27 *Submission No. 4036*, Professor M. Ashby, p. 13.

28 *Submission No. 4036*, Professor M. Ashby, p. 14.

29 *Submission No. 4036*, Professor M. Ashby, p. 13.

30 *Submission No. 3229*, Australian Medical Association, p. 4.

31 *Submission No. 3229*, Australian Medical Association, p. 3.

effective palliative care is a clear breach of human ethics and basic human rights.³²

6.36 Dr Margaret Somerville of McGill University, Canada was also questioned on the ethical basis of the moral equivalence argument. She responded:

Euthanasia is an interesting case study in this respect, because, if you look at euthanasia simply through the lens of reason, it comes out as a reasoned response. It is logical, cognitive and rational. You referred to Helga Kuhse and Peter Singer: they are analytic philosophers who are very wedded in their tradition to almost entire reliance on reason as the way of knowing. If you only apply reason, you will come out with a pro-euthanasia stance. However, I suggest that when we apply these other things, including history or memory, and ask why for 2,000 years we have not done this and what our ethical feelings are about killing somebody else - and we use the straight language of killing - I believe we will come to different conclusions.³³

Arguments against euthanasia

6.37 Opponents of euthanasia rely on five main arguments. These are:

- the sanctity of life;
- religious beliefs;
- the slippery slope;
- erosion of medical ethics and deterioration of doctor/patient relations;
- palliative care

Sanctity of life

6.38 Opponents of euthanasia rely strongly on the principle of the “sanctity of life”. This principle recognises that no person may directly kill another and is described in the following terms:

The sanctity of life principle is usually grounded in the notion of human dignity: the intrinsic, equal and inalienable worth of the human person, said to be deserving of the highest reverence and respect ... The sanctity of life principle has been a cornerstone of

32 *Evidence*, Australian Association of Hospice and Palliative Care, p. 133.

33 *Evidence*, Dr M. Somerville, p. 175.

ethics, practice and law in our civilisation and something of a litmus test of the progress of civilisations.³⁴

6.39 The sanctity of life principle recognises the special worth of human life. Accordingly, its proponents, including people of Christian, Jewish, Muslim and Eastern religions and many secular philosophies, concur in opposing direct killing of innocent human beings as intrinsically immoral and/or as always a harm to the victim, the killer and the common good. Therefore, euthanasia whether voluntary or involuntary, is direct killing.³⁵

6.40 The submission of the Australian Bill of Rights Group summarised the views contained in many other submissions when it stated:

Voluntary euthanasia represents such a radical reversal of the principles ... of the sanctity of life and the dignity of the person that any law which allows legal killing for whatever reason must be regarded as abhorrent ... a paradigm shift in our thinking which is so radically opposed to what we hold sacred - the preservation of human life - that we ought to proceed with extreme caution.³⁶

6.41 Mr F. Denton, a private citizen, Ballarat, Victoria, opposed euthanasia “precisely because it involves the deliberate act to kill another person”. Mr Denton stated:

Society has come gradually to realise that killing is an inappropriate action even in the case of serious capital crime. There is an ever present danger of an injustice occurring, whenever a person is killed even after exhaustive judicial process. Thus the prospect of allowing members of the medical profession to exercise the right to kill their patients without preceding judicial scrutiny is an astounding exercise in trust.³⁷

6.42 Similarly, Dr John Fleming, Director of the Southern Cross Bioethics Institute, expressed the view that euthanasia could apply to a far bigger population than those convicted of capital offences” and therefore “we need to exercise the same kind of caution where euthanasia is concerned”.³⁸

6.43 Dr Margaret Somerville, Professor in the Faculty of Medicine, McGill University, Montreal, Canada, told the Committee that although there are medical cases that “put a very powerful [emotional] pull on us”, it would be a “tremendous mistake for society” to legalise euthanasia. Dr Somerville’s view is not based on the sanctity of life but rather fundamental norms of a civilised society. She elaborated on this, when giving evidence to the Committee by conference call from Canada. She said:

34 *Submission No. 4563*, Dr A. Fisher, p. 7.

35 *Submission No. 4563*, Dr A. Fisher, p. 8.

36 *Submission No. 4511*, Australian Bill of Rights Group, p. 3.

37 *Submission No. 7247*, Mr F. Denton, p. 1.

38 *Submission No. 4676*, Southern Cross Bioethics Institute, p. 6.

The reason I believe that is if you look at the most fundamental norm or value on which our types of societies are based it is that we do not kill each other. No matter how compassionate and merciful your reasons for carrying out euthanasia, it still alters that norm that we do not kill each other to one where we do not usually, but in some cases we do. I simply do not think we can afford to do that because of what it would do to societal values. So it is not just because I am worried about abuse of it if it were implemented, which is where a lot of people place their argument. They say, 'Let's put very stringent safeguards.' I think it is inherently wrong to do it, so it is not a question of safeguards. It is only when something is inherently right that you then say, 'Let's make sure that, being inherently right, it is always used rightfully.' So I am not even into that. I think it would be inherently wrong for us to do this, and that is why we should not do it.³⁹

6.44 Proponents of voluntary euthanasia recognise that whilst the ethic of sanctity of life is “extremely important” it is not absolute and that for the suffering terminally ill patient, autonomy, dying with dignity and the relief of suffering can counter-balance and outweigh the sanctity of life.⁴⁰

6.45 Professor Peter Baume has strongly criticised arguments against voluntary euthanasia based on the sanctity of life. Professor Baume maintains that:

Some of the same people who put the argument about the sanctity of human life go out and bless armies bent on killing other human beings. ... The histories of Northern Ireland, of the Balkans, of Rwanda, of the Thirty Years War, of the Inquisition, are scarcely testament to a working belief in the sanctity of life. Further, many of those who argue loudly for "sanctity of life" one day are the same people who, on another day, want capital punishment reintroduced for specified categories of crime.⁴¹

Religious beliefs

6.46 Major religious denominations in Australia recorded their opposition to euthanasia. The Anglican Primate of Australia, the Most Reverend Dr Keith Rayner, advised the Committee that the General Synod of the Anglican Church of Australia, the senior legislative body of the Church, has expressed grave concern about moves to legalise euthanasia and affirms that life is a gift from God, not to be taken, and is therefore not subject to matters such as freedom of individual choice.⁴²

39 *Evidence*, Dr M Somerville, p. 172.

40 *Submission No. 3127*, Voluntary Euthanasia Society of Victoria, p. 9.

41 Professor P Baume, "Voluntary euthanasia and law reform", *Australian Quarterly*, Vol. 68, No. 3, 1996, p. 20.

42 *Submission No. 8742*, Primate of the Anglican Church of Australia, p. 1.

6.47 The Primate's submission also advised that the National Forum of the National Council of Churches, the most representative body of the Christian churches in Australia, has rejected euthanasia as "contrary to God's law and the values of a civilised society".⁴³ The Churches that comprise the National Forum are as follows:

Anglican Church of Australia	Religious Society of Friends
Antiochian Orthodox Church	Roman Catholic Church
Armenian Apostolic Church	Romanian Orthodox Church
Assyrian Church of the East	The Salvation Army-Eastern Territory
Churches of Christ in Australia	The Salvation Army-Southern Territory
Coptic Orthodox Church	Syrian Orthodox Church
Greek Orthodox Church	Uniting Church

6.48 Dr Anthony Fisher OP referred the Committee to pronouncements by His Holiness Pope John Paul II on euthanasia. His Holiness has stated:

the direct and voluntary killing of an innocent human being is always gravely immoral.

and

any State which makes such a request legitimate and authorised it to be carried out would be legalising a case of suicide - murder, contrary to the fundamental principles of absolute respect for life and of the protection of every innocent life.

6.49 Dr Fisher advised that the term "innocent" is used to exclude those cases where the absolute necessity of the defence of either society or the individual requires that human life be taken. Therefore, the prohibition applies to all acts of deliberate killing of a human being, whatever the motive might be.⁴⁴

6.50 Archbishop Barry Hickey, representing the Australian Catholic Bishops Conference, explained the theological arguments against euthanasia in the following terms:

Very basically, it is a view drawn from a religious premise that human life comes from God and therefore God is the master of human life. It is not within our right to take human life. Therefore, we say it is sacred and that the day of our death is something that is not to be determined by ourselves but by God. That is the theological view.⁴⁵

6.51 Other religious denominations also lodged submissions opposing euthanasia.⁴⁶ The submission from the Board for Social Responsibility, NSW Synod, Uniting Church in Australia was less rigid and unequivocal on the issue of euthanasia.⁴⁷

43 *Submission No. 8742*, Primate of the Anglican Church of Australia, p. 4.

44 Dr Neil Brown, "The 'harm' in euthanasia", *Australian Quarterly*, Vol. 68, No. 3, 1996, p. 27.

45 *Evidence*, Australian Catholic Bishops Conference, p. 237.

46 *Submission No. 8319*, Islamic Council of New South Wales, p. 1.

6.52 Voluntary Euthanasia Societies and others indicated that religiously inspired reasons for opposing voluntary euthanasia are respected but religious views held by some should not be allowed to compel others not holding such views, to be bound by them.⁴⁸ Dr David Swanton, appearing on behalf of voluntary euthanasia societies made the following call for tolerance:

The [Euthanasia Laws] bill seeks to demand that all people must adhere to mainstream religious doctrine whether they like it or not. This is blatant intolerance of those who dare to have different values to the mainstream religions. It is hypocrisy and arrogance from the bill's supporters to call for tolerance, when they offer none, and to presume that they know what is best for other people, when they do not. What I am asking is for tolerance to be shown to all members of society including terminally ill people who want voluntary euthanasia. To do this, euthanasia arguments must be comprehended with an open mind, devoid as far as possible of any cultural, religious or other bias. Australians deserve the best possible laws from our federal parliament.⁴⁹

6.53 Similarly, the Humanist Society of Western Australia emphasised that the recognition of voluntary euthanasia would provide rights to those who wish to avail themselves of those rights but would have no effect on religious and other people who prefer not to utilise them.⁵⁰

The slippery slope

6.54 The slippery slope argument is based on the proposition that the practice of euthanasia is profoundly corrupting and ultimately uncontrollable.⁵¹ Submissions to the inquiry used the term to describe at least three different circumstances. These are:

- that acceptance of voluntary euthanasia will lead to an acceptance of involuntary euthanasia
- that euthanasia for the terminally ill would lead to euthanasia for lesser diseases and conditions;
- that acceptance of euthanasia will diminish social mores by diminishing respect for the value of human life.

6.55 The Senior Pastor of the Bathurst Baptist Church, Rev Mike Robinson, expressed his deep concern about the “very real possibility of what I call the thin edge of the wedge” and

47 *Submission No. 2217*, Board for Social Responsibility, NSW Synod, Uniting Church in Australia, p. 1.

48 *Submission No. 8745*, New South Wales Voluntary Euthanasia Society, p. 7.

49 *Evidence*, Voluntary Euthanasia Societies, pp. 226-7.

50 *Submission No. 7482*, Humanist Society of Western Australia, p. 1.

51 *Submission No. 4563*, Dr A. Fisher, p. 13.

“we are faced with a decision that could open the door to all manner of social mayhem”. He explained:

If we allowed the thin edge of the wedge with abortion - the beginning of life why should we think we wont do the same thing with the matter of euthanasia - the end of life? Once we have opened the door even by a crack, there are no longer effective safeguards against that subtle and almost silent encroachment of humanly initiated death - whether in the womb or the aged folks home.⁵²

6.56 Dr Christopher Newell, a Senior Lecturer, Division of Community and Rural Health, University of Tasmania and “an Australian citizen who has several disabilities” told the Committee that “whatever one’s personal opinion, there are significant issues for those on the margins of society, including people with disabilities, which mean that so - called euthanasia cannot safely be legalised or even decriminalised”.⁵³

6.57 Mr Tony Burke, Executive Director of Euthanasia NO, emphasised that the legalising of euthanasia would place unacceptable pressures on vulnerable people in our society. He observed:

When people are considering whether or not they should be able to have a treatment or discontinue a treatment, the question is usually, ‘Is the treatment a burden?’ With euthanasia, we keep getting asked, ‘Is the person a burden?’ So for a vulnerable patient, who never would have requested euthanasia, the mere existence of the act - the mere existence of this as an option that has to be presented - is, in itself, a pressure.⁵⁴

6.58 In a similar vein, the feminist network, FINRRAGE,⁵⁵ advised that “there is much evidence to support the contention that a pro - euthanasia climate will lead to certain segments of society ‘requesting’ the hastening of their deaths through physician - assisted euthanasia and that women and people of ‘lesser merit’ will in general be amongst them.”⁵⁶

6.59 Several submissions also maintained that, if euthanasia is legalised, cultural and social mores will change over time resulting in acceptance of a “duty to die” rather than a “right to die”. According to these submissions, history shows that state authorised killing by the medical profession has the potential to destroy essential elements in the fabric of society and weakens protection for the sick and aged members of the community. An often posed question in submissions was similar to the following:

52 *Submission No. 1775*, Bathurst Baptist Church, p. 1.

53 *Submission No. 3146*, Dr C. Newell, p. 2.

54 *Evidence*, Euthanasia NO, p. 219.

55 Feminist International Network of Resistance to Reproductive and Genetic Engineering.

56 *Submission No. 4526*, Feminist International Network of Resistance to Reproductive and Genetic Engineering, p. 2.

Will the sick and frail feel pressured to take a quick exit because they are an increasing burden for whom to care? Will elderly relatives feel pressured to take a lethal overdose or injection so that anxious family members can benefit from the distribution of a keenly awaited estate?⁵⁷

6.60 Mr Charles Francis, a private citizen, wrote to the Committee that the right to die introduces the “terrifying corollary that to remain alive, the burdensome should be able to provide adequate justification and that a right to die will lead inevitably to a “duty to die”.⁵⁸

6.61 Proponents of voluntary euthanasia rejected these arguments. For example, the Right to Die - Dying with Dignity Action Group maintained that “when voluntary euthanasia is practiced openly, in accordance with agreed procedures, it is far less likely to be abused ... by stating clearly under what circumstances a patient may be helped to die, a society is in effect saying thus far and no further”.⁵⁹

6.62 Similarly, Dr David Swanton rejected the slippery slope argument as “one of sensationalist scaremongering, because there is no evidence to show that it will occur”. Dr Swanton argued that active voluntary euthanasia is fundamentally different to involuntary euthanasia. He stated:

if active voluntary euthanasia is fundamentally different to involuntary euthanasia then it is easy to draw the line, and avoid the slippery slope. Active voluntary euthanasia requires the patient’s consent and is morally right for that very reason. Involuntary euthanasia (and it is here that the anti-euthanasia lobby refers to the situation in Nazi Germany) does not require the patient’s consent, and for that reason can be considered morally wrong. It is quite straightforward to draw the line. Legalising killing in self-defence has not led to the wholesale slaughter of Australians, so why would legalising active euthanasia?⁶⁰

6.63 Dr Kuhse of Monash University also commented on the validity of the slippery slope argument. According to Dr Kuhse, these arguments are generally strong on rhetoric and weak on argument and fact, as they largely rest on predictions, themselves dependant on a swarm of unstated and contentious assumptions, and therefore not only difficult to prove but also very difficult to disprove.⁶¹

6.64 Although his submission opposed legalising euthanasia, the Reverend Dr Mark Sayers expressed doubts about the plausibility of the slippery slope argument. He stated that the “slippery slope is suspect and its implicit premise is a pessimistic view of society which

57 *Submission No. 2531*, Anglican Bishop of Canberra and Goulburn, p. 2.

58 *Submission No. 4032*, Mr C. Francis, p. 3.

59 *Submission No. 7300*, Right to Die – Dying with Dignity Action Group, p. 26; quoting an editorial in *The Age*, 5 July 1995.

60 *Submission No. 4623*, Dr D. Swanton, p. 19.

61 *Submission No. 4037*, Dr H. Kuhse, p. 12.

paternalistically treats subsequent generations as inherently morally suspect".⁶² This concession having been made the Rev Dr Sayers concluded that "a democratic society premised on respect for equal, autonomous citizens, contradicts its very 'raison d'être' when it sanctions beforehand one citizen killing another simply because ... their living lacks value".⁶³

6.65 Both proponents and opponents of euthanasia cite the experience of euthanasia in The Netherlands in support of their arguments on the "slippery slope". The situation in The Netherlands is reviewed in Chapter 8.

Erosion of medical ethics and the doctor - patient relationship

6.66 The Victorian Branch of the World Federation of Doctors Who Respect Human Life maintained that euthanasia will change the doctor - patient relationship. In its submission, the Branch stated:

Doctors have a lot of power in our society. There are many secrets patients tell them. The drugs they prescribe are potent. There can be a fine line between a therapeutic and a toxic dose. The training of a doctor has put him in a powerful position *vis a vis* an unwell patient. The only way a relationship between a powerful Doctor and a vulnerable patient can work effectively is to be based on trust. Now imagine a few years hence if euthanasia is permitted. Doctors are now public executioners as well as healers ... These two roles are incompatible. Normal medical practice will never be the same.⁶⁴

6.67 The Anglican Bishop of Canberra and Goulburn, the Right Reverend George Browning summarised concerns of many submissions when he advised that State sanctioned death will corrode relationships and trust in communities. In particular, the Bishop questioned whether patients "will continue to see the doctor or nurse as healer and comforter or, with syringe in hand, as the angel of death".⁶⁵

6.68 Professor Alan Rodger from Monash University recognised that the medical profession is not omniscient, stating:

my fellow practitioners and I are mere humans. We make mistakes - in diagnosis, in treatment and, notoriously, in prognosis. Some of us are also unethical. No Act can be perfect and hence prevent all mistakes or abuse. This Act [Northern Territory's Rights of the Terminally Ill Act] is, therefore unsafe in the hands of my profession⁶⁶

62 *Submission No. 4042*, Rev Dr M. Sayers, p. 3.

63 *Submission No. 4042*, Rev Dr M. Sayers, p. 3.

64 *Submission No. 4577*, Victorian Division of the World Federation of Doctors Who Respect Human Life, p. 3.

65 *Submission No. 2531*, Anglican Bishop of Canberra and Goulburn, p. 2.

66 *Submission No. 4579*, Professor A. Rodger, p. 3.

6.69 The Adelaide Justice Coalition also expressed concerns about doctors being given the power to end life. The Coalition advised:

Any legislation which puts the power of ending life in the hands of the health system, which in our considered opinion frequently fails in its basic duty of care to disadvantaged people is highly dangerous. It is naive to believe that such power will never be misused. In fact, we conclude that in view of the health system's many failures in its dealing with the disadvantaged, it is more likely than not that such power (if legislated for) will be misused.⁶⁷

6.70 When asked whether the legalising of euthanasia would change the medical ethic, representatives of the Australian Medical Association, Northern Territory Branch, "doubted whether there would be a "major changes". Dr Diane Howard explained:

I think the community has to come to terms with the fact that there is a deeply ingrained objection in the medical community to this concept of killing. It is very much part of the reason they become doctors and is something that is reinforced by their training and subsequent work experience ... The community has to come to terms with the fact that this is the way doctors think ... The medical profession in general are very good observers of human behaviour; we spend our days doing it all day. Those who are concerned about the risks of this act [Northern Territory's Rights of the Terminally Ill Act] and the decision making that is going to be involved would be very wise to listen to the doctors.⁶⁸

6.71 In contrast, Dr Robert Marr expressed the view that the issue of voluntary euthanasia "is really about a transfer of power from the doctor to the dying patient. According to Dr Marr, doctor - initiated euthanasia is being practiced for compassionate reasons in hospitals very frequently. A legal right to voluntary euthanasia will allow patients to request and receive medical assistance to end their life and not have to rely on the goodwill of a doctor to help them.⁶⁹

6.72 Mr Marshall Perron expressed the view that it is "an insult to Australian doctors and others in the medical profession to pretend that they would be associated with wicked scenarios" painted by opponents of voluntary euthanasia.⁷⁰

6.73 Surveys have been conducted in order to gauge the attitudes and practices of the medical profession to euthanasia. These are reviewed in Chapter 7.

67 *Submission No. 4057*, Adelaide Justice Coalition, p. 1.

68 *Evidence*, Australian Medical Association-Northern Territory Branch, pp. 75-6.

69 *Submission No. 8753*, Dr R. Marr, p. 1.

70 *Submission No. 3117*, Mr M. Perron, p. 12.

Palliative Care

6.74 The World Health Organisation states that palliative care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of other psychological, social and spiritual problems is paramount. The goal is achievement of the best possible quality of life for patients and their families. Palliative care affirms life and regards dying as a normal process.⁷¹

6.75 The Council of the Australian and New Zealand Society of Palliative Medicine advised that palliative care has always operated on the premise that “it neither hastens or postpones death” and therefore “none of the treatments given, including narcotics, are aimed at harming or killing the patient, but are designed to assist in relieving symptoms”.⁷²

6.76 Dr Michael Smith, President of the Australian Association of Hospice and Palliative Care, registered the Association’s opposition to all forms of legalisation of euthanasia because of the fundamental concern that legislating to allow euthanasia will inevitably lead to a reduction of the care available to dying people, particularly at a time when the development of palliative care in Australia stands at the “crossroads”.⁷³ Dr Smith elaborated, indicating that the basis for this concern lay in three main areas - resources, professional confusion and public fear.

6.77 He noted that funding of palliative care in Australia is a complex mix of Commonwealth, state and private funds, and that “a number of milestones are yet to be achieved”.⁷⁴ In relation to the profession, Dr Smith advised that “there still remains considerable confusion and, at times, downright ignorance about many of the details of how palliative care is provided or what it can achieve”.⁷⁵ He explained:

This is not to suggest that all health care professionals who do not practise palliative care are ignorant or uncaring: far from it. The considerable bulk of palliative care in this country will continue to be well provided by general medical, nursing and allied health practitioners. However, the level of knowledge and experience required to effectively manage the symptoms of people in such dire circumstances that they may be seeking euthanasia is still not achieved by enough practitioners. The availability of euthanasia in such circumstances can only lead to an under treatment of such symptoms and an overall worsening of the quality of life of this

71 World Health Organisation, *Cancer Pain Relief and Palliative Care*, 1990, p. 1; quoted in *Submission No. 8750*, Dr N. Muirden, p. 2. See also *Submission No. 4538*, Council of the Australian and New Zealand Society of Palliative Medicine, p. 3.

72 *Submission No. 4538*, Council of the Australian and New Zealand Society of Palliative Medicine, p. 4.

73 *Evidence*, Australian Association of Hospice and Palliative Care, p. 133.

74 *Evidence*, Australian Association of Hospice and Palliative Care, p. 133.

75 *Evidence*, Australian Association of Hospice and Palliative Care, p. 133.

group. Indeed, such a worsening is a requirement, if euthanasia is to be considered.⁷⁶

6.78 Dr Smith also commented on public fear. He said that evidence is already emerging from the Northern Territory that uncertainty and concern about euthanasia is affecting the acceptance of palliative care by patients. He advised

Instances of patients accepting palliative care only if injections are not used in the control of symptoms have already been experienced. Use of medication delivered under the skin via a needle is a common and necessary part of palliative care. Anything which interferes with these established palliative care techniques will seriously jeopardise the degree of symptom control possible ... such concerns and confusion can only become more common.⁷⁷

6.79 Dr Smith said that the availability of euthanasia had already compromised the capacity of palliative care providers to provide for terminally ill people in Australia and this could only worsen. According to Dr Smith, the introduction of euthanasia legislation will paradoxically worsen the quality of life and care of the very group it is attempting to aid. He concluded that euthanasia is no more part of palliative care than it is part of aged care, mental health or intellectual disability programs.⁷⁸

6.80 Dr Smith advised the Committee that the development of palliative care in Australia is on a par with anywhere else in the world. He noted that less than half of the people needing palliative care in this country each year actually receive it.⁷⁹

6.81 Professor Peter Ravenscroft, President of the Australian and New Zealand Society for Palliative Medicine, addressed the question of whether palliative care can solve all the problems relating to a dying patient.

6.82 He explained that suffering when dying takes two forms. The first relates to organic problems such as pain, nausea, vomiting, constipation and depression and that these can generally be managed satisfactorily with few exceptions by an expert palliative care team, comprising doctors, nurses, occupational therapists, physiotherapists, pharmacists and social workers all working together. Professor Ravenscroft emphasised that an expert palliative care team is not a general practitioner working alone. According to the Professor, an expert palliative care team can therefore manage the pain in most cases so that it will not interfere with life.⁸⁰

6.83 Professor Ravenscroft advised that the second form of suffering relates to “existential problems” that include “loss of self-worth, loss of control, fear, guilt, anger, resentment and anxiety at being so disabled”.⁸¹ According to the Professor, existential problems lead patients

76 *Evidence*, Australian Association of Hospice and Palliative Care, p. 133.

77 *Evidence*, Australian Association of Hospice and Palliative Care, p. 133.

78 *Evidence*, Australian Association of Hospice and Palliative Care, p. 134.

79 *Evidence*, Australian Association of Hospice and Palliative Care, p. 134.

80 *Evidence*, Australian and New Zealand Society for Palliative Medicine, p. 134.

81 *Evidence*, Australian and New Zealand Society for Palliative Medicine, p. 134.

to request euthanasia more often than pain does. This in turn creates problems for doctors. He explained:

They are situations which doctors find most difficult to deal with. They cannot be dealt with in the short time allocated by a GP consultation and that is something that we have been trying to do something about but have really been unable to. They require skills such as counselling, which many doctors have not been taught or mastered.⁸²

6.84 Other evidence also expressed the view that requests for voluntary euthanasia are extremely rare when concerted efforts are made to alleviate physical, spiritual and emotional suffering in terminally ill patients. Requests for voluntary euthanasia in times of stress will be revised when the stress is removed.⁸³ According to this evidence, requests for euthanasia are usually a call for help rather than a call for euthanasia.⁸⁴

6.85 Proponents of voluntary euthanasia rejected the view that voluntary euthanasia medically is unnecessary because palliative care can meet all conditions. In his evidence, Professor Peter Baume stated:

Can I say something en passant about palliative care? It is something we support. Everyone should have good palliative care; but palliative care, even the best palliative care, leaves about five per cent of people unrelieved. The figure may be a bit more or a bit less than five per cent, but that five per cent still remains a problem which we must address. For the other 95 per cent of people, palliative care is very effective and it is developing. That five per cent figure might shrink, but it exists at the present time. If someone living in the Territory makes a request for voluntary euthanasia under the Northern Territory law, and they are tested by all the provisions in that act and they come through those provisions, then I am prepared to say they should be able to make use of the act.⁸⁵

6.86 According to the South Australian Voluntary Euthanasia Society, studies show that grave distress experienced by patients cannot always be relieved. The Society stated that “voluntary euthanasia is not an alternative to palliative care, but an option of last resort if palliative care does not relieve the patient’s distress.”⁸⁶

6.87 Similarly, Dr Roger Hunt, a palliative care doctor for over 12 years, supported this view, stating that “palliative care will never eliminate all suffering - this is an impossible

82 *Evidence*, Australian and New Zealand Society for Palliative Medicine, p. 134.

83 *Submission No. 4518*, Professor T. Cramond, p. 2.
Submission No. 4462, Professor J. Murtagh, p. 1.

84 *Submission No. 4512*, Dr R. Chye, p. 1.

85 *Evidence*, Professor P. Baume, pp. 121-2.

86 *Submission No. 1618*, South Australian Voluntary Euthanasia Society, pp. 2-3.
Submission No. 3127, Voluntary Euthanasia Society of Victoria, p. 8.

dream” concluding that “there is a place for euthanasia in terminal care”.⁸⁷ Mrs Rosemary Dewick, a registered nurse who appeared on behalf of the Voluntary Euthanasia Societies stated emphatically that “I do not think it is possible for everybody to be treated with palliative care ... It is most effective in most cases, but there are cases where it is just not effective”.⁸⁸ She explained:

A lot of people cannot tolerate morphine ... from where I sit as a registered nurse, I have seen horrendous episodes with morphine and interaction with other drugs, hallucinations and the trauma. It is made out that morphine will palliate anything ... Sometimes it does not even palliate the pain; it does not fix the pain. This happens sometimes - not all the time - but that is why I am trying to address the cases where the pain and the suffering cannot be controlled.⁸⁹

6.88 Ms Gwen Phillips, also addressed this issue when she spoke at the Open Public Forum in Darwin She stated:

I have seen people reach the extreme. Not everyone will. Those who die from a heart attack or a haemorrhage or an organ malfunction are the lucky ones. But the unfortunate ones will continue on until they are nothing more than a skeleton with skin stretched over it, their bones exposed in their joints. No amount of palliative care can stop that. They will be incontinent, suffering and begging to die ... They do not want to look like some thing lying in a bed that instils horror into people who visit them. They want their loved ones to think of them with dignity, not with horror. Euthanasia is purely an option. When they say, ‘We've had enough, we'll have it now’, rather than waiting for the doctor to give it to them, it may only be a matter of a few weeks or a few days. This is not a law; it is a humane option. The difference is that this is voluntary.⁹⁰

6.89 Several submissions recognised the dramatic improvements in palliative care but maintained that there are nevertheless some people whose symptoms may respond well to palliation, who place a great emphasis on dignity, independence, personal responsibility control. One such submission concluded:

Palliative care cannot usually restore the ability to go to the toilet alone, or get out of bed unassisted, or to wash, or to interact with loved ones. Some people have no desire to live totally in the care of others ... In his letter before he died with assistance under the [Northern Territory’s Rights of the Terminally Ill Act] Bob Dent said ‘I have no wish for further experimentation by the palliative

87 *Submission No. 194*, Dr R. Hunt, p.4.
Submission No. 8753, Dr R. Marr, p. 1.

88 *Evidence*, Voluntary Euthanasia Societies, p. 235.

89 *Evidence*, Voluntary Euthanasia Societies, p. 235.

90 *Evidence*, Ms G. Phillips, p. 98.

care people in their efforts to control my pain’ and ‘I cannot even get a hug in case my ribs crack ... Being unable to live a normal life causes much mental and psychological pain, which can never be relieved by medication’.⁹¹

6.90 The Motor Neurone Disease Association emphasised that palliative care can meet many but not all of the needs of people living with MND, a disease that causes death through a progressive disabling process. The Association is of the view that, although palliative care is the recommended option, patients with MND should have a range of choices, including the right to make a choice not to continue living with MND.⁹²

6.91 In response to these arguments, palliative care experts indicate that no studies have been undertaken to show that there is a “percentage” who cannot be assisted totally by palliative care.⁹³ Additionally, Dr Smith of the Australian Association of Hospice and Palliative Care observed that “there is an implication very often in this discussion that X per cent - two, three, five or whatever it is - has no relief of any sort ... that palliative care is either pass or fail; you either get total relief or you get no relief at all”. Dr Smith explained that “the group of people who do not get complete relief of their symptoms in fact do receive a proportionate degree of relief”.⁹⁴

6.92 Members of the Committee sought clarification of how palliative care can assist that small percentage of patients whose suffering is acute. Professor Ravenscroft commented:

I think we have to focus on a small proportion and realise that, although we may not get the pain for the people in that group under total control, my experience is that we get it under such good control that they can live with it. There are many other problems that come up at that time. Let us suppose we have the hypothetical patient who really does have such severe pain. I think we have to talk to them about whether they want to go on with this or whether they would like some more sedation. We have to talk to them about those sorts of things, and usually the patient will tell you what it is that they want.⁹⁵

6.93 When asked what he would do for those patients who indicate that they have just “had enough”, Professor . Ravenscroft replied:

I have not had that experience, but if they did I would be talking to them about their mental state. I would be talking to them about family issues. I would be exploring the reasons why they had come to that conclusion, because often there are reasons that need to be sorted out ... Often, people who are in that circumstance have it

91 *Submission No. 4503*, New South Wales Council for Civil Liberties, p. 3.

92 *Submission No. 4058*, Motor Neurone Disease Association of Australia, pp. 2-3.

93 *Evidence*, Australian and New Zealand Society of Palliative Medicine, p. 136.

94 *Evidence*, Australian Association of Hospice and Palliative Care, p. 136.

95 *Evidence*, Australian and New Zealand Society of Palliative Medicine, p. 145.

explored by a sympathetic team and that may actually be a doctor or it might be an art therapist because a person just cannot tell you how bad it is, they need to paint it for you - or a music therapist.⁹⁶

6.94 The Committee also questioned Dr Margherita Nicoletti, Medical Officer, ACT Hospice, Australian Catholic Bishops Conference, on this matter. She responded that “physical pain is the easy thing to control ... it is emotional and spiritual pain that is more difficult to control in someone who is terminally ill. She explained that when physical pain cannot be controlled, it is often a manifestation of a spiritual problem. Dr Nicoletti elaborated:

Palliative care is more than just morphine, I have got to say. Morphine plays a smaller and smaller part in palliative care science. There are other medications, other drugs; there are other ways of dealing with pain in particular. Pain is not the biggest issue in the dying. I think it is more a spiritual, a grief, an emotional thing. Often when people have pain which is out of control it is compounded by their other suffering, which can be addressed in other ways.⁹⁷

96 *Evidence*, Australian and New Zealand Society of Palliative Medicine, p. 145.

97 *Evidence*, Australian Catholic Bishops Conference, p. 239.

CHAPTER 7

SURVEYS IN AUSTRALIA ON EUTHANASIA

Introduction

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

7.2 These surveys fall broadly into the following three categories:

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

General Public Attitudes

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

The Morgan Polls

7.4 Since 1962 a Morgan Poll has asked:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Newspoll

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

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

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

7.12 The Newspoll also asked the following question:

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

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

Practices and Attitudes of the Medical Profession

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

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

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

6 *The Australian*, 9 July 1996.

7 *The Australian*, 9 July 1996.

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

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

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

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

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

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

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

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

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

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

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

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

Waddell et al., 1996

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

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

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

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

7.23 The authors of the study concluded that that:

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

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

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

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

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

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

7.24 The authors of the survey commented:

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

Flinders University, 1996

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

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

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

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

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

Kuhse, Singer and Baume 1997

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

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

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

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

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

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

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

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

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

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

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

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

- although it used a similar questionnaire to the two van der Maas surveys, the van der Maas surveys involved lengthy face-to-face interviews with doctors; the Kuhse, Singer and Baume questionnaire was sent by post and self-administered;²⁵
- the 1991 Dutch survey employed a prospective study (together with a retrospective study and a death certificate study); the Kuhse, Singer and Baume survey only employed a retrospective questionnaire. The prospective study carried out in the Dutch study involved doctors filling out a questionnaire each time they made a medical decisions relating to the end of life; being contemporaneous it was arguably more accurate than a retrospective study;²⁶
- similarly, the follow-up Dutch survey relating to deaths in 1995 employed a death certificate study as well as a retrospective study with interviews;²⁷
- the response rate to the Kuhse, Singer and Baume survey was 64 per cent. It has been argued their results are not representative as it is likely that non-respondents may have predominantly been doctors opposed to euthanasia and particularly non-voluntary euthanasia.²⁸ (However, Professor Singer has suggested that the main reason for non-response by doctors was that they were too busy and that even if all non-respondents were opposed to non-voluntary euthanasia the incidence would still be higher in Australia than Holland.²⁹)

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

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

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

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

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

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

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

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

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

AMA Questions - 1997

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

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

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

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

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

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

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

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

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

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

Question 24

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

yes - go to Question 25

no - go to Question 26

Yes 92

No 1008

No answer 12

Question 25

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

Yes 96

No 467

No answer 549³⁷

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

Steinberg et al., 1997 (Queensland)

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

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

7.37 Five questions formed the basis of the study:

1. If good palliative care were freely available to everyone who needed it, do you think anyone would ever ask for assistance to end their lives?

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

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

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

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

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

Extent of Support for the Northern Territory Legislation

Steinberg et al., 1997 (Northern Territory)⁴²

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

7.39 The following question was put:

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

7.40 The survey results are set out below:

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

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

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

SA = strongly approve; **A** = approve; **NAD** = neither approve nor disapprove;
D = disapprove; **SD** = strongly disapprove

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

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

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

CHAPTER 8

INTERNATIONAL DEVELOPMENTS

Introduction

8.1 In this Chapter of the report, the Committee reviews several inquiries on issues relating to euthanasia conducted in overseas countries. These inquiries are:

- the House of Lords Select Committee on Medical Ethics;
- the Canadian Special Select Committee on Euthanasia and Assisted Suicide; and
- the New York State Task Force on Life and Law.

8.2 The Committee also examines the practice of euthanasia in The Netherlands and Switzerland, and the US State of Oregon's Death with Dignity Act.

House of Lords Select Committee

8.3 In January 1994, the House of Lords Select Committee on Medical Ethics presented its report on, amongst other matters:

- whether and in what circumstances actions that have as their intention or a likely consequence the shortening of another person's life may be justified on the grounds that they accord with that person's wishes or with that person's best interests.

8.4 In a unanimous report, the members of the Committee noted the "very strongly held and sincerely expressed views of those who advocated voluntary euthanasia".¹

8.5 The House of Lords Select Committee recorded their own and others experience of relatives or friends "whose dying days or weeks were less than peaceful or uplifting".² However, the Select Committee concluded that society's prohibition of intentional killing should not be weakened. The Select Committee stated:

That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia.³

1 House of Lords, Report of the Select Committee on Medical Ethics, Volume 1 - Report, HMSO, London, p. 48 (hereafter *House of Lords Report*)

2 *House of Lords Report*, p. 48.

3 *House of Lords Report*, p. 48.

8.6 The Select Committee acknowledged that there are individual cases in which euthanasia may be seen by some to be appropriate. However, it concluded that individual cases cannot reasonably establish the foundation of a policy "which would have such serious and widespread repercussions".⁴

8.7 In support of this conclusion, the Select Committee expressed the view that:

- dying is not only a personal or individual affair but affects the lives of others. The issue of euthanasia therefore is one in which the interest of the individual cannot be separated from the interests of society as a whole;⁵
- it is not possible to set secure limits on voluntary euthanasia;⁶
- vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined, to request early death;⁷
- fears that lives are prolonged by aggressive medical treatment may increasingly be allayed by the emerging consensus about the circumstances in which life-prolonging treatment may be withdrawn or not initiated;⁸
- palliative care can adequately relieve the pain and distress of terminal illness in the vast majority of cases;⁹ and
- in the small and diminishing number of cases in which pain and distress cannot be satisfactorily controlled, the professional judgement of the health care team can be exercised to enable increasing doses of medication to be given in order to provide relief, even if it shortens life. This is appropriate as long as the doctor acts in accordance with responsible medical practice with the objective of relieving pain or distress, and with no intention to kill.¹⁰

8.8 The Select Committee also found, in relation to assisted suicide, that the law should not be changed. In particular, it could find no reason to distinguish between the act of a doctor or any other person in this connection.¹¹

4 *House of Lords Report*, p. 48.

5 *House of Lords Report*, p. 48.

6 *House of Lords Report*, p. 49.

7 *House of Lords Report*, p. 49.

8 *House of Lords Report*, p. 49.

9 *House of Lords Report*, p. 49.

10 *House of Lords Report*, p. 49.

11 *House of Lords Report*, p. 54.

Canadian Special Senate Select Committee

8.9 In June 1995, the Canadian Special Senate Select Committee on Euthanasia and Assisted Suicide presented its report entitled *Of Life and Death*.¹²

8.10 In this report, a majority of the Committee recommended that the laws relating to assisted suicide and euthanasia remain intact. These members of the Committee considered that, in relation to voluntary euthanasia adequate safeguards could never be established to ensure the consent of the patient is given freely or voluntarily. Some members felt that "the common good could be endangered" if the law was changed to accommodate the few cases where pain control is ineffective. These cases were not sufficient to justify legalising euthanasia because "it could create serious risks for the most vulnerable and threaten the fundamental value of life in society."¹³

8.11 In support of this view, the majority of the Committee noted:

- the clarification of withdrawing and withholding treatment;
- better training for personnel who work with those with irreversible illnesses;
- improved management of pain relief and palliative care; and
- the moral difference between euthanasia, where the intention is to cause death and other end of life decisions (withdrawing or withholding treatment or providing treatment aimed at alleviating suffering that may hasten death) where the intention is to alleviate suffering.¹⁴

8.12 The majority, however, recommended that the law be amended to allow for a less severe penalty for voluntary euthanasia in cases where there is the essential element of compassion or mercy.¹⁵

New York State Task Force

8.13 In May 1994, the New York State Task Force on Life and the Law presented a report entitled *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*.¹⁶

8.14 Although holding different views about the ethical acceptability of assisted suicide and euthanasia, the Task Force unanimously recommended that the existing law should not be changed.¹⁷

12 Canadian Special Senate Select Committee on Euthanasia and Assisted Suicide, *Of Life and Death*, June 1995 (hereafter Canadian Senate Report).

13 *Canadian Senate Report*, p. 86.

14 *Canadian Senate Report*, pp. 86-87.

15 *Canadian Senate Report*, p. 88.

16 New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia, in the Medical Context*, 1994, Albany, NY (hereafter New York State Report).

17 *New York State Report*, pp. xii-xiii.

8.15 The report notes that even those members who did not see euthanasia as unethical or incompatible with medical practice concluded that "legalising assisted suicide would be unwise and dangerous public policy".¹⁸

8.16 In support of this view, these members of the Task Force noted that:

- the number of cases when assisted suicide or euthanasia is medically and ethically appropriate is extremely rare;¹⁹
- the benefits incurred for this small number of patients could not justify a major shift in public policy or the serious risks that legalising the practice would entail;²⁰
- the legal prohibition of such practices serves important purposes and is a highly symbolic function.²¹

8.17 The Task Force unanimously concluded that legalising assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable. According to the Task Force, the potential dangers of a dramatic change to public policy would outweigh any benefit that might be achieved.²²

The Netherlands

8.18 One of the arguments often invoked by those opposed to euthanasia is the slippery slope argument that euthanasia is profoundly corrupting and ultimately uncontrollable,²³ and that:

- acceptance of voluntary euthanasia will lead to an acceptance of involuntary euthanasia
- euthanasia for the terminally ill would lead to euthanasia for lesser diseases and conditions;
- acceptance of euthanasia will diminish social mores by diminishing respect for the value of human life.

8.19 Holland, as the only country in which euthanasia has been openly practised over a substantial period of time, has been a key reference point in relation to arguments for and against the slippery slope.

18 *New York State Report*, p. xiii.

19 *New York State Report*, pp. 134-5.

20 *New York State Report*, pp. 134-5.

21 *New York State Report*, pp. 140-1.

22 *New York State Report*, p. 120.

23 *Submission No. 4563*, Dr A. Fisher, p. 13.

8.20 In order to appreciate the situation in the Netherlands, the Committee reviews evidence on the Dutch Penal Code, court decisions expanding the range of situations in which euthanasia is permitted, guidelines and surveys of the incidence of euthanasia in Holland.

The Dutch Penal Code

8.21 Article 293 of the Dutch Penal Code makes it an offence, punishable by up to 12 years imprisonment or a fine, for a person to cause the death of another person at the latter's "express and serious request". This offence therefore applies to active voluntary euthanasia.

8.22 Article 294 of the Code makes it an offence, punishable by three years imprisonment or a fine, for a person to intentionally incite, assist, or procure the means for another to commit suicide. This offence therefore applies to physician-assisted suicide.

8.23 Articles 293 and 294 were enacted in the late 19th century, a policy decision having been made to distinguish euthanasia from murder and assisted suicide and provide for a lesser penalty than those relating to murder.

8.24 Article 40 of the Penal Code sets out the basis of a "defence of necessity" (*noodtoestand*) which prevents the application of Articles 293 or 294 where court-determined criteria are observed before active voluntary euthanasia or assisted suicide takes place.

8.25 Breaches of the criteria often result in relatively light sentences for doctors involved. Since 1991, there has been an agreement between the Royal Dutch Medical Association and the Dutch Ministry of Justice that gives a doctor protection against prosecution if, in relation to active voluntary euthanasia or assisted suicide, the doctor complies with certain guidelines.

8.26 Strictly, neither euthanasia nor assisted suicide has been "legalised" or "decriminalised" in Holland. They remain offences, subject to the defence of necessity. However, the way the defence of necessity has been interpreted and applied has led to the open practice of euthanasia in Holland.

Court Decisions

8.27 In 1971, Dr Geertruida Postma injected a patient, her mother, with morphine and curare, resulting in the patient's death.²⁴ The patient had suffered a brain haemorrhage, was partly deaf, had difficulty speaking, and had to be tied to a chair to avoid falling. On a number of occasions she asked her daughter to end her life. Dr Postma was charged under Article 293 of the Dutch Penal Code. In 1973, the Leeuwarden criminal court found Dr Postma guilty but only ordered a one week suspended sentence and one year's probation. The court indicated that it was possible to administer pain-relieving drugs leading to the death of the patient in certain circumstances provided the goal of treatment was the relief of physical or

24 In Holland euthanasia is usually effected by putting the patient to sleep with a barbiturate followed by a lethal injection of curare: Angell M, "Euthanasia in the Netherlands - Good or Bad?," *The New England Journal of Medicine*, November 28 1996, p. 1676.

psychological pain arising from an incurable terminal illness. In this case, however, Dr Postma's primary goal was to cause the death of the patient.²⁵

8.28 In 1973, following the Postma decision, the KNMG (Royal Dutch Medical Association) issued a statement supporting the retention of Article 293 but arguing that the administration of pain relieving drugs and the withholding or withdrawal or futile treatment could be justified even if death resulted.

8.29 The next watershed decision was the 1984 *Alkmaar* ruling by the Dutch Supreme Court. The 95 year old patient had been unable to eat or drink and had temporarily lost consciousness shortly before her death. After regaining consciousness she requested euthanasia from her doctor. He consulted with another physician who concurred that the patient was unlikely to regain her health. However, it is material that the patient was suffering a chronic and not a terminal illness. The doctor was convicted by a lower court and the Court of Appeals of an offence under Article 293 of the Dutch Penal Code, although no punishment was imposed. On appeal, the Supreme Court overturned the conviction, holding that the doctor was entitled to succeed in the defence of necessity under Article 40. The court agreed with the doctor's defence that he faced a conflict of responsibilities between preserving the patient's life on the one hand and alleviating suffering on the other. The Court decided that this conflict must be resolved on the basis of the doctor's responsible medical opinion measured by the prevailing standards of medical ethics. In this case the doctor was found to have properly resolved that conflict.²⁶

8.30 The criteria relating to the defence of necessity are to be gleaned from a number of Dutch court decisions, making it difficult to specify precisely what they are. However, the provisions of the Penal Code, and the defence of necessity, only become relevant issue in the event of the prosecution of a doctor.

8.31 In June 1994, the Dutch Supreme Court decided the *Chabot* case, which is regarded as another watershed decision in relation to the defence of necessity. The suffering of the 50 year old patient, Ms Hilly Boscher, was purely psychological. She had a long history of suffering depression, a violent marriage and her two sons had died, one by suicide and one of cancer. Upon the death of the second son she decided to commit suicide and approached the Dutch Federation for Voluntary Euthanasia that referred her to Dr Chabot. Dr Chabot diagnosed her as suffering from severe and intractable mental suffering. He came to the view that Mrs Boscher's case satisfied the guidelines. He consulted a number of colleagues. However, none, apart from Dr Chabot, examined Mrs Boscher. In September 1991 Dr Chabot assisted Mrs Boscher to commit suicide by prescribing a lethal dose of drugs. He reported her death to the coroner.

8.32 Dr Chabot was prosecuted under Article 294 of the Dutch Penal Code. He sought to invoke the defence of necessity. Importantly, the Supreme Court held that there was no reason in principle why the defence of necessity could not apply where a patient's suffering is purely psychological. However, the court held that for the defence to apply the patient must be

25 Singer P, *Rethinking Life and Death: The Collapse of Our Traditional Ethics*, p.144; Pence G E, *Classic Cases in Medical Ethics*, p. 51.

26 Singer P, *Rethinking Life and Death: The Collapse of Our Traditional Ethics.*, pp. 145-146; Keown J (ed), *Euthanasia Examined: Ethical, clinical and legal perspectives*, pp. 263-64.

examined by an independent medical expert. Dr Chabot had sought medical opinions from seven colleagues but none had actually seen Mrs Boscher. Accordingly, the defence of necessity failed. Dr Chabot was found guilty of an offence under Article 294. The Supreme Court declined to impose a penalty, although in February 1995 Dr Chabot received a reprimand from a Medical Disciplinary Tribunal.²⁷

8.33 Two cases determined in November 1995 relating to infants have generated controversy.

8.34 In the *Kadijk* case (Groningen District Court) a doctor was charged with offences under the Dutch Penal Code after causing the death of a 25 day old neonate girl by lethal injection at the “explicit and earnest desire of the parents’. The child was suffering from Trisomy 13 (Patau Syndrome). The symptoms of this disorder included: cleft lip and palate, skull defects, overlapping fingers, microphthalmia, serious mental retardation, multiple neurological defects, convulsions and motor retardation. The child had suffered one cardio-respiratory arrest and there was evidence of renal failure. One of the scalp defects had become ulcerated and infected. Upper limb convulsions could not be controlled with analgesia or sedation without risking kidney failure. There was also evidence that 90 per cent of Trisomy 13 children died within the first year of life. In the circumstances, the Groningen District Court upheld the doctor’s defence of necessity. Both parties have appealed.²⁸

8.35 The *Prins* case (November 1995, Amsterdam Court of Appeal) concerned a doctor who administered a lethal injection to a three day old neonate suffering from Hydrocephalus and Spina Bifida. The baby was in severe pain and expected to live no more than six months. The parents were informed of the condition and prognosis and gave a “considered and earnest request” for the baby to be killed by lethal injection. As with the *Kadijk* case, the court upheld a defence of necessity. This matter has also been appealed.²⁹

8.36 In 1995, Royal Dutch Medical Association’s guidelines were revised. First, assisted suicide is to be preferred to euthanasia where possible. Secondly, the primary doctor’s consultations should be with an experienced doctor who has no professional or family relationship with either the primary doctor or the patient. Thirdly, if a doctor is personally opposed to euthanasia the doctor must make his or her views known to the patient and help the patient find a doctor who is willing to assist.³⁰

8.37 In late January 1997 the Dutch Government announced a proposal to enhance palliative care services and foreshadowed further regulation, but not the decriminalisation of

27 Cica N, *Euthanasia-The Australian Law in an International Context, Part 2: Active Voluntary Euthanasia* (Commonwealth Department of the Parliamentary Library, 1996), pp. 26 to 27; *Submission No. 331*, Mr James Dominguez, p.7; Hendin H, *Seduced By Death: Doctors and Patients and the Dutch Cure*, Norton and Co., 1997, pp. 60-75.

28 Brownstein, E G “Neonatal Euthanasia Case Law in the Netherlands”, *The Australian Law Journal*, January 1997, p. 54 at p. 57.

29 Brownstein, E G “Neonatal Euthanasia Case Law in the Netherlands”, *The Australian Law Journal*, January 1997, p.57.

30 Cica N, *Euthanasia-The Australian Law in an International Context, Part 2: Active Voluntary Euthanasia* (Commonwealth Department of the Parliamentary Library, 1996), p. 29.

euthanasia in Holland. This followed an increase in the incidence of active voluntary euthanasia as revealed by a study of deaths during 1995.³¹

Guidelines

8.38 Since November 1990, prosecution is unlikely if a doctor complies with the guidelines set out in the non-prosecution agreement between the Dutch Ministry of Justice and the Royal Dutch Medical Association.³² These guidelines are based on the criteria set out in court decisions relating to when a doctor can successfully invoke the defence of necessity.

8.39 The substantive requirements are as follows:

- the request for active euthanasia or physician-assisted suicide must be made by the patient and must be **voluntary**.
- the patient's request must be **well considered**.
- the patient's request must be **durable and persistent**.
- the patient's situation must entail **unbearable suffering** with no prospect of improvement. The patient need not be terminally ill to satisfy this requirement.

The procedural requirements are as follows:

- the euthanasia must be **performed by a doctor**.
- before the doctor assists the patient the doctor **must consult a second doctor**. Since the 1991 case of *Chabot*, if the patient has a psychiatric disorder the doctor must cause the patient to be examined by at least two other doctors, one of who must be a psychiatrist.
- the doctor must keep a **full written record** of the case.
- the death **must be reported** to the prosecutorial authorities as a case of euthanasia or physician-assisted suicide, and not as a case of death by natural causes.³³

8.40 In 1990, the Minister for Justice and the Royal Dutch Medical Association agreed on a notification procedure. In 1994, the Dutch Parliament confirmed this procedure in

31 AAP, 22 January 1997.

32 Cica N, *Euthanasia-The Australian Law in an International Context, Part 2: Active Voluntary Euthanasia* (Commonwealth Department of the Parliamentary Library, 1996), p.23.

33 Cica N, *Euthanasia-The Australian Law in an International Context, Part 2: Active Voluntary Euthanasia* (Commonwealth Department of the Parliamentary Library, 1996) p.23; and Jitta J, "Voluntary Euthanasia: The Dutch Way", pp. 3 and 4 (attachment to Submission no. 5104, The Voluntary Euthanasia Society of Queensland Inc.).

legislation,³⁴ but it did not repeal Articles 293 and 294.³⁵ It is notable, however, that most acts of euthanasia are not reported: official studies suggest that only 18 per cent were reported in 1990 and 41 per cent in 1995.³⁶ Those not reported are generally attributed to death by natural causes on the death certificate.

The 1991 and 1995 Studies

8.41 Professor P J van der Maas has conducted an official study of the practice of euthanasia and other medical decisions relating to the end of life in Holland.³⁷ This study was conducted in 1991 based on a sample of deaths in 1990 and details of some deaths in early 1991. It is often referred to as the Rummelink report, named after the Attorney-General of the High Council of The Netherlands, who headed the study.³⁸ The follow-up study, was published in 1996 based on a sample of deaths in 1995 and using a similar methodology.

8.42 Each study gathered data on a range of medical decisions relating to the end of life, namely:

- “Euthanasia”: The First Study noted: There is a clear definition of euthanasia [in the Netherlands]: “the purposeful acting to terminate life by someone other than the person concerned at the request of the latter.”³⁹
- Assisted suicide
- Intentional life-terminating acts without explicit request
- Active euthanasia without an explicit request from the patient
- Deaths resulting from the administration of opioids in large doses

34 See generally van der Wal *et al.*, “Evaluation of the Notification Procedures for Physician-Assisted Death in the Netherlands”, *New England Journal of Medicine*, November 28 1996 (“van der Wal (1996)”), p. 1706.

35 A doctor who assists in a person’s death does not issue a death certificate and is required to inform the coroner that it was a medically-assisted death. The doctor is required to complete a checklist relating to the medical history of the patient, the request of the patient, the drugs used to induce death and a report from the other doctor consulted. The coroner is then required to collect relevant data, conduct a post-mortem examination and advise the public prosecutor of the death. The prosecutor in turn is required to consider the matter, determine whether to permit burial or cremation of the body, and report to the Prosecutor General. The latter must report to the Assembly of Prosecutors General, which determines whether or not to prosecute, although the final decision is made by the Minister for Justice. Charges are generally not brought if the act falls within the non-prosecution guidelines. (van der Wal (1996), pp. 1706-1707.)

36 van der Wal (1996), p. 1707.

37 Head of the Department of Public Health and Social Medicine in the Faculty of Medicine and Health Sciences at the Erasmus University, Rotterdam.

38 An English translation appears as van der Maas *et al.*, *Euthanasia and other Medical Decisions Concerning the End of Life*, (Elsevier, 1992).

39 van der Maas *et al.*, *Euthanasia and other Medical Decisions Concerning the End of Life*, (Elsevier, 1992), p. 5.

- Deaths resulting from the withholding or withdrawal of potentially life prolonging treatment

8.43 Each study also gathered information on a number of related matters such as the extent of compliance with the non-prosecution guidelines and reporting procedures.

8.44 Many of the arguments for and against euthanasia refer to these studies. Accordingly, it is convenient to set out below some of the important findings.

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

8.45 In his submission Dr Roger Woodruff drew the Committee's attention to the increase in Dutch voluntary euthanasia between 1990 and 1995.⁴⁰

8.46 However, it should be noted that it has been argued that this increase is a natural consequence of the aging of the population in Holland. Indeed, the authors of the follow-up study in 1995 have suggested that the increase may be due to a combination of factors:

In the reports of the 1990 study, we foresaw an increased incidence of euthanasia and the other practices examined, for several reasons - increased mortality rates as a consequence of the aging of the population, an increase in the proportion of deaths from cancer as a consequence of a decrease in deaths from ischaemic heart disease, the increasing availability of life-prolonging techniques, and, possibly, generational and cultural changes in patient's attitudes.⁴¹

40 *Submission No. 1620*, Dr R. Woodruff, p. 1.

41 van der Maas (1996), p. 1705.

The Slippery Slope? - Differing Interpretations

8.47 Dr John Keown, Queens College, Cambridge University, has conducted empirical research into the law and practice of euthanasia in The Netherlands and has published a number of papers on this matter.

8.48 Dr Keown told the Committee that court decisions, shifts in expert opinion and the 1991 and 1995 studies demonstrate that Holland is on the so-called slippery slope. He has concluded from his research that voluntary euthanasia cannot be effectively and safely regulated, cannot be limited to hard cases where the patient makes an explicit request and is suffering unbearably, but rather tends to slide to euthanasia without request and to situations where there is no longer unbearable suffering.

Firstly, since euthanasia became widely tolerated in the Netherlands, thousands of patients have had their lives intentionally shortened without an explicit request. Secondly, in many cases euthanasia has been applied even though alternatives were available and the patient's suffering was not unbearable. Thirdly, a substantial majority of cases have not been reported as the guidelines require them to be but have been illegally certified by the doctors as deaths by natural causes.⁴²

8.49 The Committee questioned Dr Keown on his interpretation of the 1991 and 1995 Dutch studies. Dr Keown replied:

It seems to me that some of the central findings, which bear on the whole slippery slope argument, are that the survey indeed uncovered a significant number of cases in which patients were euthanised even though they had not made an explicit request. The guidelines require an explicit, free and voluntary request by the patient which is persistent and durable. Yet in over 1,000 cases, the survey disclosed, patients had been terminated without making an explicit request. In fact, on a closer analysis of the figures, there were several more thousand cases where there was no explicit request. Simply taking the Dutch interpretation of the figures, there were at least 1,000 cases. The more recent survey by the author of the 1990 survey shows that there has been a slight decrease in the number of intentional terminations of life without request. In 1995 the figure was 900. But this is only a slight decrease, from 0.8 per cent of all deaths to 0.7 per cent of all deaths.⁴³

8.50 Dr Keown drew the Committee's attention to the comments of Lord Walton, the chairman of the House of Lords Committee on Medical Ethics that a delegation of the Committee who visited The Netherlands returned uncomfortable about evidence on the

42 *Evidence*, Dr J Keown, p. 154.

43 *Evidence*, Dr J Keown, p. 155.

incidence of non-voluntary euthanasia. He also noted that “the Committee’s findings are consistent with my research and my conclusions”.⁴⁴

8.51 Dr Keown also referred the Committee to a recent publication by Dr Herbert Hendin entitled *Seduced by death*, in which the author concludes on the basis of empirical research that:

The experience of the Dutch people makes it clear that legalisation of assisted suicide and euthanasia is not the answer to the problems of people who are terminally ill. The Netherlands has moved from assisted suicide to euthanasia, from euthanasia for people who are terminally ill to euthanasia for those who are chronically ill, from euthanasia for physical illness to euthanasia for psychological distress, and from voluntary euthanasia to involuntary euthanasia. Virtually every guideline established by the Dutch to regulate euthanasia has been modified or violated with impunity.⁴⁵

8.52 The Committee received several submissions on the 1991 and 1995 studies containing detailed analysis and interpretations of the statistics. These included submissions from Mr James Dominguez and Dr Roger Woodruff.⁴⁶

8.53 Voluntary euthanasia societies, Dr Helga Kuhse of Monash University and others rejected the views of Dr Keown and dismissed any notion that the experience in The Netherlands proves arguments about euthanasia and the slippery slope. On the contrary, they consider that the Dutch studies show quite the opposite.

8.54 Dr Helga Kuhse told the Committee that the two nationwide studies conducted in Holland in 1991 and 1995 are the largest ever done at any time on medical end of life decisions. When questioned on whether these studies belie an argument about a slippery slope, Dr Kuhse replied:

The Dutch studies are separated by five years and do indeed throw strong doubt on and some would say undermine this slippery slope argument. Because the 1991 study found that roughly speaking 1.8 per cent of all deaths in The Netherlands were the result of voluntary euthanasia, with 0.8 per cent of all deaths in The Netherlands having been the result of non-voluntary euthanasia, that is cases where the patient was not asked. Very often the patient could not be asked or very often the patient had expressed an earlier wish, but at the time when the doctor administered the lethal injection, the patient did not give the concurrent explicit consent. That is 0.8 per cent.

44 *Evidence*, Dr J Keown, p. 155.

45 *Evidence*, Dr J Keown, p. 155: quoting Dr H Hendin, *Seduced by death*, Norton, 1997, p. 23.

46 *Submission No. 331*, Mr J. Dominguez
Submission No. 1620, Dr R Woodruff.

In 1995 the incidence of voluntary euthanasia had slightly increased - although not very much - and the incidence of non-voluntary euthanasia had slightly decreased. It seems to me that the explanation of the Dutch researchers who published the study has persuasive force. They suggested that the slight increase of voluntary euthanasia is a result of the practice being able to be practised even more openly now than then and that the decrease in non-voluntary euthanasia shows that the slippery slope does not work. Indeed the discussion that is facilitated by the decriminalisation of voluntary euthanasia allows doctors more freely to discuss these issues with the patient. In other words, if there is a slope, the latest study seems to suggest that the slope goes upwards. In other words that there is a slight improvement in the practice.⁴⁷

8.55 Dr Robert Marr, a representative of the Doctors Reform Society and the Coalition of Organisations for Voluntary Euthanasia, drew the Committee's attention to an editorial in *The New England Journal of Medicine* that "has knocked on the head the slippery slope phenomenon that has been talked about by some anti-euthanasia people".

8.56 The Committee notes that the editorial in *The New England Journal of Medicine* states:

Are the Dutch on a slippery slope? It appears not. The first report, by van der Maas and colleagues, shows that the practices in 1995 were not much different from those in 1990. The first report, by van der Maas and colleagues, shows that the practices in 1995 were not much different from those in 1990 ... The incidence of ending life without an explicit request from the patient - the most disturbing finding in the earlier study - was slightly less in 1995 than in 1990. It would be very hard to construe these findings as a descent into depravity. As far as we can tell, Dutch physicians continue to practice physician - assisted dying only reluctantly and under compelling circumstances.⁴⁸

8.57 The Committee referred the views expressed in this editorial to Dr John Keown who, in evidence, presented a different interpretation of the results of the Dutch studies. He replied:

It seems to me that the editorial simply fails to account for the reality of the data which show clearly that there is widespread under-reporting and a significant proportion of people terminated without request. The data show there was a clear failure to observe the criteria and, therefore, it seems to me that this editorial is placing a misleading favourable gloss on the reality of Dutch euthanasia. But then it is not the first editorial to do so. Other

47 *Evidence*, Dr H. Kuhse, p. 118.

48 Angell M, "Euthanasia in the Netherlands - Good or Bad?," *The New England Journal of Medicine*, Vol. 335, No. 22, pp. 1676-78

publications as well, not least the conclusions of those who carry out the research, place a misleading and favourable gloss on the Dutch experience.⁴⁹

8.58 Dr Helga Kuhse offered a possible solution as to why such different interpretations can be placed on the same statistics. She noted:

There are people like John Keown - and I believe he will give evidence later today - who take the view that we ought to classify as euthanasia all cases of the intentional termination of life. He has used this classification for calculating the number of deaths in the Netherlands. In other words, he includes in the definition of euthanasia all cases of the intentional termination of life, even if this is done by the withdrawing of treatment or by the administration of palliative care.⁵⁰

8.59 In reply, Dr Keown told the Committee that even if the statistics of the studies are accepted as interpreted by the Dutch researchers, there is still strong evidence to support the slippery slope argument.⁵¹ He added that *The New England Journal of Medicine* "is a reputable publication, but it does not follow that everything published therein is actually correct, or accurate, or well researched or well thought out".⁵²

8.60 A further issue is whether the level of non-voluntary euthanasia in Holland can be sheeted home to the official toleration of voluntary euthanasia in that country, or whether similar rates of non-voluntary euthanasia (and other medical decisions relating to the end of life) occur in countries where euthanasia is not officially tolerated. In this regard, the recent survey conducted by Professors Kuhse, Singer and Baume in Australia has been the subject of contention.

Switzerland

8.61 When he appeared before the Committee, Mr Marshall Perron referred to the Swiss experience as one from which the Committee learn. He said:

In response to the view that it has never happened before and therefore we should not do it and it has such awful ramifications which cannot really be demonstrated so we will just jump at shadows, it is a little known fact that the Swiss have permitted and practised assisted suicide for 50 years without their society crumbling as predicted by the House of Lords and others. ... Under

49 *Evidence*, Dr J. Keown, p. 156.

50 *Evidence*, Dr H. Kuhse, p. 128.

51 *Evidence*, Dr J. Keown, p. 156; p. 162.

52 *Evidence*, Dr J. Keown, p. 156.

Swiss law some 120 people per year are assisted to suicide completely legally.⁵³

8.62 He provided the Committee with a paper by Mr Meinrad Schär which described the position in Switzerland.⁵⁴

8.63 Swiss law deals in separate provisions with voluntary euthanasia and with assisted suicide. Article 114 of the Swiss Penal Code creates a specific offence for voluntary euthanasia:

A person who ends another person 's life for estimable motives, namely for pity, at the serious and urgent request of that person will be punished with imprisonment.

8.64 The punishment for this offence is less than that for murder. Under Swiss law the motive of the person convicted is a major consideration in sentencing. Although it seems that there are no reported judicial decisions on the point,⁵⁵ it has been suggested that in a voluntary euthanasia case the motive may be regarded as so benevolent that no penalty is imposed.⁵⁶

8.65 Article 115 of the Swiss Penal Code deals with assisted suicide. It was enacted in 1937⁵⁷ and it provides:

A person who, for selfish motives, persuades or assists another person to commit suicide will be punished, in case of completed or attempted suicide, with penal servitude up to five years or with imprisonment.

8.66 If there is no selfish motive, assisting another to commit suicide is not criminal. However it seems that Swiss doctors are reluctant to provide the assistance.⁵⁸

8.67 Mr Meinrad Schär's paper described the operation of a Swiss voluntary association called EXIT which assists seriously sick and terminally ill people to die and which has more than 60,000 members. He outlined the procedures as follows:

1. The patient personally (not relatives or friends) makes contact with the headquarters of EXIT (day and night service).
2. A collaborator of EXIT visits the patient in order to establish that it is the genuine wish of a person of sound mind who decides

53 *Evidence*, Mr M Perron, p. 28.

54 M Schär (EXIT, Swiss Society for Humane Dying), "Assisted Suicide in Switzerland: When is it permitted?", mimeo, undated but apparently late 1996.

55 Canada, Senate, *Of Life and Death: Report of the Special Senate Committee on Euthanasia and Assisted Suicide*, June 1995, p. A-173.

56 M Sayid, "Euthanasia: A Comparison of the Criminal Laws of Germany, Switzerland and the United States", (1983) 6 *Boston College International and Comparative Law Review* 533, 553.

57 M Schär "Assisted Suicide in Switzerland: When is it permitted?", mimeo, undated, p. 3.

58 M Schär "Assisted Suicide in Switzerland: When is it permitted?", mimeo, undated, p. 3.

and that he is not coerced or influenced by a third person. Then a date for assisted suicide is fixed.

3. The patient will be invited to ask his physician for a certificate of the diagnosis and - if possible - prognosis.

4. The decision as to whether assistance in dying can be offered is taken by a physician of EXIT. (In doubtful cases a group of three collaborators - a lawyer, a physician and a psychiatrist - decide)

5. An EXIT helper then visits the patient and assists him to self-delivery. He promises the patient that he will stay with him until death has occurred. ... There is always a witness present, mostly a relative to whom the suicidal person has close contact.

The patient is then given two tablets of "Dramamine". (He or she becomes completely relaxed and talks freely about his or her life. There is no fear and no anxiety about dying). After half an hour the patient is given 10 g of sodium-pentobarbitone (a barbiturate) dissolved in about 100 to 150 ml of tap water. ...

6. Within less than five minutes the patient will fall into a deep sleep and within two hours - with few exceptions - he will die peacefully.

7. Immediately after death we call the police. The prosecution attorney, the coroner, a criminologist and other "officials" will show up in order to find out whether or not laws have been violated.

Up to now no collaborator of EXIT has had to appear before the court for helping a person to commit suicide.

8.68 The conditions that EXIT imposes for providing assistance require that the person being assisted be: 18 years old or older; mentally competent; a member of EXIT; a resident of Switzerland; suffering from a serious illness and/or unbearable health troubles with poor prognosis; and willing to die with the help of EXIT. The diagnosis of the disease and its prognosis have to be confirmed by a physician.⁵⁹

Oregon's Death with Dignity Act

8.69 In the November 1994 general election, the voters in the US State of Oregon approved by a vote of 51 to 49 per cent a ballot measure that allowed a restricted form of physician-assisted suicide. The resulting Act was called the Death With Dignity Act. For the first time in the United States a law had been enacted that permitted physician-assisted suicide.

8.70 The Act allows a terminally ill patient to obtain a doctor's prescription for a fatal drug dosage for the express purpose of ending his or her life. However, the Act does not allow the doctor to carry out the killing of the patient: the patient must self-administer the fatal drug.

8.71 To use the Act the patient must be an adult resident of Oregon suffering from a 'terminal disease'. This is defined as 'an incurable and irreversible disease that has been

59 M Schär "Assisted Suicide in Switzerland: When is it permitted?", mimeo, undated, p. 6.

medically confirmed and will, within reasonable medical judgment, produce death within six months'. The patient must make two oral requests at least fifteen days apart, and one written request witnessed by two people, voluntarily expressing a wish to die. The prescription must not be given sooner than 15 days after the initial oral request and 48 hours after the written request. The decision must be an informed one, based on, amongst other things, knowledge of palliative care alternatives. Two doctors must verify that the patient has a terminal disease, is mentally competent, and has made a voluntary and informed decision.

8.72 The validity of the Death With Dignity Act was challenged on the grounds that it infringed several protections guaranteed by the US Constitution. A preliminary injunction was granted by the Federal District Court in Oregon on 27 December 1994 that prevented the Act from being used. In August 1995, the Court found that the Act was unconstitutional because it failed to provide the equal protection required by the Fourteenth Amendment.⁶⁰ A permanent injunction was granted.

8.73 The Court found that the Act singled out terminally ill patients who wish to commit suicide and excluded them from the protection conferred on others by the laws of Oregon. Those laws criminalise causing or aiding someone to commit suicide, and provide protection from committing suicide for persons found to be a danger to themselves, including involuntary commitment procedures.

8.74 The Court found that the procedures set out in the Death with Dignity Act did not provide sufficient safeguards to prevent the mentally incompetent from using its procedures or ensuring that the decisions to seek a prescription and to self-administer the fatal drugs were truly voluntary and uncoerced. The Court made a large number of criticisms of the Act. For example, one inadequacy identified by the Court in the Act was that neither of the two doctors required to be involved in the procedures had to be mental health specialists. Another was that no social evaluation was required to see if social services might assist the patient to live in greater comfort. It found unsatisfactory the length of time for reflection provided in the Act. It criticised the fact that the Act did not require that the actual administration of the drug be taken in the doctor's presence, or at any particular time or in any particular manner. The drugs could be taken weeks or months later at a time when the person was incompetent or unduly influenced.

8.75 An appeal was lodged with the US Court of Appeals for the Ninth Circuit from the decision of the District Court in this case, and the injunction remained in force. On 27 February 1997, the Court of Appeals dismissed the challenge to the Oregon law saying that the plaintiffs, a group of patients, doctors and nursing homes, lacked the standing to challenge it. From media reports, it appears that the Court did not address the merits of the constitutional challenge. Those challenging the law have said they will appeal the decision, and the Oregon Deputy Attorney General was reported as saying that the law "is likely to remain on hold through the next phase of the litigation".⁶¹

60 *Lee v Oregon* 891 F.Supp 1429 (1995).

61 "Federal Appeals Court Dismisses Challenge to Oregon Assisted-Suicide Law", *Washington Post*, 28 February 1997, p. A10.

8.76 In March 1996 in deciding an appeal in a different case involving physician-assisted suicide, *Compassion in Dying v Washington State*,⁶² the majority opinion from the Court of Appeals for the Ninth Circuit said that the District Court case on the Oregon Act was erroneously decided. The *Compassion in Dying* case involved a constitutional challenge to a Washington State law that prohibits assisted suicide, including physician-assisted suicide. Thus it approached essentially the same legal issue from the opposite direction to the Oregon case, in which the challenged statute expressly permitted physician-assisted suicide.

8.77 The decision by the full court of the Ninth Circuit Court of Appeals to uphold the challenge is itself on appeal to the US Supreme Court.⁶³ Also on appeal to the Supreme Court is a decision holding that a New York State law barring physician-assisted suicide is unconstitutional.⁶⁴ Oral argument on both appeals was heard together on 8 January 1997, with a decision expected at some time before July.

62 79 F.3d 790 (1996).

63 The case has proceeded under the name *State of Washington v Glucksburg*, No. 96-110, US Supreme Court, October 1996 term.

64 *Vacco v Quill*, No. 95-1858, US Supreme Court, October 1996 term.

CHAPTER 9

SUMMARY

Introduction

9.1 If enacted, the Euthanasia Laws Bill 1996 will remove the legislative power of the Australian Capital Territory, Norfolk Island and the Northern Territory to enact laws that permit voluntary or involuntary euthanasia. In particular, the Bill will override the Northern Territory's *Rights of the Terminally Ill Act 1995*, which under certain conditions permits physician-assisted suicide and active voluntary euthanasia.

9.2 The Committee received evidence that the Commonwealth Parliament has the power under section 122 of the Constitution to enact the Euthanasia Laws Bill. If this evidence is accepted, the threshold question that the Senate should then address is whether it is **appropriate** for the Parliament to do so.

9.3 The Committee is of the view that the Senate, when deciding on whether in this instance it is appropriate for the Parliament to do so, should have regard to the following significant issues:

- the "Territory rights" issue;
- the claim that the Bill may contain or lead to legal uncertainty;
- the claim that the Northern Territory's Rights of the Terminally Ill Act is having unacceptable impacts on the Aboriginal community; and
- the more general moral, philosophical, ethical and social arguments about euthanasia.

9.4 In the following sections, the Committee summarises the various arguments relating to these issues.

The "Territory rights" issue

9.5 The Committee heard evidence that Rights of the Terminally Ill Act affects Australia's ethos and social fabric and our international standing and reputation. It has additional national significance as all Australians can use the Act. It is therefore not just limited to the people of the Northern Territory.

9.6 Opponents of voluntary euthanasia maintain that:

- (a) the Northern Territory cannot be left to determine for all Australians a matter of such profound importance and significance;
- (b) the Northern Territory Legislative Assembly initially decided the matter by only a single vote;

- (c) the Rights of the Terminally Ill Act is a bad law in that it allows intentional killing and assisted suicide; and
- (d) no other legislature anywhere in the world has seen fit to enact legislation like the Act.

9.7 Proponents of voluntary euthanasia maintain that:

- (a) the Euthanasia Laws Bill is an unprecedented breach of the conventions and practices underpinning self-government in the Territories;
- (b) the Bill represents an erosion of the basic democratic and constitutional rights of Territorians;
- (c) the Commonwealth Parliament should not interfere in matters over which it has transferred legislative power to the Territories;
- (d) the removal of this power will send the unacceptable message that the Territory Legislatures are somehow inferior and that their citizens are second-class;
- (e) Commonwealth intervention in relation to the Territories is also seen as discriminatory and *ad hoc*, as the Commonwealth could not enact similar legislation that could apply to the States; and
- (f) positive international comment and support for the Rights of the Terminally Ill Act.

9.8 The Committee received evidence that the Commonwealth Parliament does not have a head of power under which national legislation could override any State legislation dealing with euthanasia. On the other hand, evidence was adduced that the Commonwealth has a variety of mechanisms that could limit the operation of State legislation along the lines of the RTI Act.

Legal issues – uncertainty

9.9 The Bill withdraws the power of the Territories to make laws that permit "intentional killing". The Bill does not define the term "intentional killing", and the Committee received evidence that the term has no generally accepted legal meaning. As a result, it was said that enactment of the Bill would lead to uncertainty in at least two respects:

- as to the validity of existing Territory Acts that allow a doctor in some cases to withdraw or withhold medical treatment or administer pain-relieving drugs, even though the doctor knows that the death of the patient will result; and
- as to whether the Territories retain the power to enact legislation of this kind, or to legislate to clarify uncertainties that already exist in aspects of the law in this area.

9.10 In addressing this issue, the Committee received advice from the Attorney-General's Department and submissions and opinions from eminent lawyers. During the course of the inquiry, two views on the meaning of "intentional killing" emerged. The Committee's report shows that this area of law is complex and technical.

9.11 The first view, suggested by the Attorney-General's Department, maintained that "intentional killing" has an uncertain and broad meaning. The view that enactment of the Bill

would lead to uncertainty was also expressed by, amongst others, the ACT Attorney-General, Mr Gary Humphries MLA, and the Northern Territory Solicitor-General. On this view, the Bill may interfere with generally accepted practices in palliative care and the withholding or withdrawal of burdensome and futile medical treatment. It may also create uncertainty about the validity of existing and future laws relating to aspects of medical end-of-life decisions.

9.12 The second view, supported in particular by Mr Tom Hughes QC and Mr Joseph Santamaria QC, maintained that "intentional killing" has a clear and narrow meaning. On this view, the Bill would not interfere with generally accepted medical practices. Moreover, the Bill would not lead to the uncertainties noted above.

9.13 In assessing these views, the Committee draws the attention of the Senate to the advice of Mr Geoffrey Dabb, First Assistant Secretary, Criminal Law Division of the Attorney-General's Department, on the quality of the drafting of the Bill. He thought the Bill showed all the signs of being drafted with a high degree of professional competence, and struck the right balance between simplicity and complexity.¹

Aboriginal issues

9.14 Submissions received from Aboriginal communities supported the enactment of the Euthanasia Laws Bill to override the Rights of the Terminally Ill Act.

9.15 The Committee heard conflicting evidence on whether traditional Aboriginal culture recognises euthanasia and also on the attitude of Aboriginal communities to the Northern Territory's Rights of the Terminally Ill Act.

9.16 During the course of the inquiry, a major concern emerged whether the Northern Territory legislation may impact on the willingness of Aborigines to access medical services, given their cultural beliefs and customary laws.

9.17 The Northern Territory Government denied that there has been any decrease in the use of medical facilities by Aborigines and provided some statistics to support this view.

9.18 The Committee also heard evidence from Mr Chips Mackinolty, who was engaged by the Northern Territory Government to provide an unbiased and factual education campaign on euthanasia to Aboriginal communities, following the enactment of the legislation. Mr Mackinolty told the Committee that, even though he personally supported his own right to euthanasia as a non-Aboriginal, his experience in conducting the education campaign had brought him to the view that the Northern Territory's Rights of the Terminally Ill Act should be repealed because of its potential to deter Aborigines from seeking prompt medical attention. Mr Mackinolty expressed the view that the very existence of the Northern Territory legislation is a significant threat to Aboriginal health.

1 *Evidence*, Attorney-General's Department, p. 202.

General moral, philosophical, ethical and social issues

9.19 The Committee reports that it heard well argued, considered and sincere views for and against voluntary euthanasia.

9.20 Proponents of voluntary euthanasia drew the Committee's attention to arguments based on individual rights, autonomy and choice. Those in favour of voluntary euthanasia maintain that the general public, as represented by opinion polls, overwhelmingly support its legalisation and that such a move will merely bring under stringent control and regulation what in reality is already happening in practice.

9.21 Opponents of voluntary euthanasia drew the Committee's attention to arguments based on the sanctity of life, religious beliefs, the impact on the old, the vulnerable and the disabled, the "slippery slope" to involuntary euthanasia, the deterioration of social mores and the erosion of medical ethics.

9.22 Both sides of this debate recognise the fundamental importance of effective and available palliative care.

9.23 Some proponents of voluntary euthanasia see it as an option of last resort if palliative care cannot effectively relieve a patient's distress, suffering or loss of dignity. On the other hand, some opponents of voluntary euthanasia argue that palliative care neither hastens nor postpones death. To these opponents, voluntary euthanasia is no more a part of palliative care than it is part of aged care, mental health or intellectual disability programs.

9.24 In assessing these arguments the Committee was referred to developments in The Netherlands, where voluntary euthanasia, although not legal, is practiced openly and is officially tolerated. Both sides of the debate used developments in the law as well as studies conducted in 1991 and 1995 to support their views on whether the Dutch experience provides evidence of the slippery slope. There seems to be no consensus on how to interpret the Dutch data in the Dutch context. The relevance of the Dutch experience to Australia provided further grounds for disagreement.

Conclusion

The Committee makes no recommendation to the Senate on the Euthanasia Laws Bill because it is a private member's Bill and is subject to a "conscience vote".

ADVICE TO THE SENATE

Introduction

If enacted, the *Euthanasia Laws Bill 1996* will remove the legislative power of the Australian Capital Territory, Norfolk Island and the Northern Territory to enact laws that permit euthanasia. In particular, the Bill will override the Northern Territory's *Rights of the Terminally Ill Act 1995*, which under certain conditions permits physician-assisted suicide and active voluntary euthanasia.

We believe that the Preface and Chapters 1-9 (excluding the Conclusion) set out a fair and representative summary of the evidence submitted to the Committee.

Does the Constitutional Power Exist?

We are in no doubt that the Commonwealth Parliament has the power under section 122 of the Constitution (which gives the Commonwealth unfettered power to legislate in respect of the Territories) to enact the *Euthanasia Laws Bill 1996*. In our view therefore, the question is whether it is appropriate for the Parliament to do so.

Should the Constitutional Power be Exercised?

Once the threshold question of Constitutional capacity is answered in the affirmative then the Senate then needs to address its collective mind to the question of whether the power ought to be exercised in any circumstance, and if so, in what circumstances.

We acknowledge that the Commonwealth Parliament should only withdraw legislative powers it has conferred on its Territories in exceptional circumstances. We consider that in this instance it is right for the Parliament to do so. In coming to this conclusion we have had regard to the following major issues:

- the "Territory rights" issue;
- the claim that the Bill will lead to legal uncertainty;

- the claim that the Northern Territory's *Rights of the Terminally Ill Act 1995* is having unacceptable impacts on the Aboriginal community; and
- the more general moral, philosophical, ethical and social arguments about euthanasia.

The "Territory rights" issue

We consider that the *Rights of the Terminally Ill Act 1995* represents a fundamental shift in Australia's ethos and social fabric. It has additional national significance as all Australians, indeed all people, can use the Act. It is therefore not just a matter for the people of the Northern Territory.

The Northern Territory Legislative Assembly decided the matter by only a single vote. A repeal Bill was defeated in the Territory's Legislative Assembly on the Territory Rights argument. However, the personal views of a majority of the Members of the Legislative Assembly was that they opposed euthanasia in principle. It appears that without the possibility of the *Euthanasia Laws Bill 1996* the Northern Territory Legislative Assembly may have repealed the *Rights of the Terminally Ill Act 1995* of its own volition without Commonwealth intervention. This would clearly have been the preferable course.

There appears to have been an inappropriate merging of the concepts of States' Rights and Territories' Rights in some of the submissions. The Constitutional framework of Australia divides legislative responsibility between the States and the Commonwealth. The Territories derive their legislative capacity from the Commonwealth, whereas the States do not.

States therefore, are different to Territories. Territorians are therefore subjected to a different legislative process than are the residents of the various States.

We are of the view that it may be desirable to legislate on a Commonwealth level. However, such a power is not apparent to us. The Committee did not seek submissions on this specific point.

In those circumstances the only power open to the Commonwealth is to legislate in respect of its Territories.

Given that the Territories in question have been provided limited forms of self-government, we are agreed that the Commonwealth should not intervene other than in exceptional circumstances. It is difficult to envisage a more exceptional circumstance than euthanasia being as it is an issue that deals with the life and death of Australian citizens, indeed potentially all the people in the world.

As an aside, we are of the view that the Northern Territory's progress to Statehood should not be impeded by this issue or any vote which may override the Territory on this occasion.

Legal issues – uncertainty

The Bill withdraws the power of the Territories to make laws that permit "intentional killing".

The Bill does not define the term "intentional killing", and the Committee received evidence that the term has no generally accepted legal meaning.

In addressing this issue, the Committee received advice from the Attorney-General's Department and submissions and opinions from eminent lawyers. During the course of the inquiry, two views on the meaning of "intentional killing" emerged. The Committee's report shows that this area of law is complex and technical.

The first view, suggested by the Attorney-General's Department, maintained that "intentional killing" has an uncertain and broad meaning. On this view, the Bill may interfere with generally accepted practices in palliative care, including the withholding or withdrawal of burdensome and futile medical treatment. It may also create uncertainty about the validity of existing and future laws relating to aspects of medical end-of-life decisions.

The second view, supported in particular by Mr Tom Hughes QC and Mr Joseph Santamaria QC, maintained that "intentional killing" has a clear and narrow meaning. On this view, the Bill

would not interfere with generally accepted medical practices. Moreover, the Bill would not lead to the uncertainties noted above.

We find the second of these views persuasive.

In reaching this conclusion, we note:

- any uncertainty that might be created by the Bill does not affect its purpose, that is to prevent active voluntary euthanasia; and
- evidence to the effect that a degree of uncertainty may be inescapable in any legislation in this area, and that this should not inhibit the Parliament from enacting that which is otherwise appropriate legislation.

We further note that the Courts do have recourse to the Explanatory Memorandum and the Parliamentary debates which would clearly indicate that the legislature intended the "narrow" meaning. Uncertainty in legislation is to be avoided if possible but is also unavoidable. Our Constitution which has been in existence for nearly a century is still the daily subject of detailed disputation in the Courts as to its meaning and intent. *The Euthanasia Laws Bill 1996* like the *Rights of the Terminally Ill Act 1995*, both have potential uncertainties which will only be fully clarified through judicial interpretation.

In this context the following advice of Mr Geoffrey Dabb, First Assistant Secretary, Criminal Law Division of the Attorney-General's Department, on the quality of the drafting of the Bill is instructive:

The bill has to me has all the signs of being drafted with a high degree of professional competence and I would assume that expert legal advice has gone into the drafting of this bill. It seems to strike the right balance between simplicity and not becoming over complicated in trying to deal with every situation.¹

¹ *Evidence*, Attorney-General's Department, p. 202.

Another argument of uncertainty is whether it is feasible to codify in statute form the circumstances in which a life can be legally extinguished. The Premier of New South Wales, Hon Bob Carr MLA rhetorically asked that question in the New South Wales parliamentary debate and responded as follows:

"Is it possible to reduce to black and white law on the pages of a statute book the circumstances, and the safeguards, in which we would allow the taking of a life? I have spoken to many experts, people engaged on both sides of this argument, and what has shaped my bottom line conclusion is the view that it is not possible to codify in a law the safeguards, the circumstances, in which the extinguishing of a human life would be possible."²

Indeed many witnesses highlighted difficulties with the *Rights of the Terminally Ill Act 1995*. On one interpretation a patient with diabetes could conceivably access the provisions of the *Rights of the Terminally Ill Act 1995* and have their life terminated although their prognosis was for a full life. How do you protect against misdiagnosis or inappropriate palliative care? What real checks are there? The safeguard of one psychiatric assessment is somewhat lessened when considered in the light of endless hours of argument and contradictory expert evidence given in the Courts each day concerning a deceased's testamentary capacity ie. was the maker of the will mentally competent at the time of signing it. In such cases, psychiatrists are found on each side of the case putting views which are diametrically opposed. Psychiatry is an inexact science. The possibility for abuse is ever present.

These uncertainties must then be viewed in the context that the only independent monitoring of the process takes place when the coroner receives the relevant paperwork subsequent to the termination of the patient's life.

² Hon Bob Carr, Premier NSW, NSW Assembly Hansard, 16.10.1996 p.7.

Aboriginal issues

The Committee heard conflicting evidence on whether traditional Aboriginal culture recognises euthanasia and also on the attitude of Aboriginal communities to the Northern Territory's *Rights of the Terminally Ill Act 1995*. In this context, allegations were made that certain church groups were conducting a misinformation campaign amongst Aborigines. No actual evidence was brought forward and was specifically rejected.

Indeed evidence showed that Aboriginal communities without any church involvement were just as opposed to euthanasia as those with a Christian ethic. It is therefore apparent that the overwhelming Aboriginal opposition to the *Rights of the Terminally Ill Act 1995* is not necessarily influenced by the involvement of the Christian Church in some Aboriginal communities. Even if they were so influenced it is not a ground to reject those views especially when during the course of the inquiry, a major concern emerged about the Northern Territory legislation's impact on the willingness of Aborigines to access medical services, given their attitudes to euthanasia and western medicine.

The Northern Territory Government denied that there has been any decrease in the use of medical facilities by Aborigines and provided statistics to support this view.

The Committee also heard convincing evidence from Mr Chips Mackinolty, who was engaged by the Northern Territory Government to provide an unbiased and factual education campaign on euthanasia to Aboriginal communities, following the enactment of the legislation. Mr Mackinolty told the Committee that, even though he personally supported his own right to euthanasia as a non-Aboriginal, his experience in conducting the education campaign had brought him to the view that the Northern Territory's *Rights of the Terminally Ill Act 1995* should be repealed because of its potential to deter Aborigines from seeking prompt medical attention. Mr Mackinolty expressed the view that the very existence of the Northern Territory legislation is a significant threat to Aboriginal health.

We found the evidence of Mr Mackinolty compelling and note that it was corroborated by other evidence from Aboriginal community groups.

The only positive evidence of misinformation which was provided to the Committee was that certain Aboriginal communities have been told that euthanasia could only occur in Darwin so as to put them at ease in using local health clinics. Evidence was provided from Papunya Community via Alice Springs that these statements had been provided by local doctors:

The doctor here told us it was OK and that the clinic would never have the needle like that available. We were told Alice Springs would not have it either. Only in Darwin. But a lot of people are still a bit scared.

It was also stated by Valda Shannon of Julalikari Council who acted as the interpreter for Chips MacKinolty during the Green Ant Consultations in Tenant Creek:

We had to tell people that at Tenant Creek hospital and at Alice Springs hospital nothing like this could ever happen. Because we did not want people to decide that they were not safe at these hospitals. We had to tell them that it was only available at Darwin.

It is appreciated that this misinformation about the operation of the legislation was provided so as to encourage people to feel safe utilising local health services. However, it is important to note that this may pose dangers for the future if there is a death in accordance with the *Rights of the Terminally Ill Act 1995* at Alice Springs (see Committee report, paragraphs 5.28 - 5.30).

The Committee received close to 200 submissions from Aboriginal communities, Aboriginal organisations and individuals who identified themselves as Aboriginal. Without exception, these submissions opposed the existence of the *Rights of the Terminally Ill Act 1995*. Fear of seeking medical treatment because of legalised voluntary euthanasia was a consistent theme of these submissions.

We are of the view that the potential for the Northern Territory's *Rights of the Terminally Ill Act 1995* to deter Aborigines from accessing medical services is a further persuasive reason for the Commonwealth Parliament to exercise its powers in relation to the Territories by enacting the *Euthanasia Laws Bill 1996*.

General moral, philosophical, ethical and social issues

The Committee heard well argued, considered and sincere views for and against euthanasia.

Proponents of voluntary euthanasia drew the Committee's attention to arguments based on individual rights, autonomy and choice. Those in favour of voluntary euthanasia maintain that the general public overwhelmingly support its legalisation and that such a move will merely bring under stringent control and regulation what in reality is already happening in practice.

Opponents of voluntary euthanasia drew the Committee's attention to arguments based on the sanctity of life, religious beliefs, the "slippery slope" to involuntary euthanasia and the erosion of medical ethics.

Both sides of this debate recognise the importance of palliative care.

Opponents of voluntary euthanasia argue that palliative care neither hastens nor postpones death and therefore, voluntary euthanasia does not form any part of palliative care. No is it part of aged care, mental health or intellectual disability programs.

In assessing these arguments the Committee was referred to developments in The Netherlands, where euthanasia, although not legal, is openly practised.

Both sides of the debate used developments in the law as well as studies conducted in 1991 and 1995 to support their views on whether the Dutch experience provides evidence of the "slippery slope".

There seems to be no consensus on how to interpret the Dutch data in the Australian context.

The relevance of the Dutch experience to Australia provided further grounds for disagreement,

particularly following the publication of an Australian survey purporting to replicate the Dutch studies by Professors Kuhse, Baume and Singer.

We are of the view that an assessment of the arguments relating to general moral, philosophical, ethical and social issues also supports the exercise of the Commonwealth Parliament's power in relation to the Territories by enacting the *Euthanasia Laws Bill 1996*.

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

In particular, we share the view of the House of Lords Select Committee on Medical Ethics which held that:

"Th[e] prohibition [of intentional killing] is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished ..."

The Hon H.E. Cosgrove AM QC in his letter of December 2, 1996 relied on two long-established principles:

1. That private citizens are not permitted to destroy life. The State may do so, but only in carefully circumscribed circumstances.
2. That no person can consent to an assault on his person, unless the assault is done in order to save life or health.³

There is a powerful sentiment in that summary of the law. As soon as we allow another person to be involved in the death of a fellow human being we must have come to the conclusion that the life is not worth living. The concept of a life not worth living and

³ Submission 3256, p 1.

justifying the involvement of a third party in taking that life challenges to the very core our notions of civilisation. As soon as such a concept takes hold within the psyche of our nation we will demean the value we place on human life. Indeed many witnesses supporting euthanasia told the Committee they personally would relax the "stringent requirements" of the Rights of the Terminally Ill Act 1995, which includes a final 48 hour cooling off period.

As the Labor Premier of New South Wales, Hon Bob Carr MLA told the New South Wales Parliament on October 16, 1996:

"I wonder whether we as a Legislature are confident in making a value judgment about what the cooling off period should be for the taking of a human life. The legislative cooling off period for a person who has bought a set of encyclopedias from a door-to-door salesperson is 10 days. Are we happy to have a 48-hour cooling off period for the taking of a human life?"⁴

"Individual Rights" and "Choice"

The individual rights and autonomy argument is at first glance persuasive. However even if one supports the principle of euthanasia the question needs to be asked: "Can we sufficiently codify the circumstances in which we would allow euthanasia?" We are of the view that it is impossible. The New South Wales Premier's previously quoted comment is apposite in this regard. (See Footnote 2)

Individuals have the unfettered right to forego medical treatment. Suicide is not a crime, although we as a community spend millions of dollars each year trying to counsel and dissuade the suicidal.

The *Rights of the Terminally Ill Act 1995* does not so much change the law for the patient as it changes the law for the third party (the doctor). What is currently illegal for the doctor will

⁴ Hon Bob Carr, Premier NSW, NSW Assembly Hansard, 16.10.1996, p 7.

become legal. This has the potential to fundamentally alter the doctor/patient relationship.

Ultimately, a new right is given to doctors to terminate the lives of those who are suicidal and terminally ill. To describe this as providing a "right to die" defies logic.

Further, most supporters of euthanasia do not see it as an absolute right. As such it is by definition only available to those individuals who have been deemed to be in such circumstances as to be considered better off dead. Whilst it is understandable that a patient may come to such a conclusion, a third party would also need to arrive at such a conclusion and then be prepared to act upon that view, by administering or providing a substance with the intention of ending the patient's life.

The potential for "guilt feelings" for being a burden or too costly by those of our community who are in difficult circumstances, vis a vis their health, may become such that they perceive a subtle duty on them to exercise the euthanasia option. The choice may well become a perceived duty. This is especially so when considered in the context of comments by those such as former Governor General, Hon Bill Hayden's comments that "... there is a point when the succeeding generations deserve to be disencumbered -to coin a clumsy word - of some unproductive burdens".⁵

Dying with Dignity

This emotive description in support of euthanasia is unfortunate. The dignity or otherwise of a death is not to be determined by the physical circumstances or degree of pain in which the patient finds themselves.

With very few exceptions, pro-euthanasia submissions which dealt with the term "dignity" described particular physical circumstances and described living or dying in such circumstances

⁵ Hon Bill Hayden, Arthur Mills Oration 1995, p 8.

as necessarily involving a loss of dignity. These circumstances regularly included loss of continence and mobility.

This approach, in referring to various physical circumstances, consistently dealt with circumstances where the person had taken on certain disabilities and described such circumstances as involving a loss of dignity. A disturbing equation is thus drawn between having "dignity" and being "without disability". The term has been used as though there is a loss of dignity if somebody who was previously without disability takes on a disability in the course of a terminal illness.

Whilst it was those concerned about the impact on people with disabilities who have highlighted this issue it needs to be noted that the impact is even broader. Any notion that those who choose the path of natural death or those who choose to live with disabilities are in some way taking the less dignified path should be abhorrent to any caring society.

Unfortunately, the attitude from certain quarters that dying with dignity demands that life ends before such circumstances begin carries a message which only serves to devalue those who live in such circumstances.

Anecdotal Evidence

In the course of the inquiry, and in the course of the debate in the community, much has been made of anecdotal evidence of individuals dying in harsh circumstances. Such extraordinary circumstances warrant the most compassionate response for the person themselves and for the carers and family involved.

Regardless of whether or not euthanasia might be the appropriate response in such circumstances, the task before the Committee, and in turn before the Senate, is to determine how a change in the law so as to allow such a response, stands up as a matter of public policy. The parallel, often made to the inquiry in oral and written submissions, between legalised euthanasia and legalised capital punishment is particularly useful at this point. Supporters of

capital punishment frequently refer to horrific crimes as the justification for a change in the law, in the same way that supporters of legalised euthanasia refer to horrific deaths. This approach could only carry any validity if the impact of the change in the law was entirely confined to people in such circumstances. Such an approach lacks credibility.

Whilst many a moving and passionate submission was presented detailing individual circumstances, we are of the view that:

No question as serious as euthanasia should be settled on individual cases. A general principle must be found which transcends particular cases. As with capital punishment, one principle which could be universally applied is that human life should be valued to the extent which puts it beyond the state.⁶

There was the inevitable provision of anecdotal evidence of those who had been misdiagnosed or made "miraculous recoveries" from a death bed situation, at which time they would have had access to euthanasia.

Also noteworthy was the overwhelming objection by doctors to euthanasia. As those at the "coal face" they would be only too aware of the misdiagnosis and other errors that can be made.

This may also explain why lawyers are disproportionately, as to the rest of the community, so strongly opposed to capital punishment.

Legalising what is common practice

This argument is logically weak. Whether euthanasia is a "common practice" is widely disputed. Even if it were it would not of itself provide a justification. Indeed, if it is widely practiced, although it is against the law, it highlights the real concerns of many opponents of

⁶ *Evidence*, Australian and New Zealand Society for Palliative Medicine, p135.

euthanasia who argue that the illegal excesses of a minority of doctors will simply become commensurately worse, with pro-euthanasia legislation.

The Place of a Moral Standpoint

The view that Australia is a pluralist society with diverging values within its citizenry is no justification to uproot a foundation stone of our notions of civilisation and the value we place on human life. There are occasions where the legislature is called upon to provide leadership. Both sides of the debate acknowledge that whilst opinion polls are important as a guide to the legislature, polls of themselves cannot be the ultimate basis for or against legislation.

Different Concepts and Important Distinctions

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

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

Physician assisted suicide or euthanasia has one purpose - to kill the patient.

Those who blur these concepts seek to establish that legalised euthanasia is only a small step for a legislature to take. It needs to be recognised that the step taken by the Northern Territory is this: to move from a situation, where no citizen may intentionally take the life of another citizen, to a regime, where certain citizens are given a full legal sanction and Parliamentary endorsement, to intentionally take the lives of certain other citizens.

This by any objective analysis represents a major shift.

Conclusion

When the *Euthanasia Laws Bill 1996* was referred to this Committee, the Selection of Bills Committee nominated four specific areas of inquiry.

These were:

- the desirability of the enactment of the provisions;
- the constitutional implications for the Territories of the enactment of the provisions;
- the impact of the enactment of the provisions on the Northern Territory criminal code; and
- the impact on, and attitudes of, the Aboriginal community.

We believe it is appropriate that our findings on these important issues be set out for the benefit of honourable Senators who charged the Committee to inquire into these areas.

Given the above evidence and conclusions, we advise that:

1. It is desirable for the *Euthanasia Laws Bill 1996* to be passed without amendment;
2. There are no Constitutional implications for the Territories;
3. There will be no adverse impact on the provisions of the Northern Territory Criminal Code; and
4. That the *Rights of the Terminally Ill Act 1995* has had, and will continue to have, an unacceptable impact on the attitudes of the Aboriginal community to health services.

The *Euthanasia Laws Bill 1996* if enacted would override the *Rights of the Terminally Ill Act 1995* and thereby relieve the Aboriginal community of its overwhelming and deeply felt concern at the Northern Territory's legislation.

Finally, we thank the 12,559 organisations and individual Australians who made submissions to the Committee and the tireless efforts of the Committee Secretariat.

ERIC ABETZ
Liberal Senator for

MARK BISHOP
ALP Senator for Western

JACINTA COLLINS
ALP Senator for Victoria

**Tasmania
Chairman**

Australia

**STEPHEN CONROY
ALP Senator for Victoria**

**CHRISTOPHER ELLISON
Liberal Senator for Western
Australia
Former Chairman**

**JEANNIE FERRIS
Liberal Senator for South
Australia**

**WILLIAM HEFFERNAN
Liberal Senator for New
South Wales**

**JOHN HOGG
ALP Senator for Queensland**

**JULIAN MCGAURAN
National Senator for Victoria**

**NICHOLAS MINCHIN
Liberal Senator for South
Australia**

**WILLIAM O'CHEE
National Senator for
Queensland**

**JOHN WOODLEY
Australian Democrat Senator
for Queensland**

**BRIAN HARRADINE
Independent Senator for
Tasmania**

Additional Comment

As members of the Senate Legal and Constitutional Legislation Standing Committee, we have sat through many hours of public hearings, read some thousands of submissions, engaged in countless discussions and heard many differing viewpoints. We have now decided not to support the Andrews Private Members Bill when it is debated in the Senate.

We have arrived at this decision for a variety of reasons which are founded in the evidence and submissions to the Committee. These include;

- **Constitutional issues**
- **Legal matters**
- **The availability of palliative care**
- **The rights of the individual.**

Constitutional Issues

The body of the Committee's report contains cogent arguments which canvass the constitutional

issues raised by the Andrews Bill. The Euthanasia Laws Bill seeks to overturn the Northern Territory's Rights of the Terminally Ill Act by amending the various Self Government Acts of the Territories. Most suggested that the Commonwealth does have the power to pass this legislation.

Notwithstanding the strong views offered, it was also suggested that the High Court may ultimately be required to rule on the constitutionality of the Andrews Bill if it is passed by the Parliament.

The Chief Minister for the Australian Capital Territory, Hon Kate Carnell indicated in her evidence to the Committee that the ACT would, if the Bill was carried, challenge it in the Court

It is noted in passing, that the High Court adjourned its hearing of a challenge to a decision of the Northern Territory Supreme Court that ruled that the Rights of the Terminally Ill Act was valid. The reason given for this adjournment was that the Andrews Bill was being considered by the Commonwealth Parliament.

Legal Issues

Many legal issues are canvassed in the body of the report, but we feel the need to reinforce the fact that the Andrews Bill does not contain any definitions of the meaning of words and terms contained in the Bill. For example, the Committee has highlighted the problems raised by the different interpretations that are given to the term "*intentional killing*".

We are especially concerned that the Committee was presented with evidence from leading counsel documenting serious unintended consequences of the bill (submission of the NT Government, especially advice of Tom Pauling QC and D Bennett QC). These matters are of critical importance and need to be addressed by the Parliament.

We suggest that the Andrews Bill is inadequate in that it does not contain definitions and that there is a distinct possibility that this will necessitate further intervention by the Courts, including the High Court, to give an interpretation.

Palliative Care

The Committee was not charged to investigate the availability of Palliative Care in Australia. Nonetheless, the availability and quality of palliative care in Australia became one of the issues of the Committee's Inquiry.

Palliative Care in Australia is under some pressure. The President of the Australian Association for Hospice and Palliative Care, Dr Michael Smith, told the Committee in evidence on 13 February 1997, that the Palliative Care Program (PCP) was under review, that it is not funded as main stream, that Palliative Care funding was cut by 10% in last years budget and there is no evidence of a commitment by the Commonwealth to the Palliative Care Program which is due for completion in July 1997.

Dr Smith in his evidence to the Committee on 13 February 1997 said;

Dr Smith-- "..... *As has been recognised in the soon to be released report of the palliative care program review 1996, the development of palliative services across Australia is now at a critical stage, as it is still incomplete. For palliative care services to mature and be funded as a mainstream health service, a number of milestones are yet to be achieved. In this difficult time, the Commonwealth has reduced its funding of palliative care for 1996-97 by 10 per cent, in the name of administrative efficiency. In the absence of agreed administrative arrangements between the Commonwealth and the states, this cut has simply meant less Commonwealth money for patient care.*

The future of the specific Commonwealth palliative care funding program, PCP, is uncertain, as it is due for completion in July 1997, with no evidence of Commonwealth commitment to its continuance. The AAHPC sees no evidence to suggest that the federal government is deliberately and specifically reducing funds for the care of dying people; nevertheless, the end result is the same: less money for dying people".

Sometimes Palliative Care is not ideal.

We were moved by the comments of New South Wales Civil Liberties Council Management Committee Member Ms Pauline Wright to the Committee on 14 February 1997, she said;

Ms Wright-- *"Palliative care is not always ideal and is not always a solution. You have, no doubt, all heard what Bob Dent said":*

"I have no wish for further experimentation by the palliative care people in their efforts to control my pain . . . I cannot even get a hug in case my ribs crack. Being unable to live a normal life causes such mental and psychological pain which can never be relieved by medication".

Rights of the Individual.

Dr Marr from the Doctors Reform Society told the Committee on 14 February 1997;

Dr Marr - *"Patients have rights, and what greater right should they have than a right to decide what happens to them at the end of their life?..... The key thing to consider is that voluntary and involuntary euthanasia is going on in Australia today and, if you are concerned about euthanasia, the best thing you can do is bring it out into the open, bring it under scrutiny, bring in safeguards and have patients having a right to have a say in what happens to them at the end of their life--not leaving it up to doctors".*

A registered nurse from the Northern Territory, Ms Sue Carter gave a different perspective at a public forum in Darwin on Thursday 23 January 1997;

SUE CARTER--*"My name is Sue Carter. I am a registered nurse. I am speaking tonight on a couple of points that come from my experience in nursing.*

The first point I want to make is that people make the comment that palliative care works and that doctors and nurses sort things out for patients. The problem with that is that no-one consults the patient in the ward about what is about to happen. What happens is that there is a discussion between nurses and doctors generally and a decision is made to 'up the morphine', as the comment is. No-one actually goes into the patient and says to them, 'Look, Mr Jones, you are really suffering here; we are going to up this morphine. The end result of that is going to be that you will lapse into unconsciousness, we cannot say when, and eventually you will die.' Nobody tells them that. So they are not giving their consent to the sort of activity that occurs at that moment, whereas voluntary euthanasia enables the patient to have control, enables them to talk to their families and to make an exit at a time that suits them. For that reason, I support it.

The other thing that concerns me is that as a nurse I know certain things. One of the things I know is that, if I want to kill myself using tablets, I go down to Woolworths and I buy a nice big box of Panadol. I take them, I go to bed, I do not tell anybody about it for six hours, and then I say, 'Hey, everybody, guess what I just did.' Three days later, I will be dead. I will have died of renal failure and liver failure. It will have been very painful and very costly to this society.

I object to the fact that certain people have access to nice drugs that enable them to be killed quickly and easily. In particular, I refer to doctors who have a very high success rate in killing themselves. So why should they have access to the nice drugs, and those of us who know have access to the yucky drugs, and those of us who do not know anything about it have to shoot ourselves or gas ourselves in a car?"

People do terminate their lives. Even elderly Australians terminate their lives and, tragically, they sometimes utilise horrific methods in order to do so. Mr Marshall Perron drew attention to this at the Committee's Darwin hearing on Friday 24 January 1997.

Mr Perron*"What I was particularly appalled at was not only the number of elderly Australians aged 75 and over who suicide, and in particular those who are 85 and older, but the methods that they choose. Unfortunately, the bureau of census and statistics is able to provide method of suicide--and senators will see some of the horrendous methods that our old people choose to die, including drinking agricultural chemicals and burning themselves and lying down before moving objects and so on--but I have no particular documentation to extrapolate that.*

I believe that many of these elderly people suicide because of the way they perceive they are going to die. I believe that the option of voluntary euthanasia

would at least delay many of those suicides in our community, possibly by years. Some of them may well suicide outside a system of voluntary euthanasia; others will take the opportunity of voluntary euthanasia; others who are now suiciding may well find that their end is nowhere near as bad as they thought it might have been''.

At page 8 of Mr Perron's submission to the Committee, he quoted some graphic statistics;

For example, in the five years to 1994 there were 672 suicides by Australians 75 or older, 137 of them by people 85 or older. Mr Perron continued....Do we think some of these lonely suicides by the elderly might have been related to how they thought they would die if they did not take control?

I suspect, every one of them.

Our oldest citizens dies by the gun, by hanging themselves, some drowned, others drank agricultural chemicals, cutting and piercing instruments were used, jumping from high places and laying before a moving object. Some even took their lives by fire.

While we would hope our senior citizens would never feel a need to end their lives deliberately, those that do should not have to resort to such horrifying violent methods.

And what of those poor souls who botch a suicide, merely succeeding in killing half their faculties?

We are sympathetic to this opinion also offered in Mr Perron's submission;

Decriminalising voluntary euthanasia will lead to reduced anxiety and trauma in our society. It will reduce violent suicides and delay some suicides to a time much closer to when death would have occurred naturally. These benefits are rarely considered in the voluntary euthanasia debate.

Statistics on suicide entitled SUICIDE BY METHOD - AUSTRALIANS 75 YEARS AND OLDER FIVE YEAR PERIOD 1990 - 1994 were attached to Mr Perron's submission (Attachment d), we too add these statistics to our additional comment.

We are concerned at the matter raised by the Senate Scrutiny of Bills Committee on the provisions of the Bill which it considered may trespass unduly on personal rights. The Committee's arguments are repeated at 1.12 of this report.

The ACT Chief Minister, Hon Kate Carnell, gave a graphic interpretation of the effect of this when she said, during the Committee hearing;

Ms Carnell ..''If passed, the bill would ensure that the people of the territories have

less democratic power than the people of the states. It would mean, for example, that people in the ACT would have fewer rights than their neighbours living in Queanbeyan. There would be some matters about which we would not be able to even consider making laws whereas over the border, 10 kilometres from here, they would have the right to contemplate such laws, even if they eventually rejected them. The Euthanasia Laws Bill is highly discriminatory in its effect. Its passage would mean that the roughly half a million people living in the territories would be deprived of the democratic rights enjoyed by other Australians simply because of their place of residence''.

It is also important to recognise the rights of the individuals who have taken advantage of the Rights of the Terminally Ill Act.

Mrs Judy Dent, widow of Mr Bob Dent, spoke at the public forum in Darwin on Thursday 23 January 1997;

JUDY DENT--"I am Bob Dent's widow. My husband had been terminally ill for some time when he chose to use the Rights of the Terminally Ill Act to end his suffering and to end my suffering. The advent of Kevin Andrews' bill upset my husband greatly. He was very relieved when the parliament of the Northern Territory passed the original legislation and so he was extremely upset to find that this compassionate, good piece of legislation might be overturned. Fortunately, it has not yet been overturned. I sincerely hope it will not be overturned.

"I know you said this was supposed to be for Territorians, but I have a statement here from the widower of Janet Mills, who also used the Rights of the Terminally Ill Act, and I would like to read that on his behalf. This is a statement from Dave Mills who lives at Naracoorte''.

I would like the Senate to know that my family totally supports the Northern Territory's Rights of the Terminally Ill Act and hopes you will vote against the Kevin Andrews bill.

It was so important for my wife Janet to have me and her youngest son present with her when she died so we could say our goodbyes with dignity. If Janet could not have used the law, she intended to take her own life. She was very worried about that because she felt that she would have to be alone to protect her family from legal problems.

Janet was a very determined woman and a special person. She would have been so pleased that the third person to use the law found it easier than she did to find a specialist to confirm her illness. She was happy with the palliative care she received, but she had just had enough at the end.

Even though we are not Territorians, Janet was so grateful to the Territory that she was able to use the law. It is still such a new thing and one day South Australia and other states might follow the Territory's lead and there

will be no need for people to travel interstate. I know she would want to thank Territorians for their thoughts and kindness in the past few weeks.

Mrs Mills own farewell note is worth quoting in part;

" I believe that euthanasia is the greatest thing for people who are sick with no chance of getting better. It's a wonderful idea and it stops people from suffering when they don't need to. No one wants to die if they don't have to, but I know I have had no hesitation in asking for this. No one should have to suffer when they don't have to.

I am pleased that the Northern Territory has such a law, even though it was so difficult for me to use, as at least now I can legally and honestly end my life. I hope this law survives and is able to help others like me, who have found the suffering has become too great. It should not be overturned by the politicians in Canberra, but given a chance to be made to work in the way it was intended. I want people to see just how important this law was to me now that I'm at the end of my life".

Janet Mills - January 1 1997. Darwin NT.

Bob Dent, the first person to die by voluntary euthanasia under the Rights of the Terminally Ill Act dictated his last letter to his wife because he was too weak to write it himself. He said, after a very vivid description of his pain and suffering since the diagnosis of prostate cancer in 1991;

..... "My own pain and suffering is made worse by watching my wife suffering as she cares for me: bathing and drying me, cleaning up after my "accidents" in the middle of the night and watching my body fade away. If I were to keep a pet animal in the same condition I am in, I would be prosecuted.

I have always been an active, outgoing person, and being unable to live a normal life causes much mental and psychological pain, which can never be relieved by medication.

I read with increasing horror newspaper stories of Kevin Andrews's attempt to overturn the most compassionate piece of legislation in the world. (Actually, my wife has to read the newspaper stories to me as I can no longer focus my eyes.)

The church and State must remain separate. What right has anyone, because of their own religious faith (to which I don't subscribe) to demand that I behave according to their rules until some omniscient doctor decides that I must have enough and goes ahead and increases my morphine until I die? If you disagree with voluntary euthanasia, then don't use it, but don't deny me the right to use it if and when I want to"

Comment on Evidence

We were not intimidated by the sheer volume of submissions, nor were we persuaded by some hysterical submissions that sought to draw a parallel between the atrocities that occurred in Nazi Germany prior to and during World War 2 and the Rights of the Terminally Ill Act of the Northern Territory.

It was unfortunate that some Church leaders sought to influence the Committee by invoking such an analogy. For instance, we note that Archbishop Barry Hickey, a member of Central Commission, Australian Catholic Bishops Conference, in his evidence to the Committee on 14 February 1997, understood the repugnance we felt when such parallels were drawn, but sought to excuse the action;

Senator McKIERNAN--"Finally, I think it is a very unfair comparison when you equate the three people who have terminated their lives in the Northern Territory with those horrific events back in history. I personally cannot accept it".

Archbishop Hickey--"I can understand the repugnance you feel at the comparison being made. I can only say that people feel very deeply on this issue. Our submission is about the breach of a principle that underlies this legislation: the principle that life is to be protected. That is already written into our laws for the common good.

Having said this, we accept the right of the Catholic Church or any other Church to lobby for support on this, or any other issue. We are aware that the Catholic Church is a very vigorous and enthusiastic supporter of the Andrews Bill. It has been a very active lobbyist in these proceedings we understand that the Church is quite pleased with its efforts on this occasion.

We will vote against the Euthanasia Laws Bill so that we do not deny others the right to use the Northern Territory's Rights of the terminally Ill Act.

SENATOR NICK BOLKUS

SENATOR JIM McKIERNAN

SUICIDE STATISTICS

Attachment d)

SUICIDE BY METHOD – AUSTRALIANS 75 YEARS AND OLDER FIVE YEAR PERIOD 1990 – 1994

Analgesics and other sedatives	13
Barbiturates	26
Tranquilisers	31
Other drugs	23
Agricultural chemicals	17
Corrosive and caustic substances	2
Unspecified substance	1
Gas (LPG)	3
Carbon Monoxide	78
Hanging	171
Suffocation by plastic	46
Other means	8
Drowning	40
Firearms	130
Cutting and piercing instruments	14
Jumping from natural or man made structures	34
Jumping or lying before moving object	15
Burns/fire	10
Electrocution	<u>10</u>
TOTAL	672

(137 of them 85 or older)

Source: ABS

Additional Statement

The *Euthanasia Laws Bill 1996* ("the Bill") is a Private Members Bill that if enacted will curtail the power of the ACT, Norfolk Island and the Northern Territory respectively, to legalise voluntary euthanasia under certain conditions. The Bill raises issues of profound moral, ethical, social and legal significance. As such, each Senator will be free to vote on whether the Bill should pass in accordance with the dictates of his or her conscience.

The reference to the Committee required it to investigate and report to the Senate on the provisions of the *Euthanasia Laws Bill 1996* in accordance with nominated areas of inquiry.

The Committee has endeavoured to adduce evidence and report all sides of the argument and the views of stakeholders in the ensuing euthanasia debate, in an impartial way. Notwithstanding the inherent value of the committee process, the value of the process in this context has been the facilitation of a detailed and rigorous investigation of the issues at hand. Due to the nature and enormity of the issues involved, it was important to ensure that this value was not eroded by giving prominence to any particular viewpoint. Members of the public were entitled to expect that the process of eliciting and receiving evidence would be even-handed.

In Chapters 1-8 of the Report, the Committee has attempted to set out the competing arguments fairly. A summary of specific issues which arise for consideration in deliberation of the Bill has been included in Chapter 9 for the assistance of Senators and interested members of the community.

The proposed legislation the subject of this inquiry is not a Government Bill. Euthanasia as such is not the subject of stated policy of either of the main political parties. Moreover an unusually large number of Senators were active Participating Members of the Committee for the purpose of the Inquiry. It is fair to say that a diverse range of views were sincerely expressed by Committee Members. In these circumstances, I do not regard it as appropriate or helpful for the Committee to have formulated and made recommendations according to conventional Committee procedures. In my view a different response than an "adversary joust" was required.

Ultimately it is a matter for the conscience of each individual Senator how they assess the evidence, what matters inform their individual consciences, what weight is given to the views of their constituency and ultimately how each will vote on the Bill. The responsibility placed on individual Senators to vote according to conscience should be accorded respect. I do not regard my conscience as having superior claim to being correct on such matters.

In these unique circumstances, I propose to take the unusual step of not publishing my own conclusions in this report, but rather, to do so separately in the context of the upcoming Senate debate which is scheduled for 18-20 March 1997.

Given the nature of this Inquiry, the unusually large number of Participating Members and tight time constraints, it is to the credit of the Secretariat, headed by Neil Bessell, that an inquiry of this magnitude was able to deal with so many submissions and marshal the evidence with such competence.

I wish to thank all my colleagues for their participation and individual insights into this most profound and significant matter.

SENATOR HELEN COONAN

5 March 1997

Voluntary Euthanasia A Criticism of the Report of the Senate Legal and Constitutional Committee on the Euthanasia Laws Bill 1996

**Senator Bob Brown
Australian Greens Senator for Tasmania
March 1997**

"After all the debate and controversy, I said to people that I hoped that they would be able to give me the right to exercise my right as an individual. It is not hard to ask for a person's rights as an individual. A man lives his life, whether for or against the law, and irrespective of whether he has received the rights that he has demanded or has had a cheerful life or otherwise. When he is about to make his last request, should we be in a position to deny him that last right which he wants? That is the question which I believe honourable members of this House will have to come to grips with by themselves..."

Wes Lanhupuy, 1995
Former Member for Arnhem
Northern Territory Legislative Assembly

GPO Box 404
Hobart Tas 7001
Ph. 03 6234 1633

Overview

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

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

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

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

The Northern Territory's Legislative Assembly has voted three times to pass and then to defend its Rights of the Terminally Ill Act. The Act ensures that the handful of people in the Territory facing such unwanted suffering are granted the option to die with dignity, at their own request, aided by agreeable medical assistance.

The (Andrews) Euthanasia Laws Bill aims to override that Act and, in so doing, to override both the rights of the Territory Assembly and other Territories and of that handful of dying citizens who choose the option of voluntary euthanasia. It also raises uncertainties about the ACT's *Medical Treatment Act 1994* and the Northern Territory's *Natural Death Act 1988*.

Such profoundly complex and important matters warranted a special committee with ample opportunity to travel throughout Australia and ensure the widest possible personal consultation with the community.

Instead, the matter has been dealt with by the Senate's standing Legal and Constitutional Legislation Committee, in inordinate haste, with a formidable turnover of key members, and frequent absence of voting members from hearings, and no hearings at all in any State of the Commonwealth or major city other than Canberra and Darwin. This, despite a record public response for any matter before a Senate committee.

The shortcomings and inevitable biases of the process are reflected in the summary of the Senate Committee Report where, for example, there is no reference to the public support for the *Rights of the Terminally Ill Act 1995* in the Northern Territory and no reference to the recent *Medical Journal of Australia* article showing that 3.5% of deaths in Australia involve a doctor administering a lethal dose without the patient's explicit and concurrent request.

The report of this Committee reflects the arguments presented but not the weight of public support for voluntary euthanasia in Australia.

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

This raises the question of whether so important a matter as legislation for or against voluntary euthanasia, with such major personal implications, should be determined by the people themselves through a referendum.

Short of such a popular resolution, the Senate now stands as arbiter.

Like the pioneering legislation of New Zealand and South Australia in the 1890s, giving women the vote, the Northern Territory has shown great courage in leading the world in reform toward guaranteeing the basic right of citizens to have voluntary euthanasia as an option for themselves. The Senate should reflect the wishes of most Australians and defend the Northern Territory's *Rights of the Terminally Ill Act* 1995.

Senator Bob Brown
Australian Greens Senator for Tasmania

CONSIDERED REPORT

1. INTRODUCTION

1.1. The main report (hereafter the Senate Committee Report) is flawed in many ways. It contains inaccuracies and omits important information and arguments. The result is a document characterised by a "professional bias" that is unworthy of the Australian Senate.

1.2 When the *Euthanasia Laws Bill* 1996 (hereafter the Andrews Bill) was referred to the Senate Legal and Constitutional Legislation Committee, an opportunity was thereby created to produce a careful and balanced analysis of this controversial legislative proposal. The Senate Committee could - and should - have produced a report that explored the difficult legal and social questions raised by the Andrews Bill in a thorough and even manner. The Senate Committee did not do this.

1.3 This alternative report identifies the most problematic of the many weaknesses of the Senate Committee Report. Hopefully this will alert Senators and other readers of the Senate Committee Report to the need to approach many of its arguments and findings with caution. Hopefully this will also raise awareness of the need to consider information and arguments that are omitted from, misrepresented in, or downplayed in the Senate Committee Report.

1.4 Ideally this alternative report would comprise a detailed analysis of the evidence, submissions and information considered by the Senate Committee. Time and resource constraints make this impossible. This alternative report therefore begins with some preliminary comments about the Senate Committee's inquiry and handling of evidence. It then focuses on the Summary that is contained in Chapter 9 of the Senate Committee Report and comments on each problematic paragraph of that chapter.

2. PRELIMINARY COMMENTS

2.1 A number of preliminary comments should be made about the Senate Committee's inquiry, before embarking on more specific criticisms of the Senate Committee Report.

2.2 The first comment is a criticism of procedural aspects of the Senate Committee's inquiry into the Andrews Bill.

The Senate Committee was given insufficient time to conduct its inquiry. The closing date for submissions to the Senate Committee was 12 December 1996 and the Senate Committee was required to report on or before 24 February 1997. (This reporting deadline subsequently was extended to 6 March 1997 because the Senate Committee rescheduled its Canberra hearings due to the death of Senator Panizza.) The Senate Committee therefore only had around two

months to assess in excess of 12 000 written submissions, and to receive and assess oral evidence.

In turn, the Senate Committee gave interested persons insufficient time to present their views to the Senate Committee. Only one month was allowed for such persons to prepare a written submission to the Senate Committee. It was not made clear to the public that those who had not submitted a written comment by the submission deadline of 12 December 1996 would be considered ineligible by the Senate Committee to give oral evidence at the subsequent hearings in Darwin and Canberra. This will have effectively excluded a number of key potential witnesses from participating in the inquiry.

The Senate Committee also failed to allocate sufficient time for public hearings on the Andrews Bill. Only two days and one night of official hearings were allowed. This ridiculously small allocation of time prevented full and effective exploration of many issues by the witnesses who appeared at these hearings. A number of witnesses who should have been given the opportunity to give oral evidence at these hearings were not asked to do so, or were unable to travel to Canberra or Darwin on the appointed hearing dates (note that the dates of the Canberra hearings were changed with minimum notice). Note that no hearings were conducted outside of Canberra and Darwin.

The overall effect of these procedural defects has been to discredit the Senate Committee's inquiry and the Senate Committee Report which is based on that inquiry. It is perhaps trite to observe that justice should not only be done, it should be seen to be done. The Senate Committee was under an obligation to ensure that the procedural aspects of its inquiry into the Andrews Bill were conducted, *and were seen to be conducted*, with scrupulous fairness. These and other procedural problems with the inquiry give the impression that the progress of the Andrews Bill through the Federal Parliament is being rushed, so that the Andrews Bill is exposed to as little public criticism as possible.

2.3 The second comment is a criticism of the Senate Committee's failure - both in its inquiry and in the Senate Committee Report - to explore the implications for Senators and for the Australian public of the fact that Senators must exercise a "conscience vote" when voting on the Andrews Bill.

It may be supposed that many Senators are currently asking themselves exactly what their obligations are when they cast their conscience vote on the Andrews Bill. They may be wondering to what extent their public duties, as democratically elected representatives of the Australian people, oblige them to set aside their personal moral beliefs about whether active voluntary euthanasia is right or wrong. They may be wondering whether there really are "party lines" (or at least "factional lines") on this issue, and how the public record of their vote on the Andrews Bill may influence their political future within their party or faction. They may also be wondering about what they should do as members of a Parliament that makes laws in a liberal, pluralist, tolerant and multicultural democracy. They may be wondering how they should respond to the very strongly held, and forcefully expressed, views of powerful religious groups in a country that is not (yet) a theocracy. Neither the Senate Committee's inquiry nor the Senate Committee Report provide thoughtful exploration of these issues.

A related issue that has been neglected by the Senate Committee is the question of whether there should be a referendum in Australia to determine what the law on active voluntary

euthanasia should be. The Senate Committee Report should have examined the advantages and disadvantages of using a referendum to determine this issue, and exploration of whether this would be a more appropriate way of determining the law on active voluntary euthanasia than allowing a conscience vote on the Andrews Bill.

The Senate Committee's lack of consideration of the role of the Australian people in the lawmaking process on this issue is also evident in the manner in which the Senate Committee assessed information about Australian opinion polls. Although Chapter 7 of the Senate Committee Report contains some information about relevant Australian opinion poll results - which indicate an extremely high level of support in the Australian community for legalising active voluntary euthanasia - the discussion of this information is incomplete and slanted. The Senate Committee Report infers that ordinary Australians are really not properly informed about, and therefore do not understand, the issues surrounding the legalisation of active voluntary euthanasia. These inferences are incorrect, patronising and offensive.

It may be helpful to refer to the words of Mr Rick Bawden, a member of the Australian public who made the following statement at a public hearing in Darwin convened by the Senate Committee:⁷

RICK BAWDEN: Last time I saw it, 74 per cent of Australians were in favour, 19 per cent were against and seven per cent just did not know. Kim Beazley says that we have to get closer to the people, and yet he votes against it. John Howard is always spouting about mandates. This is a mandate that would give most politicians an orgasm.

I feel that it comes down to a right of choice, a basic human right... I am asking you guys - I am pleading with the Senate - to defeat this bill because we all want the right to choice. Who in this room wants the right to choice? If you do, just say "choice."

AUDIENCE MEMBERS: Choice!

2.4 The third comment is a criticism of the Senate Committee's failure - both in its inquiry and the Senate Committee Report - to recognise the need to develop laws that are informed by empirical evidence about the practices that will be affected by those laws.

The Senate Committee Report does not explore the problems that may arise if law and policy about active voluntary euthanasia are driven by incorrect assumptions about what actually happens in medical practice. It should have acknowledged the need to obtain and consider empirical evidence about decision-making at the end of life.

It should also have acknowledged that the findings of Kuhse, Singer and Baume that were recently published in the *Medical Journal of Australia*⁸ is groundbreaking and important,

⁷ Hansard Friday 24 January 1997

⁸ H Kuhse et al, "End-of-life decisions in Australian medical practice," *The Medical Journal of Australia*, Vol 166, 17 February 1997.

because they provide *the only empirical evidence about medical end-of-life decisions in Australia*. The summary of the Senate Committee Report does not even mention the Kuhse, Singer and Baume research.

The Senate Committee Report instead devotes undue attention to a variety of criticisms of the methodology and findings of Kuhse, Singer and Baume. The Senate Committee report appears to endorse those criticisms, because it makes minimal effort to counter them. Many of the cited criticisms can be easily addressed by referring to information contained in *Medical Journal of Australia* article itself, and to information provided to the Senate Committee by the researchers themselves.

The Senate Committee Report also fails to discuss a number of important findings of the Kuhse, Singer and Baume research. The most egregious omission is the failure to discuss the finding that 3.5 % of all deaths in Australia (around 4 400 deaths each year) involve a doctor administering drugs with the explicit intention of ending the patient's life, *without a concurrent explicit request by the patient*. This finding indicates that the Australian incidence of this kind of behaviour is *four times* higher than in the Netherlands.

It should also be noted that, during the course of the Senate Committee's inquiry, a number of prominent members of the Senate Committee cast aspersions on the academic professionalism of Professor Kuhse and Professor Baume in respect of this research. "Shooting the messenger" is an unworthy tactic regardless of its rhetorical effect.

2.5 The fourth comment is a criticism of the Senate Committee's emphasis - both in its inquiry and in the Senate Committee Report - on abstract, theoretical and speculative arguments at the expense of concrete evidence about *what actually happens in practice to real people*.

Accordingly, it is appropriate here to include some statements on this matter from letters I have received from ordinary Australians urging me to oppose the Andrews Bill. The people are not politicians, philosophers, religious leaders or public commentators. Their statements speak for themselves:

STATEMENT 1:

My family suffers from a hereditary form of motor neurone disease. I have seen my father and brother die very slowly - it usually takes about two years - gradually losing all muscular control, including the power of speech. No specific treatment is available, and certainly no cure.

My father developed pneumonia several times. They could cure that, and at first did - knowing that pneumonia would eventually finish him off, if paralysis of the respiratory muscles did not get him first.

My brother, to hasten his own release, eventually refused all nourishment. Not all that hard, no doubt, as his swallowing capacity was so seriously impaired.

I cannot be sure that either of them would have availed himself of euthanasia, had it been available. But, like most Australians, I do know that any human being in such a condition is entitled, with all due safeguards, to choose to terminate pointless suffering, to die.

In exercising your conscience vote on Mr Kevin Andrews' Euthanasia Laws Bill, I strongly urge you to respond in a human spirit and to agree that the terminally ill should be able to choose, in good conscience, to put an end to their agony.

STATEMENT 2:

In a long career of 50 years of General Practice ... I can recall [one case] when I had wished to comply with the patient's request to terminate her long battle against cancer of the brain for which at that time there was as no adequate palliative care. I didn't do this because I didn't dare risk the possible charge of murder. She was a Nurse who had withdrawn from her family and was living alone, so that her agony and despair might not distress them and she repeatedly asked me to kill her, but as mentioned, I didn't dare have a corpse at the end of a needle; in which case she would have died in my company and with my moral support. I had to leave her sufficient morphine to relieve her symptoms or cause death according to her own wishes. The poor woman was left to die alone without her family or a medical companion in a lonely bed sitting room. I don't know what your personal views are, but I hope you will vote with tolerance.

STATEMENT 3:

I seek your support AGAINST passage of the Andrews Bill by the Senate.

May I recount my recent experience.

A Lady well known to me first encountered a suspect growth in 1956 - and had her first experience of surgery for this condition.

In October 1995 she had her 19th surgical intervention for the same condition - and this was followed by radiotherapy treatment for a now confirmed cancer.

In February 1996 the Lady was found immersed in a bath of water.

The Autopsy revealed that she had died from a (massive) overdose.

I married the Lady in 1954.

She deserved a more dignified exit.

3. RESPONSE TO SUMMARY OF SENATE COMMITTEE REPORT

3.1 *Comment on paragraph 9.2:*⁹

This paragraph of the Senate Committee Report somewhat overstates the strength of the constitutional validity of the Andrews Bill. This overstatement reflects larger problems with the way in which the Senate Committee Report approaches the constitutional dimensions of the debate surrounding the Andrews Bill. (See further section 3.4 of this alternative report, below).

Section 122 of the Australian Constitution confers a power on the Commonwealth to make laws for the government of any Territory. This is a plenary power, unlimited by subject matter. The Federal Parliament therefore clearly has the constitutional power to enact a law that has the effect of overturning the *Rights of the Terminally Ill Act* 1995 (NT) (hereafter the *RTI Act*). It is not quite as clear, however, whether the way in which the Andrews Bill seeks to bring about this result is within the scope of the Commonwealth's powers under section 122.¹⁰ This doubt, which arises from a statement by the majority of the High Court in the *Capital Duplicators Case*¹¹ is averted to glancingly in paragraphs 4.56-4.57 of the Senate Committee Report, but is not fully discussed or analysed.

3.2 *Comment on paragraph 9.3:*

This paragraph of the Senate Committee Report identifies the following four significant issues as the focus of the Senate Committee's deliberations and of its report:

- the "Territory rights" issue;
- the claim that the Bill will lead to legal uncertainty;
- the claim that the Northern Territory's *Rights of the Terminally Ill Act* is having unacceptable impacts on the Aboriginal community; and

⁹ This and subsequent paragraph references refer to paragraphs of the Senate Committee Report.

¹⁰ See *Constitutional Arguments Against Removing the Territories' Power to Make Laws Permitting Euthanasia*, Research Note No. 33, Department of the Parliamentary Library, March 1996.

¹¹ *Capital Duplicators Pty Ltd v. Australian Capital Territory* (1992) 177 CLR 248 at 283 per Brennan, Deane and Toohey JJ and at 284 per Gaudron J.

- the more general moral, ethical and social arguments about euthanasia.

These four issues are not the same as the four central issues to which the Senate directed the Senate Committee's attention when it referred the Andrews Bill to the Senate Committee on 7 November 1996; *viz*:

- the desirability of the enactment of the provisions [of the Andrews Bill];
- the constitutional implication for the Territories of the enactment of the provision;
- the impact of the enactment of the provisions on the Northern Territory criminal code; and
- the impact on, and attitudes of, the Aboriginal community.

The Senate Committee was not directed by the Senate to explore "the more general moral, ethical and social arguments about euthanasia." It seems to have extracted a mandate to do so from the Senate's request that attention be given to "the desirability of the enactment of the provisions" of the Andrews Bill.

This modification of the scope and emphasis of its inquiry was inappropriate for a number of reasons. The first reason is that the appropriate focus of the Senate Legal and Constitutional Committee's attention is - as the name of the Committee suggests - legal and constitutional matters. This Committee does not have the expertise, personnel or resources to conduct a reputable inquiry into the moral, ethical and social dimensions of controversial matters such as euthanasia. Had the Senate required such an inquiry, it would have referred the Andrews Bill to a body that did have the appropriate expertise, personnel and resources to explore these important issues properly. The Senate Committee obviously considered that the general moral, ethical and social arguments about euthanasia were sufficiently important to receive attention. Rather than clumsily attempting the task of assessing these arguments itself, it should have commented on the need for additional exploration of these issues to be undertaken by another body before the Senate votes on the Andrews Bill.

The second reason why it was inappropriate for the Senate Committee to extend its own terms of reference in this way was that the Australian public was not put on notice that the inquiry would extend to the moral, ethical and social dimensions of euthanasia. The Senate Committee Report will be the first clear public indication that the Senate Committee wished to make statements about these matters. Announcing this intention at the very end of the inquiry process, after the Senate Committee has finished receiving and assessing submissions, will have deprived members of the Australian public of the opportunity to contribute a wider range of perspectives to, and broaden the focus of, this aspect of the debate.

The third reason is connected with the second. The Senate Committee only conducted public hearings in two Australian cities, Darwin and Canberra. Whilst this *may* be justifiable in the context of an inquiry that has Territory matters as its focus, it certainly is *not* appropriate for an inquiry whose scope has broadened to encompass general moral, ethical and social arguments about euthanasia. These moral, ethical and social arguments are not Territory-

specific and the Senate Committee should not have contemplated addressing them if it could not conduct hearings in a much wider range of locations in every State and Territory of Australia.

The fourth reason why the Senate Committee's exploration of general moral, ethical and social arguments about euthanasia is inappropriate is that this aspect of the debate has coloured the Senate Committee's assessment of issues upon which it *should* have focused. These issues were the *specific* questions of: whether or not enactment of the Andrews Bill is desirable; the legal and constitutional aspects of the debate; and the impact on, and attitudes of, the Aboriginal community. The Senate Committee's focus on the *general* question of whether euthanasia is a good or a bad thing - morally, ethically and socially - diverted its attention from rigorous examination of these important specific questions. As a result, the Senate Committee became confused about exactly what these specific questions were. Rather than exploring the desirability of the enactment of the Andrews Bill, the Senate Committee's focus was often instead on the desirability of the existence of *RTI Act*. These two questions are connected but they are not the same thing and do raise different issues. They can and should be addressed separately, especially because it is likely that the passage of the Andrews Bill would have effects beyond merely repealing the *RTI Act*. These broader legal, constitutional and political effects of enacting the Andrews Bill have not been adequately explored by the Senate Committee.

3.3 *Comment on paragraph 9.5:*

This paragraph averts to evidence that the *RTI Act* "affects Australia's ethos and social fabric and our international standing and reputation." This statements should include a clear reference to the argument that those effects of the *RTI Act* are positive rather than negative, and that the legislative initiative taken by the Northern Territory Legislative Assembly should be applauded and preserved rather than attacked.

3.4 *Comment on paragraphs 9.6-9.7:*

These two paragraphs purport to canvass the arguments on either side of the so-called "Territory rights" issue. Presumably these are intended to summarise the main arguments in favour of, and against, the Federal Parliament taking away part of the legislative powers of the Territories by passing the Andrews Bill.

Paragraph 9.6 therefore should not refer to arguments made by "opponents of voluntary euthanasia" when describing arguments made by supporters of the Andrews Bill. It is possible to oppose voluntary euthanasia *in principle* whilst also opposing the passage of the Andrews Bill on grounds that are separate from the issue of whether or not voluntary euthanasia is a good or moral thing. Similarly, paragraph 9.7 should not refer to arguments made by "proponents of voluntary euthanasia" when describing arguments made by opponents of the Andrews Bill. Many opponents of the Andrews Bill do so even though they are not proponents of voluntary euthanasia. This inappropriate slippage in terminology is just one example of the Senate Committee's inability to separate its exploration of the general moral,

ethical and social dimensions of euthanasia from its analysis of the specific issues it was asked to address (in this case, the constitutional implications of the enactment of the Andrews Bill).

The summary of the opposing arguments in paragraphs 10.6 and 10.7 of the Senate Committee Report on the constitutional implications of the Andrews Bill is unimpressive.¹² This reflects the general quality of the fuller discussion of these arguments in Chapter 3 of the Senate Committee Report.

It is important to note that the main constitutional objections to the Andrews Bill are political rather than legal. The fact that these objections are political, however, does not make them unsubstantial. Six major constitutional objections to the Andrews Bill may be identified and deserve brief mention here:

OBJECTION 1: It is inappropriate for the Federal Parliament to single out the Territories in the manner that the Andrews Bill seeks to do. Passage of the Andrews Bill would send a message to those Australians who reside in Territories that they are in some way second-class citizens within the Commonwealth. It would send the message that the Federal Parliament considers that, unlike State parliaments, the democratically elected legislatures of the Territories cannot be trusted to make laws responsibly and appropriately. In effect, the Federal Parliament would be stating that the Territories are governed by second-class legislators.¹³

OBJECTION 2: Although the Federal Parliament does technically have the power under section 122 of the Australian Constitution to remove some (or all) of the legislative powers it has granted to the self-governing Territories, the Federal Parliament has to date never exercised this power in this way. A political convention has developed against taking back powers granted to subordinate legislatures. Although this convention is not legally enforceable it should inhibit the Federal Parliament from passing legislation that removes any of the legislative powers conferred on any of the Territories at self-government.

¹² A more useful summary of these opposing arguments may be found in two Research Notes recently prepared by the Information and Research Service, Department of the Parliamentary Library: *Constitutional Arguments In Favour of Removing the Territories' Power to Make Laws Permitting Euthanasia*, Research Note No. 32, Department of the Parliamentary Library, March 1996; *Constitutional Arguments Against Removing the Territories' Power to Make Laws Permitting Euthanasia*, Research Note No. 33, Department of the Parliamentary Library, March 1996.

¹³ This was the stated view of Fr Frank Brennan in his oral evidence to the Senate Committee: see *Senate Proof Committee Hansard*, Friday 14 February 1997, p 212. Compare the view of constitutional lawyer Mr George Williams on this matter: *Senate Proof Committee Hansard*, Friday 14 February 1997, p 213.

An analogy can be drawn with the convention that formerly inhibited the Imperial (British) Parliament from exercising its powers to overturn the laws passed by the Australian Federal and State Parliaments. Until 1942¹⁴ and 1986 respectively these Australian Parliaments technically were subordinate to the Imperial Parliament, which could at any time have acted to overturn laws passed by these self-governing colonies. The Imperial Parliament did not interfere with the lawmaking of these self-governing entities, and indeed clearly rejected the option of doing so. In 1934 the State of Western Australia petitioned the British Government to enact legislation to enable Western Australia to secede from the Australian Federation. The Joint Select Committee formed by the British Government to examine this request rejected the proposal, noting "the long standing constitutional convention that the Parliament would not interfere in the affairs of the Dominion, self-governing State or Colony save at the request of the Government of that Dominion."¹⁵ The Federal (Australian) Parliament now should exercise similar restraint and decline to interfere with the lawmaking of its self-governing Territories.

Another analogy can be drawn with the restraint that the Commonwealth exercises on many matters on which it could, or might attempt to, interfere with State lawmaking and other decision-making. This occurs because the Commonwealth recognises that there are circumstances where it would be politically and socially imprudent to exercise the (limited) legislative powers it has over the States simply because it has those powers. One example of such restraint by the Commonwealth is the restrictions it imposed in the *Intergovernmental Agreement on the Environment* (1992) on its undoubted power to legislate unilaterally to nominate World Heritage areas without consulting the States.

OBJECTION 3: Undertakings have been given to confer full Statehood on the Northern Territory. Passage of the Andrews Bill would create problems in the lead-up to Northern Territory Statehood. Removing powers that have already been granted at self-government could seriously impede the progress of the Northern Territory towards Statehood. Further, passage of the Andrews Bill would introduce doubts as to whether any future grant of Statehood would give the Northern Territory the full range of legislative and executive powers enjoyed by the existing States. If the Andrews Bill's removal of legislative powers over euthanasia survived the grant of Statehood, the Northern Territory would still be treated as a second-class jurisdiction compared with the other Australian States. If the conferral of Statehood restored the Northern Territory's powers to make laws about euthanasia, there is little point in passing the Andrews Bill as it can only be of transitional effect.

OBJECTION 4: Euthanasia is undeniably a morally controversial issue of national significance. So are issues such as prostitution, X-rated videos, pornography, abortion,

¹⁴ The *Statute of Westminster* was passed by the Imperial Parliament in 1931 but not adopted in Australia until 1942, when the Federal Parliament passed the *Statute of Westminster Adoption Act 1942* (Cth), which had effect from 3 September 1939: see R Lumb and K Ryan, *The Constitution of the Commonwealth of Australia Annotated*, Butterworths, 1981, p 100.

¹⁵ See K Booker, A Glass and R Watt, *Federal Constitutional Law: An Introduction*, Butterworths, 1994, pp 315-6.

fertility treatment and the use of controversial drugs. Removing the Territories' power to make laws permitting euthanasia would set a dangerous precedent. It would make the Federal Parliament more likely to take steps to remove the Territories' lawmaking powers in relation to these other politically contentious issues. Even if the Federal Parliament did not go on to do this, the *ad hoc* basis on which it is contemplating removing the Territories' powers to make laws permitting euthanasia threatens the certainty that should exist for Territory citizens when their elected representatives pass a valid law. The Federal Parliament should not embark on this slippery slope towards extreme, unpredictable and inappropriate interference with lawmaking in the Territories.

OBJECTION 5: The *Northern Territory (Self-Government) Act 1978* (Cth) contains a mechanism for invalidating legislation passed by the Northern Territory Legislative Assembly that the Commonwealth considers inappropriate. Section 9 of this self-government legislation specifically states that the Governor-General may disallow legislation passed by the Northern Territory Legislative Assembly, in part or in its entirety, within six months of the Administrator's assent to the legislation. Alternatively, the Governor-General can recommend amendments to the legislation. Disallowance by the Governor-General repeals the legislation. The Governor-General did not use this mechanism to disallow the *RTI Act* within six months of the Administrator's assent to it, which occurred on 16 June 1995. The Commonwealth therefore did not take the opportunity to use the appropriate mechanism to repeal the *RTI Act*. It should not now use the inappropriate mechanism of the Andrews Bill to do so.

OBJECTION 6: If the supporters of the Andrews Bill were really motivated by a desire to avert completely the threat to human rights and to Australia's international reputation that is allegedly posed by legalising active voluntary euthanasia, they would propose a law that applies throughout Australia.¹⁶ The Commonwealth could rely on the following heads of power to enact a national euthanasia law: the corporations power, the implied nationhood power,¹⁷ the appropriations power, and/or the external affairs power.

It is important to note here that the scope of the Commonwealth's power under the external affairs power is largely untested. The totality of evidence presented to the Senate Committee by lawyers with expertise in constitutional and international law did not rule out the possibility

¹⁶ In the debate in the House of Representatives on the Andrews Bill on 9 December 1996, National Party MP Ian Sinclair (a supporter of the Andrews Bill) proposed an amendment that would have required the Attorney-General "to have an alternative bill prepared and presented to the House in a form which does not discriminate against the people of any part of Australia and which would enable Members to vote according to their views on the issue of euthanasia on the basis of a possible uniform, national approach to the issue." The Sinclair amendment was defeated by 82 votes to 45. On 12 December 1996, ALP Senator Bob Collins gave notice of his intention to move a similar motion in the Senate.

¹⁷ On the basis that the subject of euthanasia is sufficiently central to "the character and status of the Commonwealth as a national polity": *Davis v. Commonwealth* (1988) 166 CLR 79 at 93 per Mason CJ, Deane and Gaudron JJ.

that the external affairs power could form a basis for passing a national law prohibiting active voluntary euthanasia, especially if the scope of the external affairs power is considered to extend beyond mere implementation of *obligations* under international law.¹⁸ It therefore is far from settled that the Federal Parliament lacks the constitutional power to pass a national law prohibiting (or indeed permitting) active voluntary euthanasia.

3.5 *Comment on paragraph 9.8:*

This paragraph of the Senate Committee Report addresses some of the subject matter of *OBJECTION 6*, discussed immediately above. It refers to evidence that the Commonwealth Parliament "does not have a head of power under which national legislation could override any State legislation dealing with euthanasia." This statement is partially accurate: the Australian Constitution does not expressly confer on the Commonwealth the power to make laws about euthanasia. However, the Australian Constitution does confer a range of other legislative powers on the Commonwealth. A number of these heads of power could be relied on in combination to pass a national euthanasia law. It is neither unusual nor untenable for the Commonwealth to rely on combinations of different heads of power in this way. The Federal Parliament recently enacted the *Workplace Relations Act 1996* (Cth) using this approach, even though it has no express power over industrial relations. One wonders whether the Senate Committee would describe the method chosen by the Federal Parliament to enact this industrial relations legislation in the disparaging tones adopted in the Senate Committee Report's discussion of using such an approach to enact a national euthanasia law: as relying on a "menu of mechanisms that could limit the operation of State [euthanasia] legislation"¹⁹ or as merely "piecemeal" application of its constitutional powers.²⁰

3.6 *Comment on paragraph 9.9:*

This paragraph of the Senate Committee Report identifies what the Senate Committee considers to be the central legal questions in connection with passage of the Andrews Bill. The paragraph averts to a number of possible effects that passage of the Andrews Bill could have on existing and future laws in the Territories.

The paragraph omits important details and arguments to which reference should have been made. Without these details and arguments, the Senate Committee Report's analysis of the legal uncertainties that would be created by passing the Andrews Bill is inaccurate and

¹⁸ See particularly evidence of Mr George Williams, Professor George Zdenkowski, the Attorney-General's Department and Fr Frank Brennan, from which selective extracts appear at paragraphs 3.40-3.44 of the Senate Committee Report.

¹⁹ Paragraph 9.8 of the Senate Committee Report.

²⁰ Paragraph 3.45 of the Senate Committee Report.

misleading. The following points identify some major problems with the Senate Committee's discussion of these aspects of the Andrews Bill:

- The drafter of the Andrews Bill used words and terms that are legally imprecise. The Andrews Bill aims to remove the Territories' powers to make laws that:

... permit or have the effect of permitting (whether subject to conditions or not) the form of intentional killing of another called euthanasia (which includes mercy killing) or the assisting of another person to terminate his or her life.

The Andrews Bill does not define what is meant by "intentional killing", "euthanasia", "mercy killing" or "the assisting of another person to terminate his or her life" in this context. None of these terms has a clear legal meaning in Australia. It therefore is impossible to say which of the various meanings of these terms and phrases apply to the Andrews Bill.

The Senate Committee received a range of legal opinions on this matter. The lawyers who expressed views on this matter to the Senate Committee disagreed strongly as to the meaning of these key terms and phrases in the Andrews Bill. No particular interpretation offered by these lawyers can be said to represent the correct view or final answer.

Paragraph 9.9 of the Senate Committee Report does concede that the undefined phrase "intentional killing" has no generally accepted legal meaning, and that this lack of definition is the basis of a number of arguments about the legal uncertainty that could result from enacting the Andrews Bill. The summary of the Senate Committee Report contains no discussion, however, of the other undefined terms and phrases in the Andrews Bill - such as "euthanasia", "mercy killing" and "the assisting of another person to terminate his or her life" - nor of the range of arguments against enacting the Andrews Bill that are based in the uncertainty of *these* terms and phrases. The Senate Committee Report's focus on "intentional killing" and its possible meanings unacceptably narrows the focus of the Senate Committee's discussions of the legal problems that could result from passing the Andrews Bill.

- Paragraph 1.5 of the Senate Committee Report concedes that the Andrews Bill "does not define the terminology it uses." It declines, however, to clearly state that this lack of definition is problematic. Indeed, the Senate Committee goes out of its way to draw the Senate's attention to a statement by Mr Geoffrey Dabb of the Criminal Law Division of the Attorney-General's Department, to the effect that "the Bill showed all the signs of being drafted with a high degree of professional competence, and struck the right balance between simplicity and complexity."²¹ This statement is not consistent with the general thrust and effect of the legal analysis presented to the Senate Committee by Mr Dabb. The Senate Committee Report's reference to this rather anomalous statement from Mr Dabb's evidence indicates that the Senate Committee went to some lengths to shield the Andrews Bill and its drafter from criticism.

²¹ Paragraph 10.13 of the Senate Committee Report.

The downplaying in the Senate Committee Report of the legal problems that could arise from passing the Andrews Bill seems astonishing in view of the totality of the evidence presented to the Senate Committee. A large part of that evidence - including much of Mr Dabb's analysis - supports the argument that there is considerable doubt as to the extent to which the Andrews Bill would remove the Territories' legislative power over medical decisions at the end of life. Strong arguments were presented that the Andrews Bill may take away more than the Territories' power to pass laws along the lines of the *RTI Act*.

- These arguments indicate that the Andrews Bill may also take away the Territories' power to pass at least four other kinds of laws:

1. *Refusal of medical treatment legislation.*

The Northern Territory and the Australian Capital Territory (as well as Victoria and South Australia) have legislation recognising the right of a competent adult to refuse unwanted medical treatment in advance, even if the refusal will lead to the patient's death.²²

If the Andrews Bill did remove the power to pass this kind of law, the Territories would not be able to improve their present statutory regimes by amending or replacing their current refusal of medical treatment legislation. It is also possible that the Andrews Bill would actually invalidate part or all of this current legislation. This invalidation might even have retrospective effect.

The lawyers who expressed opinions on these questions to the Senate Committee disagreed strongly as to the likely impact of the Andrews Bill on the Territories' refusal of medical treatment legislation and on their power to make such laws. No particular argument offered by these lawyers can be said to represent the correct view or final answer.

2. *Legislation that clarifies the legal situation where a patient's death is hastened by the administration of pain killing drugs.*

Again, the lawyers who expressed opinions on this matter to the Senate Committee differed strongly - both on what is the legal situation (in the Territories and elsewhere in Australia) where a patient's death is hastened by the administration of pain killing drugs, and on the impact of the Andrews Bill on the Territories' power to enact legislation clarifying that legal situation. No particular argument offered by these lawyers can be said to represent the correct view or final answer.

Overall, these legal opinions revealed that there is currently a great deal of uncertainty in Australia about whether or not - and, if so, exactly when - it is legal for doctors to administer pain-relieving drugs in doses large enough to hasten a suffering patient's death.

²² In the Northern Territory, the relevant legislation is the *Natural Death Act 1988* (NT) and in the ACT it is the *Medical Treatment Act 1994* (ACT). The South Australian legislation is the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) and the legislation in Victoria is the *Medical Treatment Act 1988* (Vic).

Evidence before the Senate Committee also indicated that the legal position of nurses involved in the care of such a patient is particularly unclear. The evidence also indicated that the law on this matter may vary between different Australian States and Territories.

The legal opinions received by the Senate Committee on this matter point to the following key questions, none of which are adequately discussed in the Senate Committee Report:

- **Exactly what does the philosophical doctrine of "double effect" allow a doctor to do when a dying patient is suffering?**

The doctrine of double effect was repeatedly referred to in arguments before the Senate Committee about when a doctor may justifiably administer pain killing drugs that hasten a patient's death. There was considerable confusion, however, as to exactly what any given commentator meant when he or she referred to that doctrine.

The Senate Committee Report offers the following definition of "double effect":

... the administration of drugs (eg large doses of opioids) with the intention of relieving pain, but foreseeing that this might hasten death even though the hastening of death is not actually intended.²³

This definition is extremely unhelpful. It is completely unclear when a doctor administering such drugs can be said to possess "the intention of relieving pain" and when hastening of death can be said to be "actually intended" by the doctor. Does the doctor's intention to relieve pain have to be the doctor's *sole* intention for the doctor to be ethically protected by this doctrine, or is it enough that pain relief was the doctor's *primary* or *dominant* intention? Is a doctor ethically protected if he or she administers the drugs knowing that this will *probably* hasten death, rather than simply foreseeing that this *might* hasten death? To be said to *actually intend* the patient's death, must the doctor *wish for* or *desire* that death?

Further doubt is introduced by the lack of clarity as to whether a doctor who is competently administering modern palliative care can ever hasten a patient's death without "actually intending" that death. The Senate Committee Report does not explore this important question.

- **Is the philosophical doctrine of double effect part of the Australian common law?**

The double effect doctrine originates in Roman Catholic theology. It is not an ethically uncontroversial doctrine. It therefore is not self-evident that the double effect doctrine *should* form part of the common law of Australia in relation to situations where a patient's death is hastened by the administration of pain relieving drugs. These points were not explored in the Senate Committee Report.

23

See definitions provided in Preface to the Senate Committee Report.

Nor is it clear whether or not this doctrine *does* represent the position at common law in Australia. English case law establishes that a doctor will be immune from criminal liability if his or her primary intention in these circumstances can be characterised as an intention to relieve pain, rather than an intention to hasten death.²⁴ This English legal position seems to rest at least partly on the philosophical doctrine of double effect. Due to the absence of Australian case law, however, it is far from clear whether the English position also represents the common law position in Australia.

- **If the double effect doctrine is part of the common law of Australia, is it therefore also part of the criminal law of the Northern Territory?**

The criminal law of the Northern Territory is codified. Arguably this limits or even excludes doctrines and principles that form part of the common law. Even if the double effect doctrine is part of the common law of Australia, therefore, it may not form part of the criminal law in the Northern Territory. The Senate Committee heard opposing arguments on this question.

The Senate Committee Report seems to assume, without justification, that the double effect doctrine (whatever that may be) *does* form part of the common law of Australia, and that problems attending the uncertainty about the legal impact of enacting the Andrews Bill will simply disappear if one assumes that this common law applies in the Northern Territory. The Senate Committee's argument is both confusing and unconvincing:

... at the risk of oversimplification, the effect of uncertainty about Territory powers to legislate is to allow the (admittedly somewhat uncertain) common law principles to prevail, either directly or by using them to assist in interpreting criminal statutes. This might be thought acceptable given that New South Wales and Tasmania, for example, continue to operate with these principles.²⁵

3. *Legislation specifying when a doctor may lawfully withdraw or withhold life-sustaining medical treatment from an incompetent patient, who has not specified his or her wishes in advance.*

There is no Australian case law determining when a doctor may withdraw or withhold life-sustaining treatment - including artificial hydration and nutrition - from such a patient. It can be argued that passage of the Andrews Bill would remove the Territories' power to

²⁴ *R v. (Bodkin) Adams* [1957] Crim LR 365; *R v. Cox* (1992) BMLR 38. For a criticism of the English common law position, see I. Kennedy, *The Quality of Mercy: Patients, Doctors and Dying*, Upjohn Lecture, Royal Society of Medicine, London, April 1994.

²⁵ Paragraph 4.40 of the Senate Committee Report.

enact legislation specifying the circumstances under which such treatment may be withdrawn or withheld.²⁶ The Senate Committee Report does not address this argument.

4. *Legislation exempting from criminal penalty, or providing for more lenient treatment of, the friends or family of a dying patient who end that patient's life for genuinely compassionate motives.*

It can be argued that the Andrews Bill would remove the Territories' power to enact this kind of legislative reform, on the basis that such reform can be seen as having the effect of permitting "mercy killing."²⁷ The Senate Committee Report does not address this argument.

- There are a number of "savings clauses" in the Andrews Bill which purport to preserve the Territories' power to pass at least the first two of these categories of laws.²⁸ It is extremely unclear whether or not the savings clauses do preserve those aspects of the Territories' lawmaking power. The savings clauses also use terms and phrases that are undefined and the legal meaning of which is uncertain. Again, the legal opinions on this matter received by the Senate Committee revealed nothing approaching consensus on the legal effect to these savings clauses. Again, no particular argument offered by these lawyers can be said to represent the correct view or final answer.
- Many aspects of the Australian law relating to medical decisions at the end of life are already uncertain. This is acknowledged at paragraph 4.19 of the Senate Committee Report. Australian legislators generally have shown great reluctance to enact new laws to clarify the respective rights and responsibilities of dying patients, their family members and their doctors. The failure of the relevant authorities to enforce existing laws has increased the doubt as to exactly when and how a doctor - or others caring for the patient - may lawfully hasten a patient's death.
- These legal doubts do not create problems for legislators or law enforcers: by avoiding these "hard questions", the difficult process of arriving at legal answers to those questions can be neatly avoided. Nor do these legal doubts create problems for doctors who are happy to make decisions about how and when their patients should die, regardless of what the law might say about the matter, and without anyone else scrutinising those decisions.

²⁶ See *Euthanasia Laws Bill 1996 - Bills Digest No 45 1996-97*, Department of the Parliamentary Library, 1996.

²⁷ *Ibid.*

²⁸ See paragraph 1.3 of the Senate Committee Report.

These legal doubts do, however, create enormous practical problems for: doctors who would like to manage their patients' dying process openly and honestly; doctors who would like to be more confident that their behaviour is not even *technically* criminal; patients who would like to have more control over the time and manner of their own death; and those family members or close friends of the patient who would like to know when their opinions and wishes should be considered or followed. The Senate Committee Report's statement that the current "high degree of uncertainty in this area of law .. *apparently causes no practical problems*"²⁹ therefore seems both ill-considered and somewhat offensive. Interestingly, the Senate Committee Report relies on this erroneous statement to imply that the increased legal uncertainty introduced by the passage of the Andrews Bill would not alter this "problem free" situation, and thus to infer that passage of the Andrews Bill would be acceptable.³⁰

- The additional legal uncertainty that passage of the Andrews Bill would cause in the Territories would be highly undesirable. The resulting uncertainty as to what kind of legislation the Territories would retain the power to pass, as to which of the Territories' current laws might be invalid, and as to exactly how the law permits doctors to manage the dying process, could exacerbate the problems and stresses facing many dying patients, their doctors and their loved ones.

This legal doubt could result in expensive court cases to test the scope of the legal changes effected by the Andrews Bill. These would clarify the legal position, but only slowly and in a piecemeal fashion.

The Senate Committee Report implies that the Federal Parliament would then step into the breach and enact appropriate legislation for the Territories, to dispel the doubts and problems that the Andrews Bill threatens to bring to the Territories' laws regulating medical decisions at the end of life.³¹ It is naive to assume that the Federal Parliament would assume the responsibility of making legislative statements on some of the most controversial aspects of the doctor-patient relationship. Further, the prospect of leaving an on-going responsibility of this kind with the Commonwealth raises, and increases the force of, a number of the constitutional arguments against the Andrews Bill that were discussed above (in section 3.4 of this alternative report).

3.7 *Comment on paragraphs 9.10 - 9.12:*

Paragraph 9.10 rightly concedes that the law relating to the meaning(s) of "intentional killing" is "complex and technical." Having recognised this important fact, the same paragraph goes on to affirm the misleading oversimplification of this area of law that is provided in Chapter 4 of the Senate Committee Report.

²⁹ Paragraph 4.37 of the Senate Committee Report, emphasis added.

³⁰ Paragraph 4.37 of the Senate Committee Report.

³¹ Paragraphs 4.42 and 4.44 of the Senate Committee Report.

Paragraph 9.10 states that only "two views" on the meaning of "intentional killing" emerged from the legal arguments presented to the Senate Committee during the course of its inquiry. In a sense this is true, because only two views on the meaning of "intentional killing" were given serious attention by *the only two legal commentators whose responses to submissions made by other parties were actively and repeatedly sought by the Senate Committee*. These two commentators were Mr Joseph Santamaria QC of Owen Dixon Chambers, Melbourne, and Mr Geoffrey Dabb of the Criminal Law Division of the Attorney-General's Department, Canberra. Mr Santamaria QC presented no fewer than three written submissions to the Senate Committee, the last of these (dated 27/2/97) clearly in response to a specific invitation to do so from the Senate Committee. The Senate Committee also invited him to give oral evidence. Similarly, Mr Dabb presented two written Briefing Notes to the Senate Committee, and was invited to give oral evidence and supplementary written information resulting from that evidence. It is hardly surprising, therefore, that only two views "emerged" on the meaning of "intentional killing", as neither of the two legal commentators who were permitted to remain in the debate considered any other than the so-called "narrow" and "broad" views of intention to be plausible. Both commentators rejected a third view of intention that Mr Dabb characterised as the "extremely broad view" and neither commentator explored other possible views.

It is likely that there are more than two plausible interpretations of the legal meaning of "intentional killing." There is certainly a wider range of opinion relating to the "two views" that were debated by Mr Dabb and Mr Santamaria QC. It is also likely that these different ways of analysing the legal meaning of "intentional killing" would have been raised, and properly explored, had the Senate Committee made equally vigorous efforts to seek the further opinions of other lawyers who had made submissions to the Senate Committee relevant to this question. These lawyers included: Mr Tom Pauling QC, Mr Gary Humphies, Mr Rex Wild QC, Mr David Bennett QC, Mr Tom Hughes QC, Dr Margaret Otlowski, Mr WJ Karczewski, Ms Natasha Cica, Mr Michael Eburn and Ms Meg Wallace. A number of these individuals should have been formally offered right of reply to the criticisms of their initial submissions that are contained in the supplementary opinions of Mr Santamaria QC in particular.

The Senate Committee seems to have been too impressed by the volume and complexity of the arguments forwarded by Mr Dabb and Mr Santamaria QC. Both Mr Dabb's and Mr Santamaria's arguments contain faults and inconsistencies. The arguments made by Mr Santamaria QC in particular reveal some basic misunderstandings Australian law governing the doctor-patient relationship, including the assumption that Australian courts would develop that law in accordance with English legal principles that are more paternalistic, and more protective of the medical profession, than the legal principles recently developed by Australian judges.

The bulk of the Senate Committee Report's discussion of these legal issues comprises an account of the Dabb/Santamaria debate about the meaning of "intentional killing."³² That discussion therefore is inappropriately narrow in focus.

3.8 *Comment on paragraph 9.13:*

³² See Chapter 4 of the Senate Committee Report.

This paragraph refers to a comment extracted from the legal analysis presented to the Senate Committee by Mr Dabb of the Attorney-General's Department. The comment incorrectly implies that the totality of Mr Dabb's analysis would support passage of the Andrews Bill. This is an inappropriate inference. The probity of this reference to a rather anomalous comment has been questioned above.

3.9 *Comment on paragraphs 9.14 - 9.15:*

These paragraphs of the Senate Committee Report refer to attitudes in "Aboriginal communities" towards the Andrews Bill and the *RTI Act*.

The Senate Committee fails to make a number of important points in these paragraphs. First, it fails to acknowledge that, even though submissions to the Senate Committee from a number of Aboriginal communities in the Territory opposed the *RTI Act*, there can be no single "Aboriginal view" on the matters raised by that legislation and by the Andrews Bill. There are important differences in religious and cultural perspective between different Aboriginal communities in Australia. There are also important differences in personal perspective on these matters amongst the approximately 265 000 Australians who are Aboriginal. The Senate Committee did not consult people from the full range of Aboriginal communities within, and outside, the Northern Territory. It did not consult Aboriginal people from the full range of personal perspectives on the issue of voluntary euthanasia.

Second, the Senate Committee fails to acknowledge in these paragraphs there inevitably will be inconsistencies, and possibly conflict, between the values and rules of the mainstream legal culture in Australia and the values and rules of traditional Aboriginal law. Many other Australian laws conflict with aspects of traditional Aboriginal law. Rather than dwelling on the fact that such inconsistencies may well exist between the *RTI Act* and traditional Aboriginal laws and traditions, the Senate Committee Report should have explored ways in which such inconsistencies could be minimised to ensure respect for both legal cultures.

3.10 *Comment on paragraph 9.16 - 9.17:*

The Senate Committee Report gives the overall impression that it supports the view that the continuing existence of the *RTI Act* will threaten the health and lives of Aboriginal Australians in the Northern Territory. Paragraph 9.16 refers to this threat as a "major concern."

These paragraphs of the Senate Committee Report downplay the empirical evidence on this matter presented by the Northern Territory government. The Senate Committee Report instead seems to favour the personal and speculative opinions presented to the Senate Committee on this issue by a number of individuals who oppose the *RTI Act*.

There is no doubt that Aboriginal Australians have suffered, and continue to suffer, from "mistrust of and alienation from the health services provided by mainstream society."³³

Equally there is no doubt that this has had a disastrous impact on their mortality and morbidity. This is a source of national shame and Australia must take steps to improve this situation. Mere passage of the Andrews Bill would do nothing to improve the health situation of Aboriginal Australians.

3.11 *Comment on paragraph 9.18:*

Paragraph 9.17 refers to the evidence given to the Senate Committee by Mr Chips Mackinolty. The Senate Committee appears to have given great weight to his views. Whilst there seems little doubt that the opinions expressed by Mr Mackinolty to the Senate Committee were genuinely and strongly held by him, the fact remains that they are the personal opinions of one non-Aboriginal person.

Different opinions on the impact of the *RTI Act* were expressed by other non-Aboriginal witnesses who gave evidence to the Senate Committee, principally Ms Dawn Lawrie (the Northern Territory's Anti-Discrimination Commissioner) and Mr Creed Lovegrove (a former senior Northern Territory public servant with experience in Aboriginal affairs)/ The Senate Committee appears to have given insufficient weight to the evidence of these witnesses.

The following quotes from the oral evidence given by Ms Lawrie at the Darwin hearings should be noted:

Aboriginal people are no different from any other group of people; they are just as able to make their own minds up once they have received the information ...³⁴

I was in an Aboriginal community not so long ago and I was asked the question by some Aboriginal women, one of whom is a very close friend, 'What is this kill business, what's that law?' I said, 'You mean the euthanasia act.' We had a chat and, yes, that is indeed what she meant. I explained it in fairly straightforward terms, 'Look, this is what it means.' One of them laughed and said, 'You have to be pretty sick, you're going to die anyway,' and the other one put her arm around me and laughed and said, 'You might use it, but I don't think I would.'

That feeling could be replicated through many communities. My concern is that Aboriginal people know about it and make an informed decision, and there is absolutely no reason why neither of those things should happen.³⁵

At the Darwin hearings, Ms Helen Morris, Council President of Daguragu Community Government Council in the Northern Territory gave the following answers to questions from Senator Tambling:

³³ Oral evidence of Father Frank Brennan, *Senate Proof Hansard*, Friday 14 February 1997, p 207.

³⁴ *Senate Proof Hansard*, Friday 24 January 1997, p 83.

³⁵ *Ibid*, p 85.

Senator Tambling: I appreciate what you are saying for your community. But if I choose to die in my home here in Darwin, because I am very, very sick, and I want to die at my home or at the hospital but I am so sick that I want to give myself the needle .. do you have any feeling about my decision? Is that my business? How do you feel about that? I respect your decision in your community but how do you feel about my decision?

Ms Morris: I think that is your right, if you want to make up your own mind.

Senator Tambling: That is important, Helen, because for me to do that, for me to be able to say, 'I'm finished' and that is what I want to do in my place, I need the law. I need the euthanasia law, otherwise it is against the law, it is illegal. But it is a matter of respect on both sides.

Ms Morris: I agree with that.³⁶

The pivotal vote in support of the *RTI Act* was cast by the late Mr Wes Lanhupuy, a respected leader in the Aboriginal community and Member for Arnhem. Mr Lanhupuy made the following comments in the Northern Territory Legislative Assembly about the proposal to enact the *RTI Act*:

Like the Chief Minister, I have had close personal experience of terminal illness and I can express a personal view as to its effects and what is involve in that traumatic period when seeing someone undergoing a very hard time in their life and facing a tragic end.

When the member for Fannie Bay introduced the bill, someone commented that it would not be in the interests of Aboriginal people because they are too busy trying to live a little longer. That is true. The statistics indicate that my people are dying at an early age. The infant mortality rate is high. The World Health Organisation has commented on the poor standards and housing ...

... Having gone to a Christian school, I have practised Christian beliefs. Certainly, my name indicates the Christian influence in my early days. I am very proud of the fact that that teaching has given me the ability to be able to express my opinion on matters of religion and culture, and on behalf of my people. In relation to this issue, the church has been a major voice. Whether that is right or not is a matter on which members will make a value judgment before voting on this bill. I heard in the community that some of the churches were telling people that they should not support the bill basically because of their religious beliefs. No information whatsoever was given as a reason for that. No information was given whereby people could determine their own beliefs. That was disappointing. Organisations and the churches have been influential in the Territory since its pioneering days. It was a matter for the churches themselves to determine their position in relation to this bill. Given the congregations to which they have access, the churches had a tool with which to express their views, whether for or against the legislation, and they utilised that. Whether that best suited themselves or not is something that I cannot fathom.

I expressed my personal views about that to many Aboriginal people in my electorate but, in the end, it was a decision which they had to make by themselves. After all the debate and

controversy, I said to people that I hoped that they would be able to give me the right to exercise my right as an individual. It is not hard to ask for a person's rights as an individual. A man lives his life, whether for or against the law, and irrespective of whether he has received the rights that he has demanded or has had a cheerful life or otherwise. When he is about to make his last request, should we be in a position to deny him that last right which he wants? That is the question which I believe honourable members of this House will have to come to grips with by themselves, regardless of whether they have decided to support or oppose the bill and be that on religious or any other grounds.

Mr Speaker, I can assure you that, in the 11 years that I have been in this parliament, this is the most difficult bill that I have ever had to examine and ponder on. I have had sleepless nights over it for a whole range of reasons, not the least being my personal feelings toward it because of the personal tragedy that I mentioned earlier ... It was a very difficult time. I have never had the opportunity to raise this issue except on the last occasion that I spoke in relation to this legislation. Based on such considerations, I believe a person should have the right to be able to determine what they want if they are of sane mind.

Many people in the Northern Territory are against this bill, from Groote Eylandt to Alice Springs, Finke and Hermannsburg. The people at every Aboriginal outstation that I visited told me to 'give it away'. They had no interest in it and they asked why would they support this bill. From what they have heard, their understanding is basically that the law will give authority to the doctors to give them an injection that will cause them to die. That is the basic information that they had about this bill ...

I for one would like to see this bill supported ...

3.12 Comment on paragraphs 9.19 - 9.23:

These paragraphs rehearse a number of arguments relating to the general moral, ethical and social issues raised in favour of, and against, voluntary euthanasia.

As discussed at some length above, the Senate Committee should not have ventured into this aspect of the euthanasia debate in this inexperienced way. Without wishing to fall into the same trap as the Senate Committee, the following notes outline some responses to a number of the "general moral, ethical and social arguments" against legalising active voluntary euthanasia. It may be useful to read these in conjunction with Chapters 6-8 of the Senate Committee Report.

ARGUMENT 1 - "Sanctity of Life": There is an intrinsic value in human life. This belief is held by almost everyone in our society, whether or not these people are religious. The sanctity of life principle properly underpins our society and our laws. Allowing a doctor to comply with a patient's request to be killed would violate this fundamental principle. It would do so because it would involve the intentional and premature killing of a human being.

RESPONSE:

- The sanctity of life is a very important ethical principle, but it is not absolute. Recognised exceptions to this principle already exist. These exceptions arise where the sanctity of life

principle conflicts with other important ethical principles which we apply to decisions about how we should live.

- These other principles include respect for the individual's right to choose how to live his or her own life in accordance with his or her own personal values. Sometimes this is called the right to self-determination or the right to autonomy. The law strongly protects this right as central to ensuring respect for the dignity and liberty of the individual.
- In the medical context, the law already recognises a competent adult patient's right to refuse any kind of medical treatment, even if death will certainly result from this refusal. In this situation the individual's right to self-determination defeats the sanctity of life principle. This right to refuse life-sustaining medical treatment was described in a leading English case as follows:

Every adult has the right and capacity to decide whether to accept or to refuse medical treatment. This is so even if refusing treatment may risk permanent injury to health or even lead to premature death. It matters not whether the reasons for making the choice are rational, irrational, unknown or even non-existent. The patient's right to self-determination will outweigh the very strong public interest in upholding the concept that all human life is sacred and that it should be preserved if at all possible.

- The law should recognise active voluntary euthanasia as another situation where the individual's right to self-determination is given priority over the sanctity of life principle. It should do this because deciding how to die is one of the most intimate and personal choices that a person will ever make. It is a choice that is central to personal dignity, autonomy and liberty. In the words of the Supreme Court of the United States of America:

At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

ARGUMENT 2 - "The Community Trumps the Individual": Although individuals in a liberal democratic society have the right to make choices in accordance with their own values, they may only do so if their decisions will not harm others. Allowing doctors to accede to their patients' requests for active voluntary euthanasia would harm wider society. Accordingly, the individual does not have a "right to die". Rather, the individual has a duty to prioritise the greater good of society over his or her personal wishes and beliefs on this issue.

RESPONSE:

- Legalising active voluntary euthanasia would benefit, rather than harm, the wider Australian community.
- It would do this by ensuring greater respect for the following important societal values:
 1. *Respect for the beliefs and values of other Australians.*

Australians come from a great variety of cultural, religious and personal backgrounds. Individual Australians have very different, and often very strongly held, beliefs about what gives life (and death) dignity and meaning. Tolerance and respect for those different belief systems demands that Australians be given more say in choosing how and when they will die, in accordance with their own personal beliefs and understanding of their own lives.

2. *Compassion for the suffering of other Australians.*

It is an unpleasant fact that there are situations when little or nothing can be done to relieve a terminally ill patient's suffering. That suffering may involve physical pain, mental suffering and/or "spiritual" suffering associated with the patient's terminal illness. In these situations it is inhumane to force a person to endure suffering of a kind they are no longer willing or able to bear.

3. *Equality of Australians' access to appropriate medical care.*

Some Australians currently do have access to active voluntary euthanasia. Others do not. Whether or not they have such access depends on the attitude of the medical professionals responsible for their care. Legalising active voluntary euthanasia would enable doctors to be less secretive about their position on this issue. This would enable patients to choose doctors whose views about euthanasia best correspond to their own, and to receive medical care most appropriate to their personal needs.

ARGUMENT 3 - "The Slippery Slope": If we legalise active voluntary euthanasia, this inevitably will lead to a situation where patients are killed without - or even against - their explicit and competent request. No safeguards could prevent this happening if we took the initial step of allowing doctors to comply with their patients' requests to be killed. Eventually we would slide to the bottom of this "slippery slope" and end up with the kind of practices tolerated in Nazi Germany. The situation in the Netherlands is heading in this direction.

RESPONSE:

- There is no evidence to suggest that changing the law, to allow doctors to satisfy the requests of competent adult patients to be killed, will increase the incidence at which patients are killed in the absence of such a request.
- There is evidence, however, that the current legal prohibition in Australia on active voluntary euthanasia does not effectively prevent doctors from practising active voluntary euthanasia. The only empirical research on end-of-life medical decisions that has been conducted in Australia indicates that 1.8 % of deaths in this country (around 2 300 each year) are the result of active voluntary euthanasia.
- The same research suggests that Australian medical practice has to some extent already "slid down the slippery slope" despite the current legal prohibition on doctors killing their patients. The research indicates that 3.5 % of deaths in this country (around 4 400 each

year) involve a doctor administering drugs with the explicit intention of ending the patient's life, without a concurrent explicit request by the patient.

- Although not strictly legal, in the Netherlands active voluntary euthanasia is an accepted and openly discussed part of medical practice. Despite the more "permissive" approach in the Netherlands to regulating active voluntary euthanasia, the rate of intentional ending of life without an explicit request from the patient is significantly lower in the Netherlands than in Australia. Empirical research from the Netherlands indicates that only 0.7 % of deaths in that country involve the ending of life without the patient's explicit request (compared to 3.5 % of Australian deaths). Between 1990 and 1995 the number of such cases decreased in the Netherlands.
- There is a need for continuing empirical research to be conducted on end-of-life medical decisions, both in Australia and overseas. This research is needed to monitor exactly where current Australian medical practice is positioned on the "slippery slope" relative to the medical practice in other countries. This research is also needed to determine whether the Australian legal prohibitions on active voluntary euthanasia regulate the practice more (or less) effectively than the regulatory approaches to active voluntary euthanasia in other countries.
- Invoking the spectre of Nazi Germany provides a useful reminder that the key to the debate about euthanasia is the word "voluntary." Terminating someone's life at his or her persistent, explicit and competent request is a fundamentally different thing from killing someone without such a request. The former enhances respect for the dignity and value of the individual and for his or her rights; the latter destroys it.

ARGUMENT 4 - "Euthanasia vs Palliative Care": Patients would not ask for euthanasia if they received adequate palliative care. High standard palliative care can relieve the suffering of all patients. Patients who ask to be killed are really asking for better palliative care. Legalising euthanasia would jeopardise the funding, and hence the availability, of palliative care services in Australia.

RESPONSE:

- Even the most highly skilled, well-funded and caring palliative care teams cannot meet the needs of all patients.
- There is a small percentage of patients whose excruciating physical pain cannot be reduced to levels that are acceptable to the patient. Sometimes these cases are referred to as "hard deaths". In these cases the only way of controlling the patient's agony may be to administer sufficient morphine to induce coma, which hastens death. There currently is a debate in Australia about whether this practice is both ethical and lawful. Most opponents of active voluntary euthanasia refuse to concede that there may be ethical and legal problems with this practice. They approve of this practice because they characterise the doctor's "intention" in this situation as an intention to relieve pain rather than an intention

to cause death. They approve of this practice regardless of whether the patient has asked for or consented to this course of action: the patient's wishes are of secondary importance to the doctors' decisions about pain management.

- There is a larger percentage of patients whose physical pain is more manageable but who nonetheless reach a point where their needs cannot best be met by palliative care. This is because the palliative care team cannot reduce the patient's mental, emotional or spiritual suffering to levels that are acceptable to the patient. Sometimes this may occur because the patient's personal belief system is at odds with the values underpinning the care offered by the palliative care team.
- Palliative care and active voluntary euthanasia should be seen as part of a continuum of possible treatment options rather than as mutually exclusive alternatives. Suffering patients should not be offered "palliative care or euthanasia". They should be provided with proper information about all the different ways in which their particular suffering might be managed. They should be allowed to choose active voluntary euthanasia if and when palliative care does not meet their personal needs.
- Suffering patients cannot make real choices about their medical treatment unless good quality palliative care services are available throughout Australia. Regardless of whether active voluntary euthanasia is legalised, both Federal and State governments have a clear obligation to ensure more resources are devoted to research, training and service provision in the palliative care area.

ARGUMENT 5 - "The Law Should Leave End-of-Life Decisions to Doctors: The law is a blunt instrument that has no place at the bedside of a dying patient. Doctors are in the best position to assess the appropriate medical management of suffering patients. The current legal regime works well and protects both doctors and patients. Further, legalising active voluntary euthanasia would result in a fundamental change in medical ethics. Doctors would be pressured to become "executioners" instead of people devoted solely to saving life and healing.

RESPONSE:

- The law currently regulates many aspects of the doctor-patient relationship. This legal regulation clarifies the respective rights and responsibilities of patients and doctors. It also establishes enforceable minimum standards of treatment to which all Australians are entitled. The law can do this with a sensitivity to, and respect for, both the professionalism of doctors and the rights and expectations of patients.
- Every Australian will die, and most of us will receive medical care while we are dying. It therefore is particularly appropriate and desirable for the law to regulate this aspect of the doctor-patient relationship. Both doctors and patients are entitled to know what may or may not be done during the dying process.

- Doctors are specially trained and uniquely qualified to assess clinical situations and carry out medical treatment. They are not specially trained, nor uniquely qualified, to make decisions about the quality of an individual patient's life or decisions about what manner of death is most appropriate for that patient. The people who should make these decisions are patients themselves, after they have received appropriate advice and assistance from their doctors and other carers.
- The current legal regime does not work well. It is characterised by hypocrisy. Although the law purports to forbid active voluntary euthanasia completely, some doctors are prepared to assist some patients who request this kind of assistance. Research indicates that 1.8 % of deaths in this country (around 2 300 each year) are the result of active voluntary euthanasia: the administration of drugs with the explicit intention of ending the patient's life, at the patient's request. Doctors who carry out active voluntary euthanasia are not prosecuted, even though the law forbids this behaviour and considers it to be murder.
- The current legal regime is also characterised by uncertainty. There currently is an unresolved debate in Australia about whether or not it is legal for doctors to administer pain-relieving drugs in doses large enough to hasten a suffering patient's death. The legal position of nurses involved in the care of such a patient is particularly unclear.
- Legalising active voluntary euthanasia would not impose a fundamental change in medical ethics upon doctors. It would instead bring the law into line with the change in medical ethics that has occurred in Australia over the past two decades: the change from the ethic of paternalism ("doctor knows best") to an ethic that shows more respect for the individual rights of patients and envisages the doctor-patient relationship as more of a partnership. That ethical change has already been reflected in many aspects of the Australian law regulating the doctor-patient relationship.
- Legalising active voluntary euthanasia would not place doctors under any legal or ethical obligation to kill patients in contravention of their personal moral beliefs. Participating in active voluntary euthanasia would be entirely voluntary for doctors as well as for patients.
- Helping patients die in accordance with their wishes is consistent with the basic ethical principles underlying good medical practice. A doctor who agrees to a patient's request for euthanasia can be seen as a caring medical practitioner, acting with respect for the patient, and managing the patient's death in a way that responds to the individual patient's wishes and needs.

ARGUMENT 6 - "People Would Be Pressured Into 'Choosing' Death": If active voluntary euthanasia was a legal option, vulnerable people would be pressured into choosing to die. They would be pressured by doctors, by their relatives, and by their own feelings that they are an unwanted burden on society and on their loved ones. People who habitually place the interests of others above their own - especially women - would be particularly at risk. Legalising active voluntary euthanasia also would provide society with a good excuse to reduce spending on health care, including palliative care and special health care services for the elderly and other vulnerable groups. We would increasingly see patients

who wished to pursue palliative care (and other "expensive" alternatives to euthanasia) as selfish consumers of scarce health care resources to which they are not entitled.

RESPONSE:

- Active euthanasia should only be legalised pursuant to the informed and voluntary decision of a competent adult.
- All competent adults - including those who are terminally ill - have the right and ability to make decisions about how to lead their own lives. This includes the right and ability to decide to follow a course that other people consider to be "wrong" and would never choose for themselves. The fact that an individual is choosing something that other people think is wrong does not mean that the individual is incapable of making his or her own decisions. Nor does it mean that the individual has been pressured into choosing something that he or she does not really want. Nor does it mean that the individual has made this choice in ignorance of the consequences of his or her decision.
- Dying people will not make the decision to ask for active voluntary euthanasia in "splendid isolation" from other people. They will not make the decision without considering its implications for their families and other loved ones. People's decisions about how and when to die inevitably will be influenced by their attachments to and concerns for other people. These attachments and concerns, however, will be as complicated and unique as the individual himself or herself. Sometimes they will influence an individual to choose to die; sometimes they will influence an individual to choose to live. The final decision of whether to live or die, however, ultimately lies with the competent individual who has considered who and what is important to him or her.
- It is insulting to assert that individual women or individual members of any other "oppressed" group in society cannot make their own decisions and choices about difficult matters. Marking out some adult Australians as incapable of making decisions on ethically or socially controversial topics sets a worrying precedent. For example, it paves the way for denying that women have the right to choose to terminate a pregnancy, or to receive treatment for infertility, or to participate in drug trials or other medical research. This kind of approach is also problematic because it divides Australians into oversimplified categories. It assumes that every individual who is a member of a social group has all the characteristics and vulnerabilities, or imputed characteristics and vulnerabilities, of that group.
- Legalising active voluntary euthanasia can be a way of empowering individual members of "oppressed" or "vulnerable" groups. By removing the need for doctors to be secretive about their willingness to provide active voluntary euthanasia, legalisation would ensure that active voluntary euthanasia is available to people whose personal or professional connections do not currently provide them with information about this dying option. This would lead more equitable access in Australia to information about different ways of managing the dying process and to obtaining a doctor's assistance to die.
- Any attempts to restrict the access of all Australians to the full range of health care options needed for them to be able to make real choices about their health care should be opposed.

There is a particular need to be alert to attempts to cut spending on health care services. (Australia currently spends a lower percentage of its GDP on health care than many other OECD countries). This need to guard against the worst excesses of economic rationalism in the health care sector will exist regardless of whether active voluntary euthanasia is legalised.

3.13 *Comment on paragraph 9.24:*

This paragraph of the Senate Committee Report refers to the regulation and practice of euthanasia in the Netherlands. Neither this paragraph, nor the fuller discussion of the Dutch situation in the main body of the Senate Committee Report, provides an adequate account of the regulation of medical decision-making at the end of life in the Netherlands. The Senate Committee Report's account of the Dutch situation, and of the empirical research conducted in that country on this issue, contains many misleading inaccuracies.

Similar comments can be made in respect of the discussion in the Senate Committee Report of the legal situations and other developments relating to active voluntary euthanasia in other overseas jurisdictions, such as Canada, the United States of America and Switzerland.³⁷

The Senate Committee received oral evidence on these overseas developments from only two overseas witnesses: Dr John Keown (University of Cambridge, United Kingdom) and Professor Margaret Somerville (McGill University, Canada). Both witnesses are well-known opponents of legalising active voluntary euthanasia.

4. SUMMARY

In summary, the Committee's analysis of the key issues fails to be the adequate basis upon which conclusions could be safely made. The obvious rush to get the matter over and done with has served neither the Senate nor the public interest well.

I have prepared this alternative report, itself inexcusably rushed, and no doubt imperfect, as a counterweight. The overall result is no substitute for the more thoroughgoing inquiry and consideration which such matters deserve.

³⁷ See N. Cica, *Euthanasia - the Australian Law in an International Context: Part 2 - Active Voluntary Euthanasia*, Research Paper No 4 1996-97, Department of the Parliamentary Library, 1996, for a detailed summary of the relevant laws in the United Kingdom, the USA, Canada and the Netherlands. The information in this Research Paper is accurate as at September 1996.

Bob Brown
Australian Greens Senator for Tasmania

EUTHANASIA LAWS BILL INQUIRY

ADDITIONAL COMMENTS BY THE NORTHERN TERRITORY SENATORS

Whilst the Senate committee received a large number of submissions we are of the opinion the depth of consideration afforded at public hearings and in its deliberations in Darwin and Canberra was necessarily limited by time constraints and the quality of the report is subsequently compromised. The committee has given inadequate and scant regard to the constitutional and legal implications of the legislation.

The public forum in Darwin, with over 450 participants, convened by ourselves on the 23 Jan 1997 has elicited only one substantive quotation as a contribution to the committee report.

The Report is deficient in a number of vital areas - it fails to adequately address the fundamental anti-Territories nature of the Euthanasia Laws Bill. It fails to enter a proper discussion of democratic values and representative government, of the conventions of Self-Government, of the Northern Territory's progress towards Statehood, and a recognition of the serious danger posed by making laws which render the criminal law uncertain.

The Report, in our opinion, fails to adequately assess the significance of the grant of Self-Government to the Northern Territory in 1978. Prior to this grant, the Territory was governed by the Commonwealth. Upon that grant, the Northern Territory of Australia was established as a self-governing body politic in its own right, on traditional Westminster lines of representative, democratic government. Its powers were expressly extended to most State-type matters, capable of including that of voluntary euthanasia. This grant necessarily carried with it the fundamental conventions of Self-Government which are just as much part of Australian constitutional fabric as is the text of the *Constitution* itself. A breach of fundamental constitutional convention is an unconstitutional act. Any retraction of that grant of Self-Government, on the Commonwealth Attorney-General's Department's own opinion, is unthinkable except in the most serious situation such as civil breakdown. The Report should conclude that if the *Euthanasia Laws Bill* is enacted, the Commonwealth Parliament would be acting unconstitutionally.

The *Euthanasia Laws Bill* would erode the legislative powers and actions of the elected representatives of Northern Territory people. The Bill, if enacted, would be anti-democratic.

Further, as that Bill is only directed at Territorians within self-governing territories, it would be directly discriminating between those Territorians and other Australian residents.

The Commonwealth Parliament may have the necessary power in section 122 of the *Constitution* to legislate to force its will on Territories but the plain fact is that it should not seek to exercise that power against the will of Territorians where it would be acting unconstitutionally, undemocratically and in a discriminatory manner.

Unless the constitutional conventions are respected in our Westminster system of government and democratic principles are upheld, our whole system of government is under threat. The principles of constitutional democracy are fundamental at all levels of government and should be respected.

Beyond the considerations of Self-Government, the Report fails to come to grips with the implications for a grant of Statehood to the Northern Territory, as is presently proposed. The Bill, if enacted, may be an impediment to such a grant. It is extremely unlikely that the Bill could constitutionally continue in force beyond that grant even if sought to be amended. The Report should say that in the Northern Territory the Bill will only have a transitional effect pending any grant of Statehood.

The Report clearly indicates the uncertain effect on the wider criminal law if the Bill is enacted. This was even accepted in the views of Mr Geoffrey Dabb, First Assistant Secretary, Commonwealth Attorney General's Department, to which the Report refers. In our opinion, the Report should therefore conclude that in view of such uncertainty, the Bill should not proceed to enactment. Uncertainty in the law is never desirable, and this applies particularly to the criminal law, where the liberty of the citizen is at stake. Additionally it creates uncertainty regarding the scope of the Territories' power to legislate and hence resolve problems that may arise as a result of this legislation. This is not acceptable.

The Report is inaccurate in some respects. The case against the Oregon State law mandated at referendum as Measure 16 was dismissed by a Federal Appeal Court on 27 February 1997 and the law is now operative. The *Rights of the Terminally Ill Act* is therefore not unique.

SENATOR the Hon BOB COLLINS SENATOR the Hon GRANT TAMBLING

SENATORS FOR THE NORTHERN TERRITORY

COMMENTS OF SENATOR COONEY

In the Northern Territory there are people overborne by fearful pain and dreadful disability. They are suffering from a terminal illness. They are in full possession of their senses. They want to end their lives; and to do so with expedition and dignity. Their doctors are willing to help them do so. The Northern Territory Assembly a democratically elected legislature has passed the Rights of the Terminally ill Act which makes it lawful for them to do so. Should the Federal Parliament pass legislation which will in effect overrule that statute and make the act of a medical practitioner in intentionally killing his or her patient a crime. In my view it should.

Mr John Greenwell appearing as a member of the Canberra Branch of the Voluntary Euthanasia Society of New South Wales spoke to the Committee. His arguments were cogent and founded on principle. He proposed that the Community ought take into account and strike the right balance between three factors in deciding whether to make euthanasia lawful. These are: compassion, autonomy and the sanctity of life.

Mr Greenwell is right in holding that the issue of whether or not euthanasia ought be made lawful is one of principle. I agree with him that compassion, autonomy and the sanctity of life are factors that must be given great weight when Society is resolving the matter. But in my view there are other principles which make the legitimisation of euthanasia, at this point of time in any event, bad public policy.

Given the subject matter of this report it is proper for me to state that I am a practising Catholic and that this has a powerful effect on my attitude to euthanasia. It is appropriate for a legislator to give weight to his or her belief in formulating public policy. The great religions proclaim principles which have stood the test of time and which over the centuries many communities and cultures have embraced to their clear benefit. Accordingly it is right for a parliamentarian to take his or her belief into account when legislating but it should not be a lone factor.

No parliament should readily legitimise intentional killing. Where the State starts to sanction the deliberate delivery of death there is unacceptable danger that it will come to condone an ever widening range of slayings.

The evidence before the Committee shows that the Northern Territory Assembly is the one Parliament worldwide which has enacted a Right of the Terminally Ill Act or legislation akin to it. It seems that the ethos of societies around the world has restrained legislatures from making euthanasia lawful. Given that, is it good public policy to allow an Assembly whose jurisdiction encompass less than 200,000 people to make a law legitimising intentional killing which is unique amongst the nations?

Principles of democracy and self determination require the Federal Parliament to give great weight to the actions of the Northern Territory Assembly. But they must be set in the context of other principles.

The Northern Territory is part of Australia. The Rights of the Terminally Ill Act affects the nation as a whole. It influences the ethos, the culture, the attitude of people who live in various parts of this Country. It is likely to affect those of many who live throughout the world.

John Donne wrote in 1624 that:

"No man is an island, entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as if a manor of thy friends or of thine own were; any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee."

There are words which are often quoted and they are often quoted because they are true and recognised as true.

In the State of Victoria V The Commonwealth of Australia (122 C.L.R. 353) the Chief Justice Sir Garfield Barwick said:

"I have observed elsewhere that the Constitution does not represent a treaty or union between sovereign and independent States. It was the result of the will and desire of

the people of all the colonies expressed through referenda to be united in one Commonwealth with an agreed distribution of governmental power." (See page 370)

Later his Honour stated:

"Thus though by their union in one Commonwealth, the colonists became Australians, the territorial boundaries of the former colonies were retained for the purposes of the distribution of governmental power and function".
(see page 371)

At this point in time were any of the States to enact legislation making euthanasia legal and were the Commonwealth to hold the power to invalidate them it would be acting in accordance with good public policy to exercise it. It does not hold that power in respect of the States but it does in respect of the Territories and can execute good public policy in respect to them. The ability of the Federal Parliament to act differently in respect of the Territories and of the States is a consequence of the Constitution and not of the untoward strategy of the Commonwealth.

Jury's have a constitutional right to return the verdict they consider appropriate. Prosecutors have the duty to indict only those whom they consider it right and proper to proceed against.

Euthanasia brings relief to people in the extremes of pain. Are doctors who carry out acts which may appear to be acts of euthanasia convicted? The evidence before the Committee showed to the contrary. There was little material put before it demonstrating that members of

the medical profession were being tried or convicted for treating people in a way that lead to their deaths.

Evidence given to the Committee by some witnesses contradicted that given by others.

Opinions put before it were in conflict. While this uncertainty and contention exists it would be unsafe and against good public policy to allow a law as crucial and as radical as the Rights of the Terminally Ill Act to continue.

ADDITIONAL COMMENTS

From the referral of this matter to the Committee by the Senate on 7 November 1996 to February 1997 I held the position of Chairman. On 13 February 1997 I was appointed as a Parliamentary Secretary by the Government.

Due to the convention that Parliamentary Secretaries do not chair Senate Committees I resigned as Chairman on 15 February 1996. I have continued as a participating member of the Committee for this inquiry only as it is considering a Private Member's Bill, rather than a Government Bill.

In my view the conduct of the inquiry and the process of finalising the report have been in keeping with the usual practice of the Committee.

SENATOR CHRISTOPHER ELLISON
Senator for Western Australia

5 March 1997

APPENDIX 1

ANALYSIS OF SUBMISSIONS

1. Number of Submissions received³⁸

The Committee received 12,577 submissions. It should be noted that one submission in favour of euthanasia included a petition with 2,485 signatures.

2. Source of Submissions

The following table sets out where within Australia submissions came from, and shows what proportion of the Australian population lives in each State and Territory.

State/Territory	Number of submissions	% of total	% of total Australian population at 30/6/96
NSW	6,083	48.4%	33.8%
Qld	1,515	12.1%	18.3%
SA	730	5.8%	8.1%
Tas	352	2.8%	2.6%
Vic	1,941	15.5%	24.8%
WA	653	5.2%	9.6%
ACT	289	2.3%	1.7%
NT	992	7.9%	1.0%
Norfolk Is	4	0.032%	0.01%
totals	12,559	100%	100%

In addition, 18 submissions were received from overseas: 1 each from Canada, Finland, Hong Kong, New Zealand and the USA; 6 from the Netherlands and 7 from the United Kingdom.

3. Contents of the submissions

The following table sets out the basic position of those making submissions, as interpreted by the secretariat.

View expressed in submissions	No of submissions	Percent of total
for the Bill and/or opposed to euthanasia	11,731	93.3%
against the Bill and/or in favour of euthanasia	804	6.4%
not clear, or other considerations	42	0.3%
totals	12,577	100%

³⁸

All the information in this Appendix is based on data as at 21 February 1997.

The following two tables contain a more detailed breakdown of the attitudes expressed in the submissions, as interpreted by the secretariat.

MAIN THEME IN SUBMISSIONS OPPOSED TO EUTHANASIA

Main theme	% of submissions from those opposed (n = 11,731)	% of total submissions received (n = 12,577)
1. morally/ethically wrong, against the sanctity of life, against ordinary community perception of right and wrong	38%	36%
2. open to serious abuse, thin edge of the wedge, open to mistakes, not enough safeguards, general fear of euthanasia	26%	24%
3. opposed on religious grounds	16%	15%
4. palliative care works & is the answer, and/or more funding for palliative care needed	13%	13%
5. role of doctors, confers too much power, puts them in invidious positions, against hippocratic oath	5%	4%
6. opposed to Aboriginal cultural traditions	1%	1%
totals	100%	93%

MAIN THEME IN SUBMISSIONS IN FAVOUR OF EUTHANASIA

Main theme	% of submissions from those in favour (n = 804)	% of total submissions received (n = 12,577)
1. autonomous right of individual to choose the manner and timing of death	65.3%	4.17%
2. territory rights should be respected	20.6%	1.32%
3. compassionate: relief of pain & suffering	12.6%	0.80%
4. against euthanasia but against Andrews Bill because of Territory rights	1.0%	0.06%
5. don't want to be a burden on family and society	0.5%	0.03%
totals	100%	6.4%

4. Size of the submissions

The following table sets out the size of the submissions. Appendices to submissions have not been included in the page counts.

No of pages	No of Submissions	Percent of total
1	10,118	80.4%
2	1,839	14.6%
3	283	2.3%
4	94	0.7%
5	40	0.3%
6-10	80	0.6%
11-20	62	0.5%
more than 20	61	0.5%
totals	12,577	100%

5. Form letters as submissions

No separate statistics were collected on whether submissions were unique documents or were form letters. However, the secretariat estimates that between 600 and 650 form letters were received as submissions.

APPENDIX 2

WITNESSES WHO APPEARED BEFORE THE COMMITTEE

Darwin

24 January 1997

Northern Territory Government:

- Mr Shane Stone, Chief Minister, Northern Territory Government;
- Mr Denis Burke, Member of the Legislative Assembly;
- Mr Michael Reed, Member of the Legislative Assembly;
- Dr Shirley Hendy, Chief Health Officer;
- Mr Graham Nicholson, Senior Crown Counsel; and
- Mr Thomas Pauling, Solicitor-General for the Northern Territory.

Ms Maggie Hickey, Leader of the Opposition

Mr Marshall Perron

Coalition Against Euthanasia:

- Mr Martin Hardie, Legal Adviser;
- Mr Thomas Kiely, Member;
- Mr John McCormack, Member;
- Dr Christopher Wake, Member; and
- Mr Harry Wilson, Member.

Dr Phillip Nitschke

Northern Territory Council of Churches:

- Reverend Father Timothy Brennan, President, Northern Territory Council of Churches;
- Reverend Doctor Djiniyini Gondarra, Executive Officer, Northern Regional Council of the Uniting Aboriginal and Islander Christian Congress;
- Mr Stuart McMillan, Community Worker, Northern Regional Council of the Uniting Aboriginal and Islander Christian Congress; and
- Mrs Didamain Uibo, Anglican Church representative.

NT Voluntary Euthanasia Society Inc:

- Mrs Lynda Cracknell, President
- Mr Andrew Chapman, Vice President

Australian Medical Association - Northern Territory Branch

- Dr Vicki Beaumont, Member;
- Dr Francis Bowden, Member
- Ms Robyn Cahill, Executive Officer;
- Dr Diane Howard, Member;
- Dr Charles Kilburn, Vice President;
- Dr Sudarshan Selva-Nayagam, Member; and
- Dr Tarun Weeramanthri, Member.

Dr Nitschke - recalled

Mr Thomas C Lovegrove

Ms Dawn Lawrie

Daguragu Community Government Council:

- Mrs Topsy Dodd, Tribal Elder, Council Member;
- Mr Mick Inverway, Tribal Elder, Council Member;
- Ms Helen Morris, Council President;
- Mr Robert Roy, Recreation Officer;
- Ms Kim Muhlen-Schulte, Council Clerk; and
- Mr Roark Muhlen-Schulte, Anthropological Researcher.

Canberra 13 February 1997

Professor Peter Baume and Professor Helga Kuhse
Professor Baume and Professor Kuhse also gave in-camera evidence.

Australian Medical Association:

- Dr Harry Nespolon
- Ms Sarah Hollands

Council of the Australian & New Zealand Society of Palliative Medicine;

- Professor Peter Ravenscroft
- Dr Brian Kelly

Australian Association of Hospice and Palliative Care

- Dr Michael Smith

Mr Chips Mackinolty

Dr John Keown

Royal College of Nursing, Australia

- Ms Elizabeth Percival
- Ms Elizabeth Foley
- Ms Meg Wallace
- Ms Heather Martin

Australian Nurses Federation

- Ms Anne Marie Scully

Canberra 14 February 1997

Professor Margaret Somerville

ACT Government:

- Ms Kate Carnell, MLA: Chief Minister
- Mr Gary Humphries MLA: Attorney-General
- Mr Tim Keady: Chief Executive Attorney-General's Department
- Mr Michael Peedom: Chief Solicitor ACT Government

Australian Medical Association - recalled

- Dr Harry Nespolon

Attorney-General's Department:

- Mr Geoff Dabb, First Assistant Secretary, Criminal Law Division
- Mr Frank Marris, Acting Deputy General Counsel
- Dr Rosalie Balkin, Acting Senior General Counsel, International Law

Father Frank Brennan

Mr George Williams

Euthanasia NO:

- Mr Tony Burke
- Dr Brian Pollard
- Dr Nell Muirden
- Mrs Karin Clark

Voluntary Euthanasia Societies:

- Mr Kep Enderby QC
- Mr Gordon Taylor
- Mr John Greenwell
- Dr David Swanton
- Mrs Rosemary Dewick

Australian Catholic Bishops Conference:

- Most Reverend Barry Hickey, Archbishop of Perth
- Dr Margharita Nicolletti
- Dr Anthony Fisher OP
- Dr Warwick Neville

Coalition of Organisations for Voluntary Euthanasia:

- Ms Pauline Wright – NSW Council of Civil Liberties
- Dr Robert Marr – Doctors Reform Society
- Mr Bruce Meagher – AIDS Council of NSW

APPENDIX 3

"HOSPITAL SERVICES SUPPLIED TO ABORIGINAL PEOPLE IN THE NT, 1993-96"

**A paper provided to the Committee
by the Northern Territory Government at the Committee's hearing,
Darwin, 24 January 1997**

NOTE: Document not included in this PDF version of the report because it contains graphs that could not be formatted in the available time.