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K.M. Sharma

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EUTHANASIA IN AUSTRALASIA

*K.M. Sharma**

I. INTRODUCTION

Against all the injuries of life I have the refuge of death. If I can choose between a death of torture and one that is simple and easy, why should I not select the latter? As I choose the ship in which I sail and the house which I shall inhabit, so I will choose the death by which I leave life. In no matter more than in death should we act according to our desire. . . . [W]hy should I endure the agonies of disease . . . when I can emancipate myself from all my torments?¹

Thus asked the Roman philosopher, Lucius Seneca (4 B.C. - A.D. 65), and one cannot help but agree with his sentiments. However, for modern twentieth century man in Australia, there is no such refuge. He cannot end his life when it becomes a burden to himself and to others because euthanasia is not legal in this country. For him the choice of death over the vicissitudes of life is not in any sense a real alternative.

Vex not his ghost: O! let him pass; he hates him
That would upon the rack of this tough world
Stretch him out longer.

William Shakespeare, *King Lear*, Act V, scene 3, lines 314-16. Why this should be so is traceable to long-standing ecclesiastical and legal prohibitions against both suicide and murder. The attitude of the law is to recognize the inviolability of the human body. Hence, euthanasia, the "mercy-motivated killing" or the "merciful extinction of life" is rejected in most religions; in Hinduism, and in traditional Judaeo-Christian belief, chiefly because of the Sixth Commandment: Thou shalt not kill.

However, in a century where the average life expectancy has reached and passed seventy years (compared with forty-seven years in 1900) and where improved hygiene, nutrition and medicine have helped people escape the deadly contagions of the past, survivors are handed over in their latter years to long and lingering deaths. As one author puts it, "for every easily treated

* B.A., M.A., LL.B. LL.M. (Rajasthan), LL.M., S.J.D. (Harvard); Faculty of Law, University of New South Wales, Sydney, Australia.

1. I W. LECKY, HISTORY OF EUROPEAN MORALS FROM AUGUSTUS TO CHARLEMAGNE 108 (3d. ed. 1898).

disease of yesterday there has appeared a multitude of other diseases whose damage is chronic and not wholly reversible. Standing out among these are cancer and the degenerative diseases associated with aging and the wear and tear of life."²

Many of these sufferers would choose to end their lives if they could, preferring a gentle death to a long drawn-out and painful dying. Indeed, community surveys in Australia indicate that more than two-thirds of the general public support euthanasia and that this support is growing each year.³ However, at present in Australia, prohibitions mean the individual does not have a choice, with voluntary euthanasia (or the ending of life at his own request) being unavailable.

Euthanasia is clearly relevant not only to the elderly but to society at large. There are three relatively distinct classes of individuals to whom euthanasia becomes relevant:

First, individuals suffering from painful and terminal illness (such as cancer and multiple sclerosis), who, by definition, have at best months, weeks or perhaps only days to live.

Second, individuals diagnosed as irreversibly defective or degenerate, including the chronically mentally ill, the retarded, those with gross physical defects, and the vegetated aged. Of these individuals, some have been rendered permanently paralyzed, debilitated or comatose by either the ravages of their progressive illness or by accident and their life is often senselessly prolonged by heroic measures. They have no realistic hope of regaining cognitive function.

Third, newly-born and young children who suffer from gross mental—neurological—or physical deformities, or, perhaps, from a combination of both. The multiple, severe and disabling congenital malformations are such that, notwithstanding its longevity, the child will be unable to care for its most elemental needs, totally dependent on others for survival.⁴

2. Furlow, *Tyranny of Technology: A Physician's Look at Euthanasia*, 24 THE HUMANIST 6 (1974).

3. Lander, *Some Medical Aspects of Euthanasia*, 141 MED. J. AUSTL. 173, 177 n.18 (1984). See also Tiver, *Voluntary Euthanasia*, 12 AUSTL. NURSES J. 49 (1982); Cohen, *The Right to Live and the Right to Die*, 141 MED. J. AUSTL. 60 (1984).

4. See generally Smith, *Life and Death Decisions in the Nursery: Standards and Procedures for Withholding Lifesaving Treatment from Infants*, 27 N.Y.L.S. L. REV. 1125 (1982); Longino, *Withholding Treatment From Defective Newborns: Who Decides, and on What Criteria?*, 31 U. KAN. L. REV. 377 (1983); Note, *Withholding Treatment from Defective Infants: "Infant Doe" Postmortem*, 59 NOTRE DAME L. REV. 224 (1983); Comment, *Withholding Lifesaving Treatment From Defective Newborns: An Equal Protection Analysis*, 29 ST. LOUIS U. L. J. 853 (1985); Human Rights Commission, Australia, *Legal and Ethical Aspects of the Management of Newborns with Severe Disabilities* (Occasional Paper No. 10, Aug. 1985).

II. THE PRESENT LAW IN AUSTRALASIA

A. *Euthanasia at Common Law: Homicide?*

Against the backdrop of the English common law which has provided the foundation for criminal law in Australia, let us look a little more closely at the law in Australia as it relates to voluntary euthanasia. It is clear at common law that euthanasia is homicide. The fact that the administering physician might be acting out of compassion and from the highest of motives does not change the characterization of the offense as murder. The requisite *mens rea* or mental element of the crime—that of an intention to kill—would be present, as would the *actus reus*, the performance of the criminal act. Motive is not taken into account,⁵ nor is it relevant that the patient requested his own death,⁶ or that death from natural causes may have been imminent.

The law makes no distinction between a vicious killer and the kindly doctor if there is an intention to kill. If the physician chooses to make available to the patient the means of ending his own life, then he could be guilty under the law of aiding and abetting a suicide or attempted suicide.

It is necessary to distinguish voluntary euthanasia from other similar, but not necessarily related, situations. Voluntary euthanasia occurs when a doctor, or some other person, and the patient-victim discuss the circumstances and the latter requests death. Involuntary euthanasia is the taking of life of another without his consent, as in the case of a severely retarded newborn or unconscious person who is not expected to regain consciousness and has not previously rendered consent. Each type may be accomplished by either "passive" or "active" procedures.

The primary legal problem concerning euthanasia, voluntary or not, is that it is a euphemism for murder in that both are the product of wilful, deliberate, and premeditated acts or omissions. Thus, a doctor who administers a *requested* but lethal drug may be charged with murder regardless of motives of mercy, and the patient's *consent* will not exonerate him. The common law philosophy that life is inalienable precludes any individual from giving permission for his own extinction. But, unlike a murderer, a mercy-killer's motive is not malice or vengeance; rather, he is motivated by the very compassionate human desire to end painlessly the subject's unbear-

5. However, some European criminal law systems (e.g., Germany and Switzerland) consider motive a crucial factor in determining culpability of an accused. Silving, *Euthanasia: A Study in Comparative Law*, 103 U. PA. L. REV. 350, 351 (1953). See also Caughy, *The German Euthanasia Programme*, 98 N.Z. MED. J. 555 (1985).

6. In some countries consent to suicide does operate to mitigate the offense from murder to a lesser crime. For example, the INDIAN PENAL CODE § 300, exception 5 (1860) provides that consent of a victim over the age of eighteen to suicide vitiates the murder charge, thus resulting in reduced punishment.

able and continued suffering. The law, however, takes no cognizance of this distinction.

However, despite the strictness of the common law in punishing the taking of human life, a physician in some cases can aid a patient's desire for death by administering "passive" euthanasia. This involves no affirmative action such as administering drugs but rather the withdrawing or termination of treatment to patients. As far as this kind of euthanasia by inaction or omission is concerned, there is little or no direct authority on how far the law expects the physician's duty of care to his patient to go in preserving his life. The medical profession obviously appreciates the difference between avoiding death and prolonging life. It has been conceded by many ecclesiastics that a doctor need not use artificial and "extraordinary" means to preserve life indefinitely, but only adopt "ordinary" means when a patient is in great pain and in the process of dying. Thus, doctors may passively allow a patient to die, but not *actively* end his life.⁷

The legality of this issue does not seem to have been squarely decided by the courts. However, it is arguable that, since a physician's legal duty is principally contractual and predicated upon the patient's consent, nonfeasance, where there is no basis for presumptive consent, should go unpunished even though active euthanasia remains punishable. But it would seem lawful today in England, and possibly in Australia, to give a patient such a large quantity of drugs that it will relieve pain but at the same time hasten death.

7. For example, Pope Pius XII, in a 1957 "allocutio" (address), stated that if the use of a respirator goes "beyond the ordinary means to which one is bound, it cannot be held that there is an obligation to use them or . . . to give the doctor permission to use them. . . . There is not involved here a case of direct disposal of life of the patient; nor of euthanasia in any way; this would never be licit. Even when it causes the arrest of circulation, the interruption of attempts at resuscitation is never more than an indirect cause of the cessation of life." *Eichner v. Dillon*, 73 A.D.2d 431, 439 n.3, 426 N.Y.S.2d 517, 526 n.3 (1980) (quoting *The Prolongation of Life*, Address of Pope Pius XII to an International Congress of Anesthesiologists, Nov. 24, 1957 A.A.S. XXXXXIX (1957)), *modified sub nom.*, *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981). For a discussion of the distinction between active and passive complicity in the death of another, see *Rachels, Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78 (1975); *Abrams, Active and Passive Euthanasia*, 54 PHIL. 257 (1978); *Dinello, On Killing and Letting Die*, 21 ANALYSIS 83 (1970). See also *Gerber*, 56 AUSTL. L.J. 139 (1982) (discussing *In re B. (A Minor)*, [1981] 1 W.L.R. 1421 (C.A.)), and *R. v. Arthur* (1981, unreported), on the question of allowing mongoloid infants to die); *Gerber & Vasta*, 58 AUSTL. L. J. 291 (1984) (discussing *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983), on the removal of respirators and other life-sustaining machines, including the administration of nourishment through intravenous tubes, in the context of Australian law); *Kuhse, A Modern Myth—That Letting Die Is Not the Intentional Causation of Death: Some Reflections of the Trial and Acquittal of Dr. Leonard Arthur*, 1 J. APPLIED PHIL. 21 (1984).

The British case of *R. v. Instan*⁸ suggests that in the United Kingdom, homicide can be committed by "culpable omission." In that case a niece was found guilty of manslaughter in the killing of her aunt, by failing to provide her with food and drink, knowing full well that no one else would provide it in her place. On the other hand, a court in Sweden ruled in 1968 that a physician was not criminally liable for having shortened a patient's life by cessation of life-prolonging treatment.⁹

Apparently there has been no test case in this area in Australia although passive euthanasia is a common occurrence and is practiced by doctors without legal regulation.¹⁰ Death is induced, for example, by withdrawing life-prolonging equipment where recovery seems impossible or by the nonuse of drugs to cure infections or other problems. In these cases the patient dies of "natural causes" and difficulties of proof means that the physician escapes prosecution unless he can be charged with neglect.¹¹

B. Voluntary Euthanasia: Suicide?

Because voluntary euthanasia is analogous to assisted suicide (often treated more leniently than homicide), the legal principles relating to principal and accessory, and aiding and abetting, are significant. Generally, there was no prosecution for attempted suicide, even when it was once considered

8. 17 Cox C.C. 602 (1893).

9. Cantor, *Law and the Termination of an Incompetent Patient's Life-Preserving Care*, in THE DILEMMAS OF EUTHANASIA 75 (J. Behnke & S. Bok eds. 1975); Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228 (1973).

10. According to a recent Monash University survey 90% of the obstetricians and 76% of paediatricians had indulged in passive euthanasia at least once, and most paediatricians emphasized that changes were needed in the law relating to the treatment of severely handicapped infants. Singer *et al.*, *The Treatment of Newborn Infants with Major Handicaps: A Survey of Obstetricians and Paediatricians in Victoria*, 2 MED. J. AUSTR. 274 (1983). See generally H. KUHSE & P. SINGER, SHOULD THE BABY LIVE?—THE PROBLEMS OF HANDICAPPED INFANTS (1985).

11. A decision to withhold treatment from children would subject doctors—as well as the parents—to criminal liability. See, e.g., Fost & Robertson, *Passive Euthanasia of Defective Newborn Infants: Legal Considerations*, 88 J. PEDIAT. 883, 884-86 (1976); Chabon, *You May Face a Nightmare in the Newborn Nursery*, 7 LEGAL ASP. MED. PRAC. 43, 45 (1979). However, in a highly publicised English case, a doctor (Dr. Leonard Arthur), who had withheld treatment and food from a mongoloid infant, was found not guilty of attempted murder, even though the infant died within three days. Brahams, *Acquittal of Paediatrician Charged After Death of Infant With Down's Syndrome*, 2 LANCET 1101 (Nov. 14, 1981). But, it should be noted that this case did not resolve the legal issues involved as the doctor's acquittal was merely based on other peripheral issues and the facts of the case. Gerber, 56 AUSTR. L.J. 139, 141 (1982); Dr. Leonard Arthur: *His Trial and Its Implications*, 283 BRIT. MED. J. 1340 (1981). See C. BERNARD, GOOD LIFE/GOOD DEATH: A DOCTOR'S CASE FOR EUTHANASIA AND SUICIDE 52 (1980); SUICIDE AND EUTHANASIA (S. Wallace & A. Eser eds. 1981).

an offense under English common law.¹² But, the law treats the assistance of another in suicide as a crime, regardless of the abettor's motive or the victim's request.

There are three divergent approaches at common law concerning the abettor's liability. First, the accessory is viewed as a principal in the suicide. Second, the accessory enjoys immunity where the principal's act is not a crime. And, third, the accessory is guilty of an independent crime.

Obviously, concerning euthanasia, the relevant category is that of accessory before the fact. Where suicide is no longer a crime, incitement or abetment of suicide is a statutory misdemeanor. However, the accessory before the fact is still liable as a principal offender.

Mention must be made of the common law recognition of an individual's right to self-determination over his own body. The rendering of any nonconsensual medical treatment constitutes an assault and battery. Yet, as an exception, in an emergency, where the patient is incapable of consent, the law recognizes the right of a physician to render medical aid on an implied-consent basis. However, the concept of a right to control one's body does not extend to freedom to end one's life (suicide), to end one's life with the assistance of another (assisted suicide—euthanasia), or to end the life of another individual who is dependent on, or indistinguishable from, one's own body (abortion, euthanasia).

1. South Australia

For the act of suicide itself, South Australia has enacted provisions, like Victoria and New Zealand, similar to the United Kingdom Suicide Act, 1961. Under section 13a of the Criminal Law Consolidation Amendment Act, 1982, suicide and attempted suicide are no longer criminal offenses.¹³ Similarly, aiding or assisting a suicide is clearly, as with deliberate homicide, wrong, since intention is the key factor. Thus, it is an offense to aid and abet a person to commit suicide.¹⁴

With the enactment of the Natural Death Act, 1983, South Australia has gone further than other Australian jurisdictions with regard to euthanasia. Section 4 of the act gives effect to a "living will," namely, a written document in a prescribed form in which a person states that in the event of him/her suffering a terminal illness he/she will not be subjected to extraordinary medical measures in an artificial prolongation of the dying process, a doctor

12. See generally Parry-Jones, *Criminal Law and Complicity in Suicide and Attempted Suicide*, 13 MED., SCI. & L. 110 (1973).

13. P. BRETT & L. WALLER, *CRIMINAL LAW—TEXT AND CASES* 123 (5th ed. 1983).

14. Criminal Law Consolidation Act Amendment Act, 1982, § 13a(10) (S. Austl.).

being under a duty to act in accordance with such a declaration. This provision has the effect of legalizing a form of passive euthanasia.¹⁵

2. *England, Victoria, New South Wales and New Zealand*

In all these four jurisdictions, suicide, which was self-murder at common law, and attempted suicide, are no longer offenses, and they have virtually identical statutory provisions.¹⁶

Likewise in all Australian jurisdictions, except Victoria, the finding of *felo de se* (felon against himself, one who commits suicide) has been abolished under the respective coroners acts.¹⁷ In Victoria the situation is slightly different, with section 17 limiting the effects of the finding of *felo de se*.¹⁸

Although suicide is no longer a crime in itself, it remains an offense for any person to aid, abet, counsel or procure the suicide of another.¹⁹ In this respect, a recent English decision, *Attorney-General v. Able*,²⁰ needs to be noted. The question at issue was whether the supplying of a booklet, which in part detailed information on five ways to end one's life effectively, was conduct amounting to aiding, abetting, counselling or procuring suicide under section 2(1) of the English Suicide Act, 1961. Although the case did not finally determine the issue of whether or not the booklet's distribution was lawful (a declaration either way not being granted), Mr. Justice Woolf attempted to clarify the law. An accomplice under section 2(1) of the Suicide Act, 1961, he held, was a principal offender and so could be held liable for the offense if suicide was attempted, and, even if no suicide was at-

15. Similar legislation—Refusal of Medical Treatment Bill, 1982—introduced in the Victorian Parliament by a private member failed due to opposition from the Roman Catholic Church. See generally M. Kirby, *Euthanasia—Old Issue: New Debate*, 14 AUSTL. N.Z. J. MED. 691 (1984); Rayner, *Euthanasia*, 14 AUSTL. N.Z. J. MED. 697 (1984). Such legislation is apparently still being considered in Victoria. See Law Reform Commissioner, Victoria, *Murder: Mental Element and Punishment* 25 n.44 (Working Paper No. 8, May 1984); Maher, *Euthanasia*, 59 L. INST. J. 445 (1985). See also Hickie, *Euthanasia 1984*, 141 MED. J. AUSTL. 140 (1984); Gerber, *Life at Any Price*, 141 MED. J. AUSTL. 141 (1984); Saclier, *Voluntary Euthanasia: The Right to Choose*, AUSTL. RATIONALIST Q., No. 4, Oct.-Dec. 1980, at 13.

16. Suicide Act, 1961, § 1, 9 & 10 ELIZ. 2, ch. 60 (U.K.)—for an analysis of this statute, see generally Downey, *Suicide Act, 1961*, 25 MODERN L. REV. 60 (1962); Crimes Act, 1958, § 6A (Vic.), Crimes Act, 1900, § 31A (N.S.W.); Crimes Act, 1961, §§ 179, 180 (N.Z.).

17. Coroners Act, 1912, § 3(1) (N.S.W.); Coroners Act, 1935, § 26(3) (S.A.); Coroners Act, 1958, § 46(1) (Qld.); Coroners Act, 1920, § 21(1) (W.A.); Coroners Act, 1957, § 7(5) (Tas).

18. Coroners Act, 1958, § 17 (Vic.).

19. Suicide Act, 1961, § 2(1) (U.K.) (punishment of fourteen years of jail); Crimes Act, 1958, § 6B(2) (Vic.) (fourteen years imprisonment); Crimes Act, 1900, § 31C (N.S.W.). See also *R. v. Croft*, [1944] K.B. 295; Lanham, *Murder by Instigating Suicide*, 1980 CRIM. L. REV. 215. A very valuable survey of the law, although in some respects now obsolete, appears in Barry, *Suicide and the Law*, 5 MELBOURNE U. L. REV. 1 (1965).

20. [1984] 1 Q.B. 795 (1983).

tempted, could be convicted of an attempt to commit the section 2(1) offense. For the respondents to be held liable, three requirements had to be satisfied, namely:

- (1) the alleged offender had the necessary intent, intending to assist someone contemplating suicide to attempt suicide;
- (2) that the alleged offender distributed the booklet to someone contemplating suicide with that intention;
- (3) that the person attempting suicide "was assisted or encouraged" by the booklet to attempt or actually commit suicide.²¹

The situation in New South Wales is slightly different. Following the Crimes (Mental Disorder) Amendment Act, 1983, a distinction for punishment is drawn between aiding and abetting²² and inciting or counselling suicide.²³ The name of the amending act as relating to "mental disorders" is curious. However, Glanville Williams writes that of a study of one-hundred successful suicides, ninety-three percent were caused by mental illness, primarily a depressive condition.²⁴

Another relevant matter is suicide pacts. In England and Victoria a suicide pact is a common agreement between two or more people having for its object the death of all of them. Where a person acting in pursuance of such a pact kills the other or is a party to the other being killed by a third person, he is guilty of manslaughter.²⁵

In contrast, in New South Wales under section 31B of the Crimes Act, 1900, the survivor of a suicide pact is not guilty of murder or manslaughter, but may under section 31C be guilty of an offense of aiding, abetting, counselling or inciting suicide.

3. *The Code Jurisdictions: Western Australia, Queensland and Tasmania*

In Tasmania there is no such crime as self-murder under section 163 of the Criminal Code Act, 1924. In Western Australia and Queensland suicide

21. *Id.* at 812. The ostensible reason for banning assistance in a justified suicide situation may be the risk of abuse, but the real reason seems to be the prevailing repugnance in the Western world toward suicide in general. For an appraisal of *Able*, see Smith, *Assisting in Suicide—The Attorney-General and the Voluntary Euthanasia Society*, 1983 CRIM. L. REV. 573.

22. Crimes Act, 1900, § 31C(1) (N.S.W.) (ten years imprisonment).

23. *Id.* § 31C(2) (five years imprisonment where the offense is attempted or committed).

24. G. WILLIAMS, *TEXTBOOK OF CRIMINAL LAW* 616 n.9 (2d ed. 1983).

25. Suicide Act, 1961, § 3 (U.K.); Crimes Act, 1958, § 6B(1)(Vic.) (survivor of suicide pact who kills the deceased is guilty of manslaughter); *id.* § 6B(3) (suicide pact no defense to murder if accused not party to pact); *id.* § 6B(4) (meaning of "suicide pact").

is not treated as a form of murder²⁶ as the codes make no specific mention of it.

In Tasmania, since 1957, attempted suicide has not been a crime. In Western Australia and Queensland it remains an offense, with punishment being limited by statute (Western Australia: punishment limited to not more than one year's gaol, and if the accused admits the offense he may be dealt with summarily by justices, who may sentence him to no more than six months imprisonment;²⁷ Queensland: attempted suicide is an offense punishable by not more than one year's imprisonment²⁸).

In all three code jurisdictions, any person who instigates another to kill himself is guilty of a crime,²⁹ the punishment in Queensland and Western Australia including hard labor for life³⁰ (consent by a person to the causing of his own death not diminishing the criminal responsibility of the killer³¹). In Tasmania, the punishment is such term of imprisonment as the judge thinks fit.³²

The legal position of Australian jurisdictions is clear. In all states, except in South Australia, the law does not recognize euthanasia or mercy-killing as any special form of excusable or nonpunishable homicide, even with the consent of the person concerned. In all states aiding and abetting the death of another by his own hand is a crime. Producing a cessation of bodily functions, whether or not they are artificially maintained and regardless of whether the cessation is by positive act or deliberate omission, is a punishable homicide.

Therefore, since death in this sense cannot lawfully be contrived by the deceased or by anyone else in concert with him, there can be no legal right to die. However, it should be pointed out that mere omission to prolong life or to make available the means whereby life can be maintained—no matter for how short a period—unless it entails gross neglect or wilful abstention from invoking normal measures of skill and assistance, is not an offense.³³ In South Australia, the situation has been altered with regard to voluntary eu-

26. The reference in section 293 of the Queensland Criminal Code, 1899, and section 170 of the Western Australian Criminal Code, 1913, to "another" indicates that suicide is not included within its terms. (These and related sections deal with homicide generally.)

27. Western Australian Criminal Code, 1913, § 289.

28. Queensland Criminal Code, 1899, § 312.

29. Criminal Law Consolidation Act, 1935, § 13a(10) (S. Austl.); Queensland Criminal Code, 1899, § 7; Western Australian Criminal Code, 1913, § 7.

30. Queensland Criminal Code, 1899, § 311; Western Australian Criminal Code, 1913, § 288.

31. Queensland Criminal Code, 1899, §§ 284, 300, 301, 302, 303; Western Australian Criminal Code, 1913, §§ 261, 277, 278, 279, 280.

32. Tasmanian Criminal Code, 1924, §§ 1, 163, 289(3).

33. Else-Mitchell & Nossal, *The Right to Die*, 4 THE PROCEEDINGS OF THE MEDICO-

thanasia in certain circumstances with the enactment of the Natural Death Act, 1983, mentioned earlier.

III. THE LAW IN ACTION

The law in theory and the law in practice in Australia, as elsewhere, may be two different things as in many cases the people who administer the law seem more rational than the law itself. As is evident from many cases in so-called "mercy killings" police appear reluctant to prosecute, juries to convict and judges to punish. Some random examples may be noted:

- * Louis Repouille chloroformed his thirteen-year old son who had suffered from Down's syndrome. He was convicted in New York of second degree manslaughter with a recommendation of the "utmost clemency" and freed on a suspended sentence of five to ten years.³⁴
- * John Noxon, a prosperous Massachusetts lawyer, was convicted of electrocuting his six-month old mongoloid son. His death sentence was commuted to life imprisonment and later reduced to six years. He was paroled shortly thereafter.³⁵
- * On June 20, 1973, in a town in New Jersey, Lester Zygmanski shot his twenty-six year old brother in the head with a shotgun, who had been paralyzed from the neck down in a motorcycle accident four days prior to the shooting and had repeatedly pleaded with Lester to kill him. Indicted for murder in the first degree Zygmanski was later acquitted on grounds of temporary insanity.³⁶
- * Otto Werner pleaded guilty to voluntary manslaughter for suffocating his hopelessly crippled arthritic bedridden wife. The Illinois court found him guilty, but after hearing the testimony of his children showing the great devotion he had for his wife and that the killing had been at her request, the court allowed the guilty plea to be withdrawn and a plea of not guilty entered. He was then found not guilty.³⁷

LEGAL SOCIETY OF NEW SOUTH WALES 1968-1970, at 21, 27-28 (1970); see also Human Rights Commission, Australia, *Human Rights of the Terminally Ill* (Report No. 11, 1985).

34. Repouille v. United States, 165 F. 2d 152 (2d Cir. 1947) (summarizing the facts in the context of determining whether or not Repouille was a person of "good moral character" for naturalization under the Nationality Act of 1940).

35. Commonwealth v. Noxon, 319 Mass. 495 (1946).

36. State v. Zygmanski, No. 1197-72 (Super. Ct., Monmouth County, N.J., Oct. 15, 1973). For a discussion of this case, see Note, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1213-14 (1973); Comment, *The Right to Die*, 10 CAL. W. L. REV. 613, 614 (1974).

37. People v. Werner, Crim. No. 58-3636 (Crim. Ct., Cook County, Ill. 1958).

- * The Victorian Supreme Court in 1983 in *R. v. Larkin*³⁸ placed a nurse on a three-year good behavior bond after she pleaded guilty to a charge of aiding and abetting suicide by administering a fatal dose of insulin to her lover who had previously attempted suicide and had repeated his desire to die.
- * In the Australian Capital Territory, in 1983, the federal Attorney-General, Senator Gareth Evans decided against proceeding in a case where a woman suffering from a terminal illness who had expressed the desire to die was killed by her sister.³⁹
- * In a Western Australian case, in April 1964, Dr. Maurice Benn was sentenced to the mandatory death penalty for the mercy-killing of his mongoloid son. His sentence was soon commuted to imprisonment with hard labor for ten years. He was released on parole, in December 1968, having spent his time in prison doing scholarly research for his own publication. Upon release he resumed his position in the community and took up his former University teaching career. It was clear that public sympathy was on his side and the administrators of the law took that into account.⁴⁰

Thus, it would appear that public morality seems to be supportive of euthanasia especially in the case of painful incurable illnesses. This is borne out by a 1982 Australian survey which found that more than half the people polled approved of euthanasia "under certain circumstances."⁴¹

The medical profession appears to enjoy a high degree of immunity from criminal prosecution. It is unlikely that charges would be brought against a physician if he brought a patient's process of dying to a more rapid end through the administration of drugs ostensibly for the relief of pain, provided that what he did was consistent with accepted medical standards. In the few unreported cases where mercy-killers have actually been brought to trial, the trend in Australia has generally followed what has happened overseas.

In *R. v. Adams*⁴² Mr. Justice Devlin directed the jury that there is no special defense justifying a doctor's giving drugs which would shorten life, but continued "[i]f the first purpose of medicine, the restoration of health, can no longer be achieved, there [is] still much for the doctor to do, and he [is] entitled to do all that is proper and necessary to relieve pain and suffer-

38. Law Reform Commissioner, Victoria, *supra* note 15, at 25.

39. *Id.*

40. Based on conversation with my colleague, Professor George Winterton, of the Law School of the University of New South Wales.

41. Sydney Morning Herald, Nov. 15, 1982, at 2.

42. Unreported. The case is discussed in Palmer, *Dr. Adams' Trial for Murder*, 1957 CRIM. L. REV. 365.

ing even if the measures he [takes] may incidentally shorten life. . . ."⁴³ This direction was not challenged by the Attorney-General on behalf of the Crown.

Though there has been no test case in Australia, in situations where a physician honors a patient's request by facilitating him in some way to commit suicide (for example, by leaving an extra quantity of tablets in the knowledge or with the strong suspicion that they will be used for that purpose), *R. v. Fretwell*⁴⁴ may perhaps avail the doctor.⁴⁵ In that case, proof that an article was knowingly supplied was not held to be conclusive evidence of intent to aid. However, the more recent case, *National Coal Board v. Gamble*,⁴⁶ somewhat discredits this decision. It was made clear there that "intention" on the part of an accomplice is the *mens rea* required to hold him guilty of aiding and abetting.

The physician may, however, argue that the pills were given to ease pain or for sleeping, and invite the jury to believe him. Parry-Jones suggests that his confidence would not be misplaced. In his study of the period 1961-1970, he shows that eighty cases of aiding and abetting a suicide were reported to the Director of Public Prosecutions and criminal proceedings were instituted in twelve of them. In two cases the suicide was facilitated at the request of the deceased and penalties were merely probation for three years and binding over for two years.⁴⁷ In cases where a patient fails to take care of himself because he knows that if he does nothing death will come sooner, the death may be treated as suicide. A doctor who does nothing cannot be guilty of aiding and abetting, although there are those who argue that a doctor is under an obligation to prevent a patient from adopting a course of action which would lead to self-destruction. The plea of necessity and the case of *Leigh v. Gladstone*⁴⁸ (which dealt with the forcible feeding of a stubborn suffragette) are cited in support. However, this case would be unlikely to be followed in Australia in the above situation, as there is a "general principle of self-determination" and "the case cannot stand as authority for the proposition that there exists a duty . . . to prevent someone from refusing food and a *fortiori* medical treatment."⁴⁹ A 1965 New Zealand case, *Smith*

43. *Id.* at 375, paraphrasing Devlin, J.'s summing-up. See also P. DEVLIN, SAMPLES OF LAWMAKING 94-95 (1962).

44. [1862] Le. & Ca. 161.

45. Kennedy, *The Legal Effect of Requests by the Terminally Ill and Aged Not to Receive Further Treatment from Doctors*, 1976 CRIM. L. REV. 217.

46. [1959] 1 Q.B. 11.

47. Parry-Jones, *supra* note 12.

48. [1909] 26 T.L.R. 139.

49. Kennedy, *supra* note 45, at 227.

v. Auckland Hospital Board,⁵⁰ emphasizes this latter point. There, Mr. Justice Gresson held that a patient has the "right to decline operative investigation or treatment however unreasonable or foolish this may appear in the eyes of his medical advisers."⁵¹ If an adult patient has actually forbidden treatment, and a doctor gives it, he is acting illegally and could be prosecuted for assault.

Another type of case which has yet to be tested in Australia is one where the physician hastens the natural death of a patient by switching off a necessary mechanical aid such as an automatic respirator or an artificial kidney machine. One argument is that such mechanical aids may be classed as "extraordinary measures" for keeping the patient alive. They may involve pain and other inconvenience and the physician is under no duty to continue treatment that is a burden to the patient. If the patient has indicated that he wishes the treatment to be discontinued the physician should be absolved of his duty to continue treatment. No patient is obliged to endure treatment for ever.

The celebrated New Jersey decision of *In re Quinlan*,⁵² which involved a twenty-two year-old woman in a permanently comatose state, forced people to look long and seriously at the problem of keeping terminally ill patients alive by artificial devices (*viz.*, heart-lung machines, pacemakers, defibrillators, chronic dialysis, hypothermia, artificial or transplanted organs) in modern technologically advanced society. In that case, Karen Quinlan was placed on a respirator when she ceased breathing. When it became clear that she had no significant chance of ever regaining neurological functions and returning to cognitive or sapient life, her parents sought discontinuation of all extraordinary measures including the respirator. It was asserted that the use of a respirator violated Karen's free exercise of religion, constituted cruel and unusual punishment, and violated her right of personal privacy. The court ruled against the parents, arguing that the removal of the respirator would constitute unlawful homicide if it resulted in death. Eventually after a long court battle, the New Jersey Supreme Court rejected the first two claims but agreed that Karen's right of personal privacy encompassed her freedom to order the withdrawal of extraordinary treatment. It there-

50. 1965 N.Z.L.R. 191.

51. *Id.* at 219. See also Gerber, *Informed Consent*, 140 MED. J. AUSTL. 89 (1984); Gerber, *Informed Consent—The Last of Mrs. Sidaway?*, 142 MED. J. AUSTL. 643 (1985).

52. 70 N.J. 10, 355 A. 2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). The literature on this case is voluminous and evergrowing, prompting many legislative measures which will no doubt be of great relevance to Australian lawmakers. For a sampling of such writings, see Symposium, "In re Quinlan," 30 RUTGERS L. J. 243 (1977); Comment, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L. J. 539 (1976).

fore allowed the respirator to be unhooked.⁵³ Interestingly, hooked up to a nasogastric feeding tube and IVs, Karen Quinlan continued to breathe unaided until she finally died on June 11, 1985 of pneumonia.

Several factors have been noted relating to the application of the law in euthanasia cases where a physician is involved. Prosecutors may be reluctant to institute proceedings against a reputable doctor who has acted in difficult circumstances. Although there is scant hard evidence of the incidence of euthanasia, there can be little doubt that to some extent it is practiced at least by omission. One factor in the failure to prosecute, or if there is a prosecution the failure to convict, is the difficulty of proving causation. Even when causation can be shown, courts and juries are often motivated by sympathy for the physician's humanitarian motive.⁵⁴ These factors are probably also at work in Australia in relation to the laws on euthanasia as they are applied in practice.

IV. THE MOVEMENT FOR LEGALIZATION OF EUTHANASIA

A. *The Euthanasia Debate*

The respective positions of those arguing for and against legalization of euthanasia, and the arguments advanced by both sides on moral grounds are clear.

Pro-euthanists argue that denying a compassionate death to terminally ill persons, suffering excruciating agony, and kept alive only by the "extraordinary"⁵⁵ techniques of advanced medical science, is desperately inhumane. Furthermore, they state, it is barbaric to compel the family of a terminal patient to witness the ever-worsening stages of his ailment, and to watch the

53. The post-*Quinlan* cases reveal two lines of thinking. First, those that require court approval before physicians withhold or withdraw life support. See, e.g., *Custody of a Minor*, 385 Mass. 697, 434 N.E.2d 601 (1982); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980). And, second, those which do not require judicial involvement, preferring instead that the decision to withhold or withdraw life support be made within the patient-physician-family relationship. See, e.g., *John F. Kennedy Memorial Hosp., Inc. v. Bludworth*, 452 So. 2d 921 (Fla. 1984); *In re Guardianship of Barry*, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984); *In re Welfare of Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983), modified on other grounds, *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984). The majority of cases, however, favor the second approach enunciated by *Quinlan*. See generally LEGAL AND ETHICAL ASPECTS OF TREATING CRITICALLY AND TERMINALLY ILL PATIENTS (A. Doudera & J. Peters eds. 1982); Ainley, *Discontinuing Treatment of Comatose Patients Who Have Not Executed Living Wills*, 19 LOYOLA L.A. L. REV. 61 (1985).

54. Gurney, *Is There a Right to Die?—A Study of the Law of Euthanasia*, 3 CUM.-SAM. L. REV. 235, 251 (1972).

55. For a classic description of what constitutes "ordinary" and "extraordinary," see D. MEYERS, *MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING* 148 (1981):

slow, agonizing death of their loved one, degenerating before their eyes, being transformed from a vital and robust parent or spouse into a pathetic and humiliated creature, devoid of human dignity. Death should no longer be viewed as a personal failure, but an orchestrated overture of life and living. However, as noted, this right to choose death over life has never been recognized by the common law.

Among the major objections to legalizing voluntary euthanasia, generally advanced by those with a religious perspective, are:

- (1) that doctors are already performing *sub silentio* whatever mercy killings may be necessary;
- (2) that the use of modern pain-relieving drugs and the hospice movement to help people cope with pain and fear of death obviates the need for voluntary euthanasia;
- (3) that there is risk of mistake in medical diagnosis, and, once made, the consequences would be irreparable;
- (4) that there are possibilities of new medical discoveries to cure the incurable patient;
- (5) that it is difficult to ascertain whether the patient has *really* consented;
- (6) that legitimizing an act of killing because life is "not worth living" would undermine respect for life and could open the door to mass involuntary euthanasia or genocide.

These arguments deserve detailed refutation.

A sufficient answer to the *first* objection would be: A situation in which euthanasia is admittedly practiced by the medical profession, while labelled "homicide" by existing law, must not continue. No amount of Holmesian realism can persuade a physician that a prosecutor's willingness to look the

Ordinary means are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience.

Extraordinary means are all medicines, treatments, and operations which cannot be obtained or used without excessive expense, pain, or other inconvenience; or which, if used, would not offer a reasonable hope of benefit.

See also D. WALTON, ETHICS OF WITHDRAWAL OF LIFE-SUPPORT SYSTEMS 222-26 (1983); *In re Quinlan*, 70 N.J. 10, 48, 355 A. 2d 647, 667, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484, 490-91 (1983). The President's Commission Report, however, proposes that the traditional distinction between "ordinary" and "extraordinary" care should no longer be used to determine whether or not an individual should accept treatment, for technological advances change the extraordinary into ordinary. Instead, a useful/burdensome distinction should be adopted. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 83-89 (1983).

other way may weaken his legal obligations. Although prosecution may be rare, criminal liability is a serious and unnerving threat.

True, in relation to the *second* objection, the modern armor of tranquilizing, euphoric, pain-killing (analgesic) and stupefying (narcotic anaesthetic) drugs has helped alleviate the agony of painful suffering, but they do not cure the terminally ill patient. Additionally, there are diseases—*e.g.*, cancer of the throat, emphysema—for which even modern drugs can offer no pain-killing effect. There is also the problem of addiction (since increased dosages are generally necessary to neutralize the pain). And, there are the side-effects—vomiting, nausea and long periods of consciousness of impending doom—which may be just as undesirable.

To counter the *third* objection, the percentage of correct diagnosis is unusually high in cancer cases, and wrong diagnosis of patients commonly referred to as “human vegetables” is practically nonexistent. Any possibility of an incorrect diagnosis can, however, be rectified by legislation requiring an euthantee to be examined by several physicians.

The *fourth* objection overlooks that there exists a substantial time lag between the initial discovery and reporting of a miraculous new drug or therapy and the availability of the same to the medical profession. Is it consistent with the object of voluntary euthanasia to demand that the patient mortgage his dignity to technology and suffer in the interim on the tenuous proposition that a miraculous cure might be found? Moreover, news of a relevant medical breakthrough could stop euthanasia in relevant cases.

Concerning the *fifth* objection, a variety of protective procedural schemes to forestall some of the vexed problems of assessing the “voluntariness” of consent have been advanced. This would undoubtedly prevent problematic termination by those deranged individuals who are either fanatically fascinated by resurrection or are trapped in experiencing transitory deprivations of life values—illness, divorce, agony, frustration, financial impoverishment, or failed romance. One safeguard is that if relatives are pushing the sick person toward euthanasia, the doctor should not oblige. Similarly, mandatory time intervals allowing a patient greater reflection and intervention of neutral third parties to verify the diagnosis and the patient’s consent could be required. The physician must inform the patient of all facts necessary to his intelligent and “informed” consent. Adequate legislation can further provide a patient an opportunity to request voluntary euthanasia while still in a rational state of mind. Therefore, one of the suggested solutions is that the individual should indicate to what extent he consents to treatment, while fully in control of his faculties.

The *sixth* argument, though appealing to some and reminiscent of the per-

ils of Nazi Germany, can be countered by explaining that voluntary euthanasia will be administered to a patient only upon his freely given, intelligent and informed consent. In fact, the practice of withholding medical care from defective newborns is so pervasive that we may have already embarked on a widespread program of involuntary pediatric euthanasia in Australia: "[C]ompassionate infanticide is already standard practice where the product of birth is such as to justify the term 'monstrous', i.e., where there is a gross and physically disgusting malformation such as anencephaly (complete absence of brain). Severe spina fida, where there is no possibility of effective surgery, is also not infrequently dealt with by allowing the infant to die under sedation."⁵⁶

B. Australian Initiatives

Unfortunately, however, every doctor in Australia, except perhaps in South Australia, who presently assists a terminally ill patient to end his life remains under the threat of criminal sanctions.

The societies working for legalization of euthanasia do not necessarily want the present law changed so that the burden of termination of life will be on the physician. They believe that the person desiring death should not need to involve medical workers beyond the point of assisting him in his own suicide and that only the person incapable of suicide would need euthanasia. They argue that physicians should not have to decide on life or death for their patients—that choice should be the patient's. The Voluntary Euthanasia Society of Victoria includes the following in its proposals for legislation:

Under voluntary euthanasia legislation, the doctor's duty is to give a medical assessment—a diagnosis and prognosis—and to advise the patient, if he is capable of rational choice, of alternative treatments and the consequences of accepting or rejecting them. The patient does the deciding with the information given him or, if he has lost mental competency, by the advance declaration which he has previously made against just that eventually.⁵⁷

After the patient has made his decision about his own fate, then the medical profession only becomes really involved if the patient requires assistance to end his life. In the case of an incompetent patient the doctor has the

56. M. BURNET, ENDURANCE OF LIFE: THE IMPLICATIONS OF GENETICS FOR HUMAN LIFE 96 (1978). Cf. Ellis, *Letting Defective Babies Die: Who Decides*, 7 AM. J. L. & MED. 393 (1982); Australian College of Paediatrics, *Nonintervention in Children with Major Handicaps—Legal and Ethical Issues*, 19 AUSTRALIAN PAEDIATRIC J. 217 (1983); KUHSE & SINGER, *supra* note 10.

57. VOLUNTARY EUTHANASIA SOCIETY OF VICTORIA, VOLUNTARY EUTHANASIA—THE RIGHT TO CHOOSE 17 (1977).

means of administering painless death in accordance with the patient's previously expressed wishes.

The possibility of law reform in this area is quite clear. As previously noted, the South Australian Natural Death Act was passed in 1983 in response to these initiatives. In addition, despite the failure of the Refusal of Medical Treatment Bill in Victoria, there are moves in that state to have the law relating to "mercy killing" reformed. A Working Paper released by the Victorian Law Reform Commission as part of a review of the law of homicide generally recognizes three possibilities of reform: that a new offense of "mercy killing" could be created with a lower penalty than that for murder; that a compassionate motive could constitute a mitigating circumstance, reducing murder to manslaughter; or punishment for murder could become a discretionary sentence, to allow a judge to take motive into account in sentencing.⁵⁸ Whether the proposal relating to the creation of a separate offense will amount to anything is doubtful. The English Criminal Law Revision Committee made a similar proposal in 1976, but was forced to withdraw it because of strong critical response.⁵⁹ Likewise the South Australian Reform Committee⁶⁰ and the Canadian Law Reform Commission⁶¹ rejected the need for change, the Canadian Report emphatically recommending that "mercy killing" not be made a separate offense with special modes for sentencing,⁶² although the South Australian Committee stated that "it may be appropriate to release such a person on parole immediately after sentence."⁶³

C. Overseas Reforms

If Australian law is changed in response to pressure from groups advocating voluntary euthanasia, although it would not be a "first," it would nevertheless set an important world precedent. Changes to the law have been made in overseas countries.

Uruguayan law is perhaps the most advanced in that judges are allowed to forego punishment completely where a defendant whose previous life had been honorable commits a homicide motivated by compassion and induced

58. *Supra* note 15, at 25.

59. CRIMINAL LAW REVISION COMMITTEE, WORKING PAPER ON OFFENCES AGAINST THE PERSON 31 (1976).

60. CRIMINAL LAW AND PENAL METHODS REFORM COMMITTEE OF SOUTH AUSTRALIA, FOURTH REPORT—THE SUBSTANTIVE CRIMINAL LAW 58 (1977).

61. LAW REFORM COMM'N OF CANADA, WORKING PAPER NO. 28, EUTHANASIA, AIDING SUICIDE AND CESSATION OF TREATMENT (1982); Samek, *Euthanasia and Law Reform*, 17 OTTAWA L. REV. 86 (1985).

62. *Id.* at 20.

63. *Supra* note 60, at 58.

by repeated requests of the victim.⁶⁴

Most jurisdictions which have examined the question of euthanasia have drawn a distinction between voluntary and involuntary killings. The Italian, Netherlands, Spanish, German, Polish and Japanese Penal Codes all allow a mitigation in penalty if the killing is carried out at the request of the victim.⁶⁵ The German Penal Code makes specific provision in section 216 that in the case of "homicide upon the request of the person killed," the punishment is limited to two years, and if extenuating circumstances are present, it can be reduced to six months.⁶⁶

But involuntary euthanasia has been treated more cautiously. For example, the Swiss Penal Code covers the area of voluntary euthanasia, but the question of involuntary euthanasia is unclear.⁶⁷ The Norwegian Penal Code draws a specific distinction: Section 235 contains a special provision for mercy-motivated or requested killing of hopelessly ill people, with a 1961 amendment exempting the mercy-killer where the victim consented or was hopelessly ill from normal homicide provisions. Under section 114, a lesser degree of punishment (three days to three years) is applicable for homicide upon the victim's serious and urgent request.⁶⁸

The situation in the United States is very relevant for Australia, illustrated by the similarity between the Californian and South Australian Natural Death Acts. The "right to die" legislation, as it has been termed in the United States, is in effect an extension of a patient's well-established common-law right to refuse medical treatment,⁶⁹ rather than addressing the is-

64. URUGUAY PENAL CODE art. 37 (1933).

65. See generally Silving, *supra* note 5; Sayid, *Euthanasia: A Comparison of the Criminal Laws of Germany, Switzerland and the United States*, 6 B.C. INT'L & COMP. L. REV. 533, 547-55 (1983); Aly & Roth, *The Legalization of Mercy Killings in Medical and Nursing Institutions in Nazi Germany from 1938 Until 1941: A Completed Documentation*, 7 INT'L J.L. & PSYCHOLOGY 145 (1984).

66. STRAFGESETZBUCH (StGB) [GERMAN PENAL CODE], § 216.

67. SCHWEIZERICHES STRAFGESETZBUCH [SWISS PENAL CODE] ART. 114 (1942).

68. See generally D. MEYERS, *THE HUMAN BODY AND THE LAW—A MEDICO-LEGAL STUDY* 152-55 (1970); Silving, *supra* note 5.

69. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (Cardozo, J.): "Every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . . This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained."

For an examination of various statutes in the United States recognizing the concept of a "living will," see generally Dufraine, *Living Wills—A Need for Statewide Legislation or a Federally Recognized Right*, 3 DET. C.L. REV. 781 (1983); Capron, *Death and the Law: A Decade of Change*, 63 SOUNDINGS 290 (1980); Kirby, *The Euthanasia—Living Will Debate*, in ISSUES IN ETHICS 45 (Papers Presented at the Monash University Centre for Human Bioethics Conference on Medical Science and Preservation of Life: Ethical and Legal Dilemmas, Nov. 1981) (1982).

sue of euthanasia directly. The enactments of the American jurisdictions,⁷⁰ and the Natural Death Act of South Australia, give legal effect to a written document in a prescribed form in which a person states that in the event of terminal illness, life-prolonging treatment is not to be maintained.

In such statutes, there tend to be two "thresholds"—the disease qualification, that the patient must be terminally ill⁷¹ which may mean either irreversibly dying⁷² or facing imminent death,⁷³ and a therapeutic requirement, namely, that the treatment is "artificial, extraordinary, extreme or radical."⁷⁴ Clearly, the American statutes are flexible, leaving to the physician

70. See Flaherty, *A Right to Die?*, Nat'l L. J., Jan. 14, 1985, at 1, col. 1. Since 1976, the following states have enacted such "right to die" or "natural death" legislation: Alabama: Natural Death Act, ALA. CODE §§ 22-8A-1 to -10 (1984); Arkansas: Death With Dignity Act, ARK. STAT. ANN. §§ 82-3801 to -3804 (Supp. 1983); California: Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185 to 7195 (West Supp. 1985); Delaware: Death With Dignity Act, DEL. CODE ANN. tit. 16, §§ 2501 to 2509 (1983); District of Columbia: Uniform Determination of Death Act of 1981, D.C. CODE ANN. §§ 6-2422 to -2430 (Supp. 1985); Florida: Life-Prolonging Procedure Act, ch. 84-58, 1984 FLA. LAWS 136; Georgia: GA. CODE ANN. §§ 31-32-1 to -12 (Michie Supp. 1984); Idaho: Natural Death Act, IDAHO CODE §§ 39-4501 to -4508 (Supp. 1984); Illinois: Illinois Living Will Act, ILL. ANN. STAT. ch. 110 1/2 §§ 701-710 (Smith-Hurd Supp. 1984-85); Kansas: Natural Death Act, KAN. STAT. ANN. §§ 65-28,101 to -28,109 (1980); Louisiana: Natural Death Act, LA. REV. STAT. ANN. §§ 40:1299.58.1 - .10 (West Supp. 1985); Mississippi: Act of Apr. 16, 1984, ch. 365, 1984 MISS. LAW 98; Nevada: Withholding or Withdrawal of Life Sustaining Procedures, NEV. REV. STAT. §§ 449.540 to .690 (1983); New Mexico: Right To Die Act, N.M. STAT. ANN. §§ 24-7-1 to -11 (Supp. 1984); North Carolina: Right to a Natural Death; Brain Death, N.C. GEN. STAT. §§ 90-320 to -323 (1981); Oregon: Rights With Respect To Terminal Illness, OR. REV. STAT. §§ 97.050 to .090 (1983); Texas: Natural Death Act, TEX. STAT. ANN. art. 4590h §§ 1 to 11 (Vernon Supp. 1985); Vermont: Terminal Care Document, VT. STAT. ANN. tit. 18, §§ 5251 to 5262 (Supp. 1984); Virginia: Natural Death Act of Virginia, VA. CODE § 54-325.8:1 to .8:12 (Supp. 1984); Washington: Natural Death Act, WASH. REV. CODE ANN. §§ 70.122.010 to .122.905 (West Supp. 1984-85); West Virginia: W. VA. CODE §§ 16-30-1 to 16-30-10 (Michie Supp. 1984); Wisconsin: Act of Apr. 18, 1984, Act No. 202, 2 WIS. LAWS 1274 (to be codified at WIS. STAT. ANN. §§ 154.01 to 154.15); Wyoming: WYO. STAT. §§ 33-26-144 to -26-152 (Michie Supp. 1984). The New York legislature is drafting "right to die" legislation. Joyce, *To Die or Not to Die: The New York Legislature Ponders a Natural Death Act*, 13 FORDHAM URB. L. J. 639 (1985). For a survey of natural death legislation, see PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 139-42, 309-87, and apps. D. E (1983).

71. *E.g.*, Natural Death Act, CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1984).

72. *E.g.*, Natural Death Act, KAN. STAT. ANN. §§ 65-28, 102 (1980); Right To Die Act, N.M. STAT. ANN. § 12-7-2 (Supp. 1984).

73. *E.g.*, Natural Death Act, CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1984); Natural Death Act, IDAHO CODE § 39-4503 (Supp. 1984); Withholding or Withdrawal of Life Sustaining Procedures, NEV. REV. STAT. § 499.590.610 (1983); Natural Death Act, WASH. REV. CODE ANN. § 70.122.020 (Supp. 1985); Illinois Living Will Act, ILL. ANN. STAT. ch. 110 1/2, § 702(f) (Smith-Hurd Supp. 1984-85).

74. Death With Dignity Act, ARK. STAT. ANN. § 82-3802 (Michie Supp. 1983).

the determination of what is an "extraordinary measure" or a "terminal illness."

In general, the statutes apply only to "competent adults,"⁷⁵ children and those of unsound mind being excluded. However, some jurisdictions have made provision for proxy consent. North Carolina's statute allows proxy consent for an irreversibly comatose patient who has not previously executed the document, consent being given by a spouse, legal guardian or a majority of the relatives of the first degree,⁷⁶ although the provisions make no reference to any other type of incompetent patient. The Virginia statute does not expressly allude to the rights of patients with inadequate decisionmaking capacity and refers only to competent patients.⁷⁷ In New Mexico, provision is made for proxy consent for minors,⁷⁸ although not for incompetent adults. Arkansas, however, covers both minors and incompetent adults.⁷⁹

A key feature of almost all natural-death legislation is the immunity it provides from civil or criminal liability to the physician, medical personnel, and health care institutions acting in good faith pursuant to the statute and a validly executed living will. Despite these statutes, however, in both the United States and Britain, many legislative proposals authorizing euthanasia in circumstances beyond those in the current statutes (or even at times in similar circumstances) have been consistently rejected.⁸⁰ The reasons for rejection in such cases are very possibly relevant to Australia.

First is the nonacceptance of the idea of euthanasia by a majority of the community. Legally, and by conventional standards, euthanasia is murder, although individuals in particular circumstances may see the matter differently, and there may be widely felt sympathy for an individual situation. The community abhors killing as a form of punishment and is unhappy about it as a means of settling international disputes, so it is understandable that there should generally be a rejection of the deliberate ending of a life by

75. E.g., Natural Death Act, CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1984); Natural Death Act, KAN. STAT. ANN. §§ 65-28, 102 (1980); Withholding or Withdrawal of Life Sustaining Procedures, NEV. REV. STAT. § 499.590.610 (1983); Natural Death Act, WASH. REV. CODE ANN. § 70.122.020 (Supp. 1985).

76. Right to a Natural Death; Brain Death, N.C. GEN. STAT. § 90.322 (1981 and Supp. 1983).

77. Natural Death Act of Virginia, VA. CODE § 54-325.8:1 (Supp. 1984). See generally Note, *Proxy Decisionmaking for the Terminally Ill: The Virginia Approach*, 70 VA. L. REV. 1269 (1984).

78. Right To Die Act, N.M. STATE ANN. § 24-7-4 (1981).

79. Death With Dignity Act, ARK. STAT. ANN. § 82-3803 (Michie Supp. 1983).

80. For a review of various criticisms of the concept of "living will," see generally Horan & Marzen, *Death With Dignity and the Living Will: A Commentary on Recent Developments*, 5 J. LEGIS. 81 (1978); McCormick & Hellegers, *Legislation and the Living Will*, 136 AMERICA 210 (1977).

killing, merciful though its motives may be. Legislators, in their turn, are sensitive to strongly-held community attitudes.

Secondly, in the main, doctors are undeniably wary of measures to legalize euthanasia. Their traditional role has been to safeguard life (the time-honored Hippocratic Oath obligates the medical profession to preserve life wherever possible, and to "give no deadly medicine to anyone if asked, nor suggest any such counsel"⁸¹), while at the same time they accept not only the responsibility of saving their patients from avoidable suffering but also the fact that to do this may hasten an inevitable death.⁸²

But to be a legal public executioner is another matter. If euthanasia is legal—and if doctor, patient and relatives know it—intolerable situations could arise. The doctor will in certain circumstances feel obliged to consider the possibility of euthanasia and may be aware of pressure in that direction from relatives, either on the patient or on himself. He will have the responsibility of choosing to reject the idea and being accused of allowing suffering which he could have prevented in a simple quick way. On the other hand, he will be able to bring about death deliberately and then wonder whether he was wrong. It is understandable that doctors prefer not to be faced with these new and difficult situations.

One further reason for consistent rejection of legislation would appear to be the fact that the situations envisaged in such legislation—delicate human situations, mostly with deep emotional overtones—seem not to lend themselves easily to cold legal provisions. Even some supporters of the intentions of the bills proposed in the United States and Britain have been critical of the proposed legal wording.

Other arguments against euthanasia, foreshadowed earlier, are: the commonly cited "thin edge of the wedge" argument which considers that the likely consequence for the individual and society of any move in the direction of allowing killing would be sooner or later to put all life in jeopardy; and the argument that voluntary euthanasia legislation would undermine a patient's confidence in his doctor. Patients are now secure in the knowledge that their doctors will not kill them. A further argument rests on the fallibility of medicine, doctor and patient, and the idea that some diseases regress spontaneously, cures are sometimes discovered, and some doctors make wrong diagnoses. No doubt all of these arguments weigh with legislators when they are considering whether or not to legalize euthanasia.

81. Hippocratic Oath. See H. JACOBS, *THE SPECTRE OF MALPRACTICE* 416-17 (1978); for the Australian practice, see A. BURTON, *MEDICAL ETHICS AND THE LAW* 11-14 (3d ed. 1979).

82. See Wanzer *et al.*, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 *NEW ENG. J. MED.* 955 (1984).

V. CONCLUDING REMARKS

It is now increasingly realized that "voluntary euthanasia will only be legalized when it is felt that the advantages it offers outweigh the abuses to which it might be subject and the negative results it might have."⁸³ Until law reform ensures that an incurably ill patient may have his life ended at a time of his own choosing, the most he can legally seek from his doctors in Australia is adequate relief of distress and the nonuse of excessive means of life-support. An *Advance Declaration* completed and signed by the person making it and witnessed by two nonrelatives is designed to seek this, stating:

If there is no reasonable prospect of my recovery from physical or mental illness or impairment expected to cause me severe distress or to render me incapable of rational existence, I request that I be allowed to die and not be kept alive by artificial means, and that I receive whatever quantity of drugs may be required to keep me free from pain or distress even if the moment of death is hastened.

This is not legally binding on the doctor, but it does free him from any doubt about the patient's wishes, although he is not obliged to carry them out.⁸⁴ Other similar documents designed for use under existing law are the *Memorandum of Wishes* and *Living Wills* such as proposed in the United States and South Australia. The patient can also be made aware of his present legal rights in Australia when dealing with health care officials.

It must be clearly recognized, however, that proponents of euthanasia freely acknowledge that law reform on its own would not be sufficient to bring about an ideal situation for the dying. Among other necessary improvements are better training in the handling of the dying, better techniques for controlling pain, and better communication between the dying and their relatives, and between the dying and the medical staff caring for them. Only with these improvements, coupled with changes in the law, will the good life include the right to a good death. "And why not death rather than living torment?"⁸⁵

83. D. MEYERS, *supra* note 68, at 157; Kuhse, *Euthanasia—Again: "Letting Die" is Not in the Patient's Best Interests: A Case for Active Euthanasia*, 142 *MED. J. AUSTRALIA* 610 (1985); see also 143 *MED. J. AUSTRALIA* 48, 170-71 (1985) (correspondence on Kuhse's views).

84. Under section 4(3) of the South Australian Natural Death Act, 1983, a medical practitioner has a duty to act in accordance with such a declaration. However, under section 5(3), a medical practitioner incurs no liability for a decision made by him in good faith in regard to the question of whether a patient is or is not mentally competent at the time of making the declaration, suffering a terminal illness or had an intention to revoke his direction. However, section 6(2) makes it clear the statute does not release a physician from the consequences of a negligent diagnosis as to whether the patient is suffering a terminal illness.

85. W. SHAKESPEARE, *THE TWO GENTLEMEN OF VERONA*, Act III, scene 1, line 170 (Valentine ed.).

