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Secretary
Senate Standing Committee on Legal and Constitutional Affairs
Parliament House

By email

Dear Secretary

SUBMISSION TO SENATE STANDING COMMITTEE ON LEGAL AND CONSITUTIONAL AFFAIRS

Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008

Thankyou for the invitation to make a submission to this inquiry. I endorse the submission from the Gilbert and Tobin Centre for Public Law in relation to the legal effects of the Bill. I would also like to address some of the substantive arguments that are raised against the Northern Territory laws, namely that these laws constitute a major departure from existing legal principles, for eg an impermissible extension of doctors' right to kill. In summary, my submission is that medical practitioner already have established powers to accelerate the deaths of patients and that the Northern Territory laws are a measured response to the needs of a small group of terminally ill patients. To that extent the Northern Territory laws are not a major departure, but a cautious one, which should be sensibly and dispassionately trialed. It should be noted that in the following I have relied heavily on *the Australian Medico-legal Handbook* 2008 which I co-wrote with Assoc Profs Kerridge and Parker. I would to acknowledge their efforts in that text, but the following views are my own.

The operation of the *Rights of the Terminally Ill Act*

The mechanisms of the *Rights of the Terminally Ill Act* permit a medical practitioner to 'assist' a patient to terminate their life[1], where assistance was defined to include the prescription of lethal medication and the preparation of substances for self-administration. Additionally, 'assistance' also includes the administration of a substance to the patient, thereby legalising active voluntary euthanasia on the part of the doctor and immunising the doctor against a charge of murder or manslaughter.[2] The Act requires a number of steps to be taken before providing immunity from prosecution, including:

1. The patient must have reached the age of 18 years;
2. The patient must have been suffering from a terminal illness, where there was no available cure acceptable to the patient and where available treatment was confined to the relief of pain;
3. A medical practitioner and a psychiatrist must have certified the patient's condition and (in the case of the psychiatrist) certified that the patient was not suffering from clinical depression;
4. The patient's illness was causing severe pain and suffering;
5. The medical practitioner must have informed the patient of the patient's prognosis, and the nature of any medical treatment that would be available to the patient;
6. The patient must have indicated the desire to die after being informed of the options by the doctor;
7. The doctor must have been satisfied that the patient considered the effect of their decision on their family and the doctor must have been satisfied that the patient's decision was free and voluntary and made after due consideration.[3]

Does the Act go too far?

The express purpose of the Act is to provide an exception to the general laws against assisting a suicide and committing homicide and it does expressly provide for the active and intentional killing of patients. For some this represents quite a shocking exemption which

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[1] *Rights of the Terminally Ill Act 1995* (NT), s 5.
[2] *Rights of the Terminally Ill Act 1995* (NT), ss 3, 20.

[3] *Rights of the Terminally Ill Act 1995* (NT), s 7.

departs too far from established legal principles. However, when one compares the Act with the existing state and territory laws on the management of dying, the Act no longer appears as a massive leap forward.

The right to refuse treatment and make an advance directive

Currently Australian common law recognises the right of competent patients to refuse life-sustaining treatments. Lord Donaldson put this right thus:

> This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent...[4]

A patient has the right to refuse even minor or minimally invasive treatments, even when they will sustain life. A recent English case serves to illustrate:

> **Case example**
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> *B v an NHS Trust* [2002] EWHC 429 (Fam) - After several months of no improvement in her condition, a quadriplegic and ventilator-dependent patient B, requested that she be sedated and her ventilation be withdrawn, having created an advance directive to that effect. Part of the treatment team argued that B was depressed and hence incompetent, with the result that her wishes could be ignored and treatment continued. The judge rejected this argument, found B to be competent and completely free to request the withdrawal of treatment, and upheld her decision. Only nominal damages were ordered for the unauthorised treatment and B died following the treatment withdrawal.

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4 *Re T (An Adult) (Consent to Medical Treatment)* [1992] 2 Fam 458, 460 (Lord Donaldson MR). In the same case Butler-Sloss LJ stated: 'A decision to refuse medical treatment by a patient capable of making the decision does not have to be sensible, rational or well considered': at 474. Straughton LJ agreed: 'An adult whose mental capacity is unimpaired has the right to decide for herself whether she will or will not receive medical or surgical treatment, even in circumstances where she is likely or even certain to die in the absence of treatment': at 478. The principle is the same in the United States where it has been said that 'the law protects [the patient's] right to make [his or] her decision to accept or reject treatment, whether that decision is wise or unwise': *Lane v Candura* 376 NE 2d 1232, 1236 (Mass, 1978).

Similar cases can be found in Australia. For example:

> *Re PVM* [2000] QGAAT 1 – a 39 year old man with severe brain and spinal injuries, requested the removal of artificial ventilation, but there were concerns about his competence. The Queensland Guardianship and Administrative Tribunal (GAAT) found the man to be competent and to have the right to refuse treatment. Treatment was withdrawn.

This right to refuse treatment extends to making a decision about treatment in the future. 'Advance directives' or 'living wills' are decisions made by patients about what medical treatments they would like in the future, if at some point, they cannot make decisions for themselves. Advance directives ordinarily record decisions about refusing life-sustaining treatments, but they can also contain the patient's preferences and desires about a whole range of treatment matters.

In Australia, the right to make an advance directive is sourced in common law but it has also been legislated in most States and Territories. In all jurisdictions with legislative schemes (with the possible exceptions of Qld and SA) the common law has been preserved, so that it is still possible to make an advance directive at common law, as well as under the legislation. This is set out in the following table:

Regulation of advance directives in Australia

Jurisdiction	Common law recognition?	Legislative scheme?
ACT	Yes (*Medical Treatment (Health Directions) Act* 2006, s 6)	Yes - *Medical Treatment (Health Directions) Act* 2006
NSW	Yes	No but see NSW Health policy *Using Advance Care Directives* (2004)
NT	Yes (*Natural Death Act 1988* (NT), s 5)	Yes - *Natural Death Act 1988*
Qld	No – While the *Powers of Attorney Act 1998*, s 39 states that common law is preserved it appears that the *Guardianship & Administration Act 2000* may have unintentionally	Yes- *Powers of Attorney Act 1998*

	repealed the common law	
SA	No – the common law does not appear to have been preserved in the *Consent to Medical Treatment and Palliative Care Act 1995* (SA)	Yes - *Consent to Medical Treatment and Palliative Care Act 1995*
Tas	Yes	No
Vic	Yes (*Medical Treatment Act 1988* (Vic), s 4)	Yes - *Medical Treatment Act 1988*
WA	Yes	No but see *Acts Amendment (Consent to Medical Treatment) Bill 2006* which at time of writing was being considered by Parliament

All of these schemes have legalised the withholding and withdrawal of lie-sustaining treatments, oftentimes requiring medical professionals to sedate the patient during the withdrawal process. In that sense the process of managing the withdrawal of treatment is intentional (in the legal sense) and causative (in a scientific sense).

Is it assisting a suicide to help a patient refuse treatment?

While suicide and assisted suicide are not crimes, assisting a suicide attempt is a crime in all Australian jurisdictions. This raises the issue of criminal liability for health professionals who help a patient to refuse life-sustaining treatment. Outside of cases of self-harm, is it possible to distinguish between a patient refusing treatment and a patient attempting suicide?

Common law courts from other jurisdictions have drawn such a distinction. While it has proven difficult, this has been done primarily by arguing that a person who refuses treatment generally cannot be said to intend to die or desire death. Alternatively, a patient's decision to refuse treatment has been found not to cause the death of the patient, and instead it is accepted that the patient dies from the disease or injury which required treatment, and not from the failure to treat. It is very difficult to see how such findings correspond with existing legal principles.

Numerous protections are also afforded under legislation, particularly in relation to advance directives. The effect of these provisions is to protect health care professionals who respect

patients' decisions to refuse treatment, as long as they act in good faith and without negligence.

Protection of health professionals from liability

	Legislation	Protection of health professionals
ACT	*Medical Treatment (Health Directions) Act 2006*	Section 16 states: (1) This section applies to a health professional, or a person acting under the direction of a health professional, if— (a) the health professional makes a decision that the health professional believes, on reasonable grounds, complies with this Act; and (b) the health professional, or other person, honestly and in reliance on the decision, withholds or withdraws medical treatment from a person. (2) The withholding or withdrawing of treatment is not— (a) a breach of professional etiquette or ethics; or (b) a breach of a rule of professional conduct. (3) Civil or criminal liability is not incurred only because of the withholding or withdrawing of treatment
NT	*Natural Death Act 1988*	Under s 6 the non-application of medical treatment in compliance with a direction under the Act is not considered a cause of death.
Qld	*Powers of Attorney Act 1998*	Under s 101 any person acting in accordance with an advance health directive, or a decision of an attorney for a health matter, is not liable for an act or omission to any greater extent than if the act or omission happened with the patient's consent. Section 80 of the *Guardianship and Administration Act* repeats this protection.
SA	*Consent to Medical Treatment & Palliative Care Act 1995*	Section 16 health professionals incurs no civil or criminal liability for an act or omission done or made— (a) with the consent of the patient or the patient's representative or without consent but in accordance with an authority conferred by this Act or any other Act; and (b) in good faith and without negligence; and (c) in accordance with proper professional standards of medical practice; and (d)in order to preserve or improve the quality of life. Under 17(2) medical practitioners caring for patients in the terminal phase of a terminal illness, are said to have no duty to use, or to continue to use, life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery, or in a persistent vegetative state. In 17(3)(b) it is said that the non-application or discontinuance of life sustaining measures in accordance with subsection (2) does not constitute an intervening cause of death.
Vic	*Medical Treatment Act 1988*	Under s 9 health professionals who, in good faith and in reliance on a refusal of treatment certificate, refuse to perform or continue medical

		treatment in accordance with this Act are not: (a) guilty of misconduct or infamous misconduct in a professional respect; or (b) guilty of an offence; or (c) liable in any civil proceedings, because of the failure to perform or continue treatment. It is also said that a person who acts in good faith in reliance on a refusal of treatment certificate but who is not aware that the certificate has been cancelled, is to be treated as having acted in good faith in reliance on a refusal of treatment certificate

Withholding and withdrawing of life-sustaining treatments from incompetent patients

Australian law also permits the withdrawal and withholding of life-sustaining treatments from incompetent patients, again even in circumstances where it may be necessary to actively withdraw treatment (by medicating, or removing therapeutic devices). Both the courts and guardianship tribunals have made decisions to withdraw treatment, including artificial feeding and hydration.

Case examples

In *Messiha (by his tutor) v South East Health* [2004] NSWSC 1061, the family of a patient sought a court order for the continuation of life-sustaining treatments. The patient had had a cardiac arrest and suffered severe brain damage as a result. He had a history of heart disease and severe lung disease. There was unanimous medical opinion that the best interests of the patient would be served by the managed withdrawal of treatment. However, the patient's family disputed this and believed that treatment was not futile if it continued to support the patient's life.

Howie J decided that the managed withdrawal of treatment was in the patient's best interests. He was swayed by the unanimous medical opinion as to the patient's prognosis, and believed that the treatment was burdensome and futile.

WK v Public Guardian (No 2) [2006] NSWADT 121 – this concerned Mr X who was a 73 year old man with end stage kidney disease, advanced heart disease, dementia and bowel cancer. Mr X was receiving haemodialysis. A decision was made by his

treating physician, Mr X's sister in law and other relatives and friends, to stop the dialysis. However, a friend of Mr X's, WK, objected to the decision to withdraw treatment and the decision was referred to the NSW Guardianship Tribunal. The Tribunal appointed the Public Guardian as Mr X's guardian. The Public Guardian, amongst other things, consented to the withdrawal of treatment, a not-for-resuscitation order and palliative care.

WK appealed the decision of the Public Guardian to the NSW Administrative Decision Tribunal (NSWADT). The Deputy President of NSWADT issued a stay on the decision to withdraw treatment, and ordered that further evidence be presented: *WK v Public Guardian* [2006] NSWADT 93. On the return of the application the NSWADT decided that the decision to withdraw dialysis and to refuse 'aggressive' treatment was beyond the power of the Public Guardian.

This was primarily because Part V of the *Guardianship Act*, which gives powers over treatment to the Guardianship Tribunal, appointed guardians, enduring guardians and persons responsible, was limited to giving consents to treatment which promoted and maintained health and wellbeing. On the Deputy President's reading of the Act a decision to withdrawal treatment did not promote health and wellbeing. As such, all substitute decision-makers who draw power from the NSW *Guardianship Act*, have no power to consent to the withdrawal of life-sustaining treatments.

It should be said that the authority of *WK (No 2)* is questionable. In *Re AG* [2007] NSWGT 1 (5 February 2007), the Guardianship Tribunal reviewed the findings in the *WK* matter, and gave a decision which substantially diverts from the findings of the NSWADT. The patient was a 56 year old woman with mild intellectual disability, who was born in Malta but raised in Australia. Both her parents were dead and she lived alone in her own home, receiving support services on a daily basis from a specialist care provider. AG had been diagnosed with a renal tumour with lymphadenopathy in the abdomen and pelvis. There was also the possibility that she had secondary brain tumours and her prognosis was consequently very poor. Miss AG had a history of refusing medical treatment, including fear of needles. She also

refused to acknowledge the existence of the kidney tumour, although she had accepted that she had cancer.

The Public Guardian had previously been appointed to manage AG's care but was now faced with a decision concerning a palliative care plan which included decisions to forego CPR and dialysis. The Public Guardian approached the Guardianship Tribunal for directions on the care plan, given that the *WK (No 2)* decision seemed to conclude that it was not possible for the Public Guardian to consent to such a plan.

The Tribunal decided that, generally, consent could be given or refused for medical treatment, which included palliative care. Palliative care, in turn, could include treatment limitations, such as the non-provision of treatment, on the proviso that the palliative care promoted and maintain health and wellbeing, as required by the Act. The Tribunal stated at thw eigh of authority supported the notion that treatment limitation can promote and maintain a person's health and wellbeing, if it prevents futile treatment and if it allows the person to die with comfort and dignity.

The Tribunal also found that guardians with health care functions could be given the power to be involved in advance care planning. The Tribunal also recognised that advance care planning could also be engaged in without the necessity of appointing a guardian with a health care function.

Bringing these findings back to AG's situation, the Tribunal felt that it was necessary for a specific order to be made to give the Public Guardian the power to consent to the proposed palliative care plan, and that could only be done after further the medical investigations mentioned above were completed.

Re RWG [2000] QGAAT 2 - the wife of a 73yo male with an acquired brain injury made an application for a no-CPR order and for the power to refuse antibiotics. The Qld Guardianship and Administrative Tribunal (QGAAT) agreed to the no-CPR order but would not consent to the refusal of antibiotics given the patient was not

suffering from an infection at the time of hearing and, as such, it would be premature to examine the issue.

Re MC [2003] QGAAT 13 – permission was sought to withdraw artificial feeding from an 80 year old woman in persistent vegetative state. The QGAAT found that the treatment was of no benefit to her and should be ceased.

Re HG [2006] QGAAT 26 – 58 year old man with Wernicke's encephalopathy and Korsakoff's psychosis had a brain stem stroke which left him in a 'locked-in state'. The QGAAT was asked to determine whether artificial feeding and hydration (ANH) should be continued. The QGAAT found that on the basis of medical evidence it would be inconsistent with good medical practice to continue ANH and it ordered that such treatments cease. A finding about good medical practice did not require the practice to have the unanimous support of all medical experts.

Re BWV [2003] VSC 173 – the Supreme Court of Victoria ordered a guardian to be appointed to refuse artificial feeding for a 68 yo woman with advanced Pick's disease. The Supreme Court found that artificial feeding was medical treatment and not the reasonable provision of food and water, under the Victorian legislation. Given the feeding was medical treatment, it could be refused under the *Medical Treatment Act 1988* (Vic).

RCS [2004] VCAT 1880 – the wife and brother of a patient with severe brain damage were appointed as limited guardians for the purpose of refusing medical treatment, namely antibiotics.

Korp [2005] VCAT 779: the patient had suffered a severe anoxic brain injury after an attempt was made on her life and she had fallen into a persistent vegetative state. An application was made to appoint the Public Guardian to make decisions regarding her medical treatment, including amongst other things, a decision about whether to issue a refusal of treatment certificate refusing ANH. It was argued by her husband (who at the time had been charged with her attempted murder) that the patient was a

devout Catholic who would not have refused ANH. Morris J decided that the appointment of the Public Guardian was in her best interests. The fact the patient was Catholic, did not necessarily mean that she would have wanted ANH to be continued. It was said that the hypothetical question posed by section 5B(2)(b) of the *Medical Treatment Act* is not one 'that is automatically answered in a particular way because a person holds a particular religious faith': at [36].

Why is it *not* homicide to withdraw life-sustaining treatment from a patient?

Under common law there is no criminal culpability for an omission, a failure to act. The only situation where a person becomes criminally responsible in homicide for failing to act is when that person was under a duty to act to prevent death. For example, a person who is a stranger to a child, might well watch the child drown to death and not be criminally responsible. Contrastingly, a parent of the child would be convicted of murder for not attempting a rescue.

This concept of omissions is central to end-of-life decision-making. If life sustaining treatments are not in a patient's best interests, there is no duty on the part of health professionals to provide them. Consequently, if the patient dies because life-sustaining treatments have been withheld or withdrawn there will be no criminal liability because there was no duty to provide those treatments. The failure to treat is not seen as a cause of death, rather the death is seen as a result of the person's injury or disease.

Controversially, the notion of 'omission' includes consequential actions by medical professionals necessarily undertaken in the process of withdrawing treatment, such as the turning off of mechanical ventilation, the removal of tubes during extubation, and the sedation of patients prior to extubation. This is essentially a legal fiction as if an interloper performed the same tasks on an incompetent patient the law would regard the tasks as actions and the interloper would be guilty of murder.

Apart from common law, these principles of protection from liability are also recognised in legislation in some jurisdictions (see above).

Is it permissible to accelerate the dying process?

As stated in above the protection given to health professionals who withhold or withdraw treatment in a patient's best interest is dependant upon the classification of their decision as an omission. In contrast, positive acts committed knowingly by health professionals which lead to death are considered to cause death, and hence bring about criminal responsibility in homicide.

An exception has been recognised for the use of pain-killing and sedation medications. This is often referred to as the *principle of double effect*, based on the Catholic ethical principle of the same name. The common law has recognised in a number of cases that health professionals are allowed to incidentally accelerate death when treating patients for pain and suffering and the acceleration of death is proven to be an 'unintended' outcome of palliative care. While the principle has been accepted by superior courts in many common law countries, it remains difficult to reconcile it with the criminal law concepts of intention. Nevertheless, it remains an accepted principle and has even been enshrined in legislation in SA, Qld and partially recognised in the ACT.

Protection of health professionals for pain relief which accelerates death

	Legislation	**Protection of health professionals**
ACT	*Medical Treatment (Health Directions) Act 2006*	Section 17 states: (1) This section applies in relation to a person who— (a) has given a health direction that medical treatment be withheld or withdrawn from the person; and (b) is under the care of a health professional. (2) The person has a right to receive relief from pain and suffering to the maximum extent that is reasonable in the circumstances. (3) In providing relief from pain and suffering to the person, the health professional must give adequate consideration to the person's account of the person's level of pain and suffering.
SA	*Consent to Medical Treatment & Palliative Care Act 1995*	Section17 states that (1) A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability by administering medical treatment with the intention of relieving pain or distress— (a) with the consent of the patient or the patient's representative; and (b) in good faith and without negligence; and

		(c) in accordance with proper professional standards of palliative care, even though an incidental effect of the treatment is to hasten the death of the patient. Subsection (3) states that For the purposes of the law of the State— (a) the administration of medical treatment for the relief of pain or distress in accordance with subsection (1) does not constitute an intervening cause of death…
Qld	*Criminal Code Act 1999*	Section 282A states: (1) A person is not criminally responsible for providing palliative care to another person if— (a) the person provides the palliative care in good faith and with reasonable care and skill; and (b) the provision of the palliative care is reasonable, having regard to the other person's state at the time and all the circumstances of the case; and (c) the person is a doctor or, if the person is not a doctor, the palliative care is ordered by a doctor who confirms the order in writing. (2) Subsection (1) applies even if an incidental effect of providing the palliative care is to hasten the other person's death. (3) However, nothing in this section authorises, justifies or excuses— (a) an act done or omission made with intent to kill another person; or (b) aiding another person to kill himself or herself. (4) To remove any doubt, it is declared that the provision of the palliative care is reasonable only if it is reasonable in the context of good medical practice. (5) In this section— ***good medical practice*** means good medical practice for the medical profession in Australia having regard to— (a) the recognised medical standards, practices and procedures of the medical profession in Australia; and (b) the recognised ethical standards of the medical profession in Australia. ***palliative care*** means care, whether by doing an act or making an omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering.

The central aspect of the exception is the use of medications that can be used to reduce pain, either directly or indirectly. The use of drugs which do not reduce pain, or aid other treatments in reducing pain, will not gain the protection of the exception.

Case example

In *R v Cox* (1992) 12 BMLR 38, Dr Nigel Cox injected his patient with a lethal dose of potassium chloride which was designed to cause the death of the patient. Potassium chloride has no analgesic effects. Cox had known the patient for thirteen years and he had

promised her that she would not suffer. The pain killing medication that he prescribed was ineffective and she begged him to kill her. He gave her the injection and she died within minutes.

Cox was tried and convicted of attempted murder. The charge of murder was not available as the body had been cremated before an autopsy could be performed and hence there was no evidence that the injection had killed the patient.

Ognall J in his summing-up to the jury repeated the findings of Devlin J and Farqharson J that,

> There can be no doubt that the use of drugs to reduce pain and suffering will often be fully justified notwithstanding that it will, in fact, hasten the moment of death. What can never be lawful is the use of drugs with the primary purpose of hastening the moment of death.

Conclusions

The law already recognizes the intentional and active killing of patients by health professionals, as long as certain processes are adhered to, primarily the safeguarding of the interests of the patient. By providing a different process for dying the *Rights of the Terminally Ill Act* does not depart in a massive way from existing laws but rather it provides a safeguarded process for the management of death in the terminally ill. It is likely that few patients will wish to access the Act but it was created through a democratic process and has significant safeguards. At the very least the Act should be trialed for a period of time to properly assess its effects, as has occurred in other common law jurisdictions like Oregon. It may prove necessary to amend the Act after such a trial but at the very least it is not an argument against the Act to state that the law does not allow health professionals to manage and even accelerate their patients' deaths in certain circumstances.

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