



REPORT
OF THE
CONSTITUTIONAL AFFAIRS COMMITTEE
IN RELATION TO
PETITIONS REGARDING VOLUNTARY EUTHANASIA

Presented by the Hon Murray Nixon (Chairman)

STANDING COMMITTEE ON CONSTITUTIONAL AFFAIRS

Date first appointed:

21 December 1989

Terms of Reference (as amended 12/3/98):

1. A standing committee under the name of “*Constitutional Affairs*” is established.
2. The committee consists of 3 members.
3. The functions of the committee are to inquire into and report on:
 - (a) the constitutional law, customs and usages of Western Australia;
 - (b) the constitutional or legal relationships between Western Australia and the Commonwealth, the States and Territories,
and any related matter or issue;
 - (c) a bill to which SO 230 (c) applies but subject to SO 230 (d);
 - (d) any petition.
4. A petition stands referred after presentation. The committee may refer a petition to another standing committee where the subject matter of the petition is within the terms of reference of that standing committee. A standing committee to which a petition is referred shall report to the House as it thinks fit.

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1 INTRODUCTION

The Standing Committee on Constitutional Affairs (the “Committee”) was first appointed on 21 December 1989. Under its Terms of Reference, the Committee is required, *inter alia*, to consider and report on any petition.

1.1 The Petitions

1.1.1 On 14 October 1997, 16 September 1997, 18 June 1997 and 10 June 1997 Hon Norm Kelly MLC tabled petitions (*TP #485, 526, 771, 772, 858 of 1st session, 35th Parliament*) from Ms Susan Martin requesting that the Legislative Council pass a Bill allowing for a State Referendum to legalise voluntary euthanasia and pass a bill legalising the strictly and properly regulated practice of voluntary euthanasia. On 14 October 1997, Hon Norm Kelly MLC tabled a petition (*TP 857*) euthanasia from Ms Martin calling on the House to pass a bill to legalise voluntary.

1.1.2 On 11 June 1997, 17 June 1997, 24 June 1997, 25 June 1997, 26 June 1997, 19 August 1997, 20 August 1997, 26 August 1997, 9 September 1997, 14 October 1997, and 11 November 1997, Hon Tom Stephens MLC; Hon Nick Griffiths MLC; and the President, Hon George Cash MLC, tabled petitions (*TP #490, 510, 535, 543, 549, 669, 670, 687, 695, 711, 748, 750, 859, 860, and 1001 of 1st Session of 35th Parliament*) from Mr E Locke, Mr R Egan, and Mr R Argus requesting the Legislative Council reject any Bill allowing voluntary euthanasia, including any Bill for a referendum to legalise euthanasia for the following reasons:

- “1. *Every act of euthanasia carried out with the approval of the State necessarily involves a judgement by the State that the person killed had a life that no longer mattered;*
2. *Inquiries into the legalisation of so-called “strictly regulated voluntary euthanasia” by the House of Lords Select Committee on Medical Ethics (1994), the New York State Task Force on Life and Law (1994), the Canadian Special Senate Select Committee on Euthanasia and Assisted Suicide (1995) and the Australian Senate Legal and Constitutional Legislation Committee (1996) each concluded* that it is impossible to ensure adequate safeguards for voluntary euthanasia and that therefore legalising euthanasia will always create more victims than beneficiaries;*
3. *A referendum on euthanasia would, if successful, be a substantial step towards legalised euthanasia and therefore any bill for a referendum on euthanasia should be rejected as an attempt to remove the equal protection from intentional killing enjoyed by all Western Australians under existing law.”*

* **NOTE :** The Committee draws the House’s attention to the fact that the Australian Senate Legal and Constitutional Committee made **no** recommendations. It did not conclude that “it is impossible to ensure adequate safeguards for voluntary euthanasia” as stated in these petitions. Rather, members contributed a number of joint and individual statements which were included as annexures to the Committee’s report.

1.2 Background to the Petitions

Along with abortion, the issue of euthanasia, in its many forms, is a matter which evokes great passion among community members. Both matters raise the common issues: the value of human life and what control an individual should have over his or her own life. For centuries, legislators have grappled with these and other conflicting values including: the rights of the individual against the rights of the community; and the value of legislation which embodies and sets community standards against the value of having a legislature which does not interfere in the lives of citizens.

In May 1995, the Legislative Assembly of the Northern Territory enacted the *Rights of the Terminally Ill Act 1995* (the "NT Act"), which came into force on 1 July 1996. The Act allowed a doctor, in defined circumstances, to comply with a patient's request to assist them to end their life.

On 9 September 1996, Mr Kevin Andrews MHR, introduced a private member's Bill, *Euthanasia Laws Bill 1996*, in the House of Representatives to override the Northern Territory Act and remove the power of the Northern Territory Parliament to make such laws on euthanasia. On 24 March 1997, the Senate passed the Bill with amendments. Before the Bill was passed, four people were able to make use of the Northern Territory legislation.

Such was the debate and controversy created by the NT Act and the Federal over-riding legislation, that several members of State Parliaments indicated an intention to introduce legislation similar to the NT Act into their respective State Parliaments. These declarations sparked moves to introduce opposing legislation from opponents of voluntary euthanasia.

In Western Australia, Hon Ian Taylor MLA introduced the *Medical Care of the Dying Bill* to the Legislative Assembly in March 1995. This Bill allowed a terminally ill person to refuse medical treatment in certain circumstances. The Government has promised to introduce its own legislation dealing with this matter. On 16 October 1997, the Hon Norm Kelly MLC introduced the *Voluntary Euthanasia Bill*, which would legalise voluntary euthanasia in certain circumstances.

1.3 Approach of the Committee

In the Committee's view the debate on euthanasia can be brought down to three questions:

1. Does the individual have an unfettered right to control, and by extension to end, their own life?
2. Can the act of voluntary euthanasia be taken in isolation or does it have unwanted implications for others in the community?
3. If it does have unwanted implications, can safeguards be put in place which ensure that these do not occur and also prevent abuse of the process?

The Committee resolved that rather than making any recommendations on an issue as emotive as voluntary euthanasia, it would better serve the Parliament, and in turn the Western Australian community, by providing an over-view of the arguments for and against euthanasia.

In investigating this matter, the Committee was also of the opinion that no inquiry regarding euthanasia would be complete without inquiring into palliative care, its availability and any likely impact it may have on the decision making process. The questions the Committee chose to address were:

1. Is it possible to provide a sufficiently high standard of palliative care to relieve completely a person's pain and suffering?
2. If so, why would a person still opt to shorten their life?

The space devoted to arguments for voluntary euthanasia in this report is not as great as the focus on the arguments against voluntary euthanasia. This should not be taken as an indication of a Committee preference towards that side of the debate. Rather, the reason for this is that the arguments put for voluntary euthanasia are relatively straight-forward:-

- every individual should be able to end their own life if suffering from an incurable illness and unbearable pain; and
- it is possible to draft legislation to provide a system which ensures that a person's decision to commit voluntary euthanasia is made of their own independent will and of sound mind and which is not open to abuse. It is argued that in other matters, such as contractual disputes and sexual relationships, the law operates to ensure an individual's decisions are free and voluntary.

Opponents of voluntary euthanasia, on the other hand, put up a range of arguments which concern medical, legal, political, ethical and moral issues.

The Committee took only a small number of submissions in this inquiry. Given the extensive airing of the issues by the Senate Legal and Constitutional Legislation Committee¹ and the Northern Territory Select Committee on Euthanasia², the Committee saw little point in covering the same ground after such a short time. However, the Committee was able to take evidence from pro-voluntary euthanasia campaigner Dr Phillip Nitschke, Hon John Bailey MLA and Mrs Rose Rhodes, the Regional Director of Territory Health Services, when visiting Darwin in November 1997, and also Dr Andrew Dean, Consultant Physician in Palliative Care at Sir Charles Gairdner Hospital, and Silver Chain Hospice Care Service Director, Dr Kevin Yuen.

2 DEFINITIONS

Literally, euthanasia means good or gentle death and is derived from the Greek terms good (*euth*) and death (*thanos*).

However, the more commonly-accepted definition of euthanasia is "*actions that have as their intention or likely consequence the shortening of another person's life to prevent further pain*

¹Senate Legal and Constitutional Legislation Committee, Euthanasia Laws Bill 1996, March 1997 (hereafter referred to as the Senate Inquiry).

²Northern Territory Legislative Assembly Select Committee on Euthanasia, The Right of the Individual or the Common Good, May 1995 (hereafter referred to as the NT Inquiry).

and suffering of that person". Within this definition, there are a variety of forms of euthanasia. The following definitions are drawn from the Senate Inquiry and the NT Inquiry.

2.1 Passive Active Euthanasia - a doctor switches off a respirator or life support machine at the patient's request. This is lawful at common law.

In his evidence to this Committee Dr Andrew Dean, Consultant Physician in Palliative Care at Sir Charles Gairdner Hospital, questioned whether this was really euthanasia at all.

*"If somebody is dying of natural causes and that death is being prevented by treatment, that patient has the right to say, "I do not want that treatment because it is an artificial imposition on my body". That treatment is withdrawn and the patient dies of natural causes."*³

2.2 Passive In/Non-Voluntary Euthanasia - where medical treatment is withdrawn or withheld from a patient, without that patient's request or consent.

2.3 Voluntary Active Euthanasia - where medical intervention takes place, at a patient's request, in order to end that person's life. This is presently illegal in Western Australia and it is this form of euthanasia, along with Doctor-Assisted Suicide, which is invariably referred to when discussing "legalising euthanasia".

2.4 Involuntary Active Euthanasia - a competent patient's life is shortened without that person's consent or request. (A competent patient is one who is capable of making informed decisions about his or her treatment).

2.5 Non-Voluntary Active Euthanasia - where the patient is non-competent and medical intervention takes place to end that person's life.

2.6 Doctor-Assisted Suicide - a doctor provides the know-how and the means of committing suicide but the patient commits the act.

2.7 Double-Effect - where palliative medication is administered as part of the treatment process or with the primary intention of alleviating pain, knowing that a possible outcome could be the patient's death, and death subsequently results.

2.8 Palliative Care - palliative care's purpose is not to hasten or postpone death but rather to provides relief from pain and psychological suffering associated with a terminal condition⁴.

The World Health Organisation defines palliative care as:

³ Evidence, Dr Andrew Dean, p.6.

⁴World Health Organisation, Cancer Pain Relief and Palliative Care, 1990, at p 11.

“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.”⁵

There is some debate as to whether palliative medicine can also extend a person’s life. Hon John Bailey said that with modern medicine, palliative care could in fact lengthen a patient’s life indefinitely:

“Whether it’s through just surgery that’s been done, or whatever, that in fact you may almost place people in a - in a sort of almost a form of suspended animation, but alive...it could almost leave people literally in a - in a bed semi-conscious, semi-comatose state for year...but you might take them right past the point where they believe they’ve got any quality of life at all, but could continue on indefinitely.”⁶

While not going quite so far as to say that palliative care could indefinitely extend a person’s life, Dr Kevin Yuen agreed that palliative care could “allow more life to happen”. However, this was an unintended benefit rather than an aim.

“The priority for hospice care is quality of life...It is not lengthening life; it just allows it to happen.”⁷

3 ARGUMENTS FOR VOLUNTARY EUTHANASIA

3.1 Individual Rights and Autonomy - Freedom of Choice

Supporters of voluntary euthanasia argue that each individual has the right to control their own body and to make their own choices about the appropriate treatment for a terminal illness. Similarly, people have a moral right to determine the manner of how they live their life, providing it does not impact on another, and therefore, by logical extension, about how they end that life. This argument is no more than a restatement of the classical liberal argument put by John Stuart Mill in *On Liberty* that the only purpose for which power can be exercised over an individual is to prevent that person harming another.

Euthanasia opponents argue that the act of voluntary euthanasia does have the capacity to harm others and that an individual’s actions cannot be divorced from the community in which they live (see section 4 on Arguments Against Voluntary Euthanasia for more detail). By allowing a few, for whom all else has failed, to end their lives sets a dangerous precedent that may be relied upon in cases in which the decision is not voluntary and/or warranted. In some instances, the good of the community must override the good of the individual.

⁵*Ibid.*

⁶*Evidence*, Hon John Bailey, p.23.

⁷*Evidence*, Dr Kevin Yuen, p. 12.

3.2 Death with Dignity - "The Desire to Say Goodbye to Life on One's Own Terms"

Ethicist Dr Helga Kuhse argued before the Senate Inquiry that every person had the right to have a dignified death on their own terms. She said:

*"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."*⁸

3.3 Legalising What in Reality is Already Common Practice

It is argued that by failing to legalise the act of voluntary euthanasia and imposing strict controls upon the act, the reality is that the act will nevertheless occur without any of the safeguards and protection that legislation could ensure.

Dr Robert Marr, representing the Doctors Reform Society, told the Senate Inquiry that every doctor in Australia knew that "secret euthanasia" was being practised. He said that "we need to bring it out in the open and stop sticking our heads in the sand and saying that it is not going on".

*"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 to bring it out into the open, bring it under scrutiny, bring in the 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."*⁹

Marshall Perron told the same inquiry that:

*"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"*¹⁰

He drew the Senate Inquiry's attention to the alarming number of people over the age of 75 who annually commit suicide. During a five year period in the 1990s, 672 people aged over 75 committed suicide, at a rate of 134 per year, in a variety of manners:

"Our oldest citizens dies [sic] 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.

⁸Submission No. 4037, Dr H. Kuhse, p.11.

⁹Evidence, Coalition of Organisations for Voluntary Euthanasia, p. 247.

¹⁰Submission No. 3117, Mr. M Perron, p.12.

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 of their faculties?"¹¹

The majority of members of the Senate Inquiry felt the opposite was true:

"If it is widely practised, although it is against the law, it highlights the real concerns of many opponents of euthanasia who argue that the illegal excesses of a minority of doctors will simply become commensurately worse, with pro-euthanasia legislation."¹²

This view was supported by Dr Dean, who stated:

"How many doctors will offer legal euthanasia? It is a big news story; the media will promote it. The doctors will say that this is something they can do for their patients; they can take care of their patients from cot to grave. They may not be big on the pain control side but they can put their patients out of their misery. That is a huge danger. We see it from our more elderly colleagues who are not aware of what we can do. We have seen people with pain that should have been fixed six months ago. They have shortness of breath and nausea - symptoms that should have been fixed but were not. They are the doctors who will be in danger of saying that euthanasia is the next best option because they cannot do anything for their patients."¹³

A survey by Kuhse, Singer and Baume, published in *The Medical Journal of Australia*¹⁴, revealed the following:

Total deaths (all causes) Australia 1995-1996

Active voluntary euthanasia	1.8%
Doctor-Assisted Suicide	0.1%
Intentional life-terminating acts without explicit concurrent requests	3.5%
Opiates in large doses	30.9% (In 24.4% of cases there was no intention to hasten death and in 6.5% of cases the decision was partly intended to hasten death)

¹¹*Ibid.*, p. 8.

¹²*Op Cit*, p 128.

¹³*Evidence*, Dr Dean, p. 16.

¹⁴Kuhse H et al., "End-of-Life decisions in Australian medical practice", *The Medical Journal of Australia* Vol. 166, 17 February 1997, p 195.

Withdrawing/with-holding potentially life-prolonging treatment	28.6% (In 3.9% cases there was no intention to hasten death and in 24.7% of cases it was intended to explicitly hasten death or not prolong life)
Total	64.8%

The authors of the report concluded that on the basis of these figures, and similar studies conducted in the Netherlands, the rate of intentionally ending life without an explicit request were significantly higher in Australia than in the Netherlands. The methods used to obtain these figures were criticised by witnesses to the Senate Inquiry and it was said that the figures could not be relied upon. Similarly, Dr Dean stated to the Committee that some doctors had answered questions in the affirmative through a misunderstanding of what constituted voluntary euthanasia, including withdrawal of treatment causing death and death arising out of pain relief treatment as forms of euthanasia.

3.4 Moral Equivalence

Some believe that allowing death through the withdrawal of treatment is the moral equivalent of killing someone - both involve acts taken with the direct or indirect intention to cause death and both have the same consequence.

“Laws allowing the refusal of medical treatment, but no 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 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 hypocrisy and secrecy, and does not provide procedural safeguards that ensure patient consent to medical end of life decisions.”¹⁵

Similarly, in many cases procedures for helping dying patients during pain and suffering are indistinguishable from acts of voluntary euthanasia, as palliative care can often hasten death as well as relieve pain¹⁶. This is known as the “double effect”.

Says Christine Cassel in *Physician-Assisted Suicide: Progress or Peril*¹⁷:

“In the double effect doctrine, we must believe that we are not intending death, which can begin to seem to be like denial at best, or self-delusion at worst. We fool ourselves into thinking that death is an accident.”

Those who oppose this view argue that in the case of a withdrawal of treatment a patient is allowed to die a natural death and nature is allowed to take its course, while in the latter a

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

¹⁶See evidence of Dr Andrew Dean at p 17 of this report.

¹⁷Cassel, C, *Euthanasia and physician-assisted suicide*, 1990, 218, at p 225.

patient's life is unnaturally shortened (regardless of how much shorter that period may be) and while death can be an indirect result of a doctor's act, it is not the primary intention of the doctor.

4 ARGUMENTS AGAINST VOLUNTARY EUTHANASIA

4.1 Sanctity of Life

Opponents of voluntary euthanasia say that permitting the taking of another's life fundamentally undermines the community's respect for the value of human life and the principle that all persons should be equally protected by the law from intentional killing.

On this point the House of Lords Select Committee on Medical Ethics¹⁸ noted:

*“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.”*¹⁹

Similarly, the majority annexure of the Senate Inquiry stated:

*“The concept of a life worth living and justifying the involvement of a third party in taking that life challenges to the very core of 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.”*²⁰

However, supporters of voluntary euthanasia argue that what gives human life its inherent value is human free will and consciousness of the self. Therefore, to prevent the exercise of that free will is to not protect the sanctity of that human life.

4.2 Erosion of Medical Ethics

It is also argued that permitting euthanasia will undermine the absolute commitment of a physician to heal and care for the sick.

*“Even the most humane and conscientious physician needs protection against himself and weaknesses...A physician friend of mine who worked many years in a hospice caring for dying patients explained to me most convincingly: ‘Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying.’ The psychological burden of the licence to kill...could very well be an intolerably high price to pay for physician-assisted euthanasia.”*²¹

¹⁸House of Lords, Report of the Select Committee on Medical Ethics, 1994 (Hereafter referred to as the House of Lords Inquiry), Volume 1 - Report, HMSO, London.

¹⁹*Ibid.* p 48.

²⁰*Op cit.* p 124.

²¹Kass, L, *I Will Give No Deadly Drug: Why doctors must not kill*, in Euthanasia and physician-assisted suicide, 1990, 231 at p 239.

“Any legislation which puts the power of ending life in the hands of the health system, which, is 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.”²²

Marshall Perron told the Senate Committee that this claim was an “insult to doctors and others in the medical profession”²³ while Dr Robert Marr told the Inquiry that voluntary euthanasia was a “transfer of power from the doctor to the dying patient”²⁴ - it was not for the doctor to impose life upon a person but rather to act according to their wishes.

4.3 Erosion of Doctor-Patient Relationship

Related to ground 4.2 is the belief that legalising voluntary euthanasia will critically undermine a patient’s trust in his or her doctor.

“The patient’s trust in the doctor’s whole-hearted devotion to the patient’s best interests will be hard to sustain once the doctors are licensed to kill.”²⁵

It was the likely erosion of an already fragile trust by Northern Territory Aboriginal people of medical practitioners and nurses which was cited by opponents of the NT legislation.

One witness told the NT Select Committee:

“If somebody is sick here or ill, it is really hard for a person to go to the hospital. Even the whole families will not attend the hospital because they are scared of the doctors or nurses with pills or needles. So leave it out. Leave it to the community as it is now.”²⁶

4.4 The Slippery Slope - Opening the Floodgates

It is argued that the acceptance of voluntary euthanasia under strict conditions will open the door for the following reasons:

4.4.1 Acceptance of Involuntary Euthanasia

In cases of non-competence - mental impairment or comatose state - consent will be given by another, not on the basis of the patient’s consent but on the basis of the proxy’s opinion of the value of the patient’s life and the likelihood of recovery. Such decisions are open to abuse.

²²Submission to Senate Inquiry, Adelaide Justice Coalition, p. 1.

²³Submission to Senate Inquiry, Mr M Perron p12.

²⁴Submission to Senate Inquiry, Dr Robert Marr, p1.

²⁵Ibid.

²⁶Maydjarri, 1995, Oral Evidence, Milingimbi.

Similarly, while a person may consent, such consent may be involuntary in the sense that it is not true consent and is the product of undue influence and pressure. In the cases of the vulnerable, elderly and frail, a patient's will may be overborne or subtly influenced by another.

*"We are concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imaginary to request early deathwe believe that the message which society sends to the vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but assure them of our care and support in life."*²⁷

Dr Dean told the Committee that often the perception that some patients had that they were a burden on their family was often false.

*"Research shows that families of patients in that situation value them. As observers, we often see family problems, such as family members who have not spoken to each other for years, being resolved prior to death. The period between dying and knowing that you are going to die is very precious. People achieve a lot in that time."*²⁸

A related concern is the belief that there would be an incentive to influence another's choice to end their life when a person stands to gain from that person's estate. In the case of the elderly, a family may be tempted to bring pressure to bear on the patient as a result of mounting costs of hospice or nursing home care.

Similarly, health insurance, companies and governments may have a strong financial interest in minimising expenditure on the terminally ill through palliative care, which is often expensive.

Supporters of voluntary euthanasia argue that it is possible to draft legislation to meet slippery slope concerns and ensure that the system is not open to abuse. The NT legislation attempted to deal with these concerns in a number of ways:

- any person who is likely to have a financial benefit directly or indirectly as a result of a patient's death cannot act as a proxy for that person and sign a certificate of request to die. If it is the case that such a person does act as proxy then they forfeit any financial or other benefit they would otherwise obtain;
- two doctors must certify that the patient is of a sound mind, is not suffering from a clinically treatable depression, and that the decision to end their life is made freely, voluntarily and after due consideration; and
- palliative care must not otherwise be available to alleviate the patients pain and suffering to levels acceptable to the patient.

²⁷House of Lords Inquiry, at p 49.

²⁸Evidence, Dr Dean, p. 12.

4.4.2 *Euthanasia for Lesser Diseases and Conditions*

The point at which a person becomes entitled to make a decision to end their life is far from clear. While a person has a terminal illness, they may have considerable time left to live. At what point then can they make a decision to end their life - two years before they would otherwise die, two months, two weeks or two days? Similarly, how serious must an illness be before one is entitled to make the decision to die?

By way of example, opponents of voluntary euthanasia cite the Dutch case of *Chabot* in which a doctor was charged with assisting a patient whose condition was purely psychological, to commit suicide. The female 50-year-old patient, Ms Hilly Boscher, had a long history of suffering depression, a violent marriage and her two sons had died, one by suicide and one of cancer. Dr Chabot pleaded the defence of necessity to the charge of murder. The Court found that while there was no in-principal reason why the defence of necessity could not apply where a patient's suffering was purely psychological it could not be claimed in this instance, as Dr Chabot had not had Ms Boscher examined by an independent medical expert. Nevertheless, the Court declined to impose a penalty and Dr Chabot received a reprimand from a Medical Disciplinary Tribunal.

In relation to this matter, it is notable that the Dutch legislation only requires that a person's suffering be "unbearable and unrelievable", unlike the NT legislation which requires that a person be suffering from an "illness that will, in the normal course and without the application of extraordinary measures, result in the death of the patient" and "unless there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure".

4.5 *Inability to Codify Adequate Protections*

The Canadian Special Senate Select Committee on Euthanasia and Assisted Suicide came to the conclusion in its report *Of Life and Death*²⁹ that protections could never be established to ensure the consent of the patient was given freely or voluntarily, especially in the case of the elderly and vulnerable. It felt that "the common good could be endangered" if the law was changed to accommodate the few cases where pain control was ineffective. Those 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"³⁰.

Similarly, the House of Lords Select Committee found:

"We do not think it is possible to set secure limits on voluntary euthanasia; it would be next to impossible to ensure that all acts of euthanasia were truly voluntary. These

²⁹Canadian Special Senate Select Committee on Euthanasia and Assisted Suicide, *Of Life and Death*, June 1995 (hereafter referred to as Canadian Senate Inquiry).

³⁰*Ibid.* at p 86.

*dangers are such that we believe that any decriminalisation of voluntary euthanasia would give rise to greater problems than it would solve*³¹

Dr Yuen expressed his concern to this Committee that it would be a mistake to pass a law for the benefit of a small number who, after receiving proper palliative care, were convinced they had no option but to end their life.

“I suggest that to push progress on that legislation for that group of people would possibly be making a mistake in that the larger group of people in society would be at risk as a result of some individual suffering.”

*“Once an act is deemed legal, the consequences and controls are not sufficient to guard against a host of vulnerable people in society, specifically those in nursing homes when mental states starts to waver a little.”*³²

5 PALLIATIVE CARE

The Committee sought out the evidence of Western Australian palliative care experts to determine its availability and standard in Western Australia. The picture painted by Dr Andrew Dean and Dr Kevin Yuen was, by in large, a very positive one. Dr Dean referred to WA as the “luckiest state” with palliative care while Dr Yuen stated WA was a “leading provider” of palliative care.

*“It is fair to say that Australia is certainly among the top echelons in provision of palliative care. Most states of Australia are jealous of the care we provide in WA. That is probably because Western Australia has a single uniform community service; in other words, the Silver Chain Hospice Care Service. It is a very well organised, well orchestrated set up which totally streamlines the transfer of patients from hospital to home. Other states do not have that. There are often half a dozen different care organisations with different standards and levels of training.”*³³

The only downside was the level of ignorance of this service and its availability in non-urban areas. Dr Yuen stated that up to 30% of those who needed palliative care were missing out because of this ignorance. He also said that it was doubtful whether this shortfall could be absorbed by the existing health care services.

This level of ignorance of the option of palliative care was an explanation, along with biased questionnaires, of the high level of community support of voluntary euthanasia expressed in opinion polls, they said.

“The people who are able to judge whether palliative care delivers what it says it does are people who work in the area and the patients and families who go through that process. If a referendum were held among palliative care workers and patients and

³¹ *Op Cit.* at p 49.

³² *Evidence*, Dr Kevin Yuen, p. 11.

³³ *Evidence*, Dr Dean, p. 6.

*families, although I am sure that a few would be in favour, I think 95 percent would be totally opposed to euthanasia. Those are the people who are informed. Asking the general public who have not had that experience is a bit like saying "Let's have a referendum on what radar we use at the airport."*³⁴

Dr Yuen drew the Committee's attention to a South Australian survey posted randomly to 2000 households. It showed that only 30% of those surveyed had an idea of what hospice and palliative care was.

*"If people are considering euthanasia prior to considering comprehensive palliative care, they have got their questions wrong. We say "Yes, we can provide palliative care." What percentage of the population now wants euthanasia? In our population of palliative care patients, we will get a handful of requests out of several thousand each year. Proportionately, it is out of keeping with the dimensions and the depth of suffering that we see."*³⁵

5.1 Preference for Palliative Care Over Voluntary Euthanasia

Proponents of palliative care argue that with proper care, those who initially wish to end their lives are doing so for reasons that can be alleviated with palliative care; such requests being motivated by pain, the personal stress caused by that pain and the depression brought about by terminal illness. Once treated, requests for voluntary euthanasia are almost always withdrawn.

*"In our experience, as well as that of others within the hospice movement, statements such as "I wish I was dead" almost invariably reflect a plea - a cry for help - from patients desperate for some relief of their suffering...requests to help them die are made in the context of either unrelieved, debilitating symptoms, or in circumstances in which they are experiencing helplessness, loneliness, depression or marked anxiety."*³⁶

Dr Andrew Dean drew the Committee's attention to the work of Dr Harry Chochenov, a Canadian psychiatrist, who found that two-thirds of patients who expressed the wish to die did so because of uncontrolled symptoms or depression. However, the requests were withdrawn in most cases when the symptoms were properly treated. Although there would be a few who would maintain this request, Dr Dean said that this would be no more than a reflection of the proportion of society who wished to commit suicide.

*"There will be people whose wishes will be totally against the fabric of society. That can be paedophiles or, say, sado-masochism - people would probably enjoy being tortured. People enjoy torturing others, but it does not mean that it should be enshrined in law so that sort of thing can take place."*³⁷

³⁴Evidence, Dr Dean, p. 6

³⁵Evidence, Dr Yuen, p. 6.

³⁶Zalberg, R and Buchanan, J "Clinical Issues in Euthanasia" Medical Journal of Australia Vol 166, 3 February 1997, 150.

³⁷Evidence, Dr Dean, p. 18.

Similarly, Dr Kevin Yuen told the Committee that in his experience requests by patients to stop the suffering were phrased in terms of a request to shorten their lives, for example “I wish this was all over”.

“If we ask patients who might be getting into the intolerable suffering phenomenon what they want, they do not ask us to kill them. They say they do not want to be experiencing pain. If you are thinking about legislation to look after the exceptional case it might not be what patients want anyway. They simply want not to suffer. That is not about asking a doctor to give them “the injection” it is purely about not wanting to suffer.”³⁸

Dr Yuen said this ignorance extended to some doctors. If the community was better informed about what could be achieved through palliative care, then the support for voluntary euthanasia would be far less.

“...we see patients who should have been referred months earlier to get the best possible quality of life. That obviously impacts very much on the whole euthanasia question. People see euthanasia as an exit, whereas there should be access to good care before that.”³⁹

There are concerns that by allowing euthanasia the standard of palliative care will be affected, as there will be no financial incentive to ensure a high standard of care. Rather, there will be a financial interest in encouraging the “treatment of death”.

“Instances of patients accepting palliative care only if injections are not used in the control of symptoms have already been experienced...Anything which interferes with these established palliative care techniques will seriously jeopardise the degree of symptom control possible.”⁴⁰

Dr Dean claimed that patients who sought voluntary euthanasia in the NT were not given the opportunity of discussing the option of palliative care, despite provisions in the NT legislation to the contrary.

“Euthanasia was the only means of controlling suffering.”⁴¹

However, in her evidence to this Committee, Mrs Rose Rhodes, the Regional Director of Territory Health Services, stated that the introduction of voluntary euthanasia legislation in the NT had in fact had the opposite effect on palliative care services. Mrs Rhodes said that legalisation of voluntary euthanasia in the NT had improved palliative care services. In addition, awareness of the alternative of palliative care had occurred, through the operation of the legislation and the coverage surrounding it, and their services had increased “threefold”. From

³⁸Evidence, Dr Yuen, p. 10.

³⁹Evidence, Dr Dean, p. 4.

⁴⁰Evidence, Australian Association of Hospice and Palliative Care to Senate Inquiry, p. 133.

⁴¹Evidence, Dr Dean, p.13.

having one dedicated palliative care bed in one hospital, Territory-wide there were now around 6-7.

“Because of the exposure, because of the flack, I guess, we could receive for being accused that, ‘Oh, well, you don’t want to spend money on palliative care, you’re killing them off’, you know? And I think that was a highly sensitive issue, so no holds barred, we were told to put on a service that is acceptable and a model that could work.”⁴²

Those in support of voluntary euthanasia also sought to highlight that palliative care could not always be effective in treating terminally-ill patients and that there would always be a few whose spiritual and emotional malaise could not be relieved. Dr Nitschke put the problem thus:

“I think everyone gets helped by palliative care. The question is, are you helped, enough to make you want to keep on living.”⁴³

Nevertheless, Dr Nitschke conceded that there would be people who wished to end their lives out of ignorance of their other options.

“It would be a tragedy if these people, who are asking to end their lives, are simply doing it because they are not being exposed to the best available palliative care options. The thing I’m very suspicious of though is this claim that one can eliminate all of these requests.”⁴⁴

Dr Nitschke drew the Committee’s attention to the case of one of the people he had assisted to end their life. The person had been receiving intensive palliative care in Sydney before deciding to travel to Darwin to end her life.

“And when one asked her why she was doing it, given that she didn’t have any pain, didn’t have any nausea, didn’t have any of the problems people had been able to identify and quantify, she said it was because she couldn’t do what she wanted to do when she was well. And it was one of those really intangible issues of quality of life. She couldn’t get up and go for walks, she couldn’t do that. She was basically bed-bound. She didn’t have any problems, any symptoms, but she was bed bound. And some people find that intolerable. For a person who’s been active in their life, they find that intolerable and, not content with that, they would rather die.”⁴⁵

The NT Inquiry reported that one in twenty people suffered unrelieved pain during the terminal phase of their illness, irrespective of the quality of palliative and hospice care available⁴⁶. This figure was also cited in submissions to the Senate Inquiry.

⁴²Evidence, Mrs Rose Rhodes, p. 13.

⁴³Evidence, Dr Phillip Nitschke, p. 50.

⁴⁴Evidence, Dr Nitschke, p. 52.

⁴⁵Ibid., p. 51.

⁴⁶Op cit. at p 27.

One Doctor who made a submission to the NT Committee claimed that in some cases it was not always possible to relieve all pain through palliative care and, at the same time, leave the patient fully conscious. He said that in some cases palliation led to narcosis and, in those circumstances, palliative care was simply a slow form of euthanasia.

At the heart of this issue is the concern of being able to die with dignity and remain independent to the last. Illustrating this point are the final words of the first person to use the NT legislation, Bob Dent:

“I have no wish for further experimentation by the palliative care people in their efforts to control my pain....I cannot 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.”

However, both Dr Yuen and Dr Dean questioned the figures reported by the NT. They said the real figure was closer to half a dozen out of every 2,000. Dr Dean went further to assert that, with all the latest advances in drugs and medical techniques, “there is no such thing as pain which cannot be improved or controlled” to a level which a patient finds acceptable. He also rejected claims that in achieving that control of pain it came at the expense of alertness or consciousness.

5.2 Palliative Care and the Double-Effect

While proponents of palliative care make a distinction between it and voluntary euthanasia, voluntary euthanasia supporters highlight the grey area between the two when the so-called “double effect” occurs. That is, in some cases, palliative care has either intentionally or non-intentionally resulted in the life of a patient being shortened.

As discussed in section 3.4 dealing with the argument on Moral Equivalence, this claim is answered by the argument that the difference between voluntary euthanasia and the double-effect lies in the intention of the doctor. That is, the primary intention of the palliative carer is not to cause death but to relieve pain even though one may be an unavoidable consequence of the other.

“People would say it is not so much the outcome of the action which is important; it is the intention behind the action.”⁴⁷

However, Dr Nitschke argued before this Committee that, in practice, this distinction was hard to maintain or determine and without the protection of the law, palliative carers faced the risk of finding themselves facing criminal charges arising out of death through sedation.

Similarly, in one submission by a specialist in palliative care to the NT Select Committee on Euthanasia, it was claimed that this distinction was no more than a semantic sleight of hand:

“If a member of a health care team claims the intention of administering ‘pharmacological oblivion’ was purely to relieve the patient’s pain and distress, then it is regarded as good palliative care and there is no legal problem. If another member of the team admits doing so with an intention of hastening the patient’s demise....then

⁴⁷Evidence, Dr Dean, p. 8.

this clinician could be charged with murder. Two ludicrously different outcomes, for these two members of the same team administering the same treatment to the same patient, simply because of different expressions of intention!”⁴⁸

Dr Andrew Dean told this Committee that with modern medical treatments it was now very unlikely that, if administered properly, palliative care would result in the shortening of a person’s life. Even morphine, which has traditionally been regarded as a life-shortening medication, should not cause death when administered to a person suffering pain.

“It is notoriously difficult to try to kill somebody with an overdose of morphine when they have pain because the pain protects them from those effects. We have had patients who accidentally or deliberately, have taken two or three weeks of morphine in one go, slept for three or four days, woken up with a filthy hangover and returned to normal at the end of that time.”⁴⁹

6 JURISDICTIONS WHICH HAVE LEGISLATED FOR VOLUNTARY EUTHANASIA

6.1 The Netherlands

6.1.1 The Law

Articles 293 and 294 of the Dutch Penal Code make voluntary euthanasia and doctor-assisted suicide an offence. However, breaches of these articles are met with relatively light sentences and the “defence of necessity” under Article 40 is available where court-determined criteria are observed.

Since 1991, there has been an agreement between the Royal Dutch Medical Association and the Dutch Ministry of Justice that gives a doctor protection from prosecution.

These criteria, as published by the Royal Dutch Medical Association, are as follows:

- the patient must have asked clearly, voluntarily and repeatedly to die;
- the patient’s suffering should be unbearable and unrelievable;
- the euthanasia must be performed by a doctor;
- a second experienced doctor who has no professional or family relationship with either the doctor or the patient should be consulted by the principal physician;
- a full written record must be kept of the case; and
- the death should be reported to the coroner to be investigated. (In his evidence to the Senate Inquiry Dr John Keown claimed that this criteria was frequently ignored - in 1995 only 41% of cases were

⁴⁸Hunt, R, 1995, Written Submission

⁴⁹Evidence, Dr Dean, p. 9.

reported and the death was regularly attributed to natural causes on the death certificate).

It is **not** a condition that the patient is terminally ill or that the suffering is physical but rather, availability of voluntary euthanasia hinges upon the voluntariness of the request and the unrelievableness of the suffering.

6.1.2 Outcomes of the Dutch Legislation

In 1990 and 1995 research, commonly known as the Rummelink reports, was conducted into the practice of voluntary euthanasia and other medical decisions relating to the end of life in Holland. It produced the following results⁵⁰:

	1990	1995
Total deaths (all causes)	128, 786	135,546
Active Voluntary Euthanasia	1.7%	2.4%
Physician-Assisted Suicide	0.2%	0.2%
Intentional life-terminating acts without explicit concurrent request	0.8%	0.7%
Opiates in large doses	18.8%	19.1%
Withdrawing/withholding potentially life-prolonging treatment	17.9%	20.2%
Total	39.4%	42.6%

The 1996 study also revealed:

- **27%** of doctors who performed euthanasia did so without a request
- **72%** of doctors routinely falsified the death certificate to make it appear that the patient had died of natural causes;
- the interval between the first request and the carrying out of euthanasia was less than a day in **3%** of cases, less than a week in **35%** of cases;
- in **22%** of cases there was only one request, in **30%** of cases the interval between the first and last request was between an hour and a week;
- approximately **12%** of doctors never discussed the request with anyone else, including the nurses or other health care professionals;

⁵⁰van der Maas, et al, *Euthanasia and Other Medical Decisions Concerning the End of Life*, (Elsevier, 1992), 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.

- in **59%** of cases pain and suffering was the most important reason for wishing to shorten life;
- in **24%** the most important reason for wishing to shorten life was fear or avoidance of humiliation and in a further **46%** was an influential factor; and
- in **2%** ‘no longer wanting to be a burden’ was given as the most important factor in wishing to end life.

On the basis of the figures previously stated and related studies, a report in the Journal of the American Medical Association on 4 June, 1997 observed:

- the group of people able to commit voluntary euthanasia had broadened to include the chronically ill and emotionally distressed; and
- death had come to be regarded as a form of treatment, and patients were given little or no choice about euthanasia.

Similarly, in his evidence to the Senate Inquiry, Dr John Keown expressed concern about the number of cases revealed of patients having their lives shortened without an explicit request. He used this as evidence of proof of slippery slope claims. He also claimed the figures were not a true reflection of the Dutch situation due to widespread under-reporting and fabrication of figures. This was a claim backed up by Dr Andrew Dean in his evidence to this Committee. Dr Dean cited “*a number of statistical and methodological flaws*” in the presentation of the data.

These claims were disputed by Dr Robert Marr of the Doctors Reform Society in his evidence to the Senate Inquiry, who noted that the percentage of voluntary euthanasia cases was less than in Australia, where it was illegal. It was also rejected by the New England Journal of Medicine, which drew attention to the fact that the number of involuntary euthanasia cases had remained constant between 1991 and 1995⁵¹.

6.1.3 Matters Relevant to the Applicability of the Dutch Laws

- Over 95% of people are covered by private medical insurance, guaranteeing a large core of basic health care, including long-term care. Therefore, relatives and hospitals have no financial interest in cutting short a person’s life; and
- palliative care is very advanced.

⁵¹Angell M, “Euthanasia in the Netherlands - Good or Bad?” *The New England Journal of Medicine*, Vol 335, No 22, pp 1676-78.

6.2 Oregon, USA

The Oregon legislation forbids voluntary-active euthanasia and requires doctor-assisted suicide. The legislation was passed in a referendum in 1994 but has never been used because of court challenges.

It has a number of criteria that need to be satisfied by a person seeking to take advantage of it:

- the patient must make an oral and written request for lethal medication to their doctor;
- the request must be witnessed by two people, one of whom has no financial interest in the outcome;
- after the first oral request, the patient must be seen by a second doctor and wait for 15 days before receiving a prescription; and
- the patient must wait for a further 48 hours after submitting their written request before ending their life.

6.3 Northern Territory

On the introduction of the NT Bill to the Legislative Assembly of the NT, Chief Minister Marshall Perron stated:

“Despite modern technological advances and the most advanced palliative care, sadly some terminally ill patients suffer a gruesome death. Even with the best medical care, some people will always demand a speedier end.”⁵²

Before being able to end their life a number of criteria must be satisfied:

- the patient is over 18;
- the patient is suffering from an incurable illness that would result in their death without “extraordinary” medical intervention;
- the illness is causing the patient severe pain or suffering;
- the patient has been informed of the nature of the illness and its likely course, the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive;
- the primary doctor’s prognosis is confirmed by another medical practitioner, who must be a psychiatrist, who must also confirm that the patient is not suffering from a treatable clinical depression;
- there is not palliative care reasonably available to alleviate the patient’s pain and suffering levels acceptable to the patient;
- the patient has waited at least 7 days after verbally requesting to die before signing a written request to die;
- the request was signed by the primary doctor and the confirming doctor; and
- after signing the request the patient has waited a further 48 hours before ending their life.

⁵²NT, *Parliamentary Record (Debates)*, 22 February 1995, p. 2496.

In the case of a patient who is physically unable to sign a request, any person who has attained the age of 18, and is not likely to financially benefit directly or indirectly from the patient's death, may sign a request at the patient's request and in their presence.

7 CONCLUSION

As stated at the introduction of this report, the Committee's task has been to summarise and extract the reports by the Northern Territory and Senate Inquiries into voluntary euthanasia and similar inquiries in the United States, Canada, Britain and the Netherlands. The Committee sought to supplement this material with the oral evidence of a small number of witnesses from the Northern Territory and Western Australia in order to expand and clarify issues arising from those reports.

It was the view of the Committee that it was not appropriate to make any recommendations about the rights or wrongs of legalising voluntary euthanasia. However, the Committee commends the questions raised at the beginning of the report as a means for Members to reach their own conclusion about the matter.

Moreover, it became evident to the Committee in the course of taking evidence that, regardless of people's view on voluntary euthanasia, there is widespread support for efficient, effective and resourced palliative care services. If such services were provided, the number of people wishing to commit voluntary euthanasia may be relatively small. Therefore, the Committee believes that there is a need for better public education about the availability of palliative care and a further examination of the ways in which a range of palliative care services can be made readily available to more people.

Further, the House may, in its consideration of any Bill relating to voluntary euthanasia, wish to refer that Bill to this Committee for specific examination of it.