SUBMISSION TO THE SENATE

LEGAL AND CONSTITUTIONAL

AFFAIRS COMMITTEE

RE THE

RIGHTS OF THE TERMINALLY ILL

(EUTHANASIA LAWS REPEAL)

BILL 2008

Dr Brian Pollard
6/72 Greenwich Road
GREENWICH NSW 2065

2/04/08
Phone: 02 9436 3516
Email: bpoll79@bigpond.net.au

Summary.

1. The first and immediate consequence of passing the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* will be the restoration of the *Rights of the Terminally Ill Act* 1995 (ROTI) in the Northern Territory, as set out in its Schedule 1 (2).

2. There are few MPs in the current parliament who would have any detailed knowledge of the content of the ROTI which was rendered ineffective, but not repealed, by the *Euthanasia Laws Act 1997*. While this lack of familiarity persists, they will be unable to make an informed contribution to the debate.

3. My analysis of the ROTI is provided below, detailing just some of the many ways in which it was open to abuse and was therefore a bad law, and still is.

4. In 1998, the *Lancet* published a review of the ROTI in action, during its short life. This documents the fact that, among other serious defects, it was unable to prevent the taking of the lives of several patients who were outside the criteria for the Act.

5. There have now been published the reports of five large parliamentary inquiries into the consequences of legalising euthanasia which **all** concluded, with reasons given, that **no** euthanasia law could **ever** be made free of the possibility that the lives of others who did not wish to die would be put at risk. The primary reason is that the so-called safeguards can never be guaranteed to work in practice.

6. The 2008 Bill would simply allow again the recycling of the many so-called safeguards known to be ineffective in achieving the security of the lives of all, particularly those suffering mental disability. There is no evidence that Senator Brown has read the reports of the inquiries mentioned above or is familiar with the extensive medical literature about the association between severe depression and a sustained wish to die.

7. Senator Brown's confidence in opinion polls in support of his views is shown to be misplaced.

8. I believe that when all these factors are taken together, there are only two rational, reasonable and acceptable options available to Members, if they wish to demonstrate a proper degree of concern for innocent human life - either to withdraw the Bill from debate or to vote against it. To allow the ROTI to be reinstated would show callous disregard for the lives of vulnerable residents of the Northern Territory and of residents in other Territories which may follow them, and would deserve universal condemnation.

Introduction.

I am a retired anaesthetist and palliative care physician who commenced in 1982, and directed for five years, the first full-time palliative care service in a University teaching hospital in New South Wales, at Concord Hospital in Sydney. I subsequently became active in the public debate on euthanasia for many years throughout Australia. In addition to many articles and interviews in the medical and lay media, I had published in 1994 a book titled *The Challenge of Euthanasia*.

As set out in Schedule 1 (2), if the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* were passed, it would immediately restore the original Northern Territory *Rights of the Terminally Ill Act*,1995 (ROTI), which had been suspended, not revoked, by the *Euthanasia Laws Act 1997*. There would be no further opportunity for parliamentary debate in which more recent, important information could be canvassed. The federal parliament now contains many new members who would have no knowledge of the details of the ROTI and others who may have only a vague recollection of them. Senator Brown is playing on this ignorance and on the resentment felt by many in the Northern Territory that they have been deprived of the right to be masters in their own house because they have been told, and believe, that the ROTI was a safe law. While this may be clever politics, it is not being fully open. In fact, as will be shown in this submission, it was considered a bad law before it was enacted and this was later proved true by a subsequent review of its performance.

My purpose is to supply the Committee, and through it the members of parliament, with enough of the detail of the ROTI to enable them to debate the Bill in an informed way, and to know in what ways it would restore a dangerous law, to the detriment of innocent lives in the Northern Territory, just as it was shown to have done previously.

My analysis concerns just some of the contents of the ROTI, made law when there had been published reports by three large overseas parliamentary inquiries into the consequences of legalising euthanasia, which *all* concluded that *no* euthanasia law could *ever* be made safe from the risk of endangering the lives of others who did not wish to die. This is because the so-called safeguards do not work in practice and there are many reasons for this. Since that time, there have been two more Australian reports, coming to the same conclusion. (All references are at the end of the submission).

Some comments on criminal law.

The value placed by law on every innocent human life is such that its intentional destruction is the greatest crime, an expression of the law's acceptance that every innocent person has a right to the integrity of his/her life, that is, not to be killed. While human rights are commonly invoked in the euthanasia debate, it is uncommon to find among them the right to the integrity of one's life. Reason would suggest that, in a society where life was highly valued, it would be the first right to be considered.

A euthanasia law would form part of the criminal code. Historically, its statutes are

intended to provide *justice, equally for every citizen*, but particularly for the vulnerable, and *consent is not to be accepted as a defence* to violations. Codes differ in detail throughout the world, but universally they concern acts that are thought wrong and so, violations are not wrong because they are illegal - they are illegal because they are wrong. Code principles may be ignored, and the resultant law may be valid, but it is unlikely it would be safe or effective in achieving only its particular purpose.

Justice cannot safely be allowed to rest on personal opinions because they cannot be settled by objective argument, and to the extent that a law might rely on subjectivity, it would be unjust and open to abuse. Yet with euthanasia, the view that another person's life had lost such value that it may be taken on request would always be dependent on the observer's personal values. There are no objective criteria to guide every observer to reach the same conclusion about the value of another person's life, in given circumstances.

Similarly, the principle of *equality* in criminal law would be, *not simply altered but overturned* by euthanasia law, in which a group of innocent persons was defined as having their lives exempt from the general protection demanded for all. In this context, an innocent person is one who poses no present or future threat to others.

As for the disallowance of *a plea of innocence because the victim agreed*, this plea would be implicit in every instance of voluntary euthanasia.

Minimal requirements for safety in any part of the criminal law are:

- clear and accurate definitions of key concepts,
- provisions set out in terms that can be interpreted in the same way by all who read them, and
- a certainty, or at least a high degree of probability, that any requisite safeguards are capable of being observed.

Analysis of the *Rights of the Terminally Ill Act* 1995, (ROTI).

Title. The Act is to 'confirm the right of a terminally ill person to request assistance…to terminate his or her life'.

Comment: No such right appears in any medical, legal or ethical code of behaviour or in any recognised document of human rights, nor is it argued here. It must therefore be presumed not to exist.

The Act is 'to provide procedural protection against the possibility of abuse of the rights recognised by this Act'.

Comment: Other rights are not mentioned but some that might be presumed to exist are a right of one person to agree to take the life of another on request and for a right to have those acts legalised. Similarly, those rights do not exist.

The terminally ill do have genuine rights, however, such as the equal, inalienable and inherent right to the integrity of their life, as set out in the United Nations' *Universal Declaration of Human Rights*, a right which is not to be made dependent on the quality of that life at a particular time and which is to be protected by law. They also have the right to be given the high standard of care appropriate to their condition that is available to all such patients in that community; and a right not to have their lives unnecessarily prolonged when they are dying and when it is in their interest to be allowed to die. This Act does not protect those rights, procedurally or in fact.

Definition. 'medical practitioner' means a medical practitioner, who has been entitled to practise as a medical practitioner…for a period of not less than 5 years and who is resident in…the Territory'.

Comment: Since the practitioner need only be entitled and may not have practised in any of that time, he or she will have had no experience at all. For the purposes of the Act, all such practitioners, experienced or not, are considered to be proficient in palliative care. In 1995, very few practitioners anywhere in Australia had received adequate training in palliative care and such palliative care services as existed in the Northern Territory then were rudimentary. There was no practising palliative care specialist in the NT.

"terminal illness'…means an illness which will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient'.

Comment: No definition of 'extraordinary' is provided and probably none could be devised which would be acceptable to everyone. The normal medical treatment for the dying is palliative care of an adequate standard and is not to be seen an any way as extraordinary. What may be unacceptable to a patient has nothing to do with a definition of illness. A refusal of one form of treatment does not confer any further entitlements on a patient, and certainly not the intentional taking of life on request. It is common experience that what one person cannot bear, others can.

Part 2. 4. 'A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient…'.

Comment: Pain, suffering and distress are subjective responses and cannot be measured or compared between patients. They have only to be claimed for that claim to be unable to be tested and to be unassailable. Suffering is a capacious reason to justify killing. Not all suffering, even in the dying, has medical causes and it is unreasonable to expect doctors to be able to deal with the social causes of suffering. Suffering of non-medical causes may be at least as burdensome as that due to social causes. May these people also be killed on request? Simply to reflect on the potential of allowing induced death for undefinable distress would reveal how ungovernable could be its outcomes.

7. (1) (b) (ii). 'the medical practitioner is satisfied, on reasonable grounds, that there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure'.

Comment: All patients have the common law right to refuse any medical treatment, except for suicidal motives, at any time, but as already stated, such refusal confers no further entitlements except those of effective palliation. At all times, there are heavy medico-legal responsibilities on doctors to provide that care, at the required level of expertise.

(c)(e). 'the medical practitioner has informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available to the patient'.

Comment: Sounds quite wonderful, until one remembers that the practitioner may not have practised for the past five years and would almost certainly know little about good palliative care or how to provide it. We are given no hint as to what 'might be available' means - either such care is available or it isn't. Such information will generally be given in private, so nobody in the future could ever be certain that the information had been correct, unbiased, adequate and well-understood, unless a disinterested observer was present and took and kept contemporaneous notes of what was said, on each occasion. If probity were to be questioned later, there would only be the doctor's word available. Every part of the criminal law is already known to be abused, so the taking of the life of an innocent person should be made as foolproof as possible, if vulnerable seriously ill patients, who did not want their lives taken, are to be protected.

(c)(h). 'the medical practitioner is satisfied…that the patient is of sound mind and that the decision has been made freely, voluntarily and after due consideration'.

Comment: This is a provision impossible to fulfil, since coercion may have been applied by someone not known to the doctor. But would coercion be a real risk? After his long inquiry into mental health, the former Human Rights Commissioner, Mr Burdekin, said he had discovered that the sick were the 'most systematically abused and the most likely to be coerced'.(1)

'the practitioner is satisfied…that the patient is of sound mind'.

Comment: As there was no practising psychiatrist in the NTat the time of the ROTI, the practitioner was the sole protection against the possibility of missing mental disturbance. It is quite insufficient for the doctor to be 'satisfied' if in fact he or she is wrong. Consider the following excerpts from the medical literature:

- no request for hastened death can be understood, without first attempting to understand the psychological landscape within which that request arises.
- psychiatrists and experts in mental health are best situated to understand and explore

the psychological underpinnings of a dying patient's request that death be hastened.

-at least 90% of patients who desire death during a terminal illness are suffering from a treatable mental illness, most commonly a depressive condition.

- this is not a diagnosis which can be made by the average doctor unless he or she has had extensive experience. The diagnosis is frequently missed in those already under medical care.

- 70% of depression responds to medical treatment.

- more can be done to benefit these patients by improving pain relief and providing palliative care than by changing the law to allow induced death.

(2) 'In assisting a patient under this Act, a medical practitioner shall be guided by appropriate medical standards and such guidelines, if any, as are prescribed'.

Comment: This is pure humbug. After the repeated instances of neglect of good medical care outlined so far in this analysis, an appeal now to 'appropriate medical standards' is simply sanctimonious. As a medical practitioner, Senator Brown knows that there are no medical guidelines for intentional killing, so readers must supply their own possible motives for his support for this clause.

Part 3. 12. concerns medical records to be kept.

Comment. These are intended for use after the patient's death, whereas the only time a review by medical and legal experts may have been advisable, and possibly critical for patient protection to ensure that all was done that should have been done, would have been before death..

13. Certification of death. 'A death as the result of assistance given under this Act shall not, for that reason only, be taken as unexpected, unnatural or violent'.

Comment: Ordinary folk may think that death by lethal injection was not natural, but they would be wrong, according to this law, for it has been designed to make black become white, for 'procedural purposes'. This is to forestall its challenge by valid legal argument. If words are not allowed to have their traditional meaning, truth cannot prevail.

14. Medical record to be sent to the Coroner.

Comment: The medical practitioner will be the sole author of that report, the principal actor in the drama and the sole survivor. What would be the chance a Coroner would find anything he was not meant to find? This is a recipe for abuse.

Part 4. (2) Construction of Act. Assistance (in inducing death) given in accordance with this Act…is taken to be medical treatment, for the purposes of the law'.

Comment**:** Describing a lethal injection as medical treatment, whatever the reason, is blatantly and inforgivably dishonest. It has been said that there can be no euthanasia without some deceit and here is the proof.

20. Immunities. These sections provide that the medial practitioner who takes life according to the provisions of this Act will not be subject to any civil or criminal actions or to any form of condemnation by a professional body.

Comment: In its ethical code for doctors, the Australian Medical Association holds that 'doctors should not be involved in interventions that have as their primary goal the ending of a person's life'. The World Medical Association has published two documents, declaring that assisted suicide and euthanasia are unethical for doctors. Unethical means morally wrong. This Bill seeks to encourage and then protect unethical behaviour in the medical profession, and does so without the profession's consent or endorsement.

Every Australian State government has established a Medical Board and Medical Tribunal to regulate ethical medical practice. Life-taking by doctors is condemned by them all and is automatic grounds for medical deregistration. What possible benefit could a community expect from having unethical doctors? This section is an affront to good medical practice and public safety and makes a mockery of a claimed respect for preventing abuse against the sickest and weakest who are least able to resist the powerful. It is a function of criminal law to protect the weak, not the strong,.

Where would be the protection for a patient who may have been left, for example, alive but permanently brain damaged, by an action permitted by an unsafe law, but for which the doctor was professionally unprepared? While it is macabre to regard not being killed as a risk, it may be quite likely, because it is reported as having sometimes happened both in the Netherlands and the USA when euthanasia was attempted, and because doctors have no training in taking life intentionally. They are not taught how to kill patients because Australian criminal law and Australian medical ethical codes of practice forbid them to do so, in conformity with equivalent laws and codes throughout the world.

Discussion.

Since Senator Brown referred to two opinion polls in his second reading speech to support his Bill, I shall comment on them. Opinion polls originated to guide policy-making in commercial and political areas. The supporters of euthanasia would now have others believe that moral dilemmas can be satisfactorily resolved by counting heads. But when it is realised that euthanasia has complex moral, legal, medical and social aspects; when talk-back radio reveals that many people have erroneous ideas of what actually constitutes euthanasia; when most get their information from rates-driven media whose primary aim is not to enlighten and when it is well-known that the wanted results can be manipulated by the structure of the questions, opinion polls can carry no certainty about euthanasia. Would it really become OK to rob old ladies when 80% thought so?

Brown cited the Newspoll of February 2007, where 80% agreed that 'doctors should be allowed to provide a lethal dose to a patient experiencing unrelievable suffering and with no hope of recovery'. (Unrelievable is only what a particular doctor has not been

able to relieve). Taking into account the capacities of good palliative care, that question should read ‘if a doctor is so negligent as to leave a patient in unrelieved suffering, severe enough to cause him/her to ask to be killed, should the doctor be allowed to compound that negligence by giving a lethal dose, instead of seeking expert help?’

In the Roy Morgan poll of June 2002, 73% agreed that ‘doctors should be allowed to give a lethal dose to hopelessly ill patients who were without hope of recovery’. I refer to previous comments about hopelessness, mental states and treatment obligations and am dismayed that Brown, a medical practitioner, should be so unaware of the principles of good medical care.

An outstanding feature of the ROTI is its pervasive emphasis on the minutiae of paper shuffling, all the certificates properly signed and so on, intended to protect the doctor at every turn, no matter what may eventuate or how negligent he or she may have been. This is not singular to this law, it applies to every euthanasia law ever presented to an Australian parliament, though this is possibly the worst. It would deny vulnerable patients any effective protection in law, if driven to ask for death by unrelieved pain, anxiety, depression or despair, perhaps as a result of the neglect or ignorance of the same doctor who decides for euthanasia, while not requiring the appropriate treatment for such states to be supplied, as a matter of right. The focus of criminal law should be on the victims, not the perpetrators, who are well able to look after themselves.

By its terms, the doctor alone:

- has the last and critical decision on whether euthanasia takes place,
- is not required to reveal to medical experts any aspects of the illness and its treatment, before euthanasia is carried out. In that case, it could never be known whether such killing was medically justifiable, if indeed it could ever be justified.
- is not required to keep, and produce to experts when required, such comprehensive documentation as would reveal the full medical facts of what occurred,
- chooses the consulting doctor,
- is not required to have or to seek any particular medical expertise in the particular illness, as is often known to be necessary, in these circumstances.

Taken together with the many other failings discussed in this commentary, these provisions leave ample scope for the virtually unfettered abuse of seriously ill patients when they are at their most vulnerable.

Contrast the flimsy requirements of this Bill with the procedure required in the only other legal context of life-taking. Such are the current demands of justice, compassion and mercy that many States now will not permit the legal taking of life, even for a convicted serial killer, partly because errors are known to be possible, despite all due care. Where capital punishment is permitted, great care is still required when dealing with suspected criminals, on account of the risk of wrongful life-taking. They are allowed legal representation, a public trial, strict rules of evidence and, if found guilty, avenues of appeal. In adopting these precautions, the State acknowledges that it has the responsibility to protect innocent life, and that it alone must be that life’s ultimate

defender.

The community understands and supports those measures. How radically different then would be the case if the State were to enact this or any similar proposal to legalise euthanasia, demonstrably open to abuse, and how ruinous for the repute of the criminal law to be seen to be adopting such widely divergent standards, especially when, with euthanasia, all the victims would be innocent. In 1994, I described this law as the most unsatisfactory and unsafe proposal for euthanasia yet put forward in Australia and I think that is still probably the case.

Kevin Andrews gave as the main reasons for the *Euthanasia Laws Bill 1997* to suppress the ROTI that it had had been passed by 'a small territory, with the population of a suburban municipality in Melbourne or Sydney, by one vote, without any house of review, without attempting to say why a law rejected by every major inquiry in the world was proper, and in the face of universal opposition from its Aboriginal population'. Additionally, it was 'poorly drafted, had inadequate safeguards and a law that fails to protect innocent people will always be a bad law'. Many prominent lawyers readily supported the ROTI, claiming that not only was it safe, but was a model of safety.

A review appeared in the *Lancet* in 1998 (2), covering the ROTI in action during its short life, for which the principal author was an internationally respected Australian professor of psychiatry. It revealed that Dr Nitschke had had no experience with dying patients prior to the Act, palliative care facilities in the NT were underdeveloped, there was no practising psychiatrist in the NT at the time, one patient who received euthanasia did not meet the requirements of the Act, a difference of opinion between doctors over the medical future of one of the patients was resolved at last by the opinion of a doctor with no expertise in terminal care of that illness, in one case relevant psychiatric evidence had been withheld, and finally, patients with treatable depression were not protected by the guidelines specifically included to deal with that problem, and their lives were taken.

While implying that there is a right to ask to have one's life taken, a right not found in any code of ethics or law, or in any declaration of human rights, the ROTI says nothing of the undoubted right to the integrity of one's life and of the right to good medical care. The title of the *Rights of the Terminally Ill Bill* is deeply ironic.

Conclusion.

The situation before the MPs when considering this Bill is unique. When a euthanasia law is debated in parliament, it is usual for members to offer their views on the morality and social utility of taking the lives of some of the seriously ill who ask for induced death. That would be irrelevant in this case, since the Bill asks for nothing more than a vote. There is no detail in the Bill to be debated, other than the consequence that another Bill in another place will be enabled, a Bill that cannot be changed by this House. But debate on that consequence is imperative, unless members are to abrogate their responsibility, a responsibility that they alone in society have, to ensure that all Bills before them are safe, and most particularly, when innocent human life is at risk. This Bill

cannot be safe when its effect will be to enable a Bill already proven to be unsafe.

To restore the ROTI, with its many shortcomings and opportunities for abuse of process, would again put at risk the lives of many of the seriously ill who did not want their lives ended, just as it did earlier. The most tragic aspect of that would be that, since abuse would be easy to conceal, it would be difficult or impossible to detect.

Although every major published inquiry in the world into the legalisation of euthanasia (3,4,5,6,7) has independently concluded that such law could never be made safe, including its reasons for this conclusion, this Bill contains no evidence of any awareness of that information.

In view of the evidence put forward in this submission, I think Members have only two rational and responsible courses of action - either to withdraw the Bill from discussion or to vote against it. To pass it into law, knowing that innocent lives will again be put at risk or actually taken, would be reprehensible and would deserve universal condemnation.

References.

1.Burdekin B. *Sydney Morning Herald*, 1993, p 13.

2, Kissane DW, Street A, Nitschke P. Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. *Lancet* 1998; **352**: 1097-1102.

3. Select Committee on Medical Ethics. House of Lords. January, 1994.

4. *When Death Is Sought - Assisted Suicide and Euthanasia in the Medical Context.* The New York State Task Force on Life and the Law. May, 1994.

5. *Of Life and Death*. Report of the Special Senate Committee on Euthanasia and Assisted Suicide. Senate of Canada. June 1995.

6. Report on the Need for Legislation on Voluntary Euthanasia. Community Development Committee, Parliament of Tasmania. June 1998.

7. Report of the Inquiry into the Voluntary Euthanasia Bill 1996. Social Development Committee, Parliament of South Australia, October 1999.

Brian Pollard MB BS DA FANZCA Grad Cert Bioethics (Hons)