THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS

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ADELAIDE, WEDNESDAY 9 MAY 1984

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EUTHANASIA - OLD ISSUE : NEW DEBATE

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The Hon Justice MD Kirby CMG
Chairman of the Australian Law Reform Commission

A BASIC AMBIVALENCE

It is not only the Christian or other theist religions which raise their voices against relaxing laws against euthanasia. Many humanists, concerned with the future of mankind, express fears about lowering legal and other barriers to abetting suicide and permitting assistance to people to a painless death. In our legal system, derived from the common law of England and profoundly influenced by the Christian culture in which that law developed, the impediments to euthanasia are partly historical. In most parts of Australia, following statutory reforms in England, the laws against suicide as such have been repealed. No longer do we bury the suicide in unhallowed ground at the crossroads, out of town, with a stake through the heart and prosecute survivors of attempted suicide. But aiding and abetting a suicide is still generally an offence. Although the guiding star of medical practice is the consent of the patient to medical intervention (without which consent the intervention will amount to an assault and a trespass) we are not prepared to follow the principle of patient autonomy to its logical conclusion. We are not prepared in the law, even with a voluntary patient and compassionate willing helpers, to permit assistance on the path to death. The patient may do it alone, without offence to the law. But when third parties intervene, even with the apparent concurrence of the patient, the law recoils and refuses to offer its condonation. This is because of the fear that the will of others might overbear the will of the patient. It is also because of the concern that death is permanent and that the law should therefore uphold, safeguard and defend human life, almost as an absolute. Also at stake is concern about any lessening of the law's protection of human life, as an absolute value.

Euthanasia literally means an 'easy, painless death'. Generally, though not necessarily, it connotes assisting the death of persons suffering from incurable conditions or terminal diseases. In the last few years, a number of cases have come before the courts, notably in North America and in England, concerning aspects of euthanasia. Generally, the cases have involved grossly deformed and retarded neonates where decisions are made, by passive conduct, to allow the child to die. Sometimes the cases have involved people at the other end of the spectrum of life : aged adults, suffering from terminal conditions, seeking relief from persistent agonising pain and looking to the medical profession to help them to a painless death. This is the path they have chosen. It is a path they cannot take unaided. They look to the medical profession, in deference to their autonomy as patients, their will and the obligation to relieve pain, to help them to the end.

Necessarily in this brief comment, it is possible only to mention some of the leading cases. I will then turn to one of many articles which are beginning to appear in American law journals urging, for the first time, the adoption of voluntary active euthanasia by the law. These articles offer practical guidelines, should active euthanasia be permitted — despite our history, despite religious and humanist reservations, despite anxiety about misuse but in deference to the fundamental respect for the autonomy of patients and the relief of unendurable and incurable pain.

THE VERY YOUNG

Deformed neonates. I cite the following recent examples:

- An unwanted operation. In Britain in August 1981, 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.[1] 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 Justice Ewbank's decision, made the child a ward of court and ordered the operation peformed. 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.[2]

. The death of a retarded baby. Also in late 1981 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'.[3] 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.[4] Such an agreement and the joint statement appear to run counter to the warning of Lord Justice Templeman that the test to be applied in such cases is not the best interest of the parent but always the best interests of the child.

There are many other cases involving neonates, with leading decisions being handed down in the United States, Britain and Canada.[5]

Practice in Australia. We in Australia are not immune from these debates. Professor Peter Singer has said 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.[6]

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.[7]

Immediately following the acquittal of Dr Leonard Arthur, medical reporters in Australia approached the Australian Medical Association for comments.[8] 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'.[9]

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 interpeted 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'.[10] 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 ...[11]

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 doctors to expose them, unguided by society, to accusations of murder. 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 VERY OLD

Public attitudes. Time does not permit consideration of all the legal implications of euthanasia, of so-called 'mercy killing'[12] or of reform of the law of suicide which, years after its amendment in England, remains

unreformed in many other parts of the Commonwealth of Nations.[13] These and other issues are addressed in a 1982 working paper of the Law Reform Commission of Canada, Euthanasia, Aiding Suicide and Cessation of Treatment.[14] The Canadian Commission recommended that existing prohibitions in the Canadian Criminal Code concerning homicide should be maintained to forbid active euthanasia in any form. It did not favour the complete decriminalisation of aiding or counselling suicide. Nor did it favour enactment of legislation to permit a patient suffering a terminal illness to forbid prolongation of medical treatment. Such legislation has been enacted in a number of States of the United States.[15] In Australia, Private Member's Bills have been introduced in two State Parliaments along similar lines.[16] However, opposition from the Roman Catholic Church has reportedly led the Victorian Labor Government to reconsider the introduction of the legislation designed to introduce 'living will' provisions into the law in Australia.[17]

Support for voluntary euthanasia, at least in the case of the seriously ill, incapacitated and dying, is not a notion of a few disturbed cranks. A national opinion poll in Australia in November 1982 revealed that 69% of the people polled believed that if an adult has a terminal or chronic illness and wished to end his life, a doctor should help him to die if asked to do so. Only 24% considered the doctor should refuse, 8% being undecided.[18] Critics of euthanasia have tended to isolate the issue of active euthanasia from the issue of the right of a terminal patient to refuse extraordinary care. But public opinion indicators suggest that the law's rigid defence of human life and its refusal to countenance moves to expedite the active termination of life (whatever its quality and whatever the distress and pain being suffered) are simply not accepted by a large majority of the population. The difficulty for reform is bringing such a distressing topic into the open and providing useful criteria and procedures that will be properly defensive of human life, but at the same time be respectful of individual autonomy, attentive to the relief of pain and distress and accepting of the natural processes by which we eventually move out of this life.

The Very Old. In Britain two members of the 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. 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.[19] 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.[20]

In the United States, more than in Commonwealth countries, decisions to withhold life-prolonging treatment from very old or incompetent patients have tended in recent years to move in increasing number from families and physicians into the courts. In 1977, in the case of Saikewicz[21], the Massachusetts Supreme Court firmly rejected the approach adopted by the Supreme Court of New Jersey in the Quinlan case when it ruled that such decisions were to be made by the patient's family and physician, subject only to review by the hospital's ethics committee.[22] The assertion of the function of the courts, as guardian of very old or incompetent persons, to make decisions on life and death has generated a flood of literature in medical, philosophical and legal journals.[23] Courts in the United States are now appointing guardians ad litem to represent incompetent persons and to conduct an adversary hearing on the issue of whether treatment should be terminated, where the termination will probably result in death. A typical recent case involved Earle Spring, a 78 year old senile hemodialysis patient whose final year of life was marked by continual court battles and banner headlines as his wife and son moved from court to court in a vain struggle to terminate treatment which they believed Earle Spring did not want. Adhering to the Saikewicz decision, the probate court in Massachusetts appointed a guardian ad litem to represent Earle Spring, conducted an adversary hearing and issued an order to terminate the treatment. The guardian appealed. The Court of Appeals approved the probate judge's order. The guardian appealed again to the Supreme Court of the State. That court determined that 'it was an error to delegate the decision to the attending physician and the ward's wife and son'.[24] The matter was then remitted to the judge at first instance. He ordered the guardian 'to refrain from authorising any further life prolonging treatment until further order of the Court'. Earle Spring was allowed to die.

Lawyers have defended the case as the assertion by the law and the courts of the ultimate respect for human life: providing legal protection for an incompetent person to make a decision that he would have made himself had he been competent and had he known all the facts. Such a view coincides with the insistence in the English Court of Appeal:

> 'Fortunately or unfortunately, ... the decision no longer lies with the parents or the doctors, but with this court'.[25]

Medical practitioners and theologians are not so sure. Spring's physician was highly critical of the way the case had been handled:

> 'If you must go to court every time a treatment is to be stopped, the implications are mind boggling. These decisions...are made perhaps hundreds of times a day in Massachusetts...I do not think courts of law can draw the line...The decision that it is up to the courts to say when treatment ends, was a very bad mistake'.[26]

And a theologian reflected:

> 'Earle Spring suffered an additional year of hemodialysis. His family experienced that suffering and endured the pain and cost of litigation, headlines, murder accusations and the agony of a public dying. The benefits for them: bitterness and financial ruin. For the public: a Supreme Court opinion that evidences little sophistication, sensitivity to medical realities, or tight legal reasoning, one that will serve only to exacerbate the already existing tensions among patients, physicians, families, lawyers, and courts'.[27]

Cases such as this may illustrate the need to defend the right to die and and to uphold the duties of medical practitioners to lessen suffering instead of concentrating on prolonging for the longest possible time — using any means and under any circumstances — a life which is no longer fully human and which is drawing naturally to its close.[28] Death has been described as the last great taboo of the 20th Century. Cases such as Quinlan, Saikewicz and Spring in the United States and the recent cases in England alert Australian lawyers and physicians to the fact that they may ultimately be forced to address, not merely the definition of death, but also the proper balance between the right to live and the suggested right, in due time, to die naturally and with dignity, harassed neither by heroic doctors nor officious lawyers and judges.

PRACTICAL GUIDELINES?

Perhaps the most interesting recent development in the United States has been the appearance of serious law review articles urging that the competent terminally ill person has or should have a legal right to choose the time and manner of death. Sometimes the assertion is grounded in the United States constitutional right to privacy. Specifically, it is urged that although terminal patients do not desire death, they are forced to confront it. Accordingly they should be free to choose between a slow, debilitating, painful death and a quick, painless one for which they must look to others to assist them. One thoughtful recent article by Stephen Wolhandler[29] asserts:

> It is inconsistent to recognise a terminal patient's legally protected right to make a decision in favour of self-euthanasia but deny that patient the means of implementing that decision ... If a case falls within [given] guidelines, the law should impose no criminal sanctions on the individuals assisting the terminal patient in committing suicide. The law should protect those who do not choose euthanasia of their own volition and who are incapable of making such decisions for themselves. This is necessary to protect society from the dangers inherent in allowing euthanasia decisions to be made by anyone other than the patient. Nevertheless, a voluntary request by a legally competent terminal patient for a gentle passing should be honoured. In addition, secondary parties whose assistance is needed to effect such requests should be protected from legal sanctions.[30]

What are the guidelines which are offered as a security against the erosion of the respect for life protected by the current law, the imposition of the will and judgment of others upon the wishes of the patient and the possibility that the patient might wish to change his or her mind?

The following guidelines have been suggested and deserve consideration. To avoid criminal liability, those assisting a competent terminally ill patient to commit suicide should, according to the American literature, be required to demonstrate satisfactory compliance with five guideline provisions:

1. The patient must be terminally ill, this to be established by two independent corroborative medical opinions that agree that the patient has less than six months to live.
2. The decision must be voluntary and made by the patient himself or herself, free of coercion. The patient's motive for making the decision should be considered irrelevant — many factors including pain, debilitation, emotional and financial burden may affect the

decision. Though made sometimes for others, it should be stressed that the decision is the patient's own choice. It should be open to the patient to request voluntary euthanasia by signing a request form in the presence of two witnesses not otherwise involved with the patient.

3. The patient must be legally competent and confirmed as such by two independent psychiatric opinions.
4. The patient's decision must be informed. The patient should be made aware by medical advice which is fully documented, of the stages of degeneration that will accompany the illness and of the possibilities of temporary or permanent remission. Adequate time should be provided to the patient to consider the advice given before thought processes become inhibited by any pain-relieving drugs.
5. As further evidence of voluntariness, the doctor should be obliged to prescribe the least active means to effectuate death. A person more capable of causing his own painless death needs less active secondary party participation. Thus the use of a more active method where less active means are available would suggest improper conduct rendering the doctor liabile to prosecution for homicide.[31]

Physicians from ancient times have taken an oath or otherwise held themselves bound to save and not to terminate life. Yet, with the advent of emergency teams showing heroic effort and using sophisticated technology, the prospect is now with us of a growing number in the ageing population who must contemplate weeks or months of excruciating pain as they await a 'natural' death. The issue of euthanasia, therefore, requires us to confront many perplexing social issues:

- Should a physician ever be obliged to assist a patient of full competence to a painless death?
- Is there a difference in quality between assisting a patient to such a death and withholding technology or medicines that would prolong life, ever so briefly?
- If the old active/passive distinction is not valid, at the margins, are we conceding at last that there is a quality of life which is not worth living and might therefore, with full moral and legal acceptance, be terminated, particularly if that is the wish of the life in question?
- Is life at any price the guiding principle or, out of respect for the quality of life, must due account be taken of the wishes of a competent patient and the obligation of the medical profession (and of society) to relieve pain — particularly where it is at a high level, protracted and incurable?

. Could modifications of our current law be introduced without unduly diminishing the physician's primary duty to prolong and save life and without diminishing society's respect for human life as such?

These are the questions which are posed by the new euthanasia debate. They are questions that are now beginning to come before our courts. Those courts will tend, in defence of human life as an absolute value, to uphold the absolutism of the past and insist on life whatever its quality. Society's public opinion would probably question such an absolutist approach. But what is to be put in its place? And do we have the institution and the political courage to confront these very hard questions? These are the issues the lawyer and the law reformer poses for this scientific meeting.

FOOTNOTES

1. Re B (a Minor), [1981] 1 Weekly Law Reports 1421.

2. ibid.

3. Sydney Morning Herald, 7 November 1981, 4.

4. ibid.

5. See editorial 'The Right to Live and the Right to Die' in Medical Journal of Australia, 21 January 1984, 59; Cf Report of Working Party, Legal and Ethical Issues, Non-Intervention in Children with Major Handicaps, Aust Paediatr J (1983) 19:217-222.

6. Cited the Age, 19 November 1980.

7. Sir Macfarlane Burnet, 'Endurance of Life : The Implications of Genetics to Human Life', 1978, 96. Cf PJ Kearney, 'Medical Wisdom and Ethics in Treatment of Severely Defective Newborn and Young Children', ed D Day, Eden Press, Montreal, 1976, 60.

8. Sydney Morning Herald, 7 November 1981.

9. ibid.

10. R Ormrod, 'A Lawyer Looks at Medical Ethics', in (1978) 46 Medico-Legal Journal, 18, 21.

11. Crimes Act 1900 (NSW), s 18(1)(a).

12. R Ling, 'Mercy Killing and the CLRC' (1982) 132 New LJ 76.

13. See Suicide Act 1961 (UK). Cf Canadian Criminal Code, s 224. The Crimes Act was amended in Victoria in 1967 and in other States since then, most recently by the Crimes (Mental Disorder) Act 1983 (NSW).

14. Law Reform Commission of Canada, 'Euthanasia, Aiding Suicide and Cessation of Treatment', Working Paper 28, 1982. See also WJ Curran, 'Quality of Life and Treatment Decisions : The Canadian Law Reform Report' in New England Journal of Medicine, Vol 310, No 5, 297 (2 February 1984).

15. GJ Strand, 'The "Living Will": The Right to Death with Dignity?', 26 Case Western Reserve L Rev 485 (1976).

16. See eg Natural Death Bill 1983 (SA); Refusal of Medical Treatment Bill 1982 (Vic).

17. J Hirst, National Times, 14 October 1983, 17-18.

18. Herald Survey, n 56 above.

19. The Times (London), 18 October 1980 ('The Road to Dusty Death').

20. See for example the Times, 24 October 1980, 13.

21. Superintendent of Belchertown State School v Saikewicz, 370 NE 2d 417 (1977).

22. In Re Quinlan 70 NJ 10, 355 A 2d 647 (1976).

23. See eg A Relman, 'The Saikewicz Decision: A Medical Viewpoint' 4 American Journal Law and Med 233 (1978).

24. In Re Spring, Mass 405 NE 2d 115 (1980).

25. Lord Justice Templeman, In re B (A minor) [1981] 1 Weekly Law Reports 1421, 1424.

26. Dr L Shear, cited JJ Paris, 'Death, Dying and the Court: The Travesty and Tragedy of the Earle Spring Case' 49 Linacre Quarterly 26 (1982), 32.

27. Paris, 40.

28. Pope Paul VI cited McCormick, The Moral Right to Privacy, abstracted in 64 Iowa L Rev 573, 583 (1979).

29. SJ Woldhandler, 'Voluntary Active Euthanasia for the Terminally Ill and the Constitutional right to Privacy', 69 Cornell Law Rev, 363 (1984).

30. ibid, 383.

31. ibid, 382.