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**SELECT COMMITTEE ON THE
VOLUNTARY EUTHANASIA BILL 1996**

LEGISLATIVE COUNCIL OF SOUTH AUSTRALIA

SUBMISSION

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1. INTRODUCTION

The Australian community has a human concern for the well-being of the sick, the dying, the aged, and those persons living with disabilities. The legal, social, and ethical environment of South Australia and the wider Australian community affects the way in which care is both given and received. A society which tells the sick, the dying and people living with the disabilities that they are loved and that their lives still have meaning provides a positive social, legal, and ethical environment for the care of the aged. That environment is further enhanced when doctors and other health care professionals respect the right of people not to have their dying unreasonably prolonged by respecting their legal and moral rights to reject treatment they regard as futile or overly burdensome, and when those same health care professionals provide appropriate palliative care management which alleviates physical and emotional distress. These principles apply to all those who are sick in body or mind, including those with terminal illnesses.

However, a society which tells those people who feel that their lives no longer have meaning and are not worth living that they may well be right to feel that way, and which gives people legal, social and ethical approval to have their lives terminated by a lethal injection, provides a very different context within which care is delivered. It is a context in which society can no longer offer a reasonable guarantee that the right to life of the vulnerable will be protected. It is a context within which the trust in health care professionals that patients and residents in residential aged care facilities will undoubtedly be eroded.

In this submission careful distinctions will be drawn which will make it clear what we understand the term “voluntary euthanasia” to include, and arguments will be adduced to show why the legalisation of voluntary euthanasia would be unwise and dangerous public policy.

2. DEFINITION OF VOLUNTARY EUTHANASIA

2.1 In this submission voluntary euthanasia is defined as the intentional killing of a patient, by act or by omission, by someone legally authorised to do so (typically a medical practitioner), at the competent request of the patient, motivated by compassion. The essential elements of voluntary euthanasia are then:

- it is voluntary
- it involves the intentional killing of the patient by act or by omission
- the patient is legally competent to request the lethal injection
- the motive is compassion for the condition in which the patient finds himself or herself

This definition conforms to the current legal and ethical norms which apply in South Australia. It distinguishes voluntary euthanasia (VE) from the legally and ethically acceptable practices of withdrawing or withholding treatment in certain circumstances, and from the intensification of pain relief treatment (ie increasing the dosages of pain relieving drugs) even when it is foreseen that such intensification may shorten the life of the patient.

2.2 VE involves *intentional killing*, ie acts or omissions in which the main, even the sole, purpose or intention is to bring about the patient's death. One cannot kill a patient and say that the intention was "to relieve suffering" as some Dutch physicians have tried to argue:

No physician who performs euthanasia does so with the sole intent to kill his or her patient. His or her intention can always be described as trying to relieve the sufferings of his or her patient. This is exactly what infuriates Dutch physicians when, after reporting the case they are treated as criminals¹

They appear not to understand the difference between *motive* and *intention*. The doctor's *motive* in killing the patient to relieve pain may be a very understandable and laudable motive. It doesn't change the fact that, *motivated* by a desire to relieve the patient's suffering, the particular act or omission chosen is chosen because the doctor *intends* to kill the patient and is therefore committing a homicide. This also applies to cases where the patient is intentionally killed by withdrawing or withholding life saving treatment, cases which may be distinguished from other situations in which treatment is withheld or withdrawn without the intention to kill the patient.

2.3 Without an understanding of *intention* it is almost impossible to distinguish, morally and legally, acts which outwardly look the same. How do we distinguish theft from borrowing, theft from a prank, or murder from accidental killing unless we establish the intention of the doer of the act? For example, stealing a pencil from another person and borrowing a pencil may be distinguished legally and morally by intention. Theft involves an *intention* to permanently deprive. What is morally and legally relevant in medical decisions at the end of life is whether in withholding or withdrawing treatment the physician intends to kill his patient, or whether his non-

¹ Johannes JM van Delden, Loes Pijnenborg, and Paul J van der Maas, "Dances with Data", *Bioethics*, vol 7, no 4, July 1993, 325

treatment decision is based upon his best clinical judgment that that treatment would either be futile or disproportionately burdensome. In cases where it is the patient who wishes no further treatment then, at least in Australian law, the doctor cannot proceed to treat. This is true even when such a refusal is thought to be suicidal. Even here in many jurisdictions in the world there is legal room for a doctor or private citizen to 'rescue' someone about to commit suicide. And since in many instances the call to be killed reflects a patient in physical pain or suffering from depression, there is ample room for the depression or physical pain to be treated resulting in a different attitude in the patient.

2.4 This submission supports the right of patients to refuse treatments that are futile or disproportionately burdensome, that is treatments which would unnecessarily prolong the patient's dying with no prospect of benefit to the patient. Here it is the quality of the treatment and not the quality of the patient's life that is at issue. Medicine is a finite art. Where there exists no meaningful treatment for a patient then the death of the patient has to be accepted as the logical outcome of the underlying pathological condition(s). This involves no intention to bring about the patient's death, but an acknowledgment that death is, in all the circumstances, inevitable and unstoppable.

2.5 Where the intensification of pain relief is concerned, in both law and morals, the operative factor is, again, *intention*. Where the physician applies pain relief treatment, with the sole purpose of alleviating pain, and even if he or she believes that the escalation of pain relief may shorten the life of the dying patient, then that physician is not engaging in euthanasia practises and is already protected in law.

This common law protection was recently codified in statute law in South Australia's *Consent to Medical Treatment and Palliative Care Act 1995*:

A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability, by administering medical treatment with the intention of relieving pain or distress-

- a) with the consent of the patient or the patient's representative; and
- b) in good faith and without negligence; and
- c) in accordance with proper professional standards of palliative care,

even though an incidental effect of the treatment is to hasten the death of the patient.²

2.6 Some people fear that they will receive unwanted treatment when they are unable to refuse it, eg when the patient is comatose. In South Australia and Victoria provision is

² *Consent to Medical Treatment and Palliative Care Act 1995*, Division 2 - The Care of People Who Are Dying, clause 17(1)

made for patients to appoint an agent with the legal right to make decisions on medical treatment in the patient's behalf. This provision is, of course, subject to certain safeguards. Agents are living persons who can take account of new circumstances and make decisions having regard to any instructions that the grantor has left.

2.7 Given that citizens have different personal views on the moral rightness or wrongness of VE the Parliament has to decide whether VE is best left as a matter of personal choice, subject to certain safeguards, or that the current legal prohibition on VE and assisted suicide should remain. This submission will now focus on the public policy issues and indicate why the law should not be changed to allow VE or assisted suicide.

3. VOLUNTARY EUTHANASIA AS A CONTRAVENTION OF HUMAN RIGHTS

3.1 The fundamental role of the state is to provide the conditions in which members of the state can collaborate together in peace for the common good. "The foundation of freedom, justice and peace in the world" is "the recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family."³

3.2 Australia has committed itself to the *Universal Declaration of Human Rights*, the *International Covenant on Civil and Political Rights*, and other human rights declarations and covenants.

3.3 Inalienable human rights are rights of which the individual may not be deprived and of which the individual may not even deprive himself or herself. Thomas Hobbes, rightly regarded as the political philosopher from the Enlightenment who most influenced modern human rights talk, described the law of nature as "a precept or general rule, found out by reason, by which a man is forbidden to do that, which is destructive of his life, or taketh away the means of preserving the same; and to omit that, by which he thinketh it may best be preserved."⁴

3.4 If fundamental human rights are not inalienable, if citizens are permitted to give up their fundamental human rights, then it undermines the ability of the government or the state to protect the fundamental rights of others, especially the weak and the vulnerable.

3.5 One fundamental human right is *freedom*.⁵ If individuals are able to give up their right to freedom and sell themselves as slaves, this undermines the ability of the state to protect the freedom of those who do not wish to be slaves. If we allow a pro-choice

³ Preamble of the *Universal Declaration of Human Rights*, 1948

⁴ Thomas Hobbes, *Leviathan, or the Matter, Forme and Power of a Commonwealth Ecclesiasticall and Civil*, edited by M Oakeshott, (Oxford: Blackwell, 1960), 84

⁵ *Universal Declaration of Human Rights*, Articles 3 and 4

position on freedom, and individuals are given the legal ‘right’ to sell themselves into slavery, then it follows that the slave trade must, to some extent, be legalised. Once that occurs, others, particularly the weak and the vulnerable, will be drawn into the slave-trade non-voluntarily. Thus the state will not legalise the slave trade for those who may wish to enter it voluntarily, even for very compassionate reasons. Indeed the slave trade and slavery are both explicitly required to be “prohibited in all their forms.”⁶

3.6 It is the same with the right to life, another fundamental human right described as inalienable. Legalised voluntary euthanasia involves a modification of the law of homicide to allow the intentional killing of a patient by a doctor at the patient’s request and out of a motive of compassion. Put another way, legal voluntary euthanasia involves an exception to the normal rule against the homicide of innocent human beings. When this occurs the state’s capacity to protect the weak and the vulnerable from non-voluntary euthanasia is greatly compromised if not completely undermined. While the *Universal Declaration of Human Rights* does not exclude voluntary euthanasia by name as it does the slave trade and slavery, it does so by calling the right to life inalienable and including the right to life along with the right to “liberty and security of person” as a fundamental inalienable human right.⁷

3.7 Fundamental human rights are inalienable because once one allows them to be alienable the fundamental human rights of all are put at an unacceptable risk.

3.8 It is ethically wrong in principle to modify the law to allow the killing of innocent human beings at their own request because this would contravene the basis of civilised society as set out in the human rights documents. Article 6(1) of the *International Covenant on Civil and Political Rights* guarantees that “every human being has the inherent right to life”. The right to life is the only right in the Covenant that is *expressly* stated to be “inherent” to everyone.

Professor Margaret Somerville, a South Australian scholar who is the Professor of Law and Medicine at the McGill University in Montreal, Canada, expressed it this way:

The most fundamental norm or value on which our types of societies are based 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 [legalised euthanasia] 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

⁶ *Ibid.*, Article 4

⁷ *Ibid.*, Article 3

it would be inherently wrong for us to do this, and that is why we should not do it. (*Australian Senate Report* pp. 66-67)

Moreover Justice Stevens, in his judgment in *Vacco v. Quill*, made this comment:

Much more than the State's paternalistic interest in protecting the individual from the irrevocable consequences of an ill-advised decision motivated by temporary concerns is at stake. There is truth in John Donne's observation that 'No man is an island.' The State has an interest in preserving and fostering the benefits that every human being may provide to the community—a community that thrives on the exchange of ideas, expressions of affection, shared memories and humorous incidents as well as on the material contributions that its members create and support. The value to others of a person's life is far too precious to allow the individual to claim a constitutional entitlement to complete autonomy in making a decision to end that life.⁸

4. VOLUNTARY EUTHANASIA AS DANGEROUS PUBLIC POLICY

4.1 Is there any empirical evidence to show that the practice of voluntary euthanasia is always accompanied by a practice of non-voluntary euthanasia? The answer to this is a clear and unequivocal 'yes'. That evidence may be found in two places, The Netherlands where it is legally tolerated, and South Australia where it is not legally tolerated.

4.2 Before we advance that evidence we need to make two important preliminary points. Firstly, one of the principal arguments advocates of VE have used is the successful experiment with VE in the Netherlands. Now that the success of that experiment has been successfully challenged with even the Dutch Government now conceding that only about 50% of VE in the Netherlands is being reported in accordance with the law, supporters of VE now wish us to believe that Dutch euthanasia is irrelevant to Australia and that we are capable of constructing a 'safe' legal framework within which VE could legally take place. However, the Dutch case is important because it shows the vulnerability to abuse of the "strict medical guidelines" set down by the Dutch Courts and endorsed by the Dutch Parliament.

4.3 Second, there is the question of "slippery slopes". It has been suggested by Helga Kuhse that opponents of legalised VE make a serious logical error in their use of the Dutch data. For Kuhse, "slippery slope" arguments are about showing "that a society is worse off after it introduced a certain practice, than it was before the practice was introduced."⁹ Her point is that we cannot say there is a slippery slope, ie "an increase in harmful consequences, following the introduction of, the practice" of VE because the

⁸ Supreme Court of the United States, No 95-1858, *Vacco v Quill*, June 26 1997, 16

⁹ Helga Kuhse, "Voluntary Euthanasia in the Netherlands and Slippery Slopes", *Bioethics News* 11 (4), 4 and cf Helga Kuhse, "Sanctity of life, voluntary euthanasia and the Dutch experience: Some Implications for public policy", *Monash Bioethics Review*, 15 (4), 19 and footnote 15 on pages 24-25

Dutch figures only tell us what went on in 1990. Since there are no comparable figures prior to that year we have nothing to compare them with. Therefore it is wrong to use the “slippery slope” argument.

Helga Kuhse is wrong in her understanding of “slippery slopes”. The “slippery slope” argument as used by the present writers and others is that there is a slippery slope from voluntary euthanasia to non-voluntary euthanasia, that whenever you have a practice of VE you will also have alongside it, as a consequence, a practice of non-voluntary euthanasia. It is not true that we have no statistical or empirical evidence of an overall increase in euthanasia once it is legally tolerated. In The Netherlands we have the figures for the number of cases of euthanasia reported in each year from 1984. In the 1990s we know that the number of cases reported to the authorities, in accordance with the law, has increased from 454 in 1990 to 1322 in 1992 to 1424 in 1994.¹⁰ In any case it would be reasonable to suppose there would be more euthanasia once it is legalised because that is what legalisation is supposed to achieve. We are constantly told of all the cases of people who would have used euthanasia if it were legally available. Common sense tells us that there would be an increase in euthanasia upon legalisation. If it could be shown that voluntary euthanasia is always accompanied by non-voluntary euthanasia then the amount of abuse or harm would also increase, ie a slippery slope. Paragraphs 4.4-4.5 will show that voluntary euthanasia is accompanied by non-voluntary euthanasia.

The Rummelink Commission stated that the Dutch doctors regard the “intolerable suffering of the patient and/or his natural desire for a ‘quiet death’ as the only grounds on which to perform euthanasia.”¹¹ John Keown has observed that “the reference to these grounds in the alternative, without disapproval, is revealing: it confirms that neither all doctors nor the Commission regard both as essential for euthanasia to be permissible.”¹² But the grounds of “desire for a quiet death” is not one of the grounds for legally tolerated euthanasia. And, as far as the actual practice of euthanasia is concerned, the Dutch Survey Report’s recorded reasons for requesting euthanasia casts considerable doubt on whether euthanasia was confined to patients who were ‘suffering unbearably’ and for whom this was a ‘last resort’ In most cases, 57%, the reason given was a ‘loss of dignity (ontluistering), while 46% said ‘not dying in a dignified way’ (onwaardig sterven), 33% said ‘dependence’ (afhankelijkheid), and 23% ‘tiredness of life’ (levensmoeheid). Only 46% mentioned ‘pain’ (pijn).¹³ Subsequent events have shown that non-life-threatening conditions now fall within the meaning of intolerable

¹⁰ From the table of disposals of euthanasia cases which appeared in the annual report of the public prosecutor, 1994 (*Jaaverslaag Openbaar Ministerie 1994*, Ministerie van Justitie, Den Haag, 1995) as it appears in John Keown, “Euthanasia in the Netherlands: sliding down the slippery slope?”, in John Keown ed., *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, (Cambridge: Cambridge University Press, 1995), 283, and footnote 159 on page 296

¹¹ The Rummelink Report, *op. cit.*, 32

¹² John Keown, *op. cit.*, 294 footnote 126

¹³ These figures may be found in *Medische Beslissingen Rond Het Levensende* - Het onderzoek voor de Commissie Onderzoek Medische Praktijk inzake Euthanasie, (The Hague, The Netherlands: Sdu Uitgeverij, 1991) [*Dutch Euthanasia Survey Report*], Tabel 5.8, page 35

pain such that a person may access to euthanasia for psychiatric reasons even though the existence of a serious psychiatric condition raises fundamental questions about the competence of the patient to make such a request.

There is in fact a slippery slope from voluntary euthanasia for those suffering intolerably with a terminal condition to those not suffering intolerably with a terminal condition, to those with non-terminal conditions such as psychiatric illness.

4.4 The evidence from The Netherlands shows that the strict medical guidelines as laid down by the courts are neither followed nor enforced. The evidence shows that the practice of voluntary euthanasia is accompanied by a bigger practice of non-voluntary euthanasia. The analysis that follows is taken from a recently published paper,¹⁴ a copy of which is attached (Appendix One) and should be read as fuller account of the position that being outlined in this submission.

The number of physician assisted deaths estimated by the Rummelink Committee Report¹⁵ is 25,306, all of which involve intentional (sometimes implicit, sometimes explicit) killing by act or by neglect, some voluntary and others non-voluntary. They are made up of:

2,300 euthanasia on request¹⁶

400 assisted suicide¹⁷

1,000 life-ending treatment without explicit request¹⁸

4,756 patients died after request for non-treatment or the cessation of treatment with the intention to accelerate the end of life¹⁹

8,750 cases in which life-prolonging treatment was withdrawn or withheld without the request of the patient either with the implicit intention (4,750) or with the explicit intention (4,000) to terminate life²⁰

¹⁴ John I Fleming, "Euthanasia: Human Rights and Inalienability", *The Linacre Quarterly*, 63 (1) 1996, 44-56

¹⁵ *Medische Beslissingen Rond Het Levenseinde* - Het onderzoek voor de Commissie Onderzoek Medische Praktijk inzake Euthanasie, (The Hague, The Netherlands: Sdu Uitgeverij, 1991) [*Dutch Euthanasia Survey Report*] and *Medische Beslissingen Rond Het Levenseinde* - Rapport van de Commissie Onderzoek Medische Praktijk inzake Euthanasie. The Hague, The Netherlands: Sdu Uitgeverij, 1991) [*Rummelink Report*]. I am indebted to the late Dr Daniel Ch. Overduin for translating the relevant sections of the two reports, thereby making the detailed evidence contained in them accessible to the English-speaking but non-Dutch-speaking public.

¹⁶ *Rummelink Report*, 13

¹⁷ *Ibid.*, 15

¹⁸ *Ibid.*,

¹⁹ There were 5,800 such cases, *cf Ibid.*, 15. However only 82% [ie 4,756] of these patients actually died. *Cf Dutch Euthanasia Survey Report*, 63 ff

²⁰ There were 25,000 such cases, *cf Ibid.*, 69. However, only 35% (8,750 cases) were done with the intention to terminate life. *Cf Ibid.*, 72; *cf also Rummelink Report*, 16

8,100 cases of morphine overdose with the implicit intention (6,750) or with the explicit intention (1,350) to terminate life.²¹ Of these 61% were carried out without consultation with the patient, ie non-voluntary euthanasia.²²

This total of 25,306 deaths amounted to 19.61 per cent of total deaths [129,000] in The Netherlands in 1990. A large proportion of them involve intentional (either implicitly or explicitly) killing by act or by neglect, ie euthanasia.

To this should be added the unspecified numbers of handicapped newborns, sick children, psychiatric patients, and patients with AIDS, whose lives were terminated by physicians, according to the *Remmelink Report*.²³ The narrow definition of euthanasia masks the real number of individuals whose lives are ended by interventions from the medical profession, and also masks the fact that more people are killed by physicians without their consent than with their consent.²⁴

This situation is clear if we take only those cases from the Dutch evidence where the doctors were "acting with the explicit purpose of hastening the end of life."²⁵ This explicit intention or purpose is explained as follows: "If a physician administers a drug, withdraws a treatment or withholds one with the explicit purpose of hastening the end of life, then the intended outcome of that action is the end of the life of the patient."²⁶

In short, 'explicit' intent is synonymous with the natural (and legal) meaning of 'intent', as purpose, goal or aim.²⁷

Now the Dutch evidence shows us that in 1990 there were 10,558 cases where there was an 'explicit' intention to hasten the end of life by act or by omission. As John Keown has put it:

This total comprises the 2,300 cases classified as 'euthanasia' in the survey; the 400 cases classified as 'assisted suicide' in the survey; 1,000 cases of administering drugs 'with the explicit purpose of hastening the end of life' without explicit request; 1,350 cases of the administration of opioids 'with the explicit purpose of shortening life'; 4,000 cases of withholding or withdrawing treatment, without explicit request, 'with the explicit purpose of shortening

²¹ There were 22,500 patients who received overdoses of morphine, cf *Ibid.*, 16.36 per cent were done with the intention to terminate life, cf *Dutch Euthanasia Survey Report*, 58

²² *Dutch Survey Report*, 61, Tabel 7.7. ["Besluit niet besproken"]

²³ The *Remmelink Report*, 17-19

²⁴ Other reviews of the evidence from the two Dutch reports supporting the present writer's analysis may be found in Richard Fenigsen, "The Report of the Dutch Governmental Committee on Euthanasia", *Issues in Law & Medicine*, 7:3, 1991, 337-344; Henk A.M.J. ten Have and Jos V.M. Welie, "Euthanasia: Normal Medical Practice?" *Hastings Center Report*, 22:2, March-April 1992, 34-38

²⁵ P.J. van der Maas, J.J.M. van Delden, and L. Pijnenborg, *Euthanasia and other Medical Decisions Concerning the End of Life*, (Amsterdam: Elsevier, 1992), 21

²⁶ *Ibid.*

²⁷ John Keown, "Dances with Data: A Riposte", *Bioethics Research Notes*, 6 (1), 1994, 1

life'; and 1,508 cases of withdrawing or withholding treatment, on explicit request, 'with the explicit purpose of shortening life'.²⁸

Simple mathematics shows that of the 10,558 cases where there was an 'explicit' intention to hasten the end of life by act or by omission, 55% were non-voluntary. This justifies the conclusion that it is impossible to quarantine non-voluntary euthanasia from voluntary euthanasia, that where voluntary euthanasia is practised more are killed without their consent than with their consent. That voluntary euthanasia inevitably leads to non-voluntary euthanasia has now been accepted by the authors of the Rummelink study:

But is it not true that once one accepts [voluntary] euthanasia and assisted suicide, the principle of universalizability forces one to accept termination of life without explicit request, at least in some circumstances, as well? *In our view the answer to this question must be affirmative.*²⁹ (my emphasis)

4.5 That non-voluntary euthanasia always accompanies voluntary euthanasia can also be seen in the Flinders University (South Australia) study of the behaviour of doctors in South Australia where euthanasia is not legally tolerated.

In their report of a sociological survey of the attitudes and practices of medical practitioners and nurses in South Australia³⁰, Christine Stevens and Riaz Hassan found that 19% of medical practitioners and nurses had ever taken active steps to bring about the death of a patient.³¹ Their most striking discovery, however, was that 49% of them had never received a request from a patient to take such active steps³². That is, in a jurisdiction in which euthanasia in any form is legally prohibited, 19% of the medical profession agreed that they had been involved in euthanasia, but half of those 19% had done so without reference to the patient.

One wonders why proponents of voluntary euthanasia imagine that law-breaking doctors will suddenly become law-abiding if voluntary euthanasia is legalised. If a group of medical practitioners (a minority) will break the law now, it would be naive to imagine that they and others will not break a voluntary euthanasia law and kill those they consider ought to have the benefit of euthanasia if only they were competent enough to ask for it.

²⁸ John Keown, "Dances with Data: A Riposte", *loc. cit.*,

²⁹ Johannes J.M. van Delden, Loes Pijnenborg and Paul J. van der Maas, "The Rummelink Study Two Years Later", *Hastings Center Report*, November-December 1993, 26

³⁰ Christine A Stevens and Riaz Hassan, "Management of death, dying and euthanasia: attitudes and practices of medical practitioners in South Australia", *Journal of Medical Ethics*, March 1994, vol 20 no 1, 41-46

³¹ *Ibid.*, 43

³² *Ibid.*

4.6 In a survey on the practices of doctors in Australia Helga Kuhse et al purported to replicate the survey carried out in the Netherlands (ie the Rummelink study).³³ This study has been subject to searching criticism. For example, Robert Manne has explained the apparent lack of scientific rigour in this study in these terms:

In their study the Rummelink researchers pointed out that in the Netherlands 30 per cent of all deaths are sudden or acute, while 70 per cent are drawn out or non-acute. Obviously only among these 70 per cent of non-acute deaths is it possible for “medical decisions concerning the end of life” - MDELs - to take place. They found that in 38 per cent of *all* deaths in the Netherlands and in 54 per cent of *non-acute* deaths that MDELs did in fact take place.

The Kuhse study arrived at a startlingly different conclusion. In Table 5 of the article the authors maintain that in 64.8 per cent of all deaths in Australia MDELs take place. As about 30 per cent of deaths in Australia must be, as in the Netherlands, sudden or acute where MDELs could not take place, what they are effectively claiming is that while in the Netherlands an MDEL takes place in a little over *half* of non-acute deaths, in Australia a medical decision concerning the end of life takes place in almost every case.³⁴

In fact the Kuhse et al study is fraught with methodological problems and can be safely set aside. For example:

- The Kuhse *et al* is not comparable to the Dutch study in size, scope and design and does not provide a basis for the comparative conclusions that the authors make between Australia and The Netherlands.
- The authors generalise from their findings in regard to medical decisions concerning the end-of-life to all Australian deaths in a way which lacks scientific rigour.
- The study has major methodological problems in the questionnaire formulation and the latter, through mistranslation, magnifies confusions that were present in the Netherlands study.
- The categories in the Kuhse *et al* survey mix decisions which are outside the law with those in conformity with the law.
- The questions also mix decisions which are traditionally held to be morally acceptable with those that are not.

³³ Helga Kuhse, Peter Singer, Peter Baume, Malcolm Clark and Maurice Rickard, “End-of-life decisions in Australian medical practice”, *Medical Journal of Australia*, vol 166, 17 February 1997, 191-196

³⁴ *The Australian*, 17 February 1997

- The Kuhse study adopts an eccentric notion of intention that has no basis in existing law or traditional morality.

Copies of the Kuhse *et al* study together with critiques from Tonti-Filippini, Fleming *et al* by way of submissions to the Senate Legal and Constitutional Legislation Committee are included as appendices to this submission.

4.7 Finally, the matter has been well summarised by Justice O'Connor of the US Supreme Court who said:

The difficulty in defining terminal illness and the risk that a dying patient's request for assistance in ending his or her life might not be truly voluntary justifies the prohibitions on assisted suicide we uphold here.³⁵

5. VOLUNTARY EUTHANASIA AND THE LAW

5.1 This section considers the meaning and importance of the sanctity of life principle under the law, the power of the South Australian Parliament to pass the *Voluntary Euthanasia Bill 1996*, the Bill's inconsistency with Commonwealth laws, and Australia's obligations under international law.

5.2 Civilised societies universally recognise the legal principle that no-one may directly kill an innocent person. This is commonly known as the 'sanctity of life' principle. This principle is one that does not depend on religious beliefs for its efficacy (although some would argue that it is derived or at least not inconsistent with the central tenets of all major religious belief systems). It is considered by nearly everyone to be an essential part of the fabric of a civilised society. It finds expression in many ways, including the prohibition of the taking of human life and the prohibition of capital punishment in all Australian jurisdictions. In South Australia it is recognised and protected by the criminal law—with its common law and statutory³⁶ offences such as murder, manslaughter, assisting in suicide, conspiracy, criminal negligence, criminal assault—and by the civil law—with its torts such as battery and negligence.

The sanctity of life principle has found explicit recognition in the common law. For example, Lord Devlin said in *R v Adams* [1957] Crim LR 365 that "no doctor, nor any man, no more in the case of the dying than of the healthy, has the right deliberately to cut the thread of life." In the leading medico-legal case of *Airedale NHS Trust v Bland* [1993] AC 789, many of the Law Lords strongly supported the sanctity of life principle. Lord Hoffmann, for example, acknowledged that while it could be grounded in religious beliefs, preferred to anchor the sanctity of life principle in intuitive values held by nearly everyone. These are not idly considered and uttered dicta. These are the

³⁵ Justice O'Connor, Supreme Court of the United States, *Vacco v. Quill*, 26 June 1997, 15

³⁶ Under the *Criminal Law Consolidation Act 1935* (SA).

considered reflections of judicial officers of the highest rank in one of the best regarded courts in the world. To adapt a comment made by a New Zealand judge, one does not lightly jettison hard-earned intellectual capital evolved by judges over several centuries (see *Crump v Wala* [1994] 2 NZLR 331 at 343). The South Australian Parliament should not, with respect, enact the Bill and so put the law of this State out of step with that prevailing in all civilised societies.

The *Voluntary Euthanasia Bill 1996* proposes something quite different from the Netherlands. Under the Penal Code in force in the Netherlands, euthanasia is still a criminal offence. What is different between the Dutch experience and what the Bill proposes is that the Dutch have taken the unusual step of using the administration of the criminal justice system as the lever that activates immunity from prosecution for any medical practitioner who performs euthanasia within stated guidelines. So the result is that the Dutch have the legal charade of appearing to uphold the sanctity of life principle via legal commands and sanctions (a positivist response, one might say), while undermining it with an appeal to *force majeure* when euthanasia is in fact practised. This is, to say the least, jurisprudentially confusing and inconsistent. It does little (if anything) to inspire confidence in the administration of justice, or respect for the law (another important legal and social value that is cherished in legal systems that are derived from the English common law). We strongly oppose any such similar move in South Australia were it to be proposed.

6. THE EFFECT OF EUTHANASIA LAWS ON MEDICAL PROFESSIONALS

6.1 The Hippocratic tradition, transmitted in modern form in the *Declaration of Geneva 1948* (and further amended in 1968 and 1983) by the World Medical Association, commits the medical profession to the “utmost respect for human life”. In 1987 the World Medical Association specifically declared: “Euthanasia is unethical”. If this Bill is enacted it will contradict the code of medical ethics of the World Medical Association and the Australian Medical Association.

6.2 It would destabilise the doctor-patient relationship by undermining the trust that exists between doctor and patient. Patients who do not want euthanasia could not be assured that the new laws would not be used beyond voluntary euthanasia and extended to nonvoluntary euthanasia or even involuntary euthanasia. There is simply no way that the South Australian Parliament can ensure that the safeguards that it seeks to legislate will not be abused or ignored in practice. The experience in the Netherlands points to the fact that one in eight deaths in 1990 associated with euthanasia were brought about without the explicit request of the patient.³⁷

³⁷ *Report of the Commission appointed by the Minister of Justice and the State Secretary for Welfare, Health and Culture on the Practise of Euthanasia in the Netherlands, under the Chairmanship of the Attorney-General, Professor Remmelink* (September 1991).

7. THE EFFECT OF EUTHANASIA LAWS ON OTHER PEOPLE

7.1 The adverse effect of euthanasia laws on other people cannot be discounted. How is a lawyer preparing a will for a very ill patient going to be satisfied that the patient has the requisite testamentary capacity to make a will or that the testator is free of undue influence if the prospect of euthanasia has been suggested by relatives?

7.2 Will the Bill if enacted lead to the undesirable outcome of very sick people being persuaded by their relatives (including beneficiaries under wills) to opt for euthanasia so that those relatives are relieved of the burden of caring for them? The Bill makes no provision for medical practitioners to assess or evaluate the motive of the patient requesting euthanasia.

7.3 The greedy and the avaricious will take comfort from the Bill because it gives them the opportunity to influence very sick people, from whose death they would benefit, to request euthanasia.

8. REFERENDA AND PUBLIC POLICY

8.1 It has been suggested that the law relating to difficult and divisive socio-moral problems is best decided by the holding of a referendum. This course of action is usually resisted in representative parliamentary democracy because it is recognised that such a course of action might not necessarily deliver a just result. Complex issues are decided by the Parliament, by elected representatives who have the time and the talent to resolve these matters having regard to the fundamental principles of democracy which includes the honouring of the community's human rights obligations. In any case, appeals are made to a referendum mainly by those who, on the basis of opinion polls, believe they know what would be the outcome. It is interesting to note those who opposed a referendum on capital punishment as recently suggested by Members of the SA House of Assembly are keen to have a referendum on euthanasia.

8.2 According to opinion polls a majority of Australians support capital punishment.³⁸ One can make a good case ethically for capital punishment. (It is one with which we would not agree, but we concede that respected ethicists have made such a case). One reason why, as a matter of public policy, we no longer have capital punishment is because we recognise that our legal institutions are staffed by fallible human beings. Innocent people have been found guilty of capital crimes and acquitted and compensated later when their innocence has been established.

³⁸ 53% of Australians favour capital punishment according to the latest Morgan Poll on the subject. Finding No. 2803, published in *The Bulletin*, September 19, 1995

Euthanasia could apply to a far bigger population than those convicted of capital offences and with far fewer safeguards. We need to exercise the same kind of caution where euthanasia is concerned that we have already exercised when we stopped the practice of capital punishment.

According to opinion polls a majority of Australians support voluntary euthanasia. One can make a good case ethically for VE. (It is one with which we would not agree, but we concede that respected ethicists have made such a case.) However, from a public policy point of view the legalisation of VE would be unwise and dangerous public policy because, as the evidence shows, more people will be killed without their knowledge and consent than with their knowledge and consent.

8.3 Public opinion provides no safe guide to morality nor to the intersection of law and morality. As legal philosopher, JW Harris, has argued:

The community's true morality is not to be discovered by taking opinion polls about particular moral issues. It is to be discovered by asking what answer to a particular issue would fit consistently with abstract rights to which the community has already committed itself in its constitution and institutional practices - such as rights to liberty, dignity, equality and respect.³⁹

So even if there were some *reliable* (and we underscore the adjective *reliable*) opinion polls that indicate that euthanasia was acceptable, this does not provide a principled and rational basis for law-making in our society. No opinion poll should be used by any government to shape law-making. This is what would be characterised as "lynch mob" justice. Every time a particularly heinous crime was committed, those people who are well-organised or well-connected could secure the passage of laws (such as capital punishment) that suit their own agenda based upon the use and manipulation of opinion polls.

8.4 Australia's foremost advocate of legalised voluntary euthanasia, Dr Helga Kuhse, has conceded the point that opinion polls and referenda should not necessarily bind parliaments to legalise voluntary euthanasia:

If there are good reasons why the people shouldn't have (legalised euthanasia), then the government shouldn't give in to the people, even if ninety per cent want a change in the law.⁴⁰

³⁹ JW Harris, *Legal Philosophies*, (London: Butterworths, 1980), 177-8

⁴⁰ Refer Christopher Newell and Ian Parsons, *Managing Mortality*, Villa Manta, 1996

9. FINDINGS OF COMMITTEES OF INQUIRY IN OTHER JURISDICTIONS

9.1 The House of Lords Select Committee on Medical Ethics, which included people who personally supported voluntary euthanasia, unanimously rejected a public policy of legalised voluntary euthanasia.

Ultimately, however, we do not believe that these arguments [in favour of legalised euthanasia] are sufficient reason to weaken society's prohibition of intentional killing. 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. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. Moreover dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.

One reason for this conclusion is that we do not think it possible to set secure limits on voluntary euthanasia. Some witnesses told us that to legalise voluntary euthanasia was a discrete step which need have no other consequences. But as we said in our introduction, issues of life and death do not lend themselves to clear definition, and without that it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused. Moreover to create an exception to the general prohibition of intentional killing would inevitably open the way to further erosion whether by design, by inadvertence, or by the human tendency to test the limits of any regulation. These dangers are such that we believe that any decriminalisation of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address.⁴¹

9.2 The New York State Task Force on Life and the Law has, among its members, people personally committed to a pro-choice position on VE and assisted suicide. Nevertheless this committee also unanimously came down against legalising either assisted suicide or voluntary euthanasia.⁴²

⁴¹ House of Lords, *Report of the Select Committee on Medical Ethics Volume 1 - Report*, (London: HMSO, 1994), 48-49

⁴² The New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and euthanasia in the Medical Context*, (Albany, NY: Health Education Services, 1994), xii

Some Task Force members do not believe that assisted suicide is inherently unethical or incompatible with medical practice. On the contrary, they believe that providing a quick, less prolonged death for some patients can respect the autonomy of patients and demonstrate care and commitment on the part of physicians or other health care professionals. Nonetheless, these members have concluded that legalizing assisted suicide would be unwise and dangerous public policy.⁴³

9.3 A majority of the Canadian Special Senate Select Committee on Euthanasia and Assisted Suicide concluded thus:

Individual autonomy cannot be absolute because individuals need each other in order to realize their goals, and likewise the actions of individuals have an impact on other people close to them and on society as a whole. Individual rights must be limited to the extent that they cause harm to other persons. While disallowing assisted suicide may seem unfair or harsh in an individual circumstance, this is outweighed by the negative impact that decriminalization would have on the popular conscience. How can society say that assisted suicide is a valid course of action without sending the message that suicide is appropriate? Since we are aware of an unacceptably high rate of suicide among young people, especially in the aboriginal community, how can we justify any action that suggests assisted suicide is a legitimate response to suffering? Accepting decriminalization would trivialize death and lead to a view of death as a solution to problems.⁴⁴

The Canadian Committee also expressed fears that

legalization could result in abuses, especially with respect to the most vulnerable members of society. The ill and the frail are particularly dependent on those around them and on the healthcare system. Inevitably, and often without realizing it, these individuals cede control over their lives to the system and to those on whom they are dependent. For this reason, it would be difficult for others to assess whether an informed choice was made without coercion. If assisted suicide were legalized and accepted by the community, how could the expectations of the people surrounding the patient not influence his or her decision, particularly if the patient feels she or he is a burden on the family... Some would feel pressured to resort to assisted suicide where financial and institutional resources are scarce. Financial restraints that affect healthcare and infrastructure could also result in attempts, perhaps unconsciously, to influence patients to die more quickly and conveniently. All of the above factors could make it difficult to establish whether a request for assisted suicide is voluntary...⁴⁵

⁴³ *Ibid.*, xiii

⁴⁴ Canadian Special Senate Select Committee on Euthanasia and Assisted Suicide, *Of Life and Death* (Ottawa: Minister of Supply and Services, 1995, Cat. No. YC2-351/1-01E), 71-72

⁴⁵ *Ibid.*, 71

To these reports should be added the conclusion of the Select Committee of the House of Assembly on the Law and Practice Relating to Death and Dying (1992).

The Committee does not agree with the proposition that the law should be changed to provide the option of medical assistance in dying. We disagree with SAVES's claims in support of its case... The Committee believes distinctions based on intent should be maintained in law.⁴⁶

9.5 Legalising VE puts at risk the right to life of all citizens, exposes the weak and the vulnerable in particular to non-voluntary euthanasia, and compromises the ability of the state to protect the fundamental inalienable rights of citizens. For the state to tolerate legal voluntary euthanasia is to derogate from its obligations in international law as outlined in paragraphs 3.1-3.7 above and 11 below.

10. SA PARLIAMENT LACKS THE POWER TO PASS THE BILL

10.1 The power of any Parliament is not absolute. In our opinion the Parliament lacks the power to pass the *Voluntary Euthanasia Bill 1996* because it would be contrary to the jurisprudential basis upon which a Parliament governs and its laws are respected. Admittedly, the law making power of the South Australian Parliament is plenary⁴⁷, but it is not absolute. The power to enact laws in South Australia is grounded in the head of power to enact laws for the “peace, order and good government” of the State.⁴⁸

10.2 Some commentators and judges have recognised that this plenary law making power is subject to implicit restrictions, even though on its face it purports to be a broadly-based grant of power.⁴⁹ In the *Union Steamship* case, the High Court said that the exercise of legislative power could be subject to some restraints by reference to rights that are deeply rooted in our democratic system of government and the common law.⁵⁰

We submit that the issue of euthanasia is just the kind of issue that could summon forth the identification and recognition of the sanctity of life as a fundamental legal right which cannot be overridden by legislation. This would mean, among other things, that the Bill would have an illegitimate legal and jurisprudential basis and, we would argue, would be beyond the legislative competence of the South Australian Parliament because it is not for “peace, order and good government” that it would have been enacted.

⁴⁶ *Second Interim Report of the Select Committee on the Law and Practice Relating to Death and Dying*, 6 May 1992, 51

⁴⁷ See, by analogy, *Union Transport Co of Australia Pty Ltd v King* (1988) 166 CLR 1.

⁴⁸ See the *Constitution Act 1934* (SA), s5., and other legislation cited in that provision.

⁴⁹ See, for example, *Building Construction Employees and Builders' Labourers Federation of New South Wales v Minister for Industrial Relations* (1986) 7 NSWLR 372 at 382-5 per Street CJ.

⁵⁰ *Union Transport Co of Australia Pty Ltd v King* (1988) 166 CLR 1 at 10.

10.3 The Committee needs to ask itself as it deliberates: is this Bill in the public welfare and for the peace, order and good government of the State of South Australia and of its people? We would be surprised if an affirmative answer emerged in light of the unanimous rejection of euthanasia by well recognised overseas committees.

10.4 TRS Allan has argued that the fundamental rule of the legal system that accords legal validity to Acts of Parliament is not itself the foundation of the legal order. He argues further that that rule of legal recognition derives its legal authority from the underlying moral and political philosophy or theory to which it belongs.⁵¹ This implies that some further basis or rationale or grundnorm must underpin positive law (such as the Bill) if it not to be dissonant with the underlying moral and political theory on which the South Australian people are prepared to entrust law-making powers to the Parliament of its elected representatives.

The Bill fails to identify this grundnorm and moreover, it does not argue the case for the existence of one. Many South Australians would be dismayed to learn that the Parliament whom they elected is prepared to pass into law a Bill that enables a highly-skilled professional to deliberately kill a fellow citizen. The passage of the Bill would do damage to the constitutional and political foundations upon which the State is governed.

11. BILL INCONSISTENT WITH COMMONWEALTH LAWS?

11.1 Recent debate surrounding the extinguishment of the Northern Territory's *Rights of the Terminally Ill Act 1995* (N.T.) assumed that the *Euthanasia Laws Act 1997* (Cth.), forbidding such laws in Australian Territories, could not apply to the States because the Commonwealth lacked constitutional power. This is, in our view, incorrect. While that Act does not apply to the States (because it was enacted using the Territories power contained in s 122 of the Commonwealth Constitution) the Commonwealth does have constitutional power to override euthanasia laws in the States based on the "external affairs" power under the Commonwealth Constitution. This happened recently in *Pearce v South Australian Health Commission & Other*⁵² where the *Reproductive Technology Act 1992* (SA) was held to be invalid, under section 109 of the Commonwealth Constitution, because it was inconsistent with section 22 of the *Sex Discrimination Act 1984* (Cth.), a Commonwealth law based on the "external affairs" power (see 11.12-11.13 below). To understand the basis of our conclusion it is necessary to understand Australia's obligations under international law.

11.2 Australia is a member of the United Nations and Australia is bound by its Charter. Moreover, Australia has approved and repeated the UN Charter in the *Charter of the*

⁵¹ TRS Allan, *Law, Liberty and Justice* (Clarendon Press, Oxford, 1993), pp 265-6.

⁵² No. SCGRG 96/1114 Judgement No. 5801, South Australian Supreme Court, 10 September 1996.

United Nations Act 1945 (Cth.).⁵³ Member nations are committed to the promotion of “universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion”⁵⁴ by way of a pledge.

All members pledge themselves to take joint and separate action in cooperation with the Organisation for the achievement of the purposes set forth in Article 55.⁵⁵

11.3 Australia has also adopted and proclaimed the *Universal Declaration of Human Rights* that seeks to amplify Article 55 of the United Nations Charter, and signed and ratified the *International Covenant on Civil and Political Rights*.

11.4 The *Universal Declaration of Human Rights* is founded upon the notion that there are human values and these values are inherent in the human individual. In the *Preamble* the Declaration states that “the foundation of freedom, justice and peace in the world” is the “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family”.⁵⁶

As far as the Declaration is concerned there are human values *inherent* in all members of the human family because of their “inherent dignity”. Since “dignity” is about true worth or excellence [“dignus” L. means worthy], and, in the context, human worth, then the claim for the inherent dignity of human beings is a claim for basic human values.

11.5 Further, the *Preamble* links human dignity, human values with human rights that it describes as “inalienable rights”, rights of which we may not be deprived and cannot deprive ourselves. I must not be sold into slavery and I am to be restrained from selling myself into slavery. *Personal autonomy in the sense of a “right” to sell one self into slavery does not exist. Likewise the “right” to be killed (the so-called right to die, or right to voluntary euthanasia) does not exist in international law. On the contrary, the rights to freedom and life are inalienable and therefore cannot be given away.* [See 3.3 - 3.7 above]

11.6 These human rights which reflect human values must, says the *Preamble*, “be protected by the rule of law” otherwise humankind may be driven, “as a last resort, to rebellion against tyranny and oppression”. This protection of the rule of law is necessary not only for human beings to live together peaceably within the State, but also so that nations may live together in peace.

⁵³ Section 5. The Act does *not* implement the United Nations Charter into municipal law.

⁵⁴ United Nations Charter, Article 55(c).

⁵⁵ United Nations Charter, Article 56.

⁵⁶ In *Secretary, Department of Health and Community Services v. J.W.B. and S.M.B.* (Marion's case.) (1992) 175 CLR 218 Brennan J. emphasised:

The law will protect equally the dignity of the hale and hearty and the dignity of the weak and lame; of the frail baby and of the frail aged; of the intellectually able and of the intellectually disabled . . . Our law admits of no discrimination against the weak and disadvantaged in their human dignity.

11.7 The *Universal Declaration of Human Rights* presents itself to the world as “a common standard of achievement for all peoples and all nations” and as a guide for every structure in society and for every individual in order that the rights identified in the Declaration may have “their universal and effective recognition and observance” secured.

11.8 Article 1 of the Declaration asserts certain things about human beings that affect the understanding of the rest of the document. Human beings, it says, “are born free and equal in dignity and rights”. This value of equality of human beings, this injunction not to show preference between individuals in the recognition of “the rights and freedoms set forth in this Declaration”, is further specified in Article 2. In particular, in the entitlement to the rights and freedoms in the Declaration there is to be no distinction of any kind, “such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”

In this way the Declaration excludes discrimination against the elderly and the very young, the physically and mentally disabled and the chronically ill. All have equal claim to the rights and freedoms enunciated in the Declaration.

11.9 Article 3 of the Declaration begins the articulation of the human values to be defended in terms of human rights. “Everyone has the right to life, liberty and the security of person.” Thus, human life is held to be both inviolable and inalienable. The Declaration does not begin with hard cases or exceptions, but with the general proposition which concerns the value of human life. Noting the order of the rights articulated is also interesting - life first, then freedom [liberty], and then security of person. Unless the State can guarantee the right to life then there are no meaningful rights to freedom or to security of person. The right to life is logically prior to considerations of the quality of the individual’s life.

11.10 While the Declaration is not part of our municipal law, the *International Covenant on Civil and Political Rights* is another matter. The *International Covenant on Civil and Political Rights* is contained in Schedule 2 of the *Human Rights and Equal Opportunity Commission Act 1986* (Cth.). Article 6(1) of the *International Covenant on Civil and Political Rights* guarantees that “every human being has the inherent right to life.” The right to life is the only right in the Covenant that is *expressly* stated to be “inherent” to everyone. The Human Rights Committee⁵⁷ has described it as the “the supreme right.”⁵⁸ It is also one of the rights which cannot be derogated from,⁵⁹ even in

⁵⁷ The Human Rights Committee is established under the *International Covenant on Civil and Political Rights* to implement the Covenant, see Part IV of the Covenant.

⁵⁸ GC 7(16), Doc. A/37/40, 94. Also in Doc. C/21/Add. I.

⁵⁹ *International Covenant on Civil and Political Right*, Article 4(2).

a “time of public emergency which threatens the life of the nation.”⁶⁰ In its General Comment,⁶¹ on Article 6, the Human Rights Committee has:

. . . noted that quite often the information given concerning article 6 has been limited to only one or other aspect of this right. *It is a right which should not be interpreted narrowly.*⁶² And the “*expression ‘inherent right to life’ cannot be properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures.*”⁶³ (Emphasis added.)

11.11 Ignoring legalities for the moment, all Australian’s have committed themselves, by way of a pledge, to uphold the universal respect for, and observance of, human rights especially the right to life. Australians have a proud tradition and history of keeping their word and the concepts of mateship and a fair go for all are based on one’s word.

Voluntary Euthanasia, even when done with genuine and compassionate motives, is a repudiation of Australia’s obligations under international law and a signal to the world that Australian’s are not true to their word.

11.12 Several Commonwealth Acts are based on wholly or substantially on the external affairs power, for example, the *Treaty of Peace Act 1919* (Cth.) (which made effective in Australia The Treaty of Peace of Versailles), the *Security Treaty (Australia, New Zealand and the United States of America) Act 1952* (Cth.) (which approved the ANZUS Treaty), the *Human Rights and Equal Opportunity Commission Act 1986* (Cth.), the *Racial Discrimination Act 1975* (Cth.) (relying on the *International Convention on the Elimination of all Forms of Racial Discrimination*), the *Sex Discrimination Act 1984* (Cth.) (relying on *inter alia* the *Convention on the Elimination of All Forms of Discrimination Against Women*) and the *Human Rights (Sexual Conduct) Act 1994* (Cth.) (relying on the right to privacy in sexual matters under Article 17 of the *International Covenant on Civil and Political Rights*).

11.13 In *Pearce v South Australian Health Commission & Others*⁶⁴ the plaintiff had separated from her husband in 1994 and lived alone. The administrator of the Queen Elizabeth Hospital’s IVF programme declined to provide the requested technology because the plaintiff did not qualify to benefit from the service by virtue of s13(3) and (4) of the *Reproductive Technology Act*.

The issue was whether the *Reproductive Technology Act 1992* (S.A.) was inconsistent with section 22 of the *Sex Discrimination Act 1984* (Cth.) on the basis of “martial

⁶⁰ *International Covenant on Civil and Political Rights*, Article 4(1).

⁶¹ *International Covenant on Civil and Political Rights*, Article 40(4).

⁶² Human Rights Committee, General Comment 6, Article 6 (Sixteenth session, 1982), *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HR/GEN/1/Rev.1 at 6 (1994) § 1.

⁶³ *Id.* at § 5.

⁶⁴ No. SCGRG 96/1114 Judgement No. 5801, South Australian Supreme Court, 10 September 1996.

status". The Court held that it was and struck down the Act, to the extent of its inconsistency, as required by section 109 of the Commonwealth Constitution.

11.14 The *Voluntary Euthanasia Bill 1996* is inconsistent with a Commonwealth law being Schedule 2 of the *Human Rights and Equal Opportunity Commission Act 1986* (Cth.) and if passed would be void. An issue exists as to whether the presence of the Covenant in Schedule 2 merely repeats the Covenant or whether it implements the Covenant in municipal law. The Covenant must be implemented in order for section 109 to be operative. A Covenant will be implemented if the *Human Rights and Equal Opportunity Commission Act 1986* (Cth.) reveals an intention to make the Covenant binding upon persons in Australia as part of our municipal law. It is inappropriate to speculate here on this point, suffice it to say that is a distinct possibility.

Even if the status of the *International Covenant on Civil and Political Rights* is insufficient to trigger section 109 it is beyond argument that Covenant gives the Commonwealth power to pass an Act similar to the *Euthanasia Laws Act 1997* (Cth.) to override State euthanasia laws.

Moreover the Commonwealth is bound by way of a pledge, to uphold the universal respect for, and observance of, human rights especially the "supreme" right to life which is contravened by voluntary euthanasia laws. Accordingly, the Commonwealth would be bound to take positive steps to protect the right by passing an Act to override the *Voluntary Euthanasia Bill 1996*, if it were passed. It is not a matter which could be left to a conscience vote.

We have seen in the case of the *Euthanasia Laws Act 1997* (Cth.) that the Commonwealth Government is prepared to promote and enact laws to override legislation of another part of Australia if it considers that this is in the national interest.

12. DEFECTS IN THE BILL

12.1 There are many defects in the Bill only some of which are analysed below. Important key terms are not defined such as "euthanasia". Others are inadequately defined like "hopelessly ill". There is a disturbing lack of any real safeguards in the Bill. Important legal issues have not been adequately addressed and parts of the Bill if passed would be void. We submit that there are a number of defects in the Bill, and not all of these can be characterised as technical in nature and so capable of improvement during the passage of the Bill through Parliament. These defects are considered below.

12.2 "Euthanasia" is not defined anywhere in the Bill. There are a variety of meanings that can be attributed to the term. The title to the Bill suggests that it is voluntary euthanasia that is intended to be allowed, but the title to an Act of Parliament is no safe guide to the way it will be interpreted. Could the Bill be used to justify involuntary and non-voluntary euthanasia because of the lack of definition of the key concept which animates it?

12.3 A cornerstone of the Bill is the definition of “hopelessly ill”. Clause 3 defines as “hopelessly ill” a person who:

has an injury or illness that (a) results in permanent deprivation of consciousness; or (b) seriously and irreversibly impairs the person’s quality of life so that life has become intolerable to that person.

12.4 The idea of a ‘hopeless’ illness is new to the euthanasia debate in Australia. Until now most proposed bills have restricted themselves to terminal illnesses. Several aspects of this definition deserve comment:

- ‘injury or illness’: this would include *any* psychological illness other than clinical depression [clause 8(3)(a)] or unsoundness of mind (clause 4).
- ‘permanent deprivation of consciousness’: this is almost impossible to determine by experienced medical practitioners that are specialists in this field. It may well be beyond the competence of medical practitioners that are GPs to make this diagnosis, thus undermining so-called safeguards in the Bill.
- ‘seriously’: the standard by which this is to be judged is not specified, but seriousness might be entirely subjective on the part of the person requesting euthanasia and/or the person performing it. No objective standard is given.
- ‘irreversibly’: irreversibility is almost impossible to determine even by experienced specialists. The person in whose opinion the condition must be irreversible is not specified, nor his competence to do so. The basis upon which they might make such a prognosis not specified either.
- ‘impairs the quality of life’: the standard by which this is to be judged is ambiguous between an objective account of harm and an entirely subjective judgment to be made by the person requesting euthanasia, their trustee and/or the medical practitioner administering euthanasia.
- ‘so that life has become intolerable to that person’: the standard by which this is to be judged is not specified, but is inherently subjective.

12.5 The constant reliance on subjective standards coupled with ambiguities provides virtually no safeguards against abuse and is a cause for grave concern. Because together these issues make the definition and application of euthanasia in the Bill *so broad and vague as to make euthanasia available to people whatever their reasons*.

12.6 Central to the safeguards in the Bill is the requirement that a “medical practitioner” must provide certain information to a patient (Clause 6), a request for euthanasia must be made in the presence of a medical practitioner and two witnesses (Clause 8), administration of euthanasia can be undertaken by a medical practitioner (Clause 12), etc. Clause 3 defines a medical practitioner as a person registered under the *Medical Practitioner’s Act 1983* (S.A.). That Act defines a medical practitioner to

mean “a person whose name is registered on the general register (whether or not it is also registered on the specialist register).”

Put simply the Bill does not require a specialist to play any part in the euthanasia process. Moreover, there is no requirement for any medical practitioner, specialist or otherwise, to have any competence to:

- make the diagnosis and prognosis of the patient’s condition;
- determine appropriate treatment and be aware of the risks, side effects and likely outcomes;
- undertake palliative care; and
- make decisions concerning the patient’s soundness of mind and whether or not they suffer from “treatable clinical depression”.

The Bill, as drafted, provides no real safeguards to patients and those “safeguards” that are present are gravely deficient. At minimum the matters required under Clauses 6 and 8 should be determined by specialists with appropriate expertise for the patient’s particular condition.

12.7 The prospect that an oral request for euthanasia could be made contrary to Clause 7(1) is disturbing. What if the witnesses (motivated by some interest such as a pecuniary interest in the patient’s estate) claimed that the requestor made the request and reduced it to writing yet the putative requestor could not, for whatever reason (such as the illness), countermand the “substituted” request? What if the witnesses refused to videotape it? Clause 7 is open to abuse and should be removed.

Both Australia and England have experienced the injustices caused by police “verbals” over the last ten years. No safeguards exist to prevent “euthanasia” verbals where the sentence is death.

12.8 The mechanism for a trustee of the advance request for euthanasia under Clause 9 of the Bill is very odd. First, it distorts a fundamental tenet of the law of trusts, namely that the trustee acts in the patient’s [beneficiary’s] best interests to promote the patient’s interests. Promoting or assisting the killing of the beneficiary could hardly be described as acting in the beneficiary’s best interests. What if the trustee does not act in the patient’s best interests? There are no civil or criminal sanctions provided for in the Bill, and it is not clear that Clause 14 will protect the trustee.

Second, the functions imposed upon the trustee under Clause 9(3) are onerous and may not be capable of verification by the trustee in time. For example, how is the trustee to ensure that the medical practitioner has fully explained the euthanasia procedures under Clause 6 if the trustee was not present when these were supposedly explained?

Third, is it intended that the trustee be subjected to the full range of fiduciary duties that any trustee at general law is subject to? The Bill does not clarify this issue. This will

make it very difficult for lawyers representing trustees to advise the prospective trustee or to give accurate legal advice and so give the trustee a measure of peace of mind.

12.9 Clause 13 allows an exemption to medical practitioners on the basis of conscientious objection. However the exemption would be, in practice, inadequate. Clause 13(2) directs a medical practitioner that they “must inform the patient . . . that another medical practitioner may be prepared to consider the request.” The first question a patient is likely to ask after a medical practitioner declines to be involved is the name of another medical practitioner. What, if any, name is the medical practitioner obliged to give? No doubt supporters of the Bill will argue a pro-euthanasia doctor. What would happen if the original medical practitioner gave the name of a pro-life medical practitioner? Would the original medical practitioner be liable for a breach of the Act or sued by the patient’s family or estate for a breach of statutory duty? The position is once again not clear but ambiguous and unpredictable.

If the medical practitioner is obliged to give the name of pro-euthanasia medical practitioner, and even if he is not, serious issues of conscientious objection and religious freedom arise.

The principal difficulty with clause 13(2) is the use of the word “must”. Freedom of conscience must allow medical practitioners to refuse to give even the limited advice that another medical practitioner would give the patient a lethal injection. It is open to a conscientious medical practitioner to regard lethal injections as being no true part of the practice of medicine. Accordingly referral to another medical practitioner who will give the patient a lethal injection may be seen as infringing the commitment to the protect his or her patient that the doctor is obliged to offer, and even as material cooperation in an evil act, a serious matter for medical practitioner who object to euthanasia on religious grounds. Clause 13(2) does not, in fact, fully protect freedom of conscience or religion both of which are recognised and safeguarded under Australia’ international laws obligations.

12.10 Clause 13(3) seeks to protect conscientious objectors from prejudice and other forms of “adverse” discrimination. Why does the *Equal Opportunity Act, 1984* (S.A.) protect against “discrimination” while a conscientious objector is only protected from “adverse” discrimination? This places an unfair and unequal burden on the conscientious objector. The criteria should be discrimination *per se*. What the undefined phrase “adverse discrimination” actually means is another uncertainty with the Bill.

12.11 Clause 13(4) is also of concern. Why is there a requirement only for “a hospital, hospice, nursing home or other institution for the care of the sick or infirm” *which does not permit euthanasia* to bring this matter to the attention of patients entering such an institution? Why isn’t there an equal requirement on those same institutions *which do permit euthanasia* to bring this matter to the attention of patients as well? A resident or patient may well be very upset to find that Mr or Ms X in the room next door, or in the bed nearby, were killed by euthanasia. This clause, as it stands, seeks to normalise euthanasia, with those opposing it not having their sensitivities equally protected.

Further, for those institutions that do not provide euthanasia all their medical practitioners and staff should be exempt from any obligation to inform a patient that another medical practitioner or another institution may perform euthanasia. This should be viewed as a form of conscientious objection for the whole institution.

12.12 Clause 16 of the Bill deems that death “is taken to have been caused by the patient’s illness”. Disregarding that the Clause will be a statutory sanctioned lie and a legal absurdity, the deeming effect of the Clause at best creates great uncertainty as to its effect and at worst undermines the jurisdiction of the State Coroner under the *Coroners Act 1975* (S.A.). Section 12 of the *Coroners Act 1975* (S.A.) provides *inter alia*⁶⁵ that:

. . . an inquest may be held in order to ascertain the cause or circumstances of the following events:

(a) the death of any person by violent, unusual or unknown cause; or . . .

Assuming that the death was not violent, the Coroner will not have jurisdiction to investigate deaths caused by euthanasia because they will not be “unusual” once it becomes common place. The cause of death is not “unknown” because Clause 16 deems death to have been caused by the patient’s illness. This problem is compounded further because the Bill gives the Coroner (nor anyone else for that matter) no role to monitor compliance with the Bill. Clause 15 merely ascribes to the Coroner the role of glorified clerk.

12.13 The Commonwealth has passed extensive laws concerning life insurance and insurance generally, with the exception of “State insurances” which have no relevance to the Bill. In short, the Commonwealth has legislation comprehensively covering the field of insurance. Clause 17(1) purports to prevent an insurer from refusing to make payment on a life policy because a patient has been intentionally killed by euthanasia. In our opinion substantive arguments exist to the effect that this Clause would be void as being inconsistent with Commonwealth laws. In any event, the Clause can only extend to policies where the proper law of the contract of insurance is South Australian law, or the insurance company is based in South Australia. Persons coming to South Australia from elsewhere do not have the benefit of the Clause. Such persons should be advised that they do not have the protection of Clause 17, failure to do so by those providing euthanasia “services” may be liable for misleading and deceptive statements.

These comments also apply to Clause 17(2). In addition, this Clause purports to “authorise” material non-disclosure to an insurer, this expressly contradicts Part IV of the *Insurance Contracts Act 1984* (Cth.) and is void.

12.14 Clause 12(2) only permits a medical practitioner or the patient to administer drugs to cause death (or for the medical practitioner to withhold or withdraw treatment). Yet Clause 14 protects the medical practitioner and a person who “assists” the medical

⁶⁵ The other heads of jurisdiction under section 12 have no relevance in the context of euthanasia.

practitioner from liability. Ignoring the ambiguity which this creates, the Bill has failed to address the law of succession consequences where the medical practitioner or the person who “assists” with the intentional killing of the patient is also a beneficiary under the patient’s will.

13. CONCLUSIONS

It is not possible to quarantine voluntary euthanasia from non-voluntary euthanasia. Any euthanasia practice, whether legal or not, contains as much non-voluntary euthanasia as voluntary euthanasia. As the House of Lords Select Committee on Medical Ethics has remarked, it is just not possible to set limits on legal VE. Over time the practice of legalised VE becomes routine and is applied to a wider circle of candidates. Recent history in The Netherlands has shown that legally tolerated euthanasia in that country is now applied to the non-terminally ill, especially psychiatric cases and children with disabilities.

The State has an obligation to provide a safe environment within which care for the sick, the disabled, and the aged can be delivered. The protection of the right to life is absolutely fundamental to a civilised society. The rich, powerful and healthy can usually take care of themselves. But the State has the obligation to protect human rights impartially. That can only be achieved when the State acknowledges that the prohibition on killing innocent human beings is one that admits of no exceptions.

Moreover, we do wrong when we are prepared to agree that there are some people whose lives are not worth living. Such an attitude encourages those whose self-esteem is already low to accept death as the only sensible way to deal with life. The provision of good palliative care can, in almost all circumstances, relieve patients of their physical and mental distress. When they are surrounded by people who love them and care for them then their natural death can have as much significance to them and their loved ones as their lives.

The State does well when it guarantees people their fundamental human rights including the legal right to refuse futile and overly burdensome treatments, when it provides proper professional standards of palliative care, and when it provides the circumstances in which a person can really die well.

No one has the right to demand State sanctioned euthanasia or assisted suicide because such a demand, if it were granted, would threaten the fundamental human rights of others and compromise our commitments to human rights and to the proper professional care of the sick, the disabled, and those otherwise physically, psychologically, or socially vulnerable.

South Australia has a proud history of law reform. South Australia has shown national leadership in many areas of law reform. For example, it was in South Australia that the first comprehensive and effective consumer protection and product liability laws were enacted in this country. Thus the *Consumer Transactions Act 1972* and the

Manufacturers Warranties Act 1974 were enacted in the belief that the inequality of bargaining power between suppliers of goods and their consumers needed the positive intervention of the law in order to protect the weak from the predations of the strong. If the Bill were to be enacted, then we consider that South Australia would have surrendered its leadership in the sphere of law reform in this country. No longer could the ill, the weak and the disadvantaged look to the South Australian Parliament to protect and uphold their rights and interests.

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** The views expressed are our own and not necessarily those of our respective institutions.*



APPENDIX ONE

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APPENDIX TWO

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SOURCE: *MEDICAL JOURNAL OF AUSTRALIA* VOL 166 17 FEB
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APPENDIX THREE

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APPENDIX FOUR

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APPENDIX FIVE

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