

MONASH UNIVERSITY

CENTRE FOR HUMAN BIO-ETHICS

CONFERENCE ON MEDICAL SCIENCE AND THE PRESERVATION

OF LIFE : ETHICAL AND LEGAL DILEMMAS

12 NOVEMBER 1981, 3.45 P.M.

THE EUTHANASIA - LIVING WILL DEBATE

The Hon. Mr. Justice M.D. Kirby
Chairman of the Australian Law Reform Commission

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BIO-ETHICS AND LAW REFORM

In 1915 Sigmund Freud wrote about the Great War in terms that are no less true about medical technology today:

In the confusion ... in which we are caught up, relying as we must on one-sided information, standing too close to the great changes that have already taken place or are beginning to, and without a glimmering of the future that is being shaped, we ourselves are at a loss as to the impressions which press in upon us and as to the value of the judgments which we form.¹

There is no doubt that the ethical problems presented by new medical technologies, some of them being pioneered in this country, require interdisciplinary meetings. But they also require close consultation with the community, in the manner that has been adopted, from the outset, by the Australian Law Reform Commission in its work.

Many medico-legal questions of a moral character have pressed upon us in recent years. In response, the law and medicine have exhibited diffidence and uncertainty. Each discipline has reflected divisions of opinion to the community at large. The intractable nature of bio-ethical problems is admitted by most speakers who turn their attention to them. No issue has caused such sharp and deeply felt division as that of the law relating to abortion. At the other end of the spectrum is the debate that initially brought the Law Reform Commission into the bio-ethical sphere.

I refer to the work we did for the report on Human Tissue Transplants.² In that report, the Commission was led by Mr. Russell Scott, whose recent book The Body as Property³ extends the discussion where the report left off. Sitting at our table, we had a number of distinguished Commissioners, including Sir Zelman Cowen, now Governor-General and Sir Gerard Brennan, now a Justice of the High Court of Australia. We also brought together a distinguished team of consultants ranging from experts in numerous medical disciplines relevant to transplantation, but also including the head of the Department of Moral Theology at the Catholic Institute of Sydney (Dr. Thomas Connolly), the Dean of the Melbourne College of Divinity (The Reverend John Henley) and Professor Peter Singer, now playing a leading role in the Centre for Human Bio-Ethics.

The Law Reform Commission's report had to tackle a number of controversial matters relevant to transplantation:

- . the definition of death in terms of irreversible loss of the function of the brain;
- . the opt-in regime for donations and the alternative regime, adopted in France and other countries, by which all persons at their death are deemed to be donors, unless, in their lifetime, they take steps to exclude this possibility;
- . the vexed question of child donations: a matter upon which the Commissioners themselves divided;
- . the retention of particular organs from autopsy cadavers, for the purposes of the development of a serum or other product profoundly useful to society.

I do not pretend that the Law Reform Commission's report on Human Tissue Transplants is the last word to be written on the topic. But one measure of its success is the fact that the laws it proposed have already been adopted in three jurisdictions of Australia. I understand it will be shortly be proposed for law in Victoria and is under close consideration in New South Wales and other jurisdictions. The report was praised in the British Medical Journal and in other overseas sources not given to commentary on Australian legal texts. Singled out for special mention were the unprecedented efforts we took to engage a community debate and to raise the perceptions of the legal and medical professions and of the lay community about the dilemmas which were posed in this particular area of operations. Solutions were presented for the consideration of the lawmakers. The lawmaking process was helped to face up to issues that would otherwise be left in the 'too hard' basket. Those who value our institutions of lawmaking and who appreciate a society governed by laws not by the whim of particular people (however sincere and talented they may be) will encourage the notion that we can find institutional means of helping the lawmaking process to face up to the legal and social dilemmas posed by modern medical technology.

That there is a need to do this is plain if we only pause for a minute to reflect upon the remarkable developments that we see almost daily in the press and upon which the law speaks, if at all, with a muted and sometimes confused voice. Take three recent examples:

An Unwanted Operation. In Britain in August, the Court of Appeal had to decide in a busy afternoon, an appeal from a decision delivered that morning by Mr. Justice Ewbank concerning the performance of an operation upon a child born with Down's syndrome.⁴ The child suffered also from an obstruction which, without operation, would be fatal. If the child had been intellectually normal, the operation would have been instantly and routinely performed. The parents did not consent to the operation. They believed, and doctors supported them, that it was in the child's interests that she be allowed, under sedation, to die naturally. The Court of Appeal reversed Mr. Justice Ewbank, made the child a ward of court and ordered the operation performed. Lord Justice Templeman posed the issue:

Is it in the best interests of the child that she should be allowed to die, or that the operation should be performed? That is the question for the court. Is the child's life going to be so demonstrably awful that it should be condemned to die; or was the kind of life so imponderable that it would be wrong to condemn her to die? It is wrong that a child's life should be terminated because, in addition to being a mongol, she had another disability. The judge erred because he was influenced by the views of the parents, instead of deciding what was in the best interests of the child.⁵

Test Tube Babies. A second, celebrated area of controversy relates to the in vitro fertilisation program. Accompanying the happy photographs of parents and children featured in the Women's Weekly and the popular press are now appearing serious articles raising questions about the ethical implications of the new procedures. Are fertilised embryos to be retained and if so for how long? Is the process to be confined to married couples only? Can the expenditures on the procedure be justified by comparison to other demands on the medical dollar to relieve suffering and promote health? If frozen embryos are to be retained, what will be the impact on the distribution of property? After the death or divorce of the natural 'parents', who is to have access to the embryo, or should it be destroyed? Will destroying it amount to a technical 'murder'? These and other questions have now been identified and will have to be examined sooner or later.

The Death of a Retarded Baby. Within the last week came the news that Dr. Leonard Arthur had been cleared by the Leicester Crown Court of the charge of attempting to murder a mentally retarded baby, John Pearson, who had been rejected by his parents. The doctor had ordered a course of 'non-treatment' for the baby, prescribing a pain-killing drug, DF 118, which also sedates and depresses appetite. As reported, there was evidence that with 'normal treatment' the child had an 80% prospect of living to adulthood. The defence case was that the drug merely eased the child's inevitable progress towards death. A statement reportedly issued after the verdict by the British Medical Association, the Royal College of Nursing and the Medical Protection Society, urged that it was 'the parents' responsibility to decide what was best for their child. It was the doctor's job to advise and help them. The verdict showed that the public was right in allowing doctors considerable freedom in coping with the burden of handicapped babies'.⁶ The report claims that 'parents may find it from now on a great deal harder to reach a tacit agreement with the doctor that the child should be left to gradually slip out of life.'⁷ Such an agreement and the joint statement appear to run counter to the warning of Lord Justice Templeman that the test is not the best interest of the parent but always the best interests of the child.

EUTHANASIA IN THE NEWS

The Case of Exit. The case of Dr. Arthur is just one of a number of cases which has recently brought the subject of euthanasia to public and legal attention. In another case, two members of the British euthanasia society EXIT were charged with aiding and abetting suicide. The jury in that case tried the secretary of the society, an Oxford don aged 34, and a 70-year-old man, Mark Lyons, who had been sent to visit eight people contemplating suicide, six of whom soon thereafter died by their own hand. Strangely enough the secretary was convicted. Lyons was discharged, having served a period in prison awaiting trial. The secretary was sentenced to imprisonment for two and a half years. According to press reports, the trial judge sentencing the secretary claimed he had flouted the law and was 'using the society, the object of which is to get the law changed, to jump the gun'. As he was led from the dock at the Old Bailey to serve his term, the secretary shouted 'This shows the idiocy of the present law'. The stated aim of EXIT was the change of the law to allow doctors to give a peaceful death to people in great distress and suffering from terminal illness.

Voluntary euthanasia, at least in the case of the seriously ill, incapacitated and dying, is not now (if it ever was) the notion of a few disturbed cranks. In Australia, England and elsewhere, sincere people have taken up the cause as an aspect of their civil liberties. In some parts of Australia attempted suicide is still a crime.⁸ When that law was repealed in England in 1961, aiding and abetting another to take his or her own life

remained a serious criminal offence. EXIT provoked the British authorities by publishing a book in October 1980 called 'The Guide to Self Deliverance'. It contained a great deal of information specifically aimed at ensuring that those who attempted to end their lives, did so with efficiency and success. The London Times and other journals gave a great deal of prominence to the book, urging, in forcefully written editorials, that people who contemplate suicide do not always do so calmly and dispassionately, taking all factors for and against into consideration. The Times urged that the book could lead to unnecessary deaths and that its publication should be stopped.⁹ The Secretary of the British Medical Association was moved to add his voice to the debate. He urged reconsideration of the publication of the booklet. Countless letters to the Times followed, including some by failed suicides.¹⁰ The prosecution of some of the figures associated with EXIT soon followed this noisy and anxious public debate. The conviction of the secretary of EXIT may well discourage law reformers in this area from taking their convictions beyond intellectual debate!

The Prosecution of Dr. Arthur. The prosecution of Dr. Arthur, on the other hand, was brought after public agitation by the anti-abortion group in Britain, LIFE. This group claims to have its supporters in hospitals throughout the country, including nurses and other health workers who inform it of doubtful cases. It was a hospital worker who gave details of the death of the baby John Pearson to LIFE. That organisation informed the police which referred the case to the Director of Public Prosecutions who ordered that Dr. Arthur be brought to trial for murder.

Symptomatic of the strong passions raised by cases of this kind are the views expressed by the competing camps. The national administrator of LIFE, Mrs. Nuala Scarisbrick, is reported to be unrepentant and critical of the perceived 'growing unwillingness of people to accept imperfection in their children'. The President of the Royal College of Physicians, Sir Douglas Black, urged that LIFE was helping to destroy the confidence of doctors and nurses by 'attempting to apply simplistic, rigid rules to situations which do not permit the proper application of such rules'.¹¹ As to the 'information systems' within hospitals, Sir Douglas felt that this would be destructive of the confidence of the medical and nursing profession. 'I feel', he said significantly, 'quite emotional about this'.¹²

The Case of Re B. When the earlier case of the Down's syndrome baby had come before the Court of Appeal, the Times reflected most editorial opinion when it concluded:

The Court of Appeal decision was certainly the right one in the circumstances. Down's syndrome, sad as it is, is not an affliction that leads inevitably to a miserable life. Many sufferers are cheerful and affectionate, and only moderately disabled. As with spina bifida, it is difficult at present to predict at birth how badly disabled the patient will be. Certainty of prediction always clarifies the ethical issues, and it is one of the most important ways in which medicine can help to relieve the dilemma in the future. The attitude of the parents, though clearly important as a clue to the baby's prospects of affection in life, cannot be a decisive factor against treatment. ... In fact, it must almost inevitably be right for the court to come down on the side of life, wherever there is a division of opinion amongst those directly concerned, so strong that the issue is brought before it.¹³

These words were denounced by Professor John Lorber of the University of Sheffield. He said that society was indulging in hypocrisy here as 300 spina bifida babies were allowed to die in Britain every year. In the 1950s and 1960s heroic efforts had been made to sustain these babies. Now, most of them grown to adulthood, they languish in nursing homes, frequently unloved, unvisited and a costly burden to themselves and to society.

Practice in Australia. We in Australia are not immune from these debates. This time last year, Professor Singer was quoted in the Age as saying that doctors, faced with the dilemma posed by the birth of a child monstrously deformed, were increasingly facing up to the question and saying 'enough is enough':

What sometimes happens is the parents will leave the baby in hospital and eventually it will develop some form of infection, possibly pneumonia. ... The doctors will then not treat it. They could easily give it a shot of penicillin ... but they let it die.¹⁴

Sir Macfarlane Burnet, reflecting on the nearly universal taboo about discussion of death in societies such as ours, argues vigorously for the right to die and, in some circumstances, the right to let die. He also asserts as a fact that this is already happening in Australia:

[C]ompassionate infanticide is already standard practice where the product of birth is such as to justify the term 'monstrous', i.e., where there is a gross and physically disgusting malformation, such as anencephaly (complete absence of brain). Severe spina bifida, where there is no possibility of effective surgery, is not infrequently dealt with by allowing the infant to die under sedation.¹⁵

Immediately following the acquittal of Dr. Leonard Arthur, medical reporters in Australia approached the Australian Medical Association for comments. An unnamed spokesman for the Association said that the dilemma of whether to intervene or to let nature take its course should be resolved by the doctor and, wherever possible, those closest to the patient.¹⁶ The Director of Medical Services at the Royal Alexandra Hospital for Children in Sydney said that decisions such as these were referred to the hospital's ethics committee. Such committees, typically, comprise doctors and clerics. They meet infrequently. They sit behind closed doors in private. Their rulings, their reasoning and the outcome of their decisions, are but rarely submitted to public and general scrutiny.

Dr. John Beveridge, the Director of the Prince of Wales Children's Hospital, said that he believed that decisions 'to make a baby comfortable but not to prolong its life' should be made by the doctor, together with his colleagues, the nursing staff, the parents and if necessary the welfare department. A spokesman for the Doctors' Reform Society said that ultimately 'the doctor had to assess the best possible course of action and that he was morally responsible for his decision'.¹⁷ The President of the Down's Syndrome Association said doctors should use every available means to save a child's life, whether it was normal or handicapped.

The case of Dr. Leonard Arthur may illustrate little more than the well known fact that it is difficult, at least in countries like Britain and Australia, to secure from a jury the conviction of a doctor for a criminal offence arising out of a difficult decision reached sincerely in the course of the daily performance of the specially onerous responsibility that doctors have to face. It may mean that the Director of Public Prosecutions in Britain (and by analogy, those who make like decisions in Australia) will be more hesitant to bring proceedings of this kind in the future. But the basic problem presented by the Arthur case will not go away. We are told by the English Court of Appeal that the test must always be the best interests of the child, not of its parents. We are told by Sir Macfarlane Burnet and by Professor Singer that cases already occur in Australia where the decision is made not to give lifesaving drugs or other assistance that would routinely be offered to a normal child. We are told by the Reform Society that the issue is ultimately the doctor's personal, private, moral responsibility. Such statements as refer to the involvement of parents refer to their involvement 'if possible'. The medical profession urges that the decision just be left with the doctors and with the nursing professionals.

Obstinate Problems. Conceding that these are intensely difficult decisions, and that they must be made rapidly, in highly charged circumstances and often with the knowledge of the special pain that will be suffered by the parents, a moment's reflection will indicate how unsatisfactory is the current state of things:

- . Accepted morality. In earlier times, there was a fairly common, accepted community morality, applied with a good degree of uniformity and interpreted and elaborated by accepted church teachings. This is not the case today. Lord Justice Ormrod, a Lord Justice of Appeal of England and himself a trained physician, asserts that 'the ability to choose in the area of morality, though it imposes immense responsibilities, represents 'one of the greatest achievements of humanity'.¹⁸ The fact remains that without a common morality, leaving it to the doctor's personal moral decision, without more principled guidance, invites disuniformity and inconsistency in the approaches that will be taken from doctor to doctor and from hospital to hospital.
- . Differing Hospital Policy. In fact, this has already happened. Doctors in one hospital refused to operate, against the parents' wishes, in the case of the Down's syndrome baby that recently came before the Court of Appeal in England. Doctors from another hospital had to be found who were willing to perform the operation. Doctors in differing hospitals reflected different community and individual approaches to the moral dilemmas posed by the case.
- . Murder includes Omissions. We have still to receive and study in Australia the charge to the jury by the judge in the Arthur case. In particular, we have to consider the reasons why he ordered that the matter should proceed only as a case of attempted murder and why he ordered an acquittal on the charge of murder itself. Statutory definitions of 'murder', in Australia at least, typically include reference to omissions as well as positive actions. Take the New South Wales definition:

Murder shall be taken to have been committed where the act of the accused, or the thing by him omitted to be done, causing the death charged, was done or omitted with reckless indifference to human life, or with intent to kill or inflict grievous bodily harm upon some person ...¹⁹

Although commentators may seek to draw a valid moral distinction between positive acts and passive refusal to act in order that nature might 'take its course' the distinction is not always easy to sustain in practice. Although arguments may turn on whether the omission 'caused' the death, this too is a debatable argument where omissions expand ever so slightly, into positive facilitating actions. Did the painkilling drug DF 118 used to sedate the baby John Pearson also have the deliberate, and conscious and intentional effect of suppressing his appetite thereby advancing his death? Who could doubt that failure to nourish a child would result in his death? Would similar treatment of a child not born with Down's syndrome ever be regarded as acceptable medical practice? If not, was this child in truth being allowed to die because of Down's syndrome? Certainly, it is arguable that the failure to give nourishment, or the failure to provide a routine operation or the failure to give 'a shot of penicillin' fall within the legal definition of 'murder', provided the requisite intent exists. It may be unreasonable to expose doctors to accusations of murder, unguided by society, but it is equally unsatisfactory that decisions of this kind made by doctors should be left to the vicissitudes of unstructured moral determinations varying from individual to individual and from hospital to hospital : made without any guidance at all or, at best, with the help only of a closed hospital committee or appeals to the traditional medical way of doing things.

THE RIGHT TO DIE

Religious Views. On the other side of the coin marked 'right to life' is the imprint of the so-called 'right to die'. According to a Gallup Poll, 72% of Australians believe that if a patient suffering from an incurable and distressing illness wishes to end his life, a doctor should be 'allowed to supply the means'. Twenty four percent disagreed. Four percent were undecided.²⁰

Although writers from a Protestant perspective have evidenced a wide range of beliefs concerning the ethics of both active and passive euthanasia, the official doctrine of the Roman Catholic Church and of the Jewish faith is clear on euthanasia and the use of extraordinary means to prolong life. The Catholic Church maintains that no person may take the life of another unless the latter is an unjustified aggressor against the individual or the common good. Whilst the Church does not support active forms of euthanasia or 'mercy killing', the Church doctrine does not require the continuation of extraordinary care to a terminal patient. Pope Pius XII offered guidelines to be used in making a decision concerning the continuation of extraordinary care of a patient.

The doctor had no rights independent of those of the patient. If the patient could refuse extraordinary treatment if conscious, the doctor could withhold such care. There was no obligation to use extraordinary measures:

There is not involved here a case of direct disposal of the life of the patient, nor of euthanasia in any way: this would never be licit.²¹

The same view was reflected by Pope Paul VI:

The duty of a doctor consists principally in applying means at his disposal to lessen the suffering of a sick person instead of concentrating on prolonging for the longest time possible — using any methods and under any circumstances — a life which is no longer fully human and which is drawing naturally to its end.²²

The ability of religions to isolate the issue of euthanasia from the issue of the right of a terminal patient to refuse extraordinary care may be important to the discussion of the moral and social implications of legislation designed to permit people, when of full capacity, to prohibit the use of extraordinary medical means to interrupt their inevitable progress towards death.

Popular Concern. This is not an academic debate. Private Member's Bills have been introduced both in South Australia²³ and Victoria²⁴ designed to permit people to execute a so-called 'living will', by which testament they would control the treatment given to them in a terminal illness. Everyone knows that Australia has an ageing population. There are many people of middle and older years who worry about the spectre of the Karen Quinlan case and of the prospect of being maintained in a state of semi-life, by mechanical contraptions under the direction of medical practitioners, without any real chance of their wishes to die peacefully being observed. For many such people, the idea of insisting upon a 'natural death' is associated with notions of individual integrity to the end and human privacy. It is associated with the claim to be able to die with dignity and the thought that dying slowly and perhaps unconsciously in a hospital with one's body connected to machines and tubes, is frightening and abnormal:

It is difficult to forget the image of Karen Anne Quinlan weighing only 70 lbs., locked into a fetal position, and attached to a respirator that kept her for months in a persistent vegetative state. The prospect of a 'natural' death, therefore, may seem preferable to technological, artificial life.²⁵

Older people, confronting as they frequently must, the experience and contemplation of death and reading of cases such as Karen Quinlan, have promoted in the United States, and now in Australia, debates designed to assert the right of the individual over his medical treatment, including up to the last moments. It was the assertion of this right which underpinned first the voluntary declarations, usually deposited with physicians or relatives, against extraordinary medical treatment and, later, the legislative proposals and enactments for 'living wills':

The problem with the autonomous right to refuse medical treatment is that you can insist on this right for years of your life, make it clearly known, but precisely at the point when it becomes most important, you slip into unconsciousness and the privilege of the right of decision passes out of your hands.²⁶

'Living Wills' Legislation. The names given to the instruments designed to limit 'extraordinary treatment' vary. Kutner has suggested, as alternative to 'living wills' other names for the document, including 'a declaration determining the termination of life', 'testament of death' 'declaration for bodily autonomy', 'declaration for ending treatment' or 'body trust'.²⁷ Additionally, the Catholic Hospital Association in the United States distributes to terminally ill patients in Catholic hospitals the equivalent of a living will called a 'Christian Affirmation of Life'.²⁸

The title of legislation designed to implement the measure also varies, though the California Natural Death Act²⁹ was the first 'right to die' legislation enacted in the United States and the first to give legal force and effect to the living will.³⁰ Following this legislation, many States in the United States have now introduced such legislation. In fact, at the last count, at least 28 States had enacted or were considering right to die legislation.³¹ Such widespread legislative support, now also reflected in Australia, merely indicates the intensity and persistence of community concern about this topic. This concern is also felt in Australia and is now being exhibited in legislative proposals.

A great body of legal writing has been generated in the United States about this topic. Curiously, there is no equivalent body of writing in this country. What follows is an attempt to distil some of the main points that have emerged in the United States legal literature.

DESIGN OF NATURAL DEATH LEGISLATION

Living Wills and Euthanasia. Euthanasia literally means 'easy, painless death'. It generally connotes assisting the death of persons suffering from incurable conditions or diseases. It is important to recognise that the 'living will' does not authorise all types of euthanasia. Depending upon the consent of the patient, euthanasia can be voluntary or involuntary. Furthermore, euthanasia can come about by positive act or by passive omission. The distinction between active and passive euthanasia is so significant that many writers now prefer to use a separate term namely 'anti-dysthanasia' to describe a doctor's failure to take positive action to prolong life. By definition a living will authorises voluntary euthanasia only. Furthermore, because of well entrenched medical ethics, the attitudes of the law to 'murder' and community responses, all legislative and most voluntary living wills contemplate passive euthanasia only i.e. the omission or withdrawal of extraordinary medical treatment. It is important to keep these limitations steadily in mind. They are vital to attract public, religious, scholarly and individual support for the living will and living will legislation. It is generally agreed that without legislation, living wills amount to little more than a non-legally binding indication to physicians of the wishes of a patient.³² Furthermore, a survey reported by Trial magazine in the United States in 1976 found³³ that only six doctors in ten would honour the wishes of a patient expressed in a voluntary living will unsupported by legislative sanction.

In the United States, which is a much more litigious and right-asserting society than Australia, the bounds of the common law rights of the patient and the duties of the doctor have been much more carefully and frequently examined in the courts than is the case here. The Natural Death legislation was drawn against the knowledge of many cases in which the constitutional and legal position of doctor and patient had been examined. For example, the criminality of 'passive euthanasia' was examined in the Quinlan case itself. The New Jersey Supreme Court concluded that removing Karen Quinlan from a respirator would not amount to criminal homicide because the ensuing death would be the result of natural causes. The court reasoned further that even if the act of removing the respirator constituted homicide, the removal would still be lawful because the patient's constitutional right of privacy included the right to refuse treatment.³⁴ The provision of a definition of death in terms of irretrievable loss of function of the brain may provide one means of avoiding the nice arguments as to whether 'pulling the plug' constitutes a criminal act or a permissible omission.³⁵

Numerous cases have arisen in the United States where doctors have requested authority from the courts to continue treatment over the patient's objections. These are cases where the patient has not yet reached a stage of reliance upon a document such as a 'living will' but can voice his own will loudly and, on occasion, in the courts. Although the decisions lack uniformity, there is an emerging pattern that asserts the right of terminal patients to refuse extraordinary treatment that will merely postpone death. In the Quinlan case, the high water mark of this trend was reached when the court upheld Karen Quinlan's right to refuse extraordinary treatment designed to continue a merely 'vegetative existence'. Since Karen was incompetent herself and could not personally refuse treatment, the court appointed her father as legal guardian and authorised him to remove the life support apparatus if the family, attending physicians and hospital ethics committee concurred in finding that no reasonable possibility of recovery existed. The court also concluded that no criminal or civil liability would attach to anyone involved.³⁶ The case is complicated for when the support systems were removed, Karen continued to breathe. Hers was not a case of 'brain death' for, in such a case, without artificial support, the normal bodily function of breathing could not occur.

Although the United States cases generally uphold the right of the competent patient to refuse treatment in a terminal condition, several limits have been proposed. They include:

1. Children. Authorisation of treatment of children over the religious objections of parents. Numerous blood transfusion acts in Australia and elsewhere already provide for this.
2. Dependant Minors. Provision for the protection of dependent minor children or unborn children. If no minor children depended upon the patient for support, even non-terminal patients have been permitted to refuse treatment for either religious or non-religious ground.³⁷ The existence of dependent minors has been considered a relevant limitation on health care autonomy.
3. Competence and Liability. Other considerations include where the patient is so weakened by his illness as to be mentally incompetent or where there is any possibility of civil or criminal liability of the hospital and attending physicians, if treatment is not given.
4. Religion. A fourth consideration given weight in the United States courts is whether the religious convictions of the patient will be abused if treatment is given or continued. Indeed, many cases are now arising where, though there is no specific religious conviction, the wishes of a terminal patient if rationally based and strongly adhered to, will be upheld by the courts.

Thus in 1972 a Wisconsin county court ruled that a 77-year-old woman could refuse the amputation of a gangrenous leg as a matter of choice, without requiring that the decision be based on her religious beliefs.

Acts and Omissions. Both our criminal and tort law recognise the distinction between acts and omissions. In tort liability has typically attached to the former but not to the latter. However, liability for non-feasance may arise where a person owes a duty recognised by law. The distinction between an act and omission is at best nebulous. Nowhere is the confusion more obvious than in the context of the physician rendering aid to a seriously ill patient, whether that patient be an old person approaching death or a newborn baby with established Down's syndrome. The current state of the law does not provide a definite answer to the commission/omission controversy. In any case, as has been pointed out, the law of murder can sometimes embrace omissions, deliberately causing and intended to cause death or serious injury. In an attempt to avoid the unsatisfactory features of this debate, a new test has been proposed, namely whether an act would cause something to occur, while an omission would merely permit something to occur. Upon this test, unplugging a respirator would merely constitute an omission rather than an act. The doctor is permitting the patient to expire, but is not himself the cause of death. Similarly, failing to perform an operation on a Down's syndrome child, even though this might routinely be performed in another case, would, according to the proposed new test, merely permit nature to take its course and the child to die for want of operation. Whether refusing nourishment and providing appetite suppressants constitutes an act or omission according to this test, is much less clear:

Under this test, injecting air into a patient's veins would still constitute an act and would be euthanasia, as would be withholding insulin shots, which do not merely prolong life but whose absence would cause death to occur. However, turning off a life support system would constitute an omission.³⁸

One has only to state these cases to see how unsatisfactory are the distinctions drawn by the law and the proposed new test does little to improve or clarify the position.

'Extraordinary' Medical Therapy. Another source of debate is the distinction between 'ordinary' and 'extraordinary' medical intervention. Advances in medical science blur the distinction and what is at one time extraordinary may, at a later time, become perfectly routine:

Many of the scientific devices by which people are kept 'alive' today must be classified as 'extraordinary' means : haemodialysis units, iron lung respirators, heart circulation pumps, intravenous feeding and the like. The line between ordinary and extraordinary therapy to preserve life is not an objective or straight one. It can only be discerned in individual cases based on the presented circumstances and will always be somewhat dissimilar.³⁹

Although some cases may be clear, as in the instance of the use of a respirator, other cases will be much less clear and the line between what is extraordinary and what is ordinary may not be capable of a sure and clear definition. If this is so, unless the law clarifies what is meant by 'extraordinary' it is bound to leave the doctor and the medical team guessing as to whether or not this or that treatment falls within the class that can be withdrawn.

Practical Matters. In considering whether living will or natural death legislation is necessary in Australia, a number of practical issues have to be weighed:

Law Upholds Life. The religious and cultural background of most people in Australia, reflected in the law, uphold the right to life. The living will asserts a right to death. One commentator puts the reservations thus:

We are loathe to admit that any degree of accident or disease could make it better to be dead. With our advanced medical capacities, we seem to believe that no condition should be permitted to be fatal, that death is never appropriate, but rather is the final insult to scientific progress.⁴⁰

Before living will legislation is enacted in Australia and before it secures the support of the community and its medical profession, something of a change of heart is required in this attitude to death. One writer put his argument for such a change of attitude in the following terms:

There is little doubt that at one time in the history of medical practice, the physician, enarmoured with the rapid advance in medical capacities, and the laymen, in awe of medicine's seemingly infinitely progress, subscribed to a 'prolonged life at any cost' philosophy. Such is not the case today.

Although we still cling to a desire for life, society is slowly realising that death, like life, must be faced rationally. For centuries enlightened democratic peoples have strived to provide a life with dignity for every individual. A death with dignity is an equally admirable goal.⁴¹

Physician Obedience. Before the advent of legislation to uphold the legal efficacy of the living will in the United States, estimates of the numbers of such wills showed that they were very significantly on the increase. A 1973 estimate set the number of such wills in the United States at 250,000.⁴² A 1976 estimate put the number at 'perhaps' 750,000 Americans.⁴³ The practical impact of the new legislation depends upon many considerations and it is difficult to escape the lament that at the critical time, if the patient is unconscious or unable to articulate his desires, his wishes may be unknown or, if known, overruled by relatives, the doctor's moral perceptions or the sheer impetus of routine procedures implemented unquestioningly and as a matter of standard emergency hospital practice. Certainly, there would appear to be evidence that, if known, many physicians will give respectful regard to the rational wishes of a patient expressed when they were competent to express them. A 1973 poll by Medical Economics magazine indicated that 75% of the doctors surveyed in the United States had personally withheld life-prolonging treatment. In the survey, 87% of family physicians and 86% of interns (the two groups most often faced with the decision) approved letting patients die. A 1973 survey of 1,000 abdominal surgeons concluded that an 'overwhelming majority' did not approve of prolonging a patient's life with extraordinary measures. Only 26 out of the 1,000 surveyed felt that life should always be prolonged as long as possible.⁴⁴ These figures tend to indicate that, in the American medical profession at least, there are relatively few who would preserve life at any cost, for example even in the face of a patient's stated desires. In fact, a 1976 poll conducted by Medical Tribune showed 77% of the family physicians surveyed said they would consider passive euthanasia for terminal patients whose suffering had become unbearable. These surveys indicate that a substantial majority of doctors in the United States, probably close to 75%, have practised or at least supported passive euthanasia. Although I have no figures for the Australian position (for we are much less fond of surveys) I would suspect that the same proportions would be true of the medical profession in this country. Apart from a small group, then, most doctors would seem intellectually and morally prepared to concede to a patient in certain circumstances the right to the patient's perception of death with dignity.

Issues as to how the patient's will is to be made known to the doctor (given changeover in medical practice and in treating physicians) and how the patient's family are to be brought in or excluded from the decision (or from the living will in the first place) are practical considerations that need attention. Quite frequently, living will legislation in the United States requires not only the normal two witnesses required in any will but suggests or requires two family witnesses, as an assurance that the family has been brought into the decision before the event, unlike the unhappy Mr. Quinlan, whose opinion was only sought after the event.

Settling Fears. Some of the fears that have been expressed in medical quarters, including in Australia, concerning living will requirements, seem to have little justification viewed against the realities of the Australian medical and legal scene. If living will legislation were enacted, it would clearly provide an exemption to doctors for any legal, ethical, professional or other liability for withholding treatment in the given terminal circumstances. But even without legislation, it might be anticipated that a living will, signed by a patient, would reduce virtually to nil the likelihood that:

- .. a physician's decision not to prolong extraordinary treatment would come to notice;
- .. that if it did come to the notice of the relatives, they would do anything but uphold the wishes of their deceased family member. In fact, many family members are glad to be relieved of the obligation of the terminal decision, by the action of the patient himself;
- .. that even if the relatives did urge proceedings on prosecuting authorities, that the latter would proceed to a criminal indictment in the face of the expressed wishes of the dead patient; and
- .. that even if the doctor was indicted, a jury would convict him.

One United States writer put it in terms probably applicable to Australia:

Since juries refuse to convict active mercy killers, it appears highly unlikely that any jury would convict a physician for refusing to prolong the life of a patient who had clearly expressed in a living will the desire to refuse treatment. A living will may actually supply legal grounds to fend off conviction. When all persons know that the patient's desires were carried out, even the likelihood of indictment decreases because of the reduced chance that anyone would complain to the prosecutor.⁴⁵

MACHINERY PROVISIONS

The United States legal literature is replete with discussion of machinery provisions required in any Natural Death Act. It would be tedious in the extreme to examine these matters of detail. They range from the manner of the execution and the form of the living will, the age at which a person may be entitled to execute such a will, the mental capacity that is required, the power and methods of revocation, the possible need for counselling before execution and the provision of facilities for a power of attorney to permit the execution of the wishes of a patient anterior to and immediately following death.

The medical witnesses before the South Australian Select Committee on the Natural Death Bill agreed that useless or distressing measures should not be, and generally are not, employed in an attempt to prolong the life of patients who are inevitably dying. They took the view initially that current medical practice was generally satisfactory and that there was little need for legislation. However, they conceded that the general public might not be aware of current practices and that patients might have substantial fears that they would be subjected to excessive technological efforts unreasonably to prolong the terminal stages of illness.⁴⁶ The committee urged the reintroduction of the Bill to incorporate the recommendations made in the report and to permit an adult person who desires not to be subjected to extraordinary measures in the event of suffering from a terminal illness to make a direction in the form of the schedule, legally binding on those treating him, prohibiting such measures.

CONCLUSIONS

The living will debate and the asserted 'right to death with dignity' represent just two of the important issues of a medico-legal nature which confront our society. How are we to help resolve these issues in a way which is satisfactory to the community and which takes full account of the cruel and sensitive choices which must be made by the physician? How do we take into account moral principles in a society where there is now no single accepted moral standard and in which there are legitimate differences of view about morality and where it leads us in bio-ethical matters?

The problems of human bio-ethics present with ever increasing frequency, urgency and complexity. If we are to be true to the tradition of English-speaking people, we will seek out institutional means of helping the lawmaking process to face up to the dilemmas posed. Clearly, the dilemmas will not conveniently go away. One institutional means for confronting issues of this kind is the Centre for Human Bio-Ethics at Monash University. Another institutional means, which has already proved useful to the lawmakers, is the Australian Law Reform Commission.

Whatever else we do, we must ensure that debates about these matters — about the fate of Down's syndrome babies, the implications of in vitro fertilisation, the monitoring of genetic engineering and the so-called 'right to die' are not carried on solely behind closed doors: whether in Departments of State or hospital ethics committees — less still hospital common rooms. The issues command the proper interest and legitimate concern of society. The institutional means we provide to address the issues must make due allowance for interdisciplinary consultation. But they must also make due allowance for consultation with the whole community.

FOOTNOTES

1. S. Freud, cited in W.J. Winslade, 'Thoughts on Technology and Death: An Appraisal of California's Natural Death Act', 26 DePaul Law Rev 717 (1977).
2. Australian Law Reform Commission, Human Tissue Transplants, (ALRC 7), 1977.
3. Russell Scott, 'The Body as Property', Alan Lane, 1981.
4. Re B. (a Minor), Times Law Report, 8 August 1981, 15.
5. ibid.
6. Sydney Morning Herald, 7 November 1981, 4.
7. ibid.
8. See Suicide Act 1961 (UK), s.1. Cf. Canadian Criminal Code, s.224. The Crimes Act was amended in Victoria in 1967, in the Criminal Code in Tasmania in 1957 and in Western Australia in 1972. In New South Wales and South Australia it is a common law misdemeanour to attempt to commit suicide. Despite recommendations for reform, no reform has been enacted.
9. The Times (London), 18 October 1980 ('The Road to Dusty Death').
10. See for example the Times, 24 October 1980, 13.
11. Sydney Morning Herald, 7 November 1981, 4.
12. ibid.

13. The Times, 10 August 1981.
14. Cited the Age, 19 November 1980.
15. Sir Macfarlane Burnet, 'Endurance of Life : The Implications of Genetics to Human Life', 1978, 96. Cf. P.J. Kearney, 'Medical Wisdom and Ethics in Treatment of Severely Defective Newborn and Young Children', ed D. Day, Eden Press, Montreal, 1976, 60.
16. Sydney Morning Herald, 7 November 1981.
17. *ibid.*
18. R. Ormrod, 'A Lawyer Looks at Medical Ethics', in (1978) 46 Medico-Legal Journal, 18, 21.
19. Crimes Act 1900 (NSW), s.18(1)(a).
20. Australian Public Opinion Polls (The Gallup Method), 4 December 1979, Poll No. 06/6/79.
21. The Prolongation of Life (an address of Pope Pius XII to an International Congress of Anesthesiologists) in J. McHugh (editor), Death, Dying and the Law, Appendix E, 78, 1976, cited in Note 'Rejection of Extraordinary Medical Care to a Terminal Patient : A Proposed Living Will Statute', 64 Iowa Law Rev 573, 583 (1979).
22. Cited in McCormick, The Moral Right to Privacy, abstracted in 64 Iowa Law Rev 573, 583-4 (1979).
23. Natural Death Bill 1980 (SA). See also Report of the Select Committee of the Legislative Council of South Australia on the Natural Death Bill 1980, mimeo, September 1980.
24. Refusal of Medical Treatment Bill 1980 (Vic).
25. Winslade, 718.
26. Statement of Dr. W. Gaylin before the United States Senate Sub-committee on Health, cited in P.H. Wilson, 'The Living Will -- Death With Dignity or Mechanical Vitality', 10 Cumberland L.Rev 163 (1979).

27. L. Kutner, Due Process of Anaesthesia : The Living Will, A Proposal, 44 Ind.L.J. 539, 551 (1969).
28. J.C. Turner, 'Living Wills — Need for Legal Recognition', 78 West Virginia L.Rev. 370 (1975-6).
29. Cal. Health and Safety Code, paras. 7185-95 (West 1976). See E.J. Flannery, 'Statutory Recognition of the Right to Die : The California Natural Death Act, 57 Boston Uni. L.Rev. 148 (1977). See also Winslade, n.1 above.
30. For a discussion see Flannery.
31. S.R. Akers, 'The Living Will — Already a Practical Alternative', 55 Texas L.Rev. 665, 667 (1977). There have been several more Bills since 1977.
32. Akers, 669.
33. The Right to Die, Trial, January 1976, 2. Cited Turner, 371.
34. In Re Quinlan, 70 NJ 10, 51-52, 355A.2d647, 669-70 (1976).
35. Akers, 672.
36. ibid.
37. id., 681.
38. J.G. Strand, 'The "Living Will" : The Right to Death With Dignity?', 26 Case.Western Reserve L.Rev. 485, 491 (1976).
39. D. Meyers, 'The Human Body and the Law', 1970, 148, cited Strand, 496-7.
40. Reeves, 'When is it Time to Die?, Prolegomenon to Voluntary Euthanasia', 8 New Eng.L.Rev. 183, 186 (1973).
41. Turner, 379-80.
42. Medical World News, 14 September 1973, 73, cited Turner, 371.
43. Strand, 509.

44. Akers, 691.
45. *ibid*, 676.
46. Report of the Select Committee of the Legislative Council of South Australia on the Natural Death Bill 1980, mimeo, 2.