Submission to:

The Select Committee on Euthanasia
of the Northern Territory Legislative Assembly

26th April, 1995

Preamble

The foundational premises of this submission are: (i) that all persons are of equal worth or dignity; (ii) that every person has a right to life, understood as a right not to be unjustly killed; (iii) that there is no such thing as a person who has a life not worth living (or that they would be better off dead); (iv) that there is no requirement according to medical ethics, law, or Christian tradition, that the maximal prolongation of life be the principal goal of all medical treatment; (v) *prima facie* a man or woman of full age and sound understanding may choose to reject medical advice and medical or surgical treatment either partially or in its entirety, even if a refusal may risk permanent injury or even lead to premature death; and (vi) that no person or section of the community ought ever be absolved from the legal responsibilities for their actions.

I Introduction

1.1 The *Rights of the Terminally Ill Bill 1995* ("the Bill") provides for the intentional killing of persons who are considered, according to "reasonable medical judgment"(clause 3), to have a terminal illness and for such acts not to be murder under the Criminal Code of the Territory. It also provides that those who participate in the process of killing the terminally ill will be protected from the law in relation to homicide which pertains to all other persons in the Territory.

1.2 (i) In the course of his second reading speech to the Northern Territory Legislative Assembly, Mr Perron claimed that the Bill was unexceptional. In his words:

> Some may view the passage of this bill as revolutionary social change. It is no such thing. Enactment will confirm that we are a mature society acknowledging the rights of mature individuals. As legislators, we have the opportunity to face up to the dilemma which has baffled politicians in many other jurisdictions for years.[1]

Respectfully, we disagree with Mr Perron's claims. We note below others who would also condemn any attempt to legalise the intentional termination of life.

(ii) Since the controversial United States cases of *re Quinlan*, *Re Conroy*, and *Cruzan v Missouri Department of Health*[2], the most significant case of a superior appellate court which has attempted to grapple with the rights of patients and the rights of the state to care for persons who are dependent, to a significant degree, on medical technology to live, is the recent House of Lords decision of *Airedale NHS Trust v Bland*[3], which concerned a young man who suffered severe injuries following the collapse of a large stand at a soccer game. His injuries left him in a persistent vegetative state. In the course of giving judgment in this case, certain Law Lords outlined the common law in relation to homicide, conveniently in the context of medical treatment:

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[1] Second Reading Speech, *Debates*, 22nd February, 1995, p.44. Unless otherwise required, references to the Second Reading Speech will be in the body of the text thus, "Debates" followed by the page number.

[2] *Re Quinlan* 70 NJ 10 (1976), 355 A 2nd 647 (1976), 429 U.S. 922 (1976); *In the Matter of Claire Conroy* 486 A 2nd 1209 (1985); *Cruzan v Director, Missouri Department of Health* 760 S.W. 2nd 408 (1988), 497 U.S. 261 (1990).

[3] *Airedale NHS Trust v Bland* [1993] A.C. 789 ("Bland's Case").

> (*Lord Goff*) It is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be.... So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia - actively causing his death to avoid or to end his suffering.
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> (*Lord Mustill*) The fact that the doctor's motives are kindly will for some, although not for all, transform the moral quality of his act, but this makes no difference in law. It is intent to kill or cause grievous bodily harm which constitutes the mens rea of murder, and the reason why the intent was formed makes no difference at all....
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> So far as I am aware no satisfactory reason has ever been advanced for suggesting that it makes the least difference in law...if the patient consents to or indeed urges the ending of his life by active means. The reason must be that, as in other cases of consent to being killed, the interest of the state in preserving life overrides the otherwise all-powerful interest of patient autonomy.[4]

1.3 In the course of this critical case, Lord Browne-Wilkinson said it was imperative that the `moral, social and legal issues raised by this case be considered by Parliament.' That has happened, including a detailed study of the law and practice of euthanasia in the Netherlands, the only country where euthanasia is practised with no effective legal deterrent. The House of Lords *Report of the Select Committee on Medical Ethics* concluded, *inter alia*:

> [para.278] we recommend that there should be no change in the law to permit euthanasia,
> [281] we strongly recommend the development and growth of palliative care services in hospices, in hospitals and in the community,
> [287] rejection of euthanasia as an option for the individual entails a compelling social responsibility to care adequately for those who are elderly, dying or disabled,
> [289] research into pain relief and symptom control should be adequately supported,
> [291] long-term care of dependent people should have special regard to maintenance of individual dignity,
> [293] we do not recommend the creation of a new offence of "mercy killing."[5]

1.4 In his speech, Mr Perron avers that opposition to his Bill "based on religious belief" is not legitimate because those beliefs `should not be forced on others' (*Debates*, p.41). One might ask, not unreasonably, why the Judeo-Christian and western humanist respect for, and insistence upon, the inherent dignity of every person should be replaced by Mr Perron's

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[4] *Airedale NHS Trust v Bland* [1993] A.C.789 at p.865 and pp.892-93 respectively. Other aspects of this difficult case are contentious; see, *e.g.*, Dr. J. Keown, "Courting Euthanasia?: Tony Bland and the Law Lords," *Ethics & Medicine* 9 (1993) 34-37; Professor J. Finnis, "*Bland*: Crossing the Rubicon?" *Law Quarterly Review* 109 (1993) 329-37; Dr. Anthony Fisher, OP, "On Not Starving the Unconscious," *New Blackfriars* 74 (1993) 130-45.

[5] House of Lords, *Report of the Select Committee on Medical Ethics*, Volume I - Report (London: HMSO, 1994), "Summary of Conclusions" p.58. We refer to this Report in this submission by reference to "Report (HL)."

utilitarian and libertarian philosophy which places the sovereignty and autonomy of the individual at the pinnacle of society.[6] Such principles run directly counter to all significant international instruments on human rights, which extol the equality and inalienable dignity inherent in all members of the human family.[7] Commentators from diverse philosophical traditions confirm that human dignity is a normative concept in international law.[8] Significantly, the *European Convention on Human Rights* 1950, to which reference was made in *Bland's Case*, together with the *International Covenant on Civil and Political Rights* 1966, specifically enjoins that "everyone's right to life shall be protected by law" (Art.2).[9]

1.5 It is well recognised that, as a matter of law, the sanctity of human life is not an unqualified principle. For example,

> ...liberal political cultures have, in varying degrees, recognised three principal scenarios as valid for the taking of human life, namely, self-defence, capital punishment and just war. Implicit in each of these scenarios is what could be called a `defence paradigm', in that there must first exist some attack or credible threat to some individual persons, a community, or the society as a whole for the taking of human life to be warranted....
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> In any of these situations...a substantial burden of justification, of giving valid reasons for actions, before diverse audiences, is required of the person or institutions that take life.[10]

The only threat posed by a person with a terminal illness is that he or she threatens the convenience, sensibilities and resources of that person's family, community or state. Such a threat hardly comes within the `defence paradigm' mentioned. Certainly, Mr Perron has made no case which could do so.

1.6 (i) The present Foreign Minister, Senator Evans, describes the following critical point as a "moral imperative":

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[6] Some commentators describe a strict libertarian/utilitarian perspective as "the cult of self-determination." J.K. Mason & R.A. McCall Smith, *Law and Medical Ethics* (4th Edition) (London: Butterworths, 1994) 326.

[7] The following international instruments all refer to "the dignity and equality inherent in all human beings": *Convention Relating to the Status of Refugees (1951); The International Covenant on Economic, Social, and Cultural Rights (1966); The International Convention on the Elimination of All Forms of Racial Discrimination (1966); The International Covenant on Civil and Political Rights (1967); The Convention on the Elimination of All Forms of Discrimination Against Women (1979); The Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief (1981); The Convention on the Rights of the Child (1989).*

[8] *E.g.* O. Schachter, ""Editorial Comment" Human Dignity as a Normative Concept,"*American Journal of International Law* 77 (1983) 848-54; C. Anderson, "Moral Norms and Social Consensus: Toward the Anthropological Foundations of Human Rights,"*Persona, Verità e Morale: Atti del Congresso Internazionale di Teologia Morale* (Roma, 7-12 Aprile, 1986) (Roma: Città Nuova Editrice, 1987) 373-77; C.S. Nino, *The Ethics of Human Rights*, (Oxford: Clarendon Press, 1993) 129-85.

[9] Lord Goff referred to the foundational principle of law in *Bland's Case* as the sanctity of human life, described as "a principle long recognised not only in our own society but also in most, if not all, civilised societies throughout the modern world"; his Lordship then quoted from the Conventions mentioned in support of this foundational principle. [1993] A.C. at pp.863-64.

[10] C.S. Campbell, "`Aid-in-dying' and the taking of human life,"*Journal of Medical Ethics* 18 (Sept.1992) 128-34 at p.130.

> Australia considers the universal enjoyment of human rights to be a matter of fundamental importance. Our human rights policies necessarily reflect the democratic nature of Australian society and the importance we attach to the worth and dignity of all human beings.[11]

Without a common, foundational agreement and understanding of the "worth and dignity of all human persons" we run the risk that

> Each of us autonomously decides when our life would be so lacking in personal dignity as to be no longer worth preserving, and we pretend that such a process masks no substantive vision of what personhood means.[12]

(ii) The approach of death mocks our mortality. We refuse to concede that there is something over which we have no control. In refusing to concede control, humanity asserts more technological authority over life's frailties and mysteries (none more disturbing than suffering and death) and/or denies that death is a reality which must be faced and that it requires more than technological wizardry and legislative sleight of hand to cope with it. Modern liberal societies view life as "the presence or absence of certain capacities....We tend to think and speak not of being a person but of having personhood, which becomes a quality added to being."[13] When suffering is added to one's life, according to the regime proposed by the Bill in question, life is unendurable and ought be ended quickly.[14] It would not, under such a regime, be such a large step then to insist that such persons are better off dead and that they have a duty to die.

1.5 As a contribution to the discussion of the Bill in the Northern Territory, this submission continues as follows: (i) an outline of a foundational anthropology (understood as a discussion of the dignity of the human person), appropriate for enactments which purport to define the care of persons in the terminal stages of illness, is provided; (ii) brief comments are provided in relation to suffering and the role of care which is fitting to the dignity of all persons; (iii) a brief appraisal of critical clauses of the Bill follows; (iv) the submission concludes with comments on philosophies of life and death in the light of some historical perspectives.

II The Dignity of the Human Person

2.1 In this section, there are two principal considerations: (i) the inherent and inalienable dignity of every person at every stage of his or her life; (ii) freedom and responsibility.

2.2 At the outset of his speech, Mr Perron rightly notes that the Bill "is a human rights issue." Later in the same address (*Debates*, pp.44-46), he quotes sections from John Stuart Mill's essay, "On Liberty", in support of his assertion that "public policies should be based on respect for personal autonomy." (*Debates*, p.42) In contrast, the *Universal Declaration of Human Rights* 1948, provides that the foundations of international law are human dignity and

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[11] *Human Rights Manual* (Canberra: Department of Foreign Affairs & Trade, 1993), Frontispiece.

[12] G. Meilander, "Terra es animata: `On Having a Life'," *Hastings Center Report* 23 (July-August, 1993) 25-32 at pp.29 & 30.

[13] *ibid.*

[14] See, *e.g. Debates*, p.42.

equality, not autonomy, and that "human rights should be protected by the rule of law." The preamble to the *Declaration* provides:

> ...recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world...[15]

2.3 (i) As noted earlier and confirmed by the text quoted, the foundational principle of international law is the inherent dignity of the human person. That is to say, every person has an unconditional dignity; to this principle there is no exception. International instruments confirm that the inherent dignity of all persons is inalienable. By this we understand the international community to say that human beings cannot be divested, or divest themselves, of their inherent dignity for any reason. For example, age or disability (due to infirmity or otherwise) do not detract from a person's dignity. In fact, a principal object of law, international or domestic, is to protect the most vulnerable - of whatever age - in the community. One's vulnerability ought not expose them to a greater risk of unjust killing than any other member of society. If the precept of universal protection is not foundational to the legal system and society generally, certain categories of persons, such as the terminally ill, immediately are relegated to a conditional dignity not worthy of the utmost protection of the law.

(ii) According to supporters of the Bill, to suffer, or not to have certain attributes or capacities, renders a person only of conditional worth and, accordingly, the best that society can offer is to kill such persons. No doubt with some hyperbole, Mr Perron questions whether someone who (allegedly) stands by and watches someone die a painful death "could watch an animal suffer an agonising death without intervening?" (*Debates* p.42) The comparison is instructive: is it appropriate to compare the suffering of a person with the suffering of an animal? According to international law alone, such a comparison is hardly compatible with the inherent dignity of the human person. As Luke Gormally notes, it is the capacity of persons to exercise the abilities for understanding, choice and rational communication which distinguish them from, and make them superior to, animals.[16] It oversimplifies the issues to suggest that the only options for a person with a terminal illness are either to suffer or to be killed. Rather, the critical question is not whether one ought to intervene in the life of someone suffering with a terminal condition but how one might, or ought, do so?

2.4 The Judeo-Christian tradition holds as true that the dignity and nobility of all persons is understood in terms of every member of the human family having an eternal dignity - based on man and woman being created in the image and likeness of God - and an eternal destiny - that everyone is called to participate in the divine life of God now and always. These claims are foundational to the Church's insistence on the intrinsic dignity of every person from the moment of conception until natural death. This basic principle, which accords, as we have seen, with international law, is the only logical, consistent and sure measure against which laws, especially of the kind proposed by the current Bill, can be measured. The very ambiguity of the concept of rights in its multitude of sources and diverse meanings makes it

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[15] The text of the Declaration is from *Basic Documents on Human Rights* (Third Edition) (ed. I. Brownlie) (Oxford: Clarendon Press, 1992) 21.

[16] L. Gormally, "Against Voluntary Euthanasia," in *Principles of Health Care Ethics*, (ed. R. Gillon) (Chichester: John Wiley & Sons Ltd., 1994) 762-74 at pp.765-66.

difficult, without a consistent principle of human dignity for all, to render the concept of human rights intelligible.

2.5 In 1972, the prominent ethicist, Joseph Fletcher, published his "Indicators of Humanhood: A Tentative Profile of Man."[17] In this article, Fletcher presented a systematic outline of the view which distinguishes between the class of human beings and the narrower class of persons. Such a view, which fits all too easily with that espoused by supporters of the Bill, holds that having a life and being a person are not one and the same thing. As Fletcher himself puts it, "to the degree that a person lacks control [over his life] he is not responsible, and to be irresponsible is to be subpersonal."[18] Professor Meilander comments:

> ...personhood [was] defined in terms of the right autonomously to determine one's future [which has given] way to personhood defined in terms of the present possession of certain capacities.[19]

To the degree that such a discriminatory view of the human person, espoused today by, *inter alia*, Peter Singer and Helga Kuhse, is part of the rationale behind the Bill, it should be rejected. The remarks of M. Siegler and A. Wiesbard are salutary:

> We have witnessed too much history to disregard how easily a society may disvalue the lives of the "unproductive." The "angel of mercy" can become the fanatic, bringing the "comfort" of death to some who do not clearly want it, then to others who "would be better off dead," and finally, to classes of "undesirable persons", which might include the terminally ill, the permanently unconscious, the severely senile, the pleasantly senile, the retarded, the incurably or chronically ill, and perhaps, the aged.... In the current environment, it may well prove convenient - and all too easy - to move from recognition of an individual's "right to die" (to use an unfortunate phrasing in the first instance) to a climate enforcing a "duty to die."[20]

2.6 (i) In case Mr Perron and supporters of the Bill would adopt the view that nothing so macabre as just described could happen in the Northern Territory, they should be reminded of two things. First, many in the United States considered that such medical practices could never happen in that country, especially in the wake of the Nuremburg Trials in 1946-49 and the more recent Eichmann trial in Jerusalem in 1961. However, by 1987, Mr. Justice Andersen of the Washington Supreme Court summarised the medico-legal position in the United States as follows:

> As recently as five years ago, or perhaps three, the idea that fluids and nutriment might be withdrawn, with moral and perhaps legal impunity, from dying patients, was a notion that would have been repudiated, if not condemned, by most health professionals. They would have regarded such an idea as morally and psychologically objectionable, legally problematic, and medically wrong. The notion would have gone "against the stream" of medical standards of care. [However,]...this practice is receiving increased

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[17] Fletcher refined his position further in his "Four Indicators of Humanhood: The Inquiry Matures," *Hastings Center Report* 4 (June, 1974) 4-7.

[18] Quoted in G. Meilander, "Terra es animata...," *op. cit.* 27.

[19] *ibid.* 30.

[20] "Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?" *Archives of Internal Medicine* 145 (1985) pp.129, 130-31.

> support from both physicians and bioethicists. This new stream of emerging opinion is typically couched in the language of caution and compassion. But the underlying analysis, once laid bare, suggests what is truly at stake: that for an increasing number of patients, the benefits of continued life are perceived as insufficient to justify the burden and cost of care; that death is the desired outcome, and - critically - that the role of the physician is to participate in bringing this about.[21]

Professor Destro comments:

> ...The difficulty lies not in allowing nature to take its course whenever continuation of treatment would be medically contra- indicated, counter-productive, or otherwise inhumane, but in the assumption that policy makers of any sort are competent to judge the quality of another person's life.[22]

(ii) The second caution for supporters of the Bill concerns the situation in the Netherlands. It will suffice to quote from the House of Lords Report at some length. After reviewing the incidence of euthanasia in that country[23], and arguments from autonomy which focused upon, *inter alia*, the claim that for those persons without religious belief, the individual is best able to decide what manner of death is fitting to the life which has been lived, the opinion of the House of Lords Committee was:

> Ultimately, however, we do not believe that these arguments are sufficient reason to weaken society's prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. Moreover dying is not only a personal affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.

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[21] *In re Guardianship of Grant*, 109 Wash.2nd 545, 747 P.2nd 445, 459 (1987).

[22] R.A. Destro, "Guaranteeing the "Quality" of Life through Law: The Emerging Right to a "Good" Life," in *Guaranteeing the Good Life: Medicine & the Return of Eugenics*, (Grand Rapids, MI: William B. Eerdmans Publishing Co., 1990) 229-66 at pp.244-45.

[23] Survey results show that of all deaths in the Netherlands, 1.8 per cent (2300 cases annually) were the result of voluntary euthanasia; there were a further 400 cases (0.3 per cent of all deaths) of assisted suicide; in 0.8 per cent of all deaths (1000 cases annually) a patient's life was terminated without the explicit request of the patient. In 41 per cent of those cases the patient was not competent to discuss the proposed course of action: quoted in the Report (HL) paras. 121 & 122, p.28. In addition to the evidence presented to the House of Lords Committee, the detailed studies of Dr. John Keown are alarming: see his "The Law and Practice of Euthanasia in the Netherlands," *Law Quarterly Review* 108 (1992) 51-78; "Some Reflections on Euthanasia in the Netherlands," and "Further Reflections on Euthanasia in the Netherlands in the Light of the Remmelink Report and the van der Maas Survey," both in *Euthanasia, Clinical Practice and the Law*, (ed. L. Gormally) (London: The Linacre Centre for Health Care Ethics, 1994) 193-218 & 219-40 respectively.

> One reason for the conclusion is that *we do not think it possible to set secure limits on voluntary euthanasia*. ...as we said in our introduction, issues of life and death do not lend themselves to clear definition, and without that it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. *It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused*. Moreover to create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence, or by the human tendency to test the limits of any regulation.[24] (emphasis added)

Mr Perron claims that the Bill is sufficiently precise that only the patient is "in total control of the process." (*Debates* p.38) After a comprehensive inquiry, the House of Lords Committee found that such precision and such control is not available in this life. The Chief Minister continues, without citing any authority, with the following proposition: "some have argued that the proposed measure will open the door to the widespread use of euthanasia without patient consent. This is surely an absurd argument, one that is strong on rhetoric and short on reason." But the evidence on this point marshalled by the House of Lords Committee is compelling in its factual findings and logic.[25] Rather it is Mr Perron's claims which are "strong on rhetoric and short on reason." Further, Professor Norelle Lickiss, Director of Palliative Care, Royal Prince Alfred Hospital in Sydney comments in relation to the findings of the House of Lords Committee:

> All is not at all well in the Netherlands, and the situation is very familiar to those living on its borders and across the channel; the fact that the House of Lords report...and the statement of the European Association of Palliative Care unequivocally decline to endorse the Dutch situation should give reason for much hesitation in Australia. Australia is a country of creativity as well as compassion and we can surely improve the care of our people without resort to euthanasia a violent solution which impoverishes the human (and medical) community. We have not, as a nation, become so impoverished, nor as a profession have we gone so far astray.[26]

2.7 In case some may think that only the House of Lords Committee, and experts in palliative care, such as Professor Lickiss, consider that it is all too likely that human life would be threatened if there were to be any change in laws which prevent the intentional taking of life, from the other side of the Atlantic, the New York State Task Force on Life and Law has commented as follows:

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[24] Report (HL) paras. 237 & 238, pp.48 & 49. Two observations here are noteworthy. The Justice Minister for the Netherlands has announced recently that she saw no reason now why involuntary euthanasia should not be legalised and that euthanasia should be permitted even for persons*not* in the terminal phase of an illness. See*The Weekend Australian* 18-19 February, 1995, p.21. Secondly, it has been widely reported recently that a number of doctors in Melbourne have admitted killing or assisting to die some patients in breach of the criminal law of Victoria. See*e.g. The Australian* 27 March, 1995, p.5. If the current law is being breached with impunity, what guarantee can there be that a more relaxed law in relation to homicide will not be abused?

[25] We comment later in this submission on patient consent.

[26] Australian Medical Association, National Forum,*Ethics and Law - The Dying Patient*, 11th August, 1994; text of Professor Lickiss' address, p.5.

> Some Task Force members do not believe that assisted suicide is inherently unethical or incompatible with medical practice. On the contrary, they believe that providing a quick, less prolonged death for some patients can respect the autonomy of patients and demonstrate care and commitment on the part of physicians or other health care professionals. *Nonetheless, these members have concluded that legalizing assisted suicide would be unwise and dangerous public policy.*[27] (emphasis added)

III Suffering, Dignified Care & Patient Autonomy

3.1 The director of medical oncology and palliative care at Heidelberg Repatriation Hospital, Dr. John Zalcberg, has stated in writing that, "...the Northern Territory, one of the few places in the world to consider legalising euthanasia, has no medical oncologist, very limited radiotherapy services, not a single palliative-care specialist, an inadequately resourced domiciliary palliative-care program and no hospice."[28] In the light of such lack of services, Mr Perron's address is even more remarkable, replete as it is with references to the quality of life of persons with a terminal illness being reduced by suffering, and that the logical and mature response is to legislate to provide a quick exit *via* `death with dignity' and to absolve from responsibility those who facilitate it. He continues, "I have found nothing in the religious arguments, which demands the imposition of a belief on others, to alter my resolve to work towards ensuring that patients' wishes are sacrosanct. Neither the doctor, the family, nor the church should be allowed to override the patient in regard to the right to die." (*Debates*, p.42)[29] The only solution offered by the Bill is the "final solution" - death. However, it might be asked, not unreasonably, whether the patient's wish to die might be altered if adequate palliative and other care was available?

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[27] *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, New York State Task Force on Life and the Law, (May, 1994) p.xiii. By way of further comment, Professor Robert Destro notes the following rapid changes in the United States in the law and health care:

> Since *Roe v. Wade* (1973) and *In re Karen Quinlan* (1976) , the courts have approved the non-treatment and resulting starvation death of a handicapped newborn...the withholding of medically indicated treatment from a handicapped infant...the denial of medically indicated surgery to a twelve-year-old boy with Down's syndrome...and the starvation and dehydration deaths of numerous incompetent adults described as "vegetative." ...Two recent cases have gone even farther: one reportedly involved the request for a lethal injection by a severely disabled, incompetent patient who died before the court could rule; the other raised euthanasia as a defense in response to a charge of first-degree murder.

R. Destro, "Guaranteeing the "Quality" of Life through Law: The Emerging Right to a "Good" Life," *op. cit.*, 246-48. For each proposition, Destro cites large numbers of cases from different jurisdictions in the United States.

[28] Letter to *The Age*, 28th February, 1995, p.14.

[29] For a detailed commentary on the crucial role of intention in relation to homicide, see the Lionel Cohen Lecture given by Lord Goff at the Hebrew University of Jerusalem on 19th May, 1987: "The Mental Element in the Crime of Murder," *Law Quarterly Review* 104 (1988) 30-59. His Lordship observes:

> It is...important that we should know what we are talking about when we use the word "intention." It is obvious that it is to be differentiated from *motive*. If I kill you for your money, my intention is to kill you but my motive is to lay my hands on your money. So also, if I kill you from the motive of compassion (so-called mercy killing) I nevertheless intend to kill you and the crime is one of murder.

ibid. pp.41-42. Proponents of the Bill fail to distinguish and conflate motive and intention.

3.2 Dr. Eric Cassel distinguishes between suffering and physical distress. Mr Perron, apparently, makes no such distinction, although it is a critical one. Dr Cassel observes:

> Suffering is experienced by persons, not merely by bodies, and has its source in challenges that threaten the intactness of the person as a complex social and psychological entity. Suffering can include physical pain but is by no means limited to it. The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick.
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> In the separation between mind and body, the concept of the person, or personhood, has been associated with that of the mind, spirit and the subjective. ...Personhood has many facets, and it is ignorance of them that actively contributes to patients' suffering. The understanding of the place of the person in human illness requires rejection of the historical dualism of mind and body.
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> ...people in pain frequently report suffering from the pain when they feel out of control, when the pain is overwhelming, when the source of the pain is unknown, when the meaning of the pain is dire, or when the pain is chronic. In all these situations, persons perceive pain as a threat to their continued existence - not merely to their lives, but to their integrity as persons.[30]

3.3 There is no doubt that pain and suffering pose critical, extremely difficult issues in the life of us all. It is incontestable that "the perception of pain, both in its acute and chronic forms, causes several emotional malfunctions of which anxiety and depression are the best documented. In turn, both these emotional disturbances lead to sympathetic arousal and to profound changes in lifestyle and in the activities of daily living."[31] Three points need to be stressed here:

(i) as noted above, much stress and suffering is caused by the process of dying which requires recognition of a person as more than a physical construct which is, so to speak, in the process of breaking down. All needs - physical, emotional, psychological and spiritual - must be attended to. This requires that there be specialists available, trained to recognise these diverse, acute needs in persons with a terminal condition. Dame Cicely Saunders, Physician and Chairman, St Christopher's Hospice, London notes: "To give ethically appropriate treatment to a dying patient and family without the involvement of more than one profession will scarcely be adequate. ...Pain, weakness and the humiliations of dependence can all be tackled."[32] With the benefit of great practical experience, Dame Cicely observes that unless there is proper and adequate expertise available,

> The moment when trauma or disease moves a patient inexorably towards death may never be identified and the change from attempts at rehabilitation or cure to palliative and supportive care and treatment does not take place.

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[30] E.J. Cassel, M.D., "The Nature of Suffering and the Goals of Medicine,"*New England Journal of Medicine* 306 (March, 1982) 639-45 at pp.639, 640 & 641.

[31] Steven Brena, M.D., "Management of Pain in the Terminally Ill Patient,"*Issues in Law & Medicine* 2 (March, 1987) 379-90 at p.381.

[32] Dame Cicely Saunders, "The Dying Patient," in*Principles of Health Care Ethics*, (ed. R. Gillon) *op. cit.*, 775-82 at pp.781 & 777.

> ...A change of condition must be recognised and responded to with appropriate measures that are ethically indicated *for that particular patient*.[33] (emphasis added)

(ii) management of physical pain is a delicate and refined specialty, as is the provision of prudent, beneficent and compassionate care. Authorities in these fields acknowledge that such care is available which need not require continued escalation of doses of drugs to anaesthetise the person.[34]

(iii) specialists, such as those already cited in this submission, have noted that pain, of varying sorts, imbalances a person's judgment. Accordingly, it can be the case that a person's protests that he or she wishes to die, are either pleas for care to deal with suffering which has not been addressed by carers, or simply not completely lucid judgements in relation to wanting to die. In an exhaustive study of "right to die" legislation in Australia, Dr. Danuta Mendelson, in the light of research in the last decade, records that cognitive disorders are a complication of cancer.[35] Secondly, in her discussion of the *Medical Treatment Act* (1988) (Vic.) she observes "that persons suffering from paranoid conditions, or from serious affective disorders, constitute the largest population of treatment disorders." She notes those who are most prone to suicide, "the elderly, the emotionally stressed, and persons who lack stable connections with others...." Competent patients can make irrational choices, even in the Northern Territory.[36] Before leaving Dr. Mendelson's study, it is instructive to recall her rhetorical question in relation to the utility of the South Australian *Natural Death Act*. She says:

> Members of the South Australian House of Assembly who commented on the draft of the Consent to Treatment and Palliative Care Bill 1992 noted that the *Natural Death Act* was not properly understood or promoted and therefore, presumably, not utilized by enough terminally ill patients to direct doctors to switch off the life supports. *But could it be that once their physical pain is alleviated, most terminally ill patients prefer to live with the support of extraordinary measures rather than to die?*[37] (emphasis added)

3.4 (i) At this juncture, notwithstanding Professor Lickiss' comment that "the arguments against euthanasia are not at their core religious"[38], it is apposite to note, briefly, the position of the Catholic Church in relation to pain and care of the dying. First, to state what it is not: while the Church seeks always (and in this there are many other "fellow travellers") to promote the sanctity of life as the foundational ethic, it is true also that "it is a convenient travesty of a sanctity of life ethic to represent it (as some authors do...) as committing doctors to maximal

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[33] *ibid.* p.775.

[34] *ibid*. p.780; Professor Lickiss, Address to the AMA National Forum, "The Dying Patient and the Law," *op. cit*., pp.1-2; Dr. Brian Pollard (retired anaesthetist and palliative care specialist), *The Challenge of Euthanasia*, (Crows Nest: Little Hills Press, 1994) Chapter Two: Palliative Care, pp.25-56.

[35] "Medico-Legal Aspects of the `Right to Die' Legislation in Australia," *Melbourne University Law Review* 19 (June, 1993) 112-152 at p.118.

[36] *ibid.* pp.126-27. See further, D.W. Brock & S.A. Wartman, "When competent patients make irrational choices," *New England Journal of Medicine* 332 (1990) 1595, 1597.

[37] "Medico-Legal Aspects of the `Right to Die' Legislation in Australia," *op. cit.* 123.

[38] N. Lickiss, AMA National Forum, Address, *op. cit.* p.7 *ff*.

prolongation of life. The sanctity of life ethic is a *negative* norm ...excluding intentional attacks on innocent human lives."[39] Secondly, the Church insists that:

> When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to a sick person in similar cases is not interrupted.
>
> Today, it is very important to protect, at the moment of death, both the dignity of the human person and the Christian concept of life against a technological attitude that threatens to become an abuse. Thus, some people speak of a "right to die," which is an expression that does not mean the right to procure death either at one's own hand or by means of someone else, as one pleases, but rather the right to die peacefully with human and Christian dignity.[40]

(ii) The Church has affirmed recently this consistent teaching concerning the refusal of medical treatment which is disproportionately burdensome compared to its benefit to the patient. The *Catechism of the Catholic Church* states:

> Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of "over-zealous" treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.
>
> Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an

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[39] L. Gormally, "Against Voluntary Euthanasia," in *Principles of Health Care Ethics*, (ed. R. Gillon) *op. cit.* 770. Mr. Gormally cites, among others who parody the sanctity of life principle, Dr. Helga Kuhse. *Cf.* Shakespeare's poignant comments from *King Lear*:

> (Lear) Meantime we shall express our darker purpose. ...'tis our fast intent to shake all cares and business from our age,
> Conferring them on younger strengths while we
> Unburdened crawl toward our death. (Act I, Sc.i,40)
>
> (Kent, on the death of Edmund) Vex not his ghost. O, let him pass!
> He hates him that would upon the rack of this tough world
> Stretch him out longer. (Act V, Sc.iii,315)

[40] *Declaration on Euthanasia*, 1980, Section IV. For a thorough-going exposition of principles of Catholic health care, see B.M. Ashley, O.P. & K.D. O'Rourke, O.P., *Health Care Ethics: A Theological Analysis*, (Third Edition) (St. Louis: The Catholic Health Association of the United States, 1989), especially pp.380-87 in relation to the use of `extraordinary measures'. For a brief medico-legal discussion of what constitutes "extraordinary measures", see M. Wallace, *Health Care and the Law*, (Second Edition) (Sydney: The Law Book Company, 1995) 326-330 who approaches the issues not from a sanctity of life perspective, and T.K. Tobin QC, "Foregoing Life-Supporting Treatment: The Civil and Criminal Law," *Bioethics Outlook* Vol.4.No.2 (June, 1993) 5-10 for someone who does.

> end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such it should be encouraged.[41]

3.5 (i) Brief comment needs to made in relation to patient autonomy. It is possible to interpret remarks by supporters of the Bill as saying that legislation of the kind proposed is necessary to provide a right for patients to refuse treatment they do not wish to receive. However, no legislative mandate is necessary; in this respect alone, the Bill is completely unnecessary. The common law has long recognised that it is licit to refuse medical treatment. For this there is abundant precedent in Canada, the United States and the United Kingdom.[42] It is important to note that while the courts have always been at pains to accept the right of patients to refuse medical treatment, they have been equally insistent to ensure that the interests of the state as the principal protector of life is never abrogated. That is to say, the state has a duty or special interest in preventing suicide and so-called "mercy killing." Further, most of the decisions stress that the state has a duty also to protect the "integrity of the medical profession" from any move towards it becoming a profession which advocates death as a solution to suffering. Thus, in *McKay v Bergstedt* it was held that:

> The State has an unquestioned duty to see that the integrity of the medical profession is preserved and that it is never allowed to become an instrument for the selective destruction of lives deemed to have little utility.[43]

(ii) The Church's teaching is clear in relation to the decision to commit suicide or euthanasia. As to the former, it "involves the rejection of love of self and the renunciation of the obligation of justice and charity towards one's neighbour, towards the communities to which one belongs, and towards society as a whole."[44] Concerning euthanasia, the Pope has said:

> Even when not motivated by a selfish refusal to be burdened with the life of someone who is suffering, euthanasia must be called a *false mercy*, and indeed a disturbing "perversion" of mercy. True "compassion" leads to sharing another's pain; it does not kill the person whose suffering we cannot bear. Moreover, the act of euthanasia appears all the more perverse if it is carried out by those, like relatives, who are supposed to treat a family member with patience and love, or by those, such as doctors, who by virtue of their specific profession are supposed to care for the sick person even in the most painful terminal stages.[45] (emphasis in the text)

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[41] *Catechism of the Catholic Church* (1992), paras.2278 & 2279.

[42] Among the leading cases in the countries mentioned are: (Canada) *Malette v Shulman* (1990) 67 D.L.R. (4th) 321; (United States) *McKay v Bergstedt* 801 P 2nd 617 (1990); (United Kingdom: Court of Appeal) *In re* T (Adult: Refusal of Medical Treatment) [1993] Fam. 95. For a useful discussion of cases from different jurisdictions and the legal position in Australia, see Leanna Darvall's *Medicine, Law and Social Change* (Aldershot: Dartmouth, 1993) Chapter 3, "Refusal of Medical Treatment," pp.51-84 and F. Trindade & P. Cane, *The Law of Torts in Australia* (Second Edition) (Melbourne: Oxford University Press, 1993) 272-75.

[43] *ibid*. For an extended discussion of society's interest in upholding the concept that all life is sacred on the one hand and, on the other, the right to self-determination and factors which may vitiate that right (such as lack of relevant knowledge, undue influence arising out of a special relationship), see the detailed judgment of Lord Donaldson M.R. in *In re* T (Adult: Refusal of Treatment) [1993] Fam. 95 at 102-116. For an important treatment of the "the integrity" of the medical profession, see E.D. Pellegrino M.D. and D.C. Thomasma Ph.D., *The Virtues in Medical Practice*, (New York & Oxford: Oxford University Press, 1993).

[44] See further, Pope John Paul II's Encyclical Letter, *The Gospel of Life (Evangelium Vitae)*, 25th March, 1995, para.66; *Catechism of the Catholic Church*, paras.2281-2283.

[45] *The Gospel of Life (Evangelium Vitae)*, para.66.

3.6 In sum, the goals of a just and humane society ought to be to provide facilities for and care of its individual members according to their specific needs. It is too easy a solution to provide only the ultimate solution, especially to certain classes of the most vulnerable, such as the elderly, and terminally ill - of whatever age.[46] Clearly, it is important that certainty of diagnosis, respect for patient autonomy, and relief of pain be identified as critical goals. They should not be seen as mutually inconsistent. If adequate palliative care facilities are available, due attention can be given to pain relief and care of the dying. Attention can be focussed on the diverse needs of the person who need not fear the approach of a "health care provider" or medical practitioner. It would only add to the suffering of persons if they found, as the House of Lords Committee observed patients in the Netherlands do, that the centuries-old trust in the medical and nursing professions was alarmingly undermined because patients never knew if their doctors were coming to palliate their suffering or to kill them.[47] Dr. Josefina Magno, Director of Hospice Education, Research and Development at the Henry Ford Hospital in Detroit and President of the International Hospice Institute summarises the current situation well:

> ...[traditionally] good medicine cures sometimes, palliates often, and comforts always, [in the modern era this axiom has been distorted to say that] good medicine cures *always*, palliates *sometimes*, and comforts *never*.[48]

The "traditional" role of medicine, as described by Dr. Magno, ought always apply.

IV The Bill

4.1 Our remarks here will be confined to only a few critical provisions of the Bill rather than to a critique of it in its entirety.

4.2 Cl.2: "assist" - the inclusive definition here is bizarre. Theoretically, under its terms, a person could be "assisted" to die by being bludgeoned or shot with a bullet or arrow. Anything equally cruel or macabre is not proscribed. In the same clause, "substance" is not defined at all.

4.3 Cl.3 refers to a request to a medical practitioner "to assist the patient to terminate the patient's life." The request is predicated upon "reasonable medical judgment" determining that the patient will die from a terminal illness within 12 months as a result of that illness. What constitutes "reasonable medical judgment" is debateable. For example, in 1992 the High Court of Australia found that what was considered by certain sections of the medical profession to be a reasonable risk ought not to be considered so according to the law, and that, in the final analysis, it was for the courts to determine what was reasonable, not the

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[46] Even advocates of euthanasia, such as Margaret Otlowski, acknowledge that the care required to meet the needs of persons who are in the final stages of their lives is a complex matter (that is, not one-dimensional) which requires a multi-disciplinary team and that optimal palliative care is essential. M. Otlowski, "Legal and ethical issues in palliative care," *Monash Bioethics Review* 14 (January,1995) 33-47.

[47] On professional responsibility, see the House of Lords Report, paras.272 & 273, p.56, and the remarks of Dame Cicely Saunders, "The Dying Patient," *op. cit.*

[48] "The Role of the Physician When Cure is No Longer Possible," *Linacre Quarterly* 58 (May,1991) 79-88 at p.79; the emphasis is Dr. Magno's.

medical profession.[49] In the case before the High Court, failure to warn of a condition which occurred once in approximately 14,000 cases was held to be negligent. In a criminal matter, such as the termination of a person's life, the standard applied by courts would be more strict. The current clause, and the framework of the Bill generally, seeks to minimise standards to a dangerously subjective level. As Professor Kamisar warned, many years ago, "no man is immune to the fear, anxieties and frustrations engendered by the apparently helpless, hopeless patient. Not even the general practitioner." He goes on to cite a number of instances of misdiagnosis, among them the situation of an eminent physician in the United States who was considered to have a "hopeless" case of tuberculosis but who was found to be suffering only from a rare malady which affects the lungs in a manner similar to TB but seldom kills. The physician, happily, was not "euthanased."[50]

4.4 Cl.4 provides that a medical practitioner may assist a patient to terminate that person's life "if satisfied that the conditions of section 6 have been met." The clause makes no provision for how the medical practitioner might be so satisfied: for example, is it on a balance of probabilities, or beyond reasonable doubt that he or she must be satisfied? Notwithstanding claims of precision and clarity by advocates of the Bill, the clause offers no help to the earnest inquirer.

4.5 Cl.6 seeks to provide a compendious "check list" for medical practitioners on the basis of which someone would be permitted to be killed. Some of the more glaring concerns with this clause are:

(i) cl.6(b): unlike cl.3 which refers to "reasonable medical grounds", this clause refers to a medical practitioner being satisfied that a person will die of a terminal condition within 12 months simply "on reasonable grounds." If there are major flaws in the reasoning and legal position with "reasonable medical grounds", *a fortiori* are there major objections with satisfaction only on "reasonable grounds."

(ii) cl.6(e): on its face, this clause is highly subjective. But there are deeper flaws. How can a medical practitioner inform the patient, as required by this clause, of "the medical treatment, including palliative care, that might be available to the patient" if, effectively, no such care or services are available in the Northern Territory? Further, the clause is silent as to what level of information the medical practitioner must provide to the person regarding the nature of the illness, etc. In the light of *Rogers v Whitaker*, the High Court would require that a very high level of information be provided. If there are no specialists in palliative care, or oncology, in the Northern Territory, how can the appropriate level of information be provided to satisfy this clause?

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[49] *Rogers v Whitaker* (1992) 175 CLR 479.

[50] Y. Kamisar, "Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation," (1958) 42 *Minnesota Law Review* 969-1042, reprinted in *Death, Dying, and Euthanasia*, (eds. D.J. Horan & D. Mall) (Frederick, MD: Aletheia Books, 1980) 406-79. Citations are from Horan and Mall, pp.424-25 & 432-34.

(iii) cl.6(f): this clause refers to there being no "medical treatment reasonably available and acceptable to the patient." The same questions raised in relation to cl.6(e) are pertinent here, together with asking how a patient can reasonably know what is acceptable (a) if there is not a range of care appropriate to their particular needs, including palliative, available, and (b) if the medical practitioner has mis-diagnosed the person's condition?

(iv) cl.6(h): the clause refers to the medical practitioner being satisfied "on reasonable grounds" as to the patient's competence and the voluntariness of the decision to seek assistance to be killed. Apart from the inconsistency, again, between earlier provisions which refer to being satisfied on "reasonable medical grounds" and here, "reasonable grounds" alone sufficing, the competence of the patient, especially one whose severe pain is not able to be palliated because of the lack of services for such in the Territory, must always be very problematical. Equally so the voluntariness of the decision. Quoting others, Kamisar's remarks are salutary:

> Anyone who has been severely ill knows how distorted his judgment became during the worst moments of the illness. Pain and the toxic effect of disease, or the violent reaction to certain surgical procedures may change our capacity for rational and courageous thought. If, say, a man in this plight were a criminal defendant and he were to decline the assistance of counsel would the courts hold that he had intelligently and understandingly waived the benefit of counsel?[51]

(v) cl.6(k): again, the highly subjective "reasonable grounds" test is provided.

4.6 Cl.7 refers to an oral request of a patient for assistance in being killed being confirmed in writing by someone else in the event that the persons making the request "is physically unable to sign the certificate of request." A not unreasonable scenario can be provided which would satisfy the requirements of the Bill but would raise many serious questions. For example, following a car accident, a person could have two broken arms and have been mis-diagnosed with internal injuries for which inappropriate medication has been given. As a result of the mis-diagnosis, they could be in great physical pain, and without recourse to specialists in palliative care to be consulted in relation to pain management. The patient is crying out for relief, including death, "anything to stop the pain." On the bare facts presented, compliance with the Bill would be satisfied, the person could be killed and those facilitating it need accept no responsibility for their behaviour, negligent or culpable though it be.

4.7 The Schedule to the Bill is worrying. For example, the second medical practitioner requirements of the Bill, according to paragraph (e) of the "Declaration of Witnesses", requires that that practitioner is currently satisfied "that the conditions of section 6 have *or*

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[51] *ibid*. pp.424-25. Kamisar notes further, from studies of specialists in neoplastic diseases at Montefiore Hospital in New York City, that in one instance, where eleven patients were admitted or transferred to the hospital, diagnosed as "advanced cancer in its terminal stage," none of the eleven had cancer at all. Doctors who detected the misdiagnosis said: "Such cases [of mistaken diagnosis of advanced cancer] are encountered even in large medical centers and probably many more could be found in areas poorly provided with medical facilities"*ibid.* p.434.

will be complied with" (emphasis added). Trust between colleagues is laudable; expectation of future compliance with highly subjective criteria on the basis of which someone will be killed, is indefensible.

4.8 Surprisingly, "terminal illness" is not defined in the Bill. What constitutes a "terminal illness" for one medical practitioner may not be so for another.

V **Lessons from History**

5.1 It is prudent to record, and to take heed from, the concise remarks of others; their import should be self-evident. First, Alfred Hoche has remarked that,

> A new age will come which from the standpoint of a higher morality will no longer heed the demands of an inflated concept of humanity and an overestimation of the value of life as such.[52]

5.2 Writing approximately thirty years later, observers at the trials of Nazi doctors noted the fulfilment of Alfred Hoche's comments. For example, one commentator (R.J. Lifton) recorded that killing became "medicalized" and the law simply took advantage of an already fertile climate of eugenic opinion, while one observer, Leo Alexander, said:

> The original concept of medicine and nursing was not based on any rational or feasible likelihood that they could actually cure and restore but rather on an essentially maternal or religious idea. The Good Samaritan had no thought of nor did he actually care whether he could restore working capacity. He was merely motivated by the compassion in alleviating suffering. Bernal states that prior to the advent of scientific medicine, the physician's main function was to give hope to the patient and to relieve his relatives of responsibility. [This perspective changed.]
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> The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the non-rehabilitable sick.
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> It is, therefore, this subtle shift in attitude that one must thoroughly investigate.[53]

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[52] A. Hoche, "Ärztliche Bemerkungen," in K. Binding and A. Hoche, *The Permission to Destroy Life Unworthy of Life (Die Freigabe der Vernichtung lebensunwerten Leben: Ihr und ihre Form*, 1920, pp.61-62.

[53] L. Alexander, "Medical Science under Dictatorship," *New England Journal of Medicine*, 241 (1949) pp. 39, 41 & 41 note 17.

5.3 More recently, Professor Peter Singer has expressed the following alarming perspective:

> We can no longer base our ethics on the idea that human beings are a special form of creation, made in the image of God, singled out from all other animals, and alone possessing an immortal soul. Our better understanding of nature has bridged the gulf that was once thought to lie between ourselves and other species, so why should we believe that the mere fact that a being is a member of the species Homo sapiens endows its life with some unique, almost infinite, value?[54]

We reject Professor Singer's views completely. To the degree that they are reflected, in any way, in the proposed legislation, we reject them also. It should be noted also that Professor Singer's colleague, Dr. Kuhse, commented at the Fifth Biennial Conference of the World Federation of Right to Die Societies (1984) that:

> If we can get people to accept the removal of all treatment and care - especially the removal of food and fluids - they will see what a painful way this is to die, and then, in the patient's best interest, they will accept the lethal injection.[55]

Such a view should be categorically rejected as medically inappropriate and repugnant to the dignity of the human person. Malcolm Muggeridge has commented perspicaciously:

> ...it is true that the delay in creating public pressure for euthanasia has been due to the fact that it was one of the war crimes cited at Nuremburg. So, for the *Guinness Book of Records*, you can submit this: that it takes just about [fifty] years in our humane society to transform a war crime into an act of compassion. That is exactly what has happened.[56]

5.4 A final, apposite warning about the restless stable from which the current Bill comes. Professor Kamisar, Professor of Law at the University of Michigan, says,

> In the years ahead, we will hear a good deal more about the "right to die" - along with "self-determination" and "personal autonomy." Proponents of assisted suicide and...euthanasia know a good slogan when they come across one. Unfortunately, it is much easier to chant a catchy slogan than to define it precisely or to spell out its limits. But as these proponents see it, if people confuse the right to active euthanasia with the right to terminate life support, so much the better. If people think that the right to enlist the assistance of others in committing suicide or the right to authorise some one else to kill you intentionally and directly is only another application or a slight variation of the "right to die" established in *Quinlan* and assumed in *Cruzan*, again, so much the better. As supporters of active euthanasia or assisted suicide see it,

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[54] "Sanctity of Life or Quality of Life?" *Pediatrics* 72 (July 1983) p.128.

[55] Quoted in "The Right to Die Movement and the Artificial Provision of Nutrition and Hydration," R. Marker, in *Critical Issues in Contemporary Health Care*, (Braintree, MA: Pope John Medico-Moral Center, 1989) 93-110 at pp.94 & 108.

[56] M. Muggeridge, "*Humanae Vitae*: What's Really at Stake?" in *Christian Married Love*, (ed. R. Dennehy) (San Francisco: Ignatius Press, 1981) p.28.

> illuminating the meaning of the "right to die" or delineating its outer limits is not their problem.
>
> They are right, of course. It is ours.[57]

Conclusion

Much anguish stems, not from death itself, but from the process of dying. Our modern world looks invariably to technology (and law) to overcome all problems only to find that, for all its positive value, the same technology enables lives to be prolonged which, formerly, would have ended at an earlier time. Living with knowledge of one's pending death requires more than technology to deal with the attendant anxiety. Institutionalisation of medicine can compound already anxious patients. The attempts to tame death by law[58] do not relieve already anxious persons of their anxiety.

The Bill is poorly drafted. Critical definitions, such as "assist", are imprecise and introduce dangerously subjective elements into the decision-making processes in determining the treatment of persons suffering - physically, emotionally, psychologically and spiritually - from a terminal illness. Arguments advanced in support of the Bill, such as patient autonomy, do not require legislative control. Better treatment and broad-based care would alleviate problems for those with a terminal illness. Futile and burdensome treatment has never been promoted or required by the law or the Church. Respect and dignity should be accorded every person at every stage of his or her life.

We urge the Committee to recommend to the Northern Territory Government that the Bill under consideration be rejected and that death, as the ultimate solution, is an unacceptable philosophical or jurisprudential base for legislation which attempts to deal with human beings who are suffering in the community. Such people are deserving of care at every stage of their lives. In our view, killing is not care.

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[57] ""Right to Die" - Good Slogan, Fuzzy Thinking", *First Things* 38 (December,1993) 6-9 at p.9.

[58] This term of art is used by Professor David Lanham of the University of Melbourne, in his recently published *Taming Death by Law* (Melbourne: Longman Professional, 1993). Professor Lanham considers the *Medical Treatment Act* (Vic.) from a decidedly *pro* euthanasia perspective. In the Preface to his book he says, "...the likelihood of a peaceful death would be enhanced if it became lawful to practise active euthanasia." Such a view should be rejected.