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A case study of pressure group activity in Western Australia: Medical care of the dying bill (1995)

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**A CASE STUDY OF PRESSURE GROUP ACTIVITY IN
WESTERN AUSTRALIA:
MEDICAL CARE OF THE DYING BILL (1995)**

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SUPERVISOR:
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**THIS THESIS IS PRESENTED
FOR THE DEGREE OF
MASTER OF ARTS
OF EDITH COWAN UNIVERSITY,
WESTERN AUSTRALIA, 2 SEPTEMBER 1999**

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ETHICS COMMITTEE APPROVAL:

EXECUTIVE OFFICER MR ROD CROTHERS, AUGUST 1997

A CASE STUDY OF PRESSURE GROUP ACTIVITY IN WESTERN AUSTRALIA:
MEDICAL CARE OF THE DYING BILL (1995)

A B S T R A C T

When the Australian Labor Party member for Kalgoorlie, Ian Taylor, presented his Private Member's Bill - the *Medical Care of the Dying Bill (1995)*, he laid the foundation for this thesis. Mr Taylor introduced his Bill to the Western Australian Legislative Assembly on 28 March 1995. The Bill codified the terminally ill patient's right to refuse medical treatment, which clarified common law.

This thesis attempts to overcome the dearth of literature in Western Australian lobbying concerning conscience-vote issues. It also identifies the key issues in understanding political lobbying, the form of pressure group activity that takes place and why certain groups respond in different ways. The pressure groups selected for this case study are examined, classified and evaluated resulting in a prescription for lobby group activity for similar conscience-vote issues.

According to the Bill's sponsor, Ian Taylor, the legislation was needed to deal with the inconsistencies in common law of the medical treatment of terminally ill people. The Law Reform Commission in its 1991 *Report on Medical Treatment for the Dying*, stated that there was a need to deal with the issue in Western Australia. Due to the advances in medical treatment practices in the past 50 years, doctors can prolong the life of patients for whom there is no cure. The major problem, however, is the Criminal Code: doctors and care providers can be at risk of prosecution and conviction if the patient's wishes are respected and medical treatment is withdrawn, leading to the patient's death. At present there is a general common law right to refuse medical treatment. According to Mr Taylor, the difficulty lies in the fact that in Western Australia, the common law is overridden by the Criminal Code. The Bill also highlighted the role of palliative care and the treatment of the dying.

The opinion of most pressure groups was that the rights of terminally ill patients should be protected and enhanced. Of the groups selected for this case study, only the Coalition for the Defence of Human Life objected to the Bill. Other groups supported the principles of the Bill, while some hoped for voluntary

euthanasia legislation and others gave tacit approval. Of all the groups the L. J. Goody Bioethics Centre distinguished itself as a key organisation which tended to monopolise political influence.

Media exposure of the issue was high, particularly in *The West Australian*. The "right to die" issue was canvassed and often was reported with references to euthanasia. At the same time the Northern Territory legislation, the *Rights of the Terminally Ill Bill (1995)*, was receiving much media attention. The issue of euthanasia was necessarily discussed in the context of national and international arenas.

The political masters of thought on citizen participation and group theory were introduced early in the thesis. John Locke, Jean-Jacques Rousseau, James Madison, Alexis de Tocqueville, Thomas Paine and John Stuart Mill provided valuable insight into the nature of modern political thought on this interesting aspect of political activity. Contemporary political writers such as Trevor Matthews, Dean Jaensch and Graham Maddox were also consulted.

The eight pressure groups selected for the study were the:

- West Australian Voluntary Euthanasia Society Inc.
- Coalition for the Defence of Human Life
- Australian Medical Association (WA Branch)
- Australian Nursing Federation (WA Branch)
- L. J. Goody Bioethics Centre
- Silver Chain Nursing Association Inc.
- Uniting Church of Australia
- Anglican Church of Australia

Information from the groups formed a significant part of this thesis. An attempt was made in the conclusion to ascertain the effectiveness of the various strategies utilised by the pressure groups and provide an insight into lobbying practices.

Ultimately, though, the contentious Bill was not given a third reading. Nor was it debated in the Legislative Council. At one stage it was considered likely that the Bill would be recommitted to parliament. The monitoring of the *Medical Care of the Dying Bill (1995)* undertaken in this thesis, indicates that this would have been a lengthy and divisive process.

"I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text."

.....
Signed

..... 2.9.99
Dated



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The past two years have been an exciting and challenging time. If it were not for Associate Professor Harry Phillips' unflagging enthusiasm and encouragement, I would possibly still be pondering the thesis.

Australian veteran lobbyist Peter Cullen "turned the lights on" for me in Canberra. His generous time with me at the Press Club has left me eternally grateful.

To those wonderful, willing participants who made this thesis possible - those I interviewed, thank you sincerely. To Ian Taylor, who breathed life into the *Medical Care of the Dying Bill (1995)*, without his vision the Bill would have languished in somebody's political mind, thank you for unwittingly creating a pressure group conscience vote scenario. His candour and lucidity in sharing a piece of Western Australia's political history is valued and appreciated.

I am always grateful to my husband Alec, for this thesis is really as much his as it is mine. Thanks to my sons, Adam, Zachary and Jacob, for sharing me with my dream.

For me, the end of this thesis really marks the beginning.

CHAPTER ONE
POLITICAL THEORISTS AND PRESSURE GROUPS

"Politics," it has been said, "is the only way to achieve change, you can't do it from the outside. You have to be in the process."¹ Indeed, one way of being in the process without being elected to the legislature is to partake in pressure group activity. Pressure group leaders invariably attempt to apply leverage to strategic places, and often that is directed toward parliament, as this thesis will demonstrate. In broad terms a pressure group is a political group which seeks to influence the decisions of government without necessarily gaining office and this has a long tradition in Western political thought.

The term "pressure group" is sometimes used as a term of abuse:

as "pressure" implies the threat of sanction being imposed if the claim is not met by the government. This is why some writers prefer the term interest group or lobby. ... A lobby (which literally means an area within the confines of a parliament, congress, chamber or assembly) is basically a group formed for the sole purpose of influencing the fate of legislation or the way in which government policy is carried out.²

An interest group, frequently used as a synonym for pressure group, may not necessarily be seeking to influence public policy. However, for the purposes of this thesis the term used will be pressure group.

¹ Glenda Jackson, Actress, Oscar Winner and politician, quoted in Mitchell, S. (1996). *The Scent of Power*. Sydney: Harper Collins Publishers, p. 89.

² Phillips, H. and Rielly, C. (1982). *Key Concepts in Politics*. Melbourne: Thomas Nelson Australia, p. 125.

This is a study of the processes of modern pressure groups in contemporary Western Australia in the 1990s. The focus of the processes is an attempt to gain passage of highly contentious legislation, namely the *Medical Care of the Dying Bill (1995)*.³ Former Leader of the Opposition in the Western Australian Legislative Assembly, Mr Ian Taylor, introduced this Bill into parliament. The Bill lapsed after Mr Taylor left State politics to contest the 1996 Federal election. However, he failed in his bid to win the seat of Kalgoorlie for the Australian Labor Party (ALP).

The Medical Care of the Dying Bill (1995) was a social reform Bill which attempted to provide an answer to a sensitive and complex issue for which, in reality, no easy answer could be provided. The parliamentary debate demonstrated the vastly different opinions and moral views held by the community. The debate was stimulating but often divisive. The media was eager and attentive towards the issue of euthanasia and the "right to die" legislation, notwithstanding the concurrent Northern Territory legislation *Rights of the Terminally Ill Bill (1995)* which sought to legalise voluntary euthanasia.

Because a conscience vote was granted to Members of the Western Australian Parliament, pressure groups lobbied parliament directly. The 57 members of the Legislative Assembly were the principal focus of pressure group activity. This provided an opportunity for groups to participate in the process of persuasion, influence and

³ See Appendix 1: Medical Care of the Dying Bill No. 35-1B.

information dissemination, thus directly affecting the political decision-making process.

This thesis reveals how pressure groups presented their strategies in attempting to gain passage, amend or stall the progress of the Bill in the Legislative Assembly. In addition, this thesis examines pressure group efficacy, the varying shades of opinion and the impact the groups in the study had on the legislation.

A thorough understanding of the activities of the pressure groups and their interplay with government initially requires consideration of the key thoughts of some of the most influential writers in this domain and thereafter, an examination of standard works of pressure groups. Perhaps at times, it is the influence of such groups rather than political parties, which guides the passage of much legislation in the parliament of Western Australia.⁴

Political Masters

The history of political theory includes many influential writers who considered the ramifications of organised

⁴ Robinson, K. (1998). *Ambiguities in Parliamentary Representation: An Examination of Representation and Party Attachment in the Western Australian Legislative Assembly*. Unpublished masters thesis, University of Western Australia, Perth, Western Australia, p. p. 52-53, 57. Fifty members of the Legislative Assembly were asked from a list of factors which would influence a Member of Parliament when making everyday decisions. Members ranked foremost their own judgement and experience, followed by constituency opinion, view of party organisation, opinion of parliamentary party colleagues; opinion of organised group ranked equal to the view of party organisation and the views of a particular individual. Robinson concluded that, "... one can see that the dominant representational style for the Legislative Assembly members appears to be a trustee one. ... a majority of members chose their own judgement and experience as the primary influence on their decision-making."

citizen participation. Few of the masters of political thought, who have written about political participation, could have anticipated the complex role that pressure groups play in our modern democracy. However, these thinkers still provide revealing insights into contemporary questions on pressure groups.

Some of the notable political philosophers contributing to political science literature in the "theory of pressure groups" are John Locke (1632-1704), Jean-Jacques Rousseau (1712-78), Thomas Paine (1737-1809), James Madison (1751-1836), Alexis de Tocqueville (1805-59) and John Stuart Mill (1806-73).⁵ The seventeenth and eighteenth century European enlightenment thinkers trace the beginnings of "modern" government, to the various contemporary versions of pressure group theory held today.⁶

Liberal political thought points us towards the "consent theory" as the ultimate foundation of legitimate authority.⁷ The evolution of the doctrine of consent can be traced through the classic liberal theorists Thomas

⁵ Prominent philosophers who wrote during the reforming age of the nineteenth century.

⁶ Enlightenment, (1971). *Encyclopedia Britannica*. (Vol. 8 p.p. 600-601.) Chicago: Encyclopedia Britannica.

The enlightenment was a movement of thought and belief, developed from interrelated conceptions of God, reason, nature and man, to which there was wide assent in Europe during the seventeenth and eighteenth centuries. Its dominant conviction was that right reasoning could find true knowledge. Natural law rationalism was provoked by Thomas Paine's *Age of Reason*, (1794), and Jean-Jacques Rousseau's writing. Lockean doctrine inspired the Declaration of Independence and the 1789 French Revolutionaries declaration reflected Locke and Rousseau's sovereignty of the nation and the General Will. The enlightenment became critical, reforming and eventually revolutionary.

⁷ Marsh, I. (1983). *Politics, Policy Making and Pressure Groups: Some Suggestions for Reform of the Australian Political System*, in Lovell D., McAllister, I., Maley, W., and Kukathas, C. (1995). *The Australian Political System*. Melbourne: Longman Australia, p. 305.

Hobbes (1588-1679) and Locke⁸ to Rousseau and Mill. Furthermore, this consent/contract theory implies that citizens of a state give up some of their "natural" rights in return for a government whose laws safeguard their rights such as life, liberty and property.⁹ Hobbes' and Locke's belief lay in extending interest group participation in public policy making, whereby the typical citizen limited his greed through a rational calculation of self-interest aided by a fearful grasp of the alternatives.¹⁰

John Locke

English philosopher and politician John Locke wrote of natural rights and natural law and was identified with the development of liberal political thought. Locke's philosophy was embodied in the *American Declaration of Independence* and in the *Bill of Rights* appended to the *United States Constitution*.¹¹ He regarded a person as a naturally social individual. Locke is sometimes regarded as an early theorist of democracy, the separation of powers and the rule of law.

⁸ *Ibid.* p. 601. The second of Locke's *Two Treatises of Government*, shone with common sense and moral appeal: government was derived from the consent of the members of the state and in practice consent meant rule by an undefined majority and an ultimate right of rebellion.

⁹ Phillips, H. and Rielly, C. (1982). *Key Concepts in Politics*. Melbourne: Thomas Nelson, p. 39.

¹⁰ Marsh, I. (1983). *Politics, Policy Making and Pressure Groups: Some Suggestions for Reform of the Australian Political System*, in Lovell D., McAllister, I., Maley, W., and Kukathas, C. (1995). *The Australian Political System*. Melbourne: Longman Australia, p. 305.

¹¹ Rodee, C. Anderson, T. and Christol, C. (1967). *Introduction to Political Science*, second edition. New York: McGraw-Hill, p. 282.

Locke considered that political obligation was based on the peoples' consent.¹² He was the pioneer of liberty, which found expression in the *Universal Declaration of Human Rights* proclaimed by the United Nations in 1948.¹³

Locke contended that civil government must be founded on contract and consent of the ruled, as opposed to tyranny or despotism.¹⁴ The theory of Locke implied that the ultimate political power and rights belonged to the people - he developed and allowed for the right of resistance of the people; of which later radicals made effective use.¹⁵ In justifying rule by the majority, Locke said a community, "being one body must move one way". Thus embodied in the democratic principle: where there cannot be universal agreement, matters should be settled according to the will or wishes of the majority.¹⁶

Locke's *Second Treatise of Government: An Essay Concerning the True Original, Extent, and End of Civil Government*, endorsed tacit consent of the population. People were deemed to consent to the system of government by virtue of their birth and belonged to within the society. The lack of positive objection was interpreted as tacit consent. Unless one withdrew from the society, one was deemed to have contracted into it. Indeed, silence meant consent.¹⁷ Clearly, Locke's view of consent is passive and

¹² Miller, D. (1987). *The Blackwell Encyclopaedia of Political Thought*. Oxford: Basil Blackwell, p. 294.

¹³ Cranston, M. (1990). John Locke and Government by Consent, in Thomson, D. (ed), *Political Ideas*. Harmondsworth: Penguin, p. 78.

¹⁴ Arblaster, A. (1987). *Democracy*. Milton Keynes: Open University Press, p. 33.

¹⁵ *Ibid.* p. 33.

¹⁶ *Ibid.* p. 69.

¹⁷ *Ibid.* p. 92.

restrictive. Yet today, democracy affords an active and positive role from citizens in a climate of freedom within which opinions can be freely expressed and discussion conducted without fear of constraint.¹⁸

Locke preferred less government. He believed government oppressed people when it had too much power.¹⁹ He argued that people had created government to serve their needs and overall government should have very little power over the individual.²⁰ Locke's approach to power, being a limited trust to the government, admits the possibility of people monitoring the performance of their representatives, indicating to them the form of legislative activity would merit approval or censure.²¹

Having had great influence over the drafters of the American Constitution, Locke opposed suicide on the basis of human life being the property not of the person living that life, who is a tenant, but of God, rendering suicide a kind of theft or embezzlement. This claim can be detached from the images of property in which Locke couched it: euthanasia can be seen as an insult to God's gift of life.²² Locke was clearly interested in societies where

¹⁸ *Ibid.* p. 93.

¹⁹ Baradat, L. (1991). *Political Ideologies, Their Origins and Impact*. New Jersey: Prentice Hall, p. 30.

²⁰ *Ibid.* p. 265.

²¹ Maddox, G. (1996). *Australian Democracy in Theory and Practice*, third edition. Melbourne: Longman Australia, p. 395.

²² Dworkin, R. (1995). *Life's Dominion, and Argument about Abortion and Euthanasia*. London: Harper Collins, p. 195. Oxford Professor Ronald Dworkin, is a contemporary political and legal philosopher in the liberal philosophical tradition. He maintained we live in a pluralistic society, that there is no consensus about moral questions and the State should remain neutral and have no policies whatsoever.

the regulation of private relationships between individuals took place.²³

Locke's liberalism was challenged by French revolutionary writer Jean-Jacques Rousseau. Rousseau and Locke disagreed on the fundamental "state of nature" of an individual. Rousseau, who regarded human beings as essentially innocent, did not share Locke's pessimistic view and as a result he rejected both the principle of constitutional government and that of representative government.²⁴

Jean-Jacques Rousseau

Locke and Rousseau drew different swords on Rousseau's influential version of the social compact; they have opposing views of the human state of nature. Rousseau's social contract required each individual to surrender all of his natural rights to a sovereign. He saw the sovereign to be the concept of General Will, where the individual and his desires became subservient to the whole community.²⁵

Rousseau's version of the social compact, set forth in 1762 in the *Social Contract*, was based on the unanimous agreement of individuals to form a social community, which would lead to the establishment of the "true" state. This state, Rousseau said, would be "rationally constructed and would act by rational self-control."²⁶ The *Social Contract*

²³ Phillips, H. and Rielly, C. (1982). *Key Concepts in Politics*. Melbourne: Thomas Nelson Australia, p. 70.

²⁴ Heywood, A. (1992). *Political Ideologies, an Introduction*. Houndmills: The MacMillan Press Ltd, p.31.

²⁵ Rodee, C., Anderson, T., and Christol, C. (1967). *Introduction to Political Science*. New York: McGraw-Hill Book Company, p. 27.

²⁶ *Ibid.* p. 27.

helped inspire the French Revolution, and it emphasised the danger of particular interests conflicting with the public interest, "the General Will". "Men," he said, "should be dependent not upon narrow groups but upon the whole - united in a total solidarity of the free and equal."²⁷ Rousseau believed sovereignty should not be surrendered to any form of government as it belonged to the people. Popular sovereignty was based on the "General Will", the collective interests in society.²⁸

Jean-Jacques Rousseau, like John Stuart Mill, wished to produce public-spirited and morally developed citizens.²⁹ Rousseau argued that organisations that intervened between the state and the individual citizen conflicted with a majority democracy. This was demonstrated in the rule of self-interested factions during the French Revolution. For Rousseau, political authority and power rested with the General Will.

The *Social Contract* was the vehicle for Rousseau's General Will and True Liberty. *Social Contract* proclaimed highly participatory communities, where citizens participated in making laws for the community. Unlike Locke, Rousseau quarrelled with Christianity insofar as it afforded individuals unwarranted self-importance.³⁰ Rousseau's model of citizen participation in government focused not on the individual but on the community.³¹ Rousseau preferred

²⁷ Hitchner, D. and Harbold, W. (1972). *Modern Government*, third edition. New York: Harper & Row, p. 152.

²⁸ Heywood, A. (1992). *Political Ideologies, An Introduction*. Houndmills: MacMillan, p.p. 30-31.

²⁹ Maddox, G. (1996). *Australian Democracy in Theory and Practice*, third edition. Melbourne: Longman Australia, p. 102.

³⁰ *Ibid.* p. 84.

³¹ *Ibid.* p. 84.

small-scale communities where citizens could be educated to prefer the good of the community to their private interests.³²

Rousseau's concept of the General Will was not an aggregation of the individual will of citizens, but coincided with the will of each person when each was thinking altruistically, in true community spirit. The General Will was jeopardised when a citizen exercised his or her private will against a community. Such a citizen would be regarded as either criminal or insane, as the private will was clearly wrong when it acted against the General Will, which was always considered to be right.³³ Thus, all forms of private association were to be discouraged as inimical to the General Will.³⁴ Rousseau suggested that at times, the General Will could be determined by majority vote of the citizens and at other times, the citizens should submit to the clear vision of a legislator.³⁵ Rousseau explained in the *Social Contract*:

Whoever refuses to obey the general will shall be compelled to do so by the whole body. This means nothing less than that he will be forced to be free; for this is the condition which, by giving each citizen to his country, secures him against all personal dependence. In this lies the key to the working of the political machine; this alone legitimates civil undertakings, which, without it, would be absurd, tyrannical and liable to the most frightening abuses.³⁶

³² Miller, D. (1987). *The Blackwell Encyclopaedia of Political Thought*. Oxford: Basil Blackwell, p. 456.

³³ Maddox, G. (1996). *Australian Democracy in Theory and Practice*, third edition. Melbourne: Longman Australia, p. 84.

³⁴ Watkins, F. (1986). *Jean Jacques Rousseau, Political Writings*. Wisconsin: The University of Wisconsin Press, p. xxxviii.

³⁵ Maddox, G. (1996). *Australian Democracy in Theory and Practice*, third edition. Melbourne: Longman Australia, p. 86.

³⁶ Muschamp, D. (1986). *Political Thinkers*. Melbourne: The MacMillan Company, p. 131.

The existence of organised pressure groups challenging government would be an anathema to Rousseau. Indeed, Rousseau has been referred to as the intellectual father of totalitarian democracy.³⁷ Rousseau's antipathy to pressure groups would find support today; clearly Rousseau would disapprove of pressure group activity in the matter of the *Medical Care of the Dying Bill* (1995).

Australian political scientist Graham Maddox reflected that the great classics of political theory were written either during or before crisis situations. In fact, Rousseau and Thomas Paine felt the rising tidal wave of revolution.³⁸ During the American Revolution, Thomas Paine had argued against interference with individual initiative from governments and urged the colonists to train their resentment on the interfering government at Westminster.³⁹

Thomas Paine

A champion of elected government Thomas Paine in writing *The Rights of Man* (1792), his largest and most important work, invariably connected him to the notion of "democracy". According to Paine, the best government was a republic, wherein a government's sole purpose was the public good. Simple democracy, in which all citizens

³⁷ Maddox, G. (1996). *Australian Democracy in Theory and Practice*, third edition. Melbourne: Longman Australia, p. 84.

³⁸ *Ibid.* p. 358

³⁹ *Ibid.* p. 370. The American revolution, won through force of arms, established a constitution that would severely restrict the opportunities for governments to interfere with private initiative and spontaneous social action.

directly participated in government, constituted a republican, representative form of government.⁴⁰

As a lobbyist in 1772, Thomas Paine excelled in his role such that he was summarily dismissed from Her Majesty's Excise Service.⁴¹ He was a pamphleteer who helped usher in the *Age of Reason*.

The importance of equal rights in liberal democratic culture is dominant in his writing. He saw injustice creeping in through majority rule, turning into persecution of the minorities.⁴² He stated that the majority must not impose conditions on a minority, which are different from the conditions it imposes on itself. As Paine noted, the only legitimate origin of government was a compact between individuals representing the nation. His notion of natural rights and civil rights are the soil of modern democracies on which the *Declaration of the Rights of Man and of Citizens* is founded - persons are born equal in everything. In this sense, he wrote in the French Declaration:

- I. Men are born, and always continue, free and equal in respect of their rights.
- II. The end of all political associations is the preservation of the natural and imprescriptible rights of man. These rights are liberty, property, security, and the right to resist oppression.⁴³

From natural rights came civil rights. Paine's belief in natural rights and a social contract was basically Lockean.

⁴⁰ Foot, M. and Kramnick, I. (1987). *The Thomas Paine Reader*. Harmondsworth: Penguin, p. 156.

⁴¹ *Ibid.* p. 39.

⁴² Hampden Jackson, J. (1990). Tom Paine and the Rights of Man, in Thomson, D. (ed), *Political Ideas*. Harmondsworth: Penguin, p. 110.

⁴³ *Ibid.* p. 112.

For example, Paine stressed equality of all individuals and the right of all to participate in government or in the choice of representatives.⁴⁴

Because Paine was once a lobbyist, he would have endorsed the diversified groups' involvement in the varied activities relating to the *Medical Care of the Dying Bill* (1995). He may also have argued from the perspective of personal autonomy of a patient to determine his or her own medical treatment. Paine was a natural rights and social contract theorist. As such, he would accord contemporary pressure groups legitimacy.

Although Thomas Paine was born in England he spent his last years in the United States and influenced the draft of the American Declaration of Independence.⁴⁵ Another great influence on America at that time was James Madison, the fourth President of the United States, who, like Paine, focussed on the notion of democracy. Madison highlighted the danger of majoritarian tyranny and shared Locke's pessimism about human nature.

James Madison

American political philosopher and statesman, James Madison, wrote in 1788 that an essential characteristic of a representative democracy was that the various interest groups in society be permitted to compete for the attention

⁴⁴ Marshall, N. (1986). Paine and the Rights of Man, in Muschamp, D. (ed), *Political Thinkers*. Melbourne: The MacMillan Company, p. 152.

⁴⁵ Hampden Jackson, J. (1990). Tom Paine and the Rights of Man, in Thomson, D. (ed), *Political Ideas*. Harmondsworth: Penguin, p. 112.

of government officials.⁴⁶ He also wrote that the great aim of government was to be "neutral between different parts of the society" so that the law neither privileged nor penalised any particular group.⁴⁷

The publication and dissemination of the *Federalist Papers*, leading to the ratification of the United States Constitution, has been called: "history's finest public relations job".⁴⁸ In the tenth essay of the *Federalist*, a concerned Madison wrote of the dangers resulting from the expression of group or factional interests. He considered their effects as: "adverse to the rights of other citizens, or to the permanent and aggregate interests of the community."⁴⁹ He anticipated the growth of interest groups and saw their place as important. This observation is confirmed in essay number ten:

The regulation of these various and interfering interests, forms the principal task of modern legislation, and involves the spirit of party and faction in the necessary and ordinary operation of government.⁵⁰

Given the "selfish nature" of people, Madison suggested the tendency to form factions was inevitable. He wrote in *Federalist 47*, the best defence against the excesses of faction was to construct government institutions in such a

⁴⁶ Baskin, O. and Aronoff, C. (1992). *Public Relations the Profession and the Practice*, third edition. Dubuque: William C. Brown Publishers, p. 354.

⁴⁷ Colson, C. and Percy, N. (1994). *A Dangerous Grace*. Dallas: Zondervan, p. 298.

⁴⁸ Baskin, O. and Aronoff, C. (1992). *Public Relations the Profession and the Practice*, third edition. Dubuque: William C. Brown Publishers, p. 26.

⁴⁹ Hitchner, D. and Harbold, W. (1972). *Modern Government*, third edition. New York: Harper & Row, p. 152.

⁵⁰ Rodee, C., Anderson, T. and Christol, C. (1967). *Introduction to Political Science*, second edition. New York: McGraw-Hill, p. 489.

way, as to prevent the accumulation of power.⁵¹

Furthermore, he described the worst kind of faction as a majority of the whole, when infected by "a common passion or interest".⁵²

Madison and Rousseau shared concerns over groups participating in the political process which may distort the democratic process, should group interests triumph over the general interest.⁵³ Madison advocated a political system that dispersed government power over a number of institutions, giving every minority group or interests the opportunity to exercise a measure of political influence. The Madisonian form of democracy ensured the voice of the majority did not silence all other opinions.⁵⁴

It was Madison that laid the path towards pluralism. Pluralism sees activity by pressure groups as natural and valuable in a democracy.⁵⁵ Pluralist thought draws attention away from the authoritarian state by arranging people into groups that reflect and embody various interests.⁵⁶ Madisonian group theory emphasised interests as opposed to factions and providing for them institutionally.⁵⁷

⁵¹ Maddox, G. (1996). *Australian Democracy in Theory and Practice*, third edition. Melbourne: Longman Australia, p. 88.

⁵² *Ibid.* p. 89.

⁵³ Hitchner, D. and Harbold, W. (1972). *Modern Government*, third edition. New York: Harper & Row, p. 152.

⁵⁴ Heywood, A. (1992). *Political Ideologies an Introduction*. Houndmills: The MacMillan Press Ltd, p. 276.

⁵⁵ Jaensch, D. (1994). *Parliament, Parties and People*, second edition. Melbourne: Longman Cheshire, p. 181.

⁵⁶ Maddox, G. (1996). *Australian Democracy in Theory and Practice* third edition. Melbourne: Longman Australia, p. 90.

⁵⁷ *Ibid.* p. 90.

Madison would no doubt agree that democracy flourished in 1995 when groups mobilised on the issue of the *Medical Care of the Dying Bill (1995)*. His assumption proved correct in anticipating the growth of interest groups, as a sizeable number were identified with the *Medical Care of the Dying Bill (1995)*.⁵⁸ However, he may not have anticipated the considerable influence of groups such as the Australian Medical Association (WA Branch) and the L. J. Goody Bioethics Centre. Nevertheless such powerful and influential groups did not silence or constrain smaller, less wealthy groups such as the West Australian Voluntary Euthanasia Society (Inc.) and The Coalition for the Defence of Human Life.

Indeed, group theorist James Madison and other American Constitution writers harboured an inherent fear of what "the masses" would do if they came to power through democratic channels. The French aristocrat, Alexis de Tocqueville amplified this for the Americans, when he toured America and wrote that the majority rule was not to be trusted.⁵⁹

Alexis de Tocqueville

French aristocrat Alexis de Tocqueville visited the United States and wrote a perceptive account of political and social democracy in *Democracy in America* in 1835, one year before James Madison's death. Throughout de Tocqueville's

⁵⁸ See Appendix 2: Table 1.1: Groups and individuals identified with the *Medical Care of the Dying Bill (1995)* and end of life medical treatment decisions.

⁵⁹ Maddox, G. (1996). *Australian Democracy in Theory and Practice* third edition. Melbourne: Longman Australia, p. 365.

writings his concern was principally the evolution of democratic society.

Alexis de Tocqueville approved of Madison's pluralism and praised the multifarious social and economic differentiation in American life. He acknowledged that businesses, as groups, were capable of forming factions that actively represented the public interest to government. Thus groups competed amongst one another when seeking to influence public policy.⁶⁰ This was an indirect and early definition of lobbying.

Alexis de Tocqueville argued in *Democracy in America* that political society was composed of competing minorities. Such organised groups prevent majoritarian democracy from becoming tyrannical or the state from exclusively controlling the lives and loyalties of its citizens.⁶¹ However, he warned of the possibility of a "tyranny of the majority" in democratic systems under which the views or interests would be sacrificed. Nevertheless, he found consolation in interest groups.

There were many times when de Tocqueville was present when legislators found themselves coerced by armed mobs. Quite rightly, He said some groups menaced free institutions and thought.⁶² He explained:

⁶⁰ *Ibid.* p. 415.

⁶¹ Outhwaite, W. and Bottomore, T. (1993). *The Blackwell Dictionary of Twentieth-Century Social Thought*. Oxford: Blackwell Publishers, p. 472.

⁶² Stone, J. and Mennel, S. (1980). *Alexis de Tocqueville On Democracy, Revolution, and Society*. Chicago: The University of Chicago Press, p. 22.

I hold it to be an impious and an execrable maxim that, politically speaking, a people has a right to do whatsoever it pleases; and yet I have asserted that all authority originates in the will of the majority. Am I then contradicting myself? ... Unlimited power is in itself a bad and dangerous thing;⁶³

His political ideal was freedom under the rule of law. Thus de Tocqueville believed people should have a large degree of control over their own affairs, through thriving institutions of local government and by banding together in free associations. This was a giant leap away from feudalism.⁶⁴

In de Tocqueville's thought, the ties of interdependence and obligation between social groups were of central significance.⁶⁵

Furthermore de Tocqueville wanted the French to be like the Americans and join in free association for all manner of civil and political objectives. He became a celebrity after the publication of *Democracy in America* in 1835 and upon his visits to England he forged a friendship and shared correspondence with John Stuart Mill. A true liberal, de Tocqueville equated democracy with full citizen participation. However, he harboured fear in the passions of the masses and mistrusted majority rule and the transient nature of groups.⁶⁶

⁶³ *Ibid.* p. 99. From *Democracy in America*, pt. 1, chap. 15.

⁶⁴ Stone, J. and Mennel, S. (1980). *Alexis de Tocqueville On Democracy, Revolution, and Society*. Chicago: The University of Chicago Press, p. 23.

⁶⁵ *Ibid.* p. 20.

⁶⁶ Maddox, G. (1996). *Australian Democracy in Theory and Practice*, third edition. Melbourne: Longman Australia, p. 365.

John Stuart Mill shared de Tocqueville's cautious heeding on democratic participation and Mill's *On Liberty* takes up de Tocqueville's theme: the tyranny of the majority.⁶⁷

John Stuart Mill

Mill read de Tocqueville's *Democracy in America* and immediately saw the dangers of the tyranny of the majority. Mill agreed with de Tocqueville that the kind of tyranny principally to be dreaded was "not over the body, but over the mind".⁶⁸ He warned that the majority may not always be right.⁶⁹ British philosopher, economist and ethical theorist, John Stuart Mill wrote great systematic works on logic and on political economy, notably *Considerations on Representative Government* (1861), *On Liberty* (1859) and *Utilitarianism* (1863)

In 1865 he was elected as parliamentary candidate for Westminster and in 1867 he helped found the first women's suffrage society, which developed into the National Union of Women's Suffrage Societies.⁷⁰ Mill's public education ideals included citizen voting, vigorous political activity in local government, jury duty and free discussion.⁷¹ He urged democratic participation in industry and voluntary associations. Mill offered little guidance for

⁶⁷ Watkins, J. (1990). John Stuart Mill and the Liberty of the Individual in Thomson, D. (ed), *Political Ideas*. Harmondsworth: Penguin, p. 155.

⁶⁸ *Ibid.* p. 155.

⁶⁹ Heywood, A. (1992). *Political Ideologies, An Introduction*. Houndmills: The MacMillan Press, p. 25.

⁷⁰ Mill, J. (1971). *Encyclopedia Britannica*, (Vol. 15, p. 462). Chicago: Encyclopedia Britannica.

⁷¹ Heywood, A. (1992). *Political Ideologies, An Introduction*. Houndmills: The MacMillan Press, p. 41.

implementing the goals of participation and competence.⁷² In this sense, he assumed that greater participation should equal greater competence, but this would not always be so.

After more than a century, Mill's utilitarian democracy still stands. He favoured democracy because it endorsed greater self-dependence, individuality and self-development. It improved its citizens, because it allowed for participation and the general interest was better protected.⁷³ Mill's view was that the electors have the right to choose their rulers or government; however, he demonstrated his ambivalence by saying, "but beyond that they should leave government to govern without interference or pressure."⁷⁴

Mill once argued that pressure groups frustrate proper representative government, in that they attempt to gain advantages and benefits for one particular group in society rather than considering the "greatest happiness of the greatest number".⁷⁵ He also regarded the legislature as the "fulcrum" of the political system,⁷⁶ which this thesis shall demonstrate when applied to conscience issues.

The democratic theory of Mill encourages pluralism where parties and pressure groups are vehicles for influencing government more or less continually. Governments are often

⁷² Thompson, D. (1976). *John Stuart Mill and Representative Government*. New Jersey: Princeton University Press, p. 180.

⁷³ McCloskey, H. (1986). Mill's Liberalism in Muschamp D (ed) *Political Thinkers*. Melbourne: The MacMillan Company, p.188.

⁷⁴ Arblaster, A. (1987). *Democracy*. Milton Keynes: Open University Press, p. 52.

⁷⁵ Phillips, H. and Rielly, C. (1982). *Key Concepts in Politics*. Melbourne: Thomas Nelson Australia, p. 128.

⁷⁶ *Ibid.* p. 70.

compelled to listen to such groups, which often represent minorities, as resulting policies come close to expressing the general interest.⁷⁷

Mill favoured a representative system of government with a bicameral system where the division of powers provided a safeguard against the tyranny of the majority. Yet, on the other hand, he feared the oppressiveness of public opinion and he asked whether public opinion would not be tyrannical.⁷⁸ Mill espoused that political participation contributed to a better-educated citizen.⁷⁹ It also increased the opportunities for citizens to improve intellectually.⁸⁰ In this sense, Mill maintained political knowledge and participation were mutually reinforcing.⁸¹

Mill encouraged individualism and the free expression of opinions. He said in *On Liberty* the more diversity and contrast there is among individuals' ways of life, the more progress toward a better way of life:

As it is useful that while mankind are imperfect there should be different opinion, so it is that there should be different experiments of living; that free scope should be given to varieties of character, short of injuries to others; and that the worth of different modes of life should be proved practically, when anyone thinks fit to try them. It is desirable, in short, that

⁷⁷ Thompson, D. (1976). *John Stuart Mill and Representative Government*. New Jersey: Princeton University Press, p. 193.

⁷⁸ McCloskey, H. (1986). Mill's Liberalism in Muschamp, D. (ed) *Political Thinkers*. Melbourne: The MacMillan Company, p. 191.

⁷⁹ Almond, G. and Verba, S. (1963). *The Civic Culture: Political Attitudes and Democracy in Five Nations*. New Jersey: Princeton University Press, p. p. 121-122. Almond and Verba in their five-nation study found that by knowing more about politics, a person was more likely to actively participate in the political process.

⁸⁰ Thompson, D. (1976). *John Stuart Mill and Representative Government*. New Jersey: Princeton University Press, p. 37.

⁸¹ *Ibid.* p. 40.

in things which do not primarily concern others, individuality should assert itself.⁸²

Further, Mill commented on parliament's role:

Parliament should be a place where every interest and shade of opinion in the country can have its cause even passionately pleaded, in the face of the government and of all other interests and opinions, can compel them to listen, and either comply, or state clearly why they do not ...⁸³

More recently, Mill could not have imagined today's democracy, nor the expansion in bureaucracy and the growth of pressure groups.⁸⁴ Furthermore, he recognised that the majority in a democracy is as capable of pursuing sinister interests as is any minority in an aristocracy or monarchy.⁸⁵ Hence the name "tyranny of the majority".

Tyranny of the Majority

Pressure groups have sometimes been criticised for organising over single issues specifically to ruin the careers of otherwise fine politicians who disagree with them on any particular emotional issue.⁸⁶ It is argued that well-organised, well-financed minorities frustrate the common good or the majority will. Most groups represent minority opinion.⁸⁷ If Locke's "silence means consent",

⁸² Acton, H. (1972). *John Stuart Mill, Utilitarianism, Liberty, Representative Government*. London: J. M. Dent & Sons Ltd, p. 115.

⁸³ Thompson, D. (1976). *John Stuart Mill and Representative Government*. New Jersey: Princeton University Press, p. 81.

⁸⁴ Hutcheson, F. (1992). A New Public, in Gobetti, D. (ed), *Private and Public*. London: Routledge, p. 179.

⁸⁵ Thompson, D. (1976). *John Stuart Mill and Representative Government*. New Jersey: Princeton University Press, p. 68.

⁸⁶ Warhurst, J. (1986). In Defence of Single-Issue Interest Groups in Lovell, D., McAllister, I., Maley, W. and Kukathas, C. (1995), *The Australian Political System*. Melbourne: Longman Australia, p. 319.

⁸⁷ *Ibid.* p.p. 318-320.

then the modern term "the silent majority", used by Richard Nixon when he promoted his war policy, could be interpreted as consensual. The term "the silent majority" was coined to describe a reference group rather than a large number of noisy, highly visible demonstrators protesting against the Vietnam War. The term "majority" could never be correctly observed or quantified and the "silence" imposed, was hard to dispute.⁸⁸

It is pressure groups which provide a balance to parliamentary government such that they provide a supplementary representative role.⁸⁹ The existence of pressure groups, regardless of their perceived "tyranny" provides checks and balances to the apparatus of government. Australian political scientist Graham Maddox explained:

The "voice of the people" is not heard through its support for any monolithic program of a party, but at least the voices of some of the people are channelled to the decision-makers through the activities of groups, and since some of the groups are opposed to each other, some possible extreme political choices are cancelled out.

It is apparent that to an extent, the "tyranny of the majority" can be tempered. It is through the activity of the lobby that pressure groups work to influence politicians and conduct their activities.

⁸⁸ Windschuttle, K. (1988). *The Media*. Melbourne: Penguin Books Australia Ltd, p. 326.

⁸⁹ Maddox, G. (1996). *Australian Democracy in Theory and Practice*, third edition. Melbourne: Longman Australia, p. 417.

Lobbying

Pressure group activity results from the need to recognise the rights of members of a society to act collectively to control their lives and to determine the nature of society in which they live.⁹⁰ Possibly the biggest threat to democracy lies, not as some might think, in the existence of pressure groups exerting the tyranny of a minority but in the apathy of the Australian people to participate in the political process. Prominent political scientist, Dean Jaensch, suggested that the Australian political culture is characterised by widespread apathy.⁹¹

Having drawn on those masters who have to some extent explained the role of pressure groups; a foundation is laid for this contemporary group study. This thesis examines the role and functions of pressure groups in the Western Australian political system, in context of the *Medical Care of the Dying Bill (1995)*. It examines the bipartisan role played by Members of Parliament (MPs), given the freedom from party discipline due to the granting of a conscience vote to all party groups represented in the Legislative Assembly.

Again, political scientist Dean Jaensch, explained that most pressure group activity takes place in the political arena, whereby a group applies pressure to one or more levels of the decision-making processes of government.⁹²

⁹⁰ Singer, P. (1982). Individual Rights and the Free Market in Sawyer, M. (ed), *Australia and the New Right*. Sydney: George Allen & Unwin, p. 41.

⁹¹ Jaensch, D. (1994). *Parliament, Parties and People*, second edition. Melbourne: Longman Cheshire, p. 188.

⁹² *Ibid.* p. 171.

Jaensch offered five potential points of access to decision-makers for group's lobbying activities. The groups consider those points as channels of access:

- *The Parliament* (Direct attempts to influence MPs particularly when a social issue is raised and a conscience vote is allowed, this can be most effective).
- *The Executive* (Comprises of cabinet ministers, senior public servants, advisory committees, statutory authorities and the upper levels of the public service).
- *Political Parties* (If the group can win support of a political party and have the group's policy written into party policy).
- *The Electorate* (The attempt to indirectly influence government through public opinion, public pressure and the ballot box. Activities can include demonstrations, media campaigns).
- *The Pressure Group* (Nature of the group's structure, its cohesiveness, aims and objectives, wealth and professional expertise).⁹³

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Lobbying Parliament

The constitutional writer Lord Bryce wrote in 1888 that "lobby" referred to persons not being members of the legislature who undertake to influence its members and thereby secure the passing of Bills.⁹⁴ Parliament is the aim of legislative lobbying, further parliament's eclipse by cabinet as a maker of public policy, has influenced interest group strategies.⁹⁵ Parliament's role is that of a deliberative assembly and this builds on parliament's historical function as custodian of the public interest.

⁹³ *Ibid.* p.p. 176-178.

⁹⁴ Davies, M. (1985). *Politics of Pressure*. London: British Broadcasting Corporation, p. ix.

⁹⁵ Matthews, T. (1993). *Interest Groups in Politics in Australia*, second edition. Smith, R. (ed), St. Leonards: Allen & Unwin, p. 250.

Lobbyists often direct their efforts elsewhere in the governmental process. This has arisen due to the high degree of discipline typical of Australian parties.⁹⁶ The *Medical Care of the Dying Bill (1995)* debate offered members a rare vote in parliament, the "conscience or free vote", where they could vote according to their own moral, political, religious, or social beliefs. Several contemporary moral issues such as abortion law reform and homosexuality have been subject to a conscience vote. When party whips are removed, and parties decide a free vote should be permitted, the lobby is very effective. Parties allow this as an act of self-interest and self-preservation for a free vote is given to avoid a party split. As this thesis will demonstrate, the exercise of lobbying MPs with delegations, submissions, letters, petitions, phone-ins and the like becomes a continually important activity.⁹⁷

Pressure groups direct their lobbying to the nerve centre, the parliament, but groups often understand that power lies in other arenas. Abbott indicated that groups engage in the use of:

... parliament as part of their general strategies to influence policy outcomes, aware that party solidarity and cabinet dominance give government far more power over the fate of policy than parliament, but equally aware that politics is not only about the exercise of power in the formal proceedings of parliament, but also of influence, both direct and indirect, along its fringes.⁹⁸

⁹⁶ Abbott, K. (1996). *Pressure Groups and the Australian Federal Parliament*. Canberra: Australian Government Publishing Service, p.63.

⁹⁷ Jaensch, D. (1994). *Parliament, Parties and People*, second edition. Melbourne: Longman Cheshire, p. 175.

⁹⁸ Abbott, K. (1996). *Pressure Groups and the Australian Federal Parliament*. Canberra: Australian Government Publishing Service, p. 112.

Eight pre-eminent groups were selected for classification and analysis for this case study. They are listed below:

- West Australian Voluntary Euthanasia Society (Inc.)
- Coalition for the Defence of Human Life
- L.J. Goody Bioethics Centre
- Australian Nursing Federation (WA Branch)
- Australian Medical Association (WA Branch)
- Silver Chain Nursing Association Inc. (Hospice Care Services)
- Anglican Church of Australia
- Uniting Church in Australia (WA Synod)

Included in the above and to provide balance, were two Protestant mainstream churches. It will be evident, as explained by Gobetti that it is only through political participation that groups can exercise control over the social forces, which shape and mould lives.⁹⁹ Often, it is during this time that pressure groups "elbow one another" in the corridors of power.

Lobbying Techniques

Lobbying was the primary activity of the groups in this study. Each group made representations to MPs and public departments. It was largely a "paper war" involving ammunition such as submissions, media releases, letters to *The West Australian*, correspondence, photocopying, paid advertising and a petition. Groups organised private and public meetings, made representations to members, conducted

⁹⁹ Gobetti, D. (1992). *Private and Public*. London: Routledge, p. 160.

countless telephone calls and spoke publicly on the *Medical Care of the Dying Bill (1995)* as part of their media relations. A public rally made an impact in the media, which possibly reached an untapped "silent majority". The groups were active both in the media and within their communication circles. One group even drafted their own alternative Bill!

The major groups offered their research facilities as a source of information. Several of the major groups offered themselves as useful "sounding boards" to Mr Taylor in the drafting of the Bill as well as for MPs who sought information.

It is an infrequent and rare situation when political lobbying is aimed at MPs rather than other institutions of government, such as the executive. In this case it provided an opportunity to study the activities of pressure groups. This, likewise, is a very rare occurrence, given the dearth of literature on pressure group activity in Western Australia. The exercise is generally too complicated and demanding and so an understanding of how the political system really operates on such issues is not widely understood.

The Lobbyist's Perspective

Author Peter Cullen, is one of the first of the freelance lobbyists in Canberra and is consultant to the government and parliament. He described a lobbyist as a specialist communicator with a vital and accepted role in the Australian polity. He suggested that lobbyists understand

how the political system works and they must have persistence, patience and public relations.¹⁰⁰

Cullen writes that the alternative to lobbying is to leave political decision-making entirely in the hands of government, which may not coincide with public interests. The costs can be great when lobbying is ignored:

in the silence that it imposes on less organised and less articulate sections of the community, ... in the perpetuation of complacency and in the inhibiting effect it may have on inventiveness and ingenuity in shaping the way government works.¹⁰¹

Cullen extols the virtues of the professional lobbyist who is well placed to impart political intelligence and information about the policies which affect a pressure group. He said Governments and Oppositions frequently made decisions based on pressure group leverage: if it was politically advantageous, if there was favourable media support, and the possibility of donations to party funds. In his experience many political decisions were a result of sustained public relations campaigns and pressure from a whole range of interested groups. Channels of access were frequently through committees, the Opposition, Independents and parliamentarians. Notwithstanding this, however, the existence of traditions, conventions, party policies and public understanding provided a democratic access for pressure groups. Cullen is critical of lobbyists who equate publicity with a result, as if publicity is an answer to a problem. Publicity is part of pressure group strategy, contributing to a desired outcome. In some

¹⁰⁰ Peter Cullen, interview with the author, 19 September 1997.

¹⁰¹ Cullen, P. (1991). *No is not an Answer: Lobbying for Success*. North Sydney: Allen & Unwin Australia, p. vii.

lobbying situations publicity may not be helpful and may even be counter-productive.

Contemporary Pressure Groups

Pressure group theory has some prominence within political literature, however, the study of pressure group activity in Western Australia is scarce. This thesis will describe such activity, thereby placing pressure group activity and influence under a metaphorical microscope.

Given the circumstances, then, this thesis will provide meaningful analyses of group functions, classification and efficacy. The methodology involved a series of interviews conducted with key spokespersons representative of each group. An account of Hansard, and the print media and interviews, further facilitate the study with prominent Australian experts, which provided a perspective to the narrative.

The next chapter will explain the "right to die" issue with an examination of the Northern Territory *Rights of the Terminally Ill Bill (1995)* legislation. Mr Taylor explains the background to the *Medical Care of the Dying Bill (1995)*, in an interview with the writer in chapter three. His candour adds a background perspective leading up to the debate in the Legislative Assembly. The parliamentary debate in chapter four gives an account of overt and covert pressure group influence and the significance of a conscience vote. It includes a summary of the Committee Stage, in which Mr Taylor likened a committee to a "cul-de-

sac into which a good idea is lured and strangled."¹⁰² An account of group strategies is explained in chapter five.

The concluding chapter resulted in a prescription for pressure group activity on contentious moral issues given conscience votes in parliament. The theorists reappeared briefly together with a summary of key aspects of the thesis. "Tips and traps" feature for pressure group activists when attempting to lobby parliament. Prominent Australian lobbyist and Returned & Services League Victorian State President, Bruce Ruxton AM OBE,¹⁰³ is well-known to Australian parliamentarians. He believes the group's success rate is around 70 per cent and this is due to its membership size and that "numbers count when it comes to making politicians sit up and listen." The "human factor" of personal lobbying is important to this group and to the groups in this thesis.

¹⁰² Western Australian Parliamentary Debates. 1 November 1995, p. 10240

¹⁰³ Bruce Ruxton, interview with the author, 8 January 1999. When contemplating pressure group lobbying techniques it is worth noting one of Australia's largest pressure groups, the Returned & Services League. It has some 1,500 sub-branches and a membership of 240,000. The RSL is a non-party political organisation run by its members. The RSL provides, amongst other things, a voice at state and national levels for the service and ex-service community. The group is active on Constitutional, defence, migration and veteran's affairs. Mr Ruxton says, "When MPs get to Canberra, they are three metres tall. When they are in their electorate offices, they are 750mm tall." Consequently much lobbying goes on at MPs electoral offices. Often the Victorian RSL headquarters co-ordinates its 400 sub-branches to lobby the local member.

The RSL's strategic lobbying approaches are directed to the Prime Minister, Premiers and Ministers. On the issue of euthanasia the RSL lobbied each MP in Federal Parliament. A comprehensive, informative submission was sent detailing its anti-euthanasia position. Mr Ruxton said it didn't matter how long the submission was as long as it was comprehensive. The RSL did not envisage the need to lobby on the Western Australian *Medical Care of the Dying Bill* (1995). It does illustrate that some of the major pressure groups, which at first appearance, would not be active in lobbying on a conscience issue, may choose to do so at some stage in the legislative process.

Various models of classifications have been used in political literature. This case study uses the functional classification model of Australian political scientist pressure group stalwart, Trevor Matthews.

Distinguishing the groups will contribute to the understanding of the nature, behaviour and activities of pressure groups. Matthews describes sectional groups (which promote their own cause) and promotional groups (whose dual purpose is to further their own cause and promote a cause for everybody to follow).¹⁰⁴ Where classification boundaries are obscure, a hybrid classification is used to describe groups that display characteristics of both promotional and sectional pressure groups.¹⁰⁵ It was Trevor Matthews who asked the following questions:

What determines how an interest group goes about attempting to influence public policy? What channels is it likely to use and which policy makers will it set its sights upon?¹⁰⁶

The answers to these questions will unfold in the following chapters.

¹⁰⁴ Matthews, T. (1993). Interest Groups, in Smith, R. (ed), *Politics in Australia*, second edition. St. Leonards: Allen & Unwin, p. 242.

¹⁰⁵ Beresford, Q., MacMaster, L. and Phillips, H. (1996). *Conflict and Consensus. Politics and Law in Australia*. Melbourne: Addison Wesley Longman Australia, p. 167. See Appendix 2: Groups and individuals identified with the *Medical Care of the Dying Bill (1995)* and end of life medical treatment decisions.

¹⁰⁶ Matthews, T. (1993). Interest Groups, in Smith, R. (ed), *Politics in Australia*, second edition. St. Leonards: Allen & Unwin, p. 246.

CHAPTER TWO
THE "RIGHT TO DIE" ISSUE

Mr Taylor's Bill should lead to a useful and necessary community discussion about the issues involved. It also offers a rare test of the mettle of WA's politicians.¹

The *Medical Care of the Dying Bill* (1995) sponsored by Labor MP Ian Taylor, was one response to the developments in medical science, particularly those of the last 10 to 15 years. Another contributing fact is that between 1982 and 1996, the population of the Perth metropolitan area increased by about 25 per cent, from 950,000 to 1.25 million people. This growth, together with the ageing of the population, has clearly increased the demand for health services.² Significantly, the rapid advance in medical technology has greatly enhanced treatment capability and from certain pressure groups, the desire to "regulate death" has increased.

This chapter will firstly examine what "right to die" means. This will then lead to coverage of the term "euthanasia". A survey of the modern euthanasia movements will be undertaken. Finally, the political stance of the parliamentary political parties in Western Australia will be visited.

¹ Bill on dying will test politicians. (1995 August 28). *The West Australian*, p. 12.

² See McCavanagh, D. (1998). *Health 2020: A Discussion Paper*. Perth: Health Department of Western Australia, p. 10.

Death, Euthanasia and Palliative Care

The *Medical Care of the Dying Bill* (1995) did not include a definition of a terminally ill person, nor was a consideration made for the time it took for a patient to die, that is, whether death was imminent or otherwise. Yet what is death? One diagnosis of death is:

the total cessation of life processes ... the absence of peripheral pulse and heartbeat, the absence of respiration, the lack of corneal reflex, and the presence of a bluish colour (cyanosis) that results from a lack of oxygen in the blood ...³

There is no universal definition of death in Western Australia, although the *Human Tissue and Transplant Act* (1982) recognised death occurred when there was cessation of brain function, including the brain stem.⁴ The Law Reform Commission of Western Australia recommended death be defined as:

For the purposes of the law of Western Australia, a person has died when there has occurred irreversible cessation of all function of the brain of the person, including the brain stem.⁵

On the other hand, Monash University euthanasia advocates Kuhse and Singer in their Law Reform Commission of Western Australia submission suggested that death be defined as the "total and irreversible loss of consciousness." That is, death of that part of the brain, which controls the higher brain functions such as thought, rather than cessation of

³ Death. (1994). *Micropaedia, Encyclopedia Britannica*. Vol. 3, p. 941, Chicago: Encyclopedia Britannica.

⁴ Thompson, J. A. (1991). *Report on Medical Treatment for the Dying*, Project No. 84. Perth: Law Reform Commission of Western Australia, p. 31.

⁵ *Ibid.* p. 31.

all brain functions. A person in this condition may have a heartbeat and spontaneous respiration.⁶ This is contrary to the notion that breathing symbolises life.

Journalist Neil Shoebridge wrote in *Business Review Weekly* of the exponential growth expected in the number of deaths of Australians. He wrote that death was "big business" and that in about 18 years it will start to become even bigger:

Australia's death rate declined from 7.6 per 1000 people in 1986 to 6.4 in 1996, but population growth pushed the annual number of deaths from 112,662 to 128,719 over the same period ... All funeral companies are waiting for 2016, when Australia's 4.1 million baby boomers - the people born between 1946 and 1960 - start to "enter" the market.⁷

Euthanasia is the direct intention to bring about death of a patient; whereas the *Medical Care of the Dying Bill* (1995) is not concerned with euthanasia - it is allowing death to occur naturally. The Bill allows for the refusal of unwanted medical treatment but does not include palliative care as "medical treatment". As an aside, it is a worthwhile exercise to consider some varied definitions of euthanasia:

Putting hopelessly ill persons to death - with or without their requesting it.⁸

The word euthanasia comes from the Greek words eu ("well") and thanatos ("death"). It means a painless and gentle death. In modern usage, it has come to imply that someone's life is ended for compassionate reasons by some passive or active steps taken by another person.⁹

⁶ *Ibid.* p. 30.

⁷ Shoebridge, N. (1998, June 8). The dying game. *Business Review Weekly*, p. 56 - 58.

⁸ Defining Death. (1989). *World Book Encyclopedia*. (Vol. 5, p. 61) Chicago: World Book Inc.

⁹ Burnell, G. (1993). *Final Choices to Live or to Die in an Age of Medical Technology*. New York: Insight Books, p. 247.

Intentionally taking life for compassionate motives, whether by an act or an omission.¹⁰

Euthanasia euphemisms can confuse the issue of death and include phrases such as the "right to die," "death with dignity," and "aid in dying". These terms can be shared terminology between those who promote euthanasia, that is those who advocate active intervention to deliberately cause death and those who intend to allow death to progress naturally. The euthanasia discussion gives the impression that a person's right to be free of painful and unwanted medical intervention is at issue.¹¹ Taken literally, "right to die" is senseless. It is hard to imagine a right to something that is unavoidable and inevitable. However, in common usage the phrase sometimes means the "right to be allowed to die" from a terminal illness, and at other times, a supposed "right to be killed".¹² Consider the following qualifications of euthanasia:

Passive voluntary euthanasia where medical treatment is withdrawn or withheld from a patient at that patient's request and death results.

Active voluntary euthanasia where medical intervention is sought by a patient in order to end their own life.

Passive involuntary euthanasia where medical treatment is withheld in order to cause death, but the withholding of treatment is not at the patient's request.

Active involuntary euthanasia where medical intervention brings about a patient's death, and the intervention is not at the patient's request.¹³

¹⁰ Pollard, B. (1994). *The Challenge of Euthanasia*. Crows Nest: Little Hills Press, p. 17.

¹¹ Marker, R. (1993). *Deadly Compassion*. New York: William Morrow and Company, Inc., p.7.

¹² Tada, J. E. (1992). *When is it Right to Die?* San Fransisco: Zondervan Publishing House, p. 59.

¹³ Ireland, I. (1996). *The Sanctity of Life: Summary Arguments Opposing Euthanasia*, Research Note No. 13. Canberra: Parliamentary Research Service, p. 1.

It is understandable that individuals often interpret euthanasia differently. Language is one of the first casualties in any controversy over fundamental human values. The abuse of words often gives justification for acts previously regarded as inhuman. Thucydides noted this phenomenon when he wrote his account of the Peloponnesian War in 446-5 B.C.: "To fit in with the change of events, words, too, had to change their usual meanings."

Thucydides thought such debasement of language was an indication of moral breakdown; correct usage therefore became a moral imperative.¹⁴

Passive euthanasia or *antidysthanasia* is the failure to prolong the life of an incurable patient. Treatment may be withdrawn or withheld. The term "passive" has been described as a misnomer, since the decision to withdraw treatment is a deliberate act. It is only passive in the sense that death is primarily due to natural causes. This practice is widely supported and undertaken without legal regulation.¹⁵ Well known author on death and dying, Elisabeth Kübler-Ross, struggled with the semantic problem:

We should also find a new definition for "euthanasia" since it is used for "good death" (e.g., the patient's own natural death without prolonging his dying process unduly), and for mercy killing, which has nothing to do with the original intent of the word euthanasia. To me this is the difference between allowing someone to die

¹⁴ Mall, D. (1980). The Rhetoric of Unknowing in Horan, D. and Mall, D. (Eds.), *Death, Dying and Euthanasia*. Washington: University Publications of America, p. 656.

¹⁵ McCulloch, J. and Emmerson, G. (1993). *Euthanasia: Murder or Mercy?* Information Kit No. 45. Brisbane: Queensland Parliamentary Library, p. 2.

his own death or killing him. I am naturally in favour of the former and opposed to the latter.¹⁶

Today, euthanasia is generally understood to be an act that causes death, usually seen as a means to end suffering.¹⁷ Australian Dr Philip Nitschke is researching and developing a voluntary euthanasia pill called the "VE Pill," to deliver death to a patient who may seek "aid in dying". *The Medical Care of the Dying Bill (1995)* is about giving dying patients the right to refuse medical treatment, yet still choose the palliative care path of treatment. It is not about actively pursuing the means to bring about death, which is characterised by euthanasia.

The Australian Association for Hospice and Palliative Care Inc., President, Dr Michael Smith,¹⁸ said the Taylor Bill fitted the ethic of benemortasia.¹⁹ However, he was disappointed Ian Taylor changed the Bill from his 1993 version. He said the Bill fell short because there was no provision for advance medical care directives. Medical enduring power of attorney was excluded, including the needs of non-competent patients. Dr Smith said he believed that non-competent patients were the ones who needed the legislation, not those who were competent.

¹⁶ Kübler-Ross, E. (1974). *Questions and Answers on Death and Dying*. New York: MacMillan Publishing Co, p. 75.

¹⁷ Dyck, A. (1974). An alternative to the ethic of euthanasia in Williams, R. (Ed.) *To Live and to Die: When, Why, and How*. New York: Springer-Verlag, p. 102.

¹⁸ Dr Michael Smith, interview with the author, 19 September 1997. Dr Smith is a lobbyist for palliative care issues.

¹⁹ The ethic of benemortasia, is used to describe a happy death. The meaning of benemortasia is deliberately unspecified so that it does not necessarily imply that a death must be painless and/or induced in order to be good. Benemortasia differs from the ethic of euthanasia in its understanding of how these values are best realised.

According to Dr Smith, the Australian Association for Hospice and Palliative Care Inc. was disappointed with the *Medical Care of the Dying Bill (1995)*, as it was finally presented. Dr Smith and the Australian Association made submissions on behalf of the Hospice and Palliative Care Board. Meetings took place with Mr Taylor to discuss a suitable draft of the Bill.

Furthermore, Dr Smith believed the Bill would not achieve much and that stronger legislation would serve the community better. Nevertheless, the Australian Association for Hospice and Palliative Care was pleased with the protection the Bill afforded medical practitioners in the treating of their patients. Dr Smith indicated that the Australian Association of Hospice and Palliative Care had established itself in Canberra. This was due to death, bereavement and euthanasia being important topics and the group's presence in Canberra would act as a central, national clearing-house of palliative care information and government relations' activities.

Palliative care's focus is on the patient rather than the disease process. Palliative care aims to promote the best quality of life possible; it allows the patient to die with dignity, and the family/carers to receive bereavement counselling and support.²⁰

The *Medical Care of the Dying Bill (1995)*, included a definition of palliative care:

²⁰ Baird, M. (1993). *Planning for Palliative Care in Western Australia*, Report of the State Planning Committee on Palliative Care to the Commissioner of Health, Western Australia, p. 37.

The provision of reasonable medical procedures for the relief of pain, suffering and discomfort; and the reasonable provision of food and water.²¹

When palliation is provided, usually in a hospice, the aim is not to deliberately terminate life. There may be the possibility of shortening the patient's life as a side effect of treatment; although the aim is not to deliberately terminate life. These acts must be defined not according to their side effects, but according to their aim, which is to relieve the pain.²²

The philosophical doctrine of "double effect" originates in Roman Catholic moral theology where the physician who acts intending to achieve a primary effect which is good (relieving pain), does not intend and is not culpable for a secondary effect which is bad (killing the patient).²³ Northern Territory lobbyist and physician Philip Nitschke calls the double standards of "double effect" as hypocrisy.²⁴

The *Medical Care of the Dying Bill (1995)* also defined the medical practitioner and medical treatment.²⁵ A Refusal of Treatment certificate was included. The Bill did not affect any other laws or palliative care provision. Notably, the Bill provided protection for medical

²¹ *Medical Care of the Dying Bill (1995)*. No. 35-1B, p.2.

²² Gomez, C. (1991). *Regulating Death, Euthanasia and the Case of the Netherlands*. New York: Free Press, p. 24.

²³ Cica, N. (1996). *Euthanasia - the Australian Law in an International Context, Part 2: Active Voluntary Euthanasia*. Canberra: Department of the Parliamentary Library, p. 3.

²⁴ *The Dying Game* [Film]. (5 May 1997). Four Corners, Sydney: Australian Broadcasting Corporation.

²⁵ See Appendix 1: *Medical Care of the Dying Bill (1995)*.

practitioners and offered conditions under which a Refusal of Treatment Certificate could operate. A \$10,000 fine would be imposed if certificates were obtained by fraud and for medical trespass, where continuing or undertaking treatment against a patient's wishes.

The *Medical Care of the Dying Bill (1995)*, was an attempt to support palliative care of dying people and to protect them from burdensome and futile treatments. The Bill would protect physicians from malpractice suits, should they be seen to not prolong a patient's life, even if that treatment was considered "burdensome" to the patient.

Modern Euthanasia Movements

The modern euthanasia movement began in England in 1935, when George Bernard Shaw and H. G. Wells started a Voluntary Euthanasia Society. The society became known as "Exit". In the United States a Unitarian Minister, Charles Potter began the movement, under the name Society for the Right to Die.²⁶

Since the 1970's in Australia, all States and the Australian Capital Territory have established voluntary euthanasia societies. The groups' purpose is political reform. The growth of such pressure groups involved in "quality of life" issues is a demonstration of society's changing social values. As this thesis demonstrates, the establishment of these groups in turn stimulates the

²⁶ Burnell, G. (1993). *Final Choices to Live or to Die in an Age of Medical Technology*. New York: Insight Books, p. 249.

creation of counter-groups to defend the so-called traditional values.²⁷

Two women, Jocelyn Tunbridge and Lilian Rubena Bull (Rubena) founded the West Australian Voluntary Euthanasia Society (Inc.) in 1980. Bull, was the first Secretary and Treasurer of the Society. She later became the society's Public Relations Officer and Editor of "WAVES News", the Society's newsletter. Bull was a social worker who worked with the Australian Red Cross. Failing health brought about her retirement in 1978, but she was an active proponent of voluntary euthanasia. She gave an address to the Western Australian School of Nursing in May 1980 and said:

Voluntary euthanasia, even when legal, may remain a concept more than a general practice. But if one person believes it to be his right, the law should protect that right and not punish the act.²⁸

Jocelyn Tunbridge and Rubena Bull both suffered lengthy illnesses before they died. As the first president of the Western Australian Voluntary Euthanasia Society, Tunbridge became a pioneer of the voluntary euthanasia movement at 74 years of age. Tunbridge died in the Alfred Carson Nursing Home in 1990. She rarely talked and could barely articulate a demand for voluntary euthanasia. Denise White of the Society explained: "Someone other than the patient has to take the initiative in such circumstances. While

²⁷ Beresford, Q., MacMaster, L, and Phillips, H. (1996). *Conflict and Consensus. Politics and Law in Australia*. Melbourne: Addison Wesley Longman Australia, p. 166.

²⁸ White, R. (1985). *The Case for Voluntary Euthanasia*. Perth: West Australian Voluntary Euthanasia Society (Inc.), p. 64.

the law remains as it is, it is not surprising that no one does."²⁹

The West Australian Voluntary Euthanasia Society had this to say about Church-based lobby groups:

Let them divorce themselves, publicly and with clarity, from those extreme groups in their ranks who by lobbying vehemently for the retention of laws that prohibit compassionate acts of voluntary euthanasia, force their own rigid and harsh moralities on everybody.³⁰

Even though aiding suicide remains illegal, the West Australian Voluntary Euthanasia Society lobby for law reform in this area.³¹ The group said that its growth in membership as well as that of worldwide voluntary euthanasia societies, showed strong public support for its aims. More recently, there was a high level of acceptance by the general public, the medical profession and the churches, of a physician's right to withhold treatment from patients in circumstances defined by the group. They believe that statutory law should reflect the Common Law concept, as there is no present affirmation in statutory law of a person's rights in this matter. The group declares that this should be rectified, with prohibitive clauses in the Western Australian Criminal Code accordingly altered.³² Yet when Mr Taylor introduced the *Medical Care of the Dying Bill (1995)*, the group criticised him for doing so and for not introducing voluntary euthanasia.

²⁹ Tribute to Jocelyn Tunbridge. (1990, December). *WAVES News*, p. 4.

³⁰ White, R. (1985). *The Case for Voluntary Euthanasia*. Perth: West Australian Voluntary Euthanasia Society (Inc.), p. 23.

³¹ *Ibid.* p. 10.

³² *Ibid.* p. 55.

Opinion Polls

Often the findings of public opinion polls are used to promote or de-rail public policy. Sometimes amazing statistics are used.³³ Premier Richard Court ruled out a referendum on the issue of voluntary euthanasia despite claims from opinion polls that showed 75 per cent of the public supported it.³⁴

Polls should never be a substitute for the media in its approach to policy analysis or thought on critical issues. Doubts exist over the media's critical understanding of a poll's shortcomings or bias. There are intrinsic limitations to the value of opinion polls.³⁵

Several MP's used the findings of opinion polls to support their position on the *Medical Care of the Dying Bill* (1995). The media frequently used opinion poll findings when reporting on the issue. Noam Chomsky is an outspoken critic of the media who noted that mainstream coverage of issues mobilised public support for special interests that

³³ Rubbery figures. (1993, May 22). *The Independent Monthly*, p. 22. Ron Brunton says facts presented in campaigns are often factoids: information that is misleading, unsubstantiated or of dubious origin, but which comes to be accepted as true after constant repetition. He maintains some information is inherently unknowable, or difficult to obtain reliably because of problems in defining what is being measured or because of the sensitivity of the issue under investigation.

³⁴ Lobbyist: fear can't stop euthanasia laws. (1997, August 4). *The West Australian*, p. 10.

Half adults lack basic reading skills. (1997, September 9). *The West Australian*, p. 6. Did the 75 per cent supporting euthanasia comprehend the question asked of them? Consider almost half of all Australian adults lack the basic reading and writing skills needed every day. Around 6.2 million Australians have literacy so poor, they cannot understand directions on a medicine label or use a bus timetable or find information in newspapers.

³⁵ Pagliaro, T. (1996). *Public Opinion Polls and their Limitations*. Perth: Parliamentary Library, p. 7.

dominate government through a process he called "manufacturing consent".³⁶ Chomsky contended that the media played a significant role in thought control in democratic society and served as a system for communicating messages and symbols to the populace. The media's function, claims Chomsky, is to inform and inculcate individuals with the values, beliefs, and codes of behaviour that will integrate them into the institutional structures of the larger society.³⁷ Chomsky's view in the light of Ian Taylor's *Medical Care of the Dying Bill* (1995) media and opinion poll treatment, will be considered in the concluding chapter.

"Teledemocracy" is a new term coined whereby pressure group's attempt to domesticate public opinion.³⁸ Author Darrell Huff was circumspect when he warned about creative statistics:

The secret language of statistics, so appealing in a fact-minded culture, is employed to sensationalise, inflate, confuse and oversimplify. Statistical methods and statistical terms are necessary in reporting the mass data of social and economic trends ... opinion polls ... But without writers who use the words with honesty and understanding and readers who know what they mean, the result can only be semantic nonsense.³⁹

³⁶ Herman, E. S. and Chomsky, N. (1988). *Manufacturing Consent. The Political Economy of the Mass Media*. New York: Pantheon Books, p. ix. Propaganda's role in the manufacturing of consent has long been recognised by writers on public opinion, propaganda, and the political requirements of social order. Walter Lippmann states propaganda had already become "a regular organ of popular government". The propaganda function of the mass media is an important aspect of their overall service.

³⁷ *Ibid.* p. 2.

³⁸ *Ibid.* p. 1.

³⁹ Huff, D. (1977). *How to Lie with Statistics*. Harmondsworth: Penguin, p. 10.

South Australian Flinders University Professor, Ian Maddocks,⁴⁰ maintained that legislation such as the *Medical Care of the Dying Bill (1995)* was not necessarily a good idea. He explained that each situation was unique and so decisions should be made at the appropriate time between the palliative care physicians and the family. Legislating for the combinations of medical care, i.e., the withholding and withdrawal of treatment and certificates for terminally ill patients would then be unnecessary. He took the view that polls should be conducted in a qualitative manner that determined what people wanted with respect to terminal care; rather than posing options, such as voluntary euthanasia. He would like to see comprehensive studies undertaken before legislation was enacted.

At a hypothetical symposium⁴¹ Professor Peter Baume took the utilitarian view and the "duty of care" position. He said that many patients were not well enough to make medical decisions. After the symposium,⁴² he reported survey results about end-of-life decisions made when physicians treated terminally ill patients - thirty eight per cent said they gave medication to the patient with the purpose of hastening death. In addition, there was no obligation to refuse or withhold treatment. Professor

⁴⁰ Professor Ian Maddocks, interview with author, 19 September 1997. Professor Maddocks has been Foundation Professor of Palliative Care at Flinders University since 1988. He was the first President of the Australian Association for Hospice and Palliative Care and the first President of the Australia New Zealand Society of Palliative Medicine. He is the Director of the International Institute of Hospice Studies and of Daw House Hospice in Adelaide.

⁴¹ Baume, P. (1997). *Hypothetical, Palliative care of the future*, panel participant at the Fourth National Conference of The Australian Association for Hospice and Palliative Care Inc. Canberra: Australian Capital Territory.

⁴² Professor Peter Baume, interview with author, 17 September 1997.

Baume explained that the Courts would solve any decision-making problems on matters raised in legislation such as the *Medical Care of the Dying Bill (1995)*, thus making the Bill unnecessary. He contemplated the likelihood of voluntary euthanasia legislation being enacted again in Australia, and declared unlikely, because the Church, as a lobby group, was too powerful and effective.⁴³ Professor Baume was quoted in an ALP report:

... that laws are required to give patients the right to refuse medical treatment and to protect doctors who comply with a patient's wishes not to receive medical treatment.⁴⁴

International Euthanasia Movements

Euthanasia activists have their share of mavericks. The media have dubbed Michigan Pathologist, Jack Kevorkian, as "Doctor Death". The West Australian Voluntary Euthanasia Society maintains, " ... we believe that Dr Kevorkian is not only a hero but that he is right."⁴⁵ Kevorkian designed a carbon monoxide machine to dispense death to anyone who asked him. To date he has left behind many dead patients and has "tip-toed past the law".

⁴³ Lobbyist: fear can't stop euthanasia laws. (1997, August 4). *The West Australian*, p. 10. Euthanasia campaigner Philip Nitschke said the "'Fear of God' instilled in politicians by the Roman Catholic Church and minority groups would not stop the introduction of right-to-die laws." In the same article, which referred specifically to euthanasia, Premier Richard Court said, "The Government is currently in the process of drafting a medical care for the dying Bill ... trying to do it in a bipartisan way to come up with a framework in which medical practitioners can work to address this difficult issue." A reader could easily confuse euthanasia with natural death legislation.

⁴⁴ Australian Labor Party. (1995). *Medical Care of the Dying a Proposal for Reform*. Perth: ALP, p. 3.

⁴⁵ To make us all feel uncomfortable. (1996, August). *WAVES News*, p. 12.

English journalist Derek Humphry, co-founded with his second wife, Ann Wickett, the Hemlock Society - the world's largest euthanasia pressure group. They wrote *Jean's Way*, the story of Humphry's first wife's battle with cancer and her assisted suicide by husband Derek. The duo set out to make death their life's work.⁴⁶ Humphry's book, *Final Exit* became a best seller in 1991 - a guide to suicide. *Final Exit* earned the Hemlock Society millions of dollars, which it funnelled into its euthanasia lobbying and advocacy programs.

The group's new legislative push - *Initiative 119*, was Hemlock's effort to legalise aid-in-dying in Washington State. Hemlock lobbied hard to change the law. The *Seattle Post-Intelligencer* described the measure as an attempt to update the state's decade-old Natural Death Act.⁴⁷ The question was put to voters:

Shall adult patients who are in a medically terminal condition be permitted to request and receive from a physician aid-in-dying?⁴⁸

Euthanasia proponents raised more than US\$1 million for the lobbying campaign, giving them a formidable five to one fund-raising advantages over opponents. Surveys indicated a potential landslide win for *Initiative 119* and medically induced death. Polls indicated 64 per cent of respondents

⁴⁶ Marker, R. (1993). *Deadly Compassion*. New York: William Morrow and Company, Inc, p. 38.

⁴⁷ *Ibid.* p. 185.

⁴⁸ *Ibid.* p. 185. Buried in the very small print of the initiative was the meaning of "aid in dying", defined as a "medical service" that would end a patient's life in a "dignified, painless and humane manner."

thought that physicians should be able to intentionally kill patients.⁴⁹

A persuasive public education campaign featuring the former U.S. Surgeon General, Dr C. Everett Koop, whose television appearances convinced many Washingtonians to vote against euthanasia. The Bill's defeat was due to the public education by the *No on 119* coalition.⁵⁰

The Netherlands

Since 1973 in the Netherlands, the Dutch have allowed physicians to end the lives of patients who request death. The Royal Dutch Society for the Promotion of Medicine ("KNMG") has adopted euthanasia as a permissible medical practice and has lent its support to the pro-euthanasia movement.⁵¹ The KNMG testified before government commissions on the desirability of the practice from a medical standpoint and on behalf of physicians' accused of homicide. The KNMG lobbied government and sent a letter to the Minister of Justice, asking for a change in the laws to permit euthanasia. Many traditional physicians resigned from the organisation in protest.⁵²

The Netherlands government decided that suffering was a matter too subjective and therefore too private - to be dictated by public policy.⁵³ The support of the KNMG has

⁴⁹ *Ibid.* p. 238.

⁵⁰ *Ibid.* p.p. 85 - 86.

⁵¹ Gomez, C. (1991). *Regulating Death, Euthanasia and the Case of the Netherlands*. New York: Free Press, p. p. 16-17.

⁵² *Ibid.* p. 40.

⁵³ Gomez, C. (1991). *Regulating Death, Euthanasia and the Case of the Netherlands*. New York: Free Press, p. 95.

been central to the tolerance and practice of euthanasia in the Netherlands. Neither the Dutch government nor the legal nor medical professions have been able or willing to undertake the task of characterising euthanasia practice.⁵⁴ However, it remains a crime to kill a patient in the Netherlands and is prohibited under the Dutch Penal Code. Physicians have been guaranteed immunity from prosecution provided that they have complied with a number of rules of careful practice. Today the Netherlands have a case of *crypthanasia*, which means "secret euthanasia", as it is alleged that vulnerable patients are euthanised without their consent.⁵⁵

Australian Law and the Withholding and Withdrawal of Medical Treatment

The focus of the euthanasia and *Medical Care of the Dying Bill (1995)* debate, is the intention to bring on the death of a patient. Under Common Law, a physician is prohibited from taking active steps to end a patient's life:

except when a physician administers a pain killer to a terminally ill patient in great suffering, knowing an incidental effect will be to shorten the patient's life, will be safe from criminal liability, providing the primary reason for giving the pain killer was to relieve suffering, not cause death.⁵⁶

In Western Australia the crime of suicide has been abolished; however, Section 288 of the Western Australian

⁵⁴ *Ibid.* p. 121.

⁵⁵ Singer, P. and Siegler, M. (1990). Sounding Board - Euthanasia - a critique. *The New England Journal of Medicine*, Vol. 322 No. 26. p. 1881.

⁵⁶ Cica, N. (1996), *Euthanasia - the Australian Law in an International Context, Part 2: Active Voluntary Euthanasia*. Canberra: Department of the Parliamentary Library, p. ii.

Criminal Code said that it remained an offence to encourage or assist another to kill him or herself. In Australia a physician who complies with a patient's request for physician-assisted suicide is exposed to criminal liability. The relevant offence is assisting suicide. Unlawful killing can be committed by an act, or by an omission. The various forms of euthanasia are murder under present law.⁵⁷ Laws which govern medical practices at or near the end of life are subject to separate laws in each State and the *Medical Care of the Dying Bill (1995)*, offered protection to physicians and health care professionals against the possibility of litigation.

The Law Reform Commission of Western Australia expressed concern at the uncertainty of the legal position when death was hastened by the administration of pain-relieving drugs. The report recommended that legislation be introduced to protect physicians from liability:

... for administering drugs or other treatment for the purpose of controlling pain, even though the drugs or other treatment may incidentally shorten the patient's life, provided that the consent of the patient is obtained and that the administration is reasonable in all the circumstances.⁵⁸

The Commission considered that although physicians' fears of prosecution are more apparent than real, a strong case could be made for the enactment of legislation in Western Australia to clarify the rights of patients. Physicians who practise medicine for the terminally ill may be subject

⁵⁷ Pollard, B. (1994). *The Challenge of Euthanasia*. Crows Nest: Little Hills Press, p. 91.

⁵⁸ Thompson, J. A. (1991). *Report on Medical Treatment for the Dying*, Project No. 84. Perth: Law Reform Commission of Western Australia, p. p. 25-27. The Commission's discussion paper and subsequent report elicited interest from many groups in the community.

to uncertainty and worry about the legal consequences of their acts. This may inhibit them from providing the most appropriate care.⁵⁹

Most Australian jurisdictions have adopted legislation defining the circumstances under which life-preserving treatment may be withdrawn from an adult patient. This type of legislation is called "enabling euthanasia" or "natural death" legislation, which clarifies the Common Law situation allowing an individual the right to refuse medical treatment.⁶⁰

The Victorian *Medical Treatment Act 1988* and Australian Capital Territory legislation share similarities with the *Medical Care of the Dying Bill (1995)*. The Victorian legislation provides for a person or an incompetent person's guardian or agent, to sign a "Refusal of Treatment Certificate" for medical procedures. Notably, treatment involving the relief of pain or the provision of food and water can not be refused.⁶¹

South Australia's *Natural Death Act 1983*, allows a person to refuse treatment. Two witnesses must sign a form. The Act does not allow for activity, which accelerates death. The Northern Territory's *Natural Death Act 1988* is modelled on the South Australian statute.

⁵⁹ *Ibid.* p. 8.

⁶⁰ McCulloch, J. and Emmerson, G. (1993). *Euthanasia: Murder or Mercy?* Information Kit No. 45. Brisbane: Queensland Parliamentary Library, p. 2.

⁶¹ *Medical Care of the Dying Bill (1995)*. p. 3.

New South Wales, Queensland and Tasmania have no relevant legislation.⁶² The Green's (WA) political party paper *Death with Dignity* legislation provides for withdrawal of medical treatment in line with similar legislation in Victoria, South Australia and the Australian Capital Territory. No Australian parliament or Court has ruled on the subject of withdrawal of life-support systems from permanently unconscious patients.⁶³

The well known Australian author and speaker opposing euthanasia, Dr Brian Pollard, has had many years of experience caring for dying people has stated that there was at present, no demonstrated need for the law to be changed.⁶⁴ Reform of medical law is known to be more difficult to effect than is generally realised. In their text, *Law and Medical Ethics*,⁶⁵ Mason and McCall-Smith articulated this view:

There is little need for (amendment or additional) legislation in respect of the terminally ill patient; the great majority of life or death decisions can be based on good medical practice which is contained by relatively clear legal and moral guidelines.

The Northern Territory Constitutional Perspective

The Northern Territory was the only Australian jurisdiction which hosted legal euthanasia. That situation came about

⁶² Where the states stand. (1995, August 25). *The West Australian*, p. 3.

⁶³ Mendelson, D. (1995). Jurisprudential aspects of withdrawal of life support systems from incompetent patients in Australia, *Australian Law Journal*. Vol. 69 (4), p. 272. Note: at the date of writing.

⁶⁴ Pollard, B. (1994). *The Challenge of Euthanasia*. Crows Nest: Little Hills Press, p. 94

⁶⁵ Mason, McCall-Smith, Law (cited in Pollard, B. (1994). *The Challenge of Euthanasia*. Crows Nest: Little Hills Press, p. 94.

because of changes in the law introduced by the *Rights of the Terminally Ill Act (1995)*. A study of the pressure group activity in the Northern Territory is beyond the scope of this thesis, however it will be briefly explored.

The Rights of the Terminally Ill Act (1995) allowed for physician-assisted suicide and active voluntary euthanasia. The Act drew both extensive criticism and extensive support from politicians, health care professionals, religious groups, pro-life and pro-choice pressure groups, academics, the media and members of the general public.⁶⁶ Ironically, there was not a branch of the Voluntary Euthanasia Society in the Northern Territory.

The Commonwealth Parliament overturned the Act on 25 March 1997. It had plenary power to pass legislation that overrode Northern Territory law under the Australian Constitution:

The Parliament may make laws for the government of any territory surrendered by any State to and accepted by the Commonwealth, or of any territory placed by the Queen under the authority of and accepted by the Commonwealth, or otherwise acquired by the Commonwealth, and may allow the representation of such territory in either House of the parliament to the extent and on the terms which it thinks fit.⁶⁷

⁶⁶ Cica, N. (1996). *Euthanasia - the Australian Law in an International Context, Part 2: Active Voluntary Euthanasia*. Canberra: Department of the Parliamentary Library, p. i.

⁶⁷ Lovell, D., McAllister, I., Maley, W. and Kukathas, C. (1995). *The Australian Political System*, Melbourne: Longman Australia. p. 724. See Commonwealth of Australia Constitution Act, Section 122, Government of Territories.

Prime Minister, John Howard, left the way open for a conscience vote by Federal MPs. The Senate voted 38:33 to "scrap" the Northern Territory law.⁶⁸

A Sydney based *Euthanasia No* lobby group used three strategies to overturn the Northern Territory legislation. They encouraged euthanasia opponents to make a submission, which may simply have been a letter. They encouraged credible groups such as Aboriginal land councils, disability groups etc, to articulate their views. They briefed opponents of the Territory law on likely questions that they would be asked and told them the views of individual senators.⁶⁹ The Senate Committee on Legal and Constitutional Affairs received an all-time parliamentary record of over 12,000 submissions from the public in relation to the *Euthanasia Laws Bill*,⁷⁰ to overturn the Northern Territory's Act. Phone calls and letters to Kevin Andrews' electorate office were 2-1 against the legalisation of euthanasia.⁷¹

Radio 6PR commentator, Howard Sattler, said that it was a rare occurrence when politicians on opposing sides publicly agreed on an issue.⁷² Euthanasia is one such issue. Sattler explained:

It will be a sad indictment of all States health ministers and an indication of an unhealthy influence of the Right-to-Life extremists if thousands of Australians

⁶⁸ Howard allows death vote. (1996, June 26). *The West Australian*, p.6.

⁶⁹ How euthanasia law was sunk. (1997, March 29-30). *The Weekend Australian*, p.p. 19-20.

⁷⁰ Victorian Liberal Backbencher Kevin Andrews, introduced a Private Member's Bill aimed at overturning the Northern Territory legislation.

⁷¹ Craig, T. (1997, February). Can he kill euthanasia? *On Being*, p. 33.

⁷² The right to die with dignity. (1995, February 5). *The Sunday Times*, p. 41.

are forced to move to the Northern Territory to realise the basic right, to die as they please.⁷³

The Political Parties

The West Australian editorial summed the extent of political party involvement:

A side effect of Mr Taylor's proposed legislation is that it gives the community a rare opportunity to make judgments about the performances of politicians unfettered by party discipline.⁷⁴

The Liberal Party and National Party of Australia form a Coalition government. The Coalition parties held the reins of government in 1995. The National Party of Australia do not have a formal policy on the right to die stating that the issue is subject to a conscience vote.

The state Liberal party platform is broad when it comes to medical care for the dying. In the long term, the Coalition plans to expand services to ease the suffering of the terminally ill.

In 1995 the Minister of Health Mr Graham Kierath, was working on a new draft of the *Medical Care of the Dying Bill (1995)*, a department spokesperson said:

Government emphasis is on palliative care rather than euthanasia and they would not support a referendum on the issue of euthanasia.⁷⁵

⁷³ *Ibid.* p. 41.

⁷⁴ Bill on dying will test politicians. (1995, August 28). *The West Australian*, p. 12.

⁷⁵ Neville Barber, Health Department of Western Australia, interview with author, 17 July 1997.

Mr Kierath said that Mr Taylor's introduction of the *Medical Care of the Dying Bill (1995)* was "a cheap, cynical trick to jump on the euthanasia bandwagon and to gain political mileage."⁷⁶ Mr Taylor hoped the Bill would pass through the parliamentary debates. He believed it was needed to emphasise the role of palliative care and the treatment of the dying. And also to protect medical personnel from being prosecuted if they provided or withdrew medical treatment to a terminally ill patient against the patient's wishes. He thought that if a patient signed a certificate which indicated their consent to the refusal of medical treatment, then all would be well.

Mr Taylor became the Bill's major sponsor because it was in an area that he hoped to influence upon his arrival in parliament. He portrayed a genuine concern for the dying and was keenly opposed to euthanasia. He believed that if medical personnel were afforded complete protection from civil and criminal liability in the medical treatment of terminally ill patients, said patients would receive better care. Mr Taylor believed many groups in the community wanted this type of Bill, which enhanced and protected the rights of terminally ill patients in order to ensure that they would die with dignity.

The Australian Labor Party's (W.A. Branch) position on medical care of the dying in 1995 was:

Labor acknowledges that people have the right to die in a peaceful and dignified manner.

⁷⁶ Euthanasia Bill attacked. (1995, March 6). *The West Australian*, p. 24.

The Federal platform of the ALP would:

Support the right of individuals to indicate ahead of time their unwillingness to have their life prolonged by artificial means should they at some later stage suffer from a terminal illness.⁷⁷

The Federal Minister for Human Resources and Health, Dr Carmen Lawrence, discussed the establishment of a framework for future laws covering euthanasia.⁷⁸ She said that there needed to be a uniform approach to the right to die health issue in Australia. Dr Lawrence said that doubts existed over the legality of passive euthanasia. This questioned the decisions that physicians and patients might make to withdraw treatment.

The Australian Democrats in Western Australia gained two seats from May 1997 in the Legislative Council. However, their patient/health professional relationship is based on the premise that:

Patients shall have the right to refuse treatment providing that such right is based upon an informed decision process.⁷⁹

Furthermore, the Australian Democrats support a patient indicating, in the presence of witnesses, the desire to

⁷⁷ Australian Labor Party. (1995). *Medical Care of the Dying. A Proposal for Reform* Perth: ALP, p. 4. The Federal Platform supports the right of individuals to indicate ahead of time their unwillingness to have their life prolonged by artificial means should they at some later stage suffer from a terminal illness.

⁷⁸ *Minister discusses establishment of a framework for future laws covering euthanasia* [Tape]. (1995, February 3) Information Storage and Retrieval System 90-9555, Department of the Parliamentary Library. Extract from transcript of an interview.

⁷⁹ Australian Democrats. (1990). *Policy Stream: Community Services; Policy Code: P9B; Official Australian Democrat Policy, August 1989, as amended July 1990*. Perth, p. 3.

disconnect life-support systems. They state their right to die policy thus:

While medical science has the capacity to keep almost any body physically alive, this is often done with a reduced quality of life, with patients left in an undignified state connected to tubes and wires, or in pain. We support the right of the individual to choose to die with dignity.⁸⁰

The Greens (WA) have not had a member in the Legislative Assembly, having representation in the Legislative Council from May 1997. The member for North Metropolitan Region, the Hon. Giz Watson, said the Greens (WA) would support:

... the call for laws to give competent patients the right to refuse medical treatment and to protect doctors who comply with a patient's wishes not to receive medical treatment. ... a call for laws to acknowledge living wills where dying patients are no longer in a position to refuse medical treatment which might prolong their life at any cost. ... take the position that some dying patients in public hospitals are still unable to access a painless death, and would support laws to give them equal rights to those who are in a similar position in private hospitals or clinics.⁸¹

Lobbied by both sides of the debate, the politicians without the constraint and protection of party policy have provided a situation for this thesis to examine pressure group activity in conscience-vote situations. As a result, this thesis will result in a prescription for lobbying in similar conscience situations.

⁸⁰ *Ibid.* p. 6.

⁸¹ Correspondence from the Hon. Giz Watson, MLC, 15 September 1998.

CHAPTER THREE

*MEDICAL CARE OF THE DYING BILL (1995) -
INITIAL LEGISLATIVE STEPS*

The Medical Care for the Dying Bill focuses on what is appropriate medical care for the dying and considers many facets of this issue, for example, treatment to alleviate symptoms, management of pain and suitable nursing strategies. It is not a Bill about killing patients.

Member for Churchlands, Dr Elizabeth Constable MLA¹

The MPs interpretations of death, euthanasia and to an extent, fear of dying, became obvious during the debate. Just how does a parliament legislate death and the ideal conditions for same? The parliamentary debate often became side-tracked. Mr Taylor said that medical treatment practices had advanced in the past 50 years such that there has been a shift in attitudes to the treatment of terminally ill patients, and whether or not they should have "heroic" medical measures performed on them to keep them alive. This is at the heart of the Bill.

Mr Taylor not only had to negotiate his Bill through parliament but he also had to explain a philosophical viewpoint. He had to keep the focus off euthanasia, please the pressure groups and make sure the legislation did not drift into some kind of "enabling euthanasia" debate or as a first step towards allowing for some kind of voluntary euthanasia. It seemed everyone had a view which Mr Taylor had to accommodate, appease or dismiss. After all, everyone is a stakeholder in death. For the most part, Mr

¹ Correspondence from Dr. E. Constable, MLA, 24 July 1997.

Taylor "rested in the arms" of Father Walter Black, the Director of the L. J. Goody Bioethics Centre. This Catholic organisation was politically pivotal in influencing Mr Taylor's thought process and translating those viewpoints into the Bill. Mr Taylor consulted intensively with Father Black from the early drafts, through the naming of the Bill and to the Committee Stage. Many Catholic MPs were steered by the instructive guidance of this pressure group, which surprisingly does not count lobbying as one of its prime activities.

Why should this group be so influential? Perhaps it is because of the connections between the Catholic medical institutions and the Australian Medical Association or possibly because our society respects traditional religious thought and ethics. Likewise our politicians are provided with resources, information and political reasons as to why such institutions offer sound guidance. As can be understood from this thesis, the L. J. Goody Bioethics Centre did everything in a co-operative, non-confrontational and helpful manner, which could explain their political influence.

The Catholic Church found the Bill to be morally acceptable in terms of: its palliative care description; and the recommendation that palliative care not be withheld or refused; there be no intention to deliberately cause death and refusal of medical treatment be lawful when it is excessively burdensome and clearly futile.

Behind the Scenes

The Attorney-General, Joseph Berinson, spearheaded medical treatment issues for the dying during the 1980s. Mr Berinson was the Attorney-General and Minister responsible in Government for handling the Law Reform Commission proposals. He called on the community to comment on them and intimated that only two months would be allowed for comments to be received.²

It was not until 1995 that a medical bill finally reached a second reading in the Western Australian Legislative Assembly. However, the Bill did not reach the Legislative Council before parliament was prorogued on 4 March 1996. Throughout the eighties there was pressure on Australian parliaments to legislate in the area of natural death.

In 1991 the incumbent Health Minister, Keith Wilson, spoke at a Forum on Natural Death organised by the Health Department of Western Australia and the Australian Medical Association (WA Branch).³ He did not see the point of medical treatment legislation. Medical treatment matters were part of the proposed changes to the *Guardianship and Administration Act (1990)*, during the years 1990-1996. The Act requires that end of life decisions go to the Supreme Court.⁴

² Mr Berinson was born in Perth on 7 January 1932. He was elected to the Thirtieth Parliament for North-East Metropolitan province from 22 May 1980. He was elected for North Metropolitan Region from 22 May 1989. With Sir John Forrest he was one of the only two persons to serve as a Minister of the Crown in both the WA and Commonwealth Governments.

³ Rights of the dying at issue. (1991, October 28). *The West Australian*, p. 38.

⁴ Gillian Lawson, Office of the Public Advocate, interview with the author, 16 June 1997.

There have been no criminal prosecutions in Australia of physicians administering pain-relieving drugs, which may have hastened death. One highly publicised case in Western Australia in 1987 concerned Dr Peter Lim. The charges against him were dismissed at the end of committal proceedings because of a lack of evidence available to support a conviction.⁵ It was claimed Dr Lim injected his patient with 30 mg of morphine as she lay dying of a heart attack on 6 December 1987.⁶ The W.A. Medical Board found Dr Lim guilty of improper professional conduct.⁷ This controversial case of a doctor's treatment of a dying patient may have hastened the drafting of the *Medical Care of the Dying Bill (1995)*.⁸

The next important step in this legislative sphere was the *State's Medical Treatment for the Dying Bill (1992)*.⁹ That Bill was never released for public comment. Mr Taylor said the ALP Caucus did an unusual thing: it had released the Bill to lobby groups for comment *before* Caucus had ratified it.¹⁰

Mr Taylor introduced the next version in 1993 with the *Medical Treatment for the Dying Bill (1993)*. This Bill was

⁵ It's not over yet, says suspended Perth doctor. (1990, August 3). *The West Australian*, p. 4.

⁶ Doctor's ordeal is over. (1989, November 8). *The West Australian*, p. 28.

⁷ It's not over yet, says suspended Perth doctor. (1990, August 3). *The West Australian*, p.4.

⁸ See also Doctor seeks law change. (1989, January 28). *The West Australian*, p. 18. Doctor 'halted bid to revive patient'. (1989, January 25). *The West Australian*, p. 5. Doctor cleared of killing charge. (1989, January 26). *The West Australian*, p. 3. Cleared doctor seeks PR. (1989, January 27). *The West Australian*, p. 12.

⁹ See Appendix 3: History of the *Medical Care of the Dying Bill (1995)*.

¹⁰ Ian Taylor, interview with the author, 21 July 1997.

first read in 1993.¹¹ The Bill failed to have the support from the Catholic Church, and the Australian Medical Association were circumspect. No Second Reading or public debate took place. Mr Taylor said the 1992 and 1993 Bills were very similar in their approach to medical care of the dying, only more controversial. The Bills were a response to the Law Reform Commission of Western Australia's findings and recommendations.¹² If Mr Taylor wanted his Bill to pass through parliament, he would have to drop the reference to incompetent patients to have the support of the Catholic Church and the Australian Medical Association. These two pressure groups were crucial to have "on side" if Mr Taylor were to have his Bill passed. There was no way these two groups would allow the law to legitimise suicide.

Health Minister Keith Wilson, refused to progress the *Medical Treatment for the Dying Bill (1993)*. As a Catholic, Mr Wilson opposed the Bill on religious and moral grounds as the Bill allowed for substituted medical judgements of non-competent patients. He believed it was wrong to legislate in such areas. However, Mr Wilson left the parliament in 1993.

Mr Wilson opposed the 1995 Bill and in his private capacity lobbied MPs by circulating a paper written by a friend of the Right to Life Association lobby group, lawyer Karin Clark, which gave legal comment on the *Medical Care of the Dying Bill (1995)*. The paper concluded that Australian law on the matter was clear and that Australian physicians had

¹¹ Western Australian Parliamentary Debates, 22 June 1993, p. 111.

¹² Ian Taylor, interview with the author, 21 July 1997.

adequate guidance in treating their patients within the bounds of the law, as was stated by Clark:

The strength of the present law lies, on the one hand, in its flexibility in a rapidly changing environment and its careful balancing of the responsibilities of health professionals and the rights of patients. The very lack of case law in this area shows how rarely such matters are disputed. The proposed enactment of the *Medical Care of the Dying Bill (1995)* is not only likely to confuse, rather than clarify the law, but withdraw from a most vulnerable class of patients the equal protection of the law.¹³

The *Medical Care of the Dying Bill (1995)* opponents included the Right to Life Association and the Coalition for the Defence of Human Life. The latter had this to say about Mr Taylor's 1993 legislation:

Right to Life Australia said it would vigorously fight any move in WA to introduce legislation allowing doctors to refuse patients medical treatment.

The state coordinator of the National pro-life group, Richard Egan, said that the group would lobby MPs to vote against a private member's Bill due to be introduced within weeks by Labor health spokesman Ian Taylor.

Right to Life's National Chairman, Margaret Tighe, said the group had fought a similar Bill in NSW, failing by one vote to prevent it going through Parliament.

Mrs Tighe said key arguments supporting such medical-treatment legislation were flawed ... no one had the right to extinguish another person's life.¹⁴

Journalist Neil Stanbury, wrote:

Mr Taylor confirmed last week the Bill would be introduced but denied it would mean legalising euthanasia. [The group said] Making distinctions

¹³ Clark, K. (1995). *Comment on the Medical Care of the Dying Bill 1995*. Unpublished manuscript, Melbourne, p. 7.

¹⁴ Lobby group fights to beat death Bill. (1993 June 21). *The West Australian* p. 12.

between withdrawal of medical assistance and direct euthanasia was dangerous and misleading.¹⁵

Opponents of the Bill such as the Right to Life groups and the Coalition for the Defence of Human Life took the view that the Bill jeopardised the longevity of vulnerable patients to the persuasion of others. A degree of misinformation could abound when it came to diagnosis, depression and what constituted "terminally ill". These groups thought it was best left at a Common Law and legislation was not needed, particularly as no Australian doctor had ever been prosecuted.

Lobby Group Emergence

Ian Taylor regarded the lobbying and consultation process as a necessary aspect of his Bill's formation for two reasons. Firstly, he believed a better Bill would result and secondly, if the key groups were involved in the consultation process they would not obstruct the Bill's passage. Pressure groups had ample opportunity to provide input during the drafting of the Bill. They contributed greatly to the preliminary research by the executive arm of government, the Health Department of Western Australia and the Law Reform Commission of Western Australia.

Lobby groups identified with the *Medical Care of the Dying Bill (1995)* were identified in 1988, when the Attorney-General instructed the Law Reform Commission of Western Australia to report on the civil and criminal law relating to medical treatment for the dying. Approximately 250 individuals and organisations responded to the preliminary

¹⁵ *Ibid.* p. 12.

request for submissions. The issues raised in the *Medical Care of the Dying Bill (1995)* were also raised in the Law Reform Commission discussion paper. A Law Reform Commission report resulted in 1991 and formed the basis for Mr Taylor's 1995 Bill.¹⁶

The topical nature of the Bill was already set in the minds of the Western Australian public, in the media and on the political agenda due to the 1995 confusion created by the euthanasia legislation in the Northern Territory. However, the *Medical Care of the Dying Bill (1995)* appeared to have public support.

Ian Taylor contemplates his Bill¹⁷

Health Minister Mr Taylor's concerns for terminally ill patients were heightened earlier when he received a letter in 1986 from four distinguished medical practitioners. Sir George Bedbrook and physicians John Patterson, Peter Spence and David Watson, stated in that letter:

It seems likely that the "demand" for special terminal care institutions will continue to grow within the State and, perhaps unfortunately, this will be envisaged by many as the creation of "free standing hospices" set apart from the mainstream of our State medical care systems. [This would] create difficulties in the co-ordinated planning of State Health policies ... the care of the terminally ill is a branch of orthodox clinical medicine which requires sophisticated management of pain and compassionate treatment of dying people.¹⁸

¹⁶ Thompson, J. A. (1991). *Report on Medical Treatment for the Dying*. Project No. 84. Perth: Law Reform Commission of Western Australia,

¹⁷ Ian Taylor, interview with author, 21 July 1997. From the same interview, see pages 55 - 63.

¹⁸ Oliver, B. (1992). *Towards a Living Place*. Perth: Cancer Foundation of WA (Inc), p. 61.

A group of nurses also approached the Health Department in 1993 who expressed their concern at the lack of guidelines on medical care procedures for the dying.¹⁹ Mr Taylor believed good, quality medical care could be compromised if medical professionals were wary of the law.

Mr Taylor's political history began in 1981 when he was elected to the seat of Kalgoorlie and in 1986 he became Health Minister. In 1990 he was Deputy Premier then Leader of the Opposition in 1994. However, he was uncomfortable in this role and tendered his resignation to the ALP on 4 February 1994. The Federal Election was announced for March 1996 and Mr Taylor contested the Federal seat of Kalgoorlie. He lost that contest against the sitting member, Graeme Campbell. As his Bill had not secured parliamentary passage, the possibility of his legislation being passed was clearly diminished. Mr Taylor is now a consultant.

When Mr Taylor began piloting his 1995 Bill through the Legislative Assembly, he visited hospitals and met medical personnel and spoke with nurses who told him of the legal uncertainties around caring for the dying. He said people should die with dignity; even if death was hastened as a result of treatment. This was not euthanasia as euthanasia involved the intention to kill, which he would not countenance.

In 1995 Mr Taylor told the ALP Caucus that he would only pursue his Bill if everyone in Caucus had a conscience

¹⁹ Talks on dying Bill changes. (1995 September 19). *The West Australian*, p. 24.

vote. This proved controversial for the ALP, as some Caucus members had objections. Nevertheless, a conscience vote was allowed. According to Mr Taylor, the Bill would have a greater chance of success if the entire parliament had a conscience vote.²⁰ As the ALP had a conscience vote, it was incumbent on the whole parliament to follow. Many people said the debate that followed in parliament was the best that had been undertaken for a number of years.

When the ALP was in opposition in 1993, Mr Taylor and Leader of the Opposition Carmen Lawrence, decided it was not an opportune time in politics to explore such contentious matters. However, as Mr Taylor had a particular interest in the area of medical care for the dying, he considered the matter unresolved. Ian Taylor understood he had a difficult task ahead of him when he chose to promote his *Medical Care of the Dying Bill (1995)*. This Bill was less controversial than the earlier Bills which dealt with the medical treatment decisions of incompetent patients.

Parliamentary counsel assisted Mr Taylor in drawing up the earlier Bills and with the benefit of those Bills behind him, he set about writing the 1995 version. Wide discussion and community input was encouraged and this took place between Mr Taylor, the government and pressure groups. He spoke with anyone who requested information and

²⁰ Dying may get right to say no. (1995 May 24). *The West Australian*, p. 3. National Party deputy leader Monty House said on 23 May 1995 that the party usually allowed a conscience vote in such circumstances. Mr Kierath said if the Bill was found to deal with a genuine moral issue, he would consider recommending to the party room that the matter be dealt with by a conscience vote.

he sent draft notes on the Bill. He invited further dialogue.

The Guardianship Tribunal sent notification to disability groups. Mr Taylor ensured he gave the Bill maximum publicity through talk-back radio, television, public meetings, such as one held on 4 May 1995 at the University of Notre Dame which attracted 38 people. Mr Taylor attended meetings with Rotary and various physicians, particularly palliative care specialists in an effort to get maximum input. Mr Taylor's impressive community consultation provided a channel of communication for groups acting as a representative voice. By all accounts, the processes were laudably democratic.²¹

Knowing that the Right to Life groups would never support the Bill, in a sense made Mr Taylor's job easier. He explained that the L. J. Goody Bioethics Centre and the Coalition of the Defence of Human Life, were two groups, which should have been aligned but were at odds with each other, as false accusations had been made. Mr Taylor said this weakened the Coalition for the Defence of Human Life's credibility with government. The fracas²² hampered a joint effort to influence the outcome of the Bill.

The West Australian Voluntary Euthanasia Society (Inc.) expressed its displeasure with Mr Taylor, attacking him personally on the strength that the Bill did not go far enough.²³ The West Australian Voluntary Euthanasia Society

²¹ Mr Taylor has kept all the submissions.

²² Briefly explained in chapter 5.

²³ Groups unite against die Bill. (1995, May 25). *The West Australian*, p. 25.

President, Ralph White, said the Bill would not do anything for patients. It would only achieve a measure of protection for physicians and caregivers. The L. J. Goody Bioethics Centre Director, Father Black, said that even proponents of euthanasia were amazed to find a Catholic Priest in agreement with some of their beliefs. He said it was right to refuse medical treatment when it involved extraordinary means; and withholding or withdrawing life-support systems once they had become futile and the right to proper pain control even if it shortened the life-span. The latter could be summed up as killing the pain, not the patient.

Mr Taylor responded saying that he was the only person in parliament prepared to act on the issue and now the West Australian Voluntary Euthanasia Society had made him the enemy. Their differences were later resolved, but Mr Taylor told the intransigent group that there was no chance State Parliament would adopt a Northern Territory type of legislation.

Pro-euthanasia activists' lobbying did not influence Mr Taylor's view on the Bill. He said his attitude did not change from the start of the Bill to the finish. His philosophy was simple - there was a certain dignity to life and that it also applied to dying people. The way dying people were treated measured the quality of society and a society that dealt with peoples' problems by euthanasia, was an impoverished society.

Mr Taylor hoped his Bill would put pressure on governments to deal with the issue of funding palliative care and hospices. When the Silver Chain Nursing Association invited Mr Taylor to visit with them on their "rounds", not one person Mr Taylor spoke to in that area supported euthanasia. Nor did the dying people Mr Taylor spoke to indicate support for euthanasia. He acknowledged opinion poll findings showing support for euthanasia but said it was more widely understood that people should not suffer unnecessarily.

It was not until Mr Taylor resigned as Leader of the Opposition that he revised the Bill giving it a new title: the *Medical Care of the Dying Bill* (1995).

Mr Taylor conceded he was strongly influenced by Catholic Father Walter Black. He said that Father Black was an outstanding lobbyist, even if he did not regard himself as one. Mr Taylor had a great deal of admiration for the way Father Black approached the issue. Father Black convinced Mr Taylor to change the title of the Bill from "medical treatment" to "medical care" of the dying as well as other significant changes to the legislation.²⁴ Father Black said it was the best form of legislation of its type anywhere in the world, in keeping with the Pope Pius XII Papal Encyclical. Prominent Catholic Independent MLA, Phillip Pandal, viewed the legislation as an answer to a difficult problem.²⁵

²⁴ Right-to-die Bill is back. (1998 March 6). *The West Australian*, p. 5.

²⁵ Western Australia Parliamentary Debates, Wednesday 23 August 1995, p.p. 7124-7126.

Mr Taylor explained the absence of certain definitions in his Bill. Such definitions would be subject to endless debate and Mr Taylor omitted them saying that certain decisions would be better left to the courts.

Mr Taylor believed the Bill would be best dealt with under its own legislation rather than to change the Criminal Code. The Bill did not allow for suicide. A section of the Criminal Code dealt with assisting people to commit suicide and the Bill stated that the Bill would not affect that part of the Criminal Code.²⁶ Mr Taylor said some Western Australian hospitals had tried to draw-up staff guidelines on whether terminally ill patients should be resuscitated. Because of the legal ramifications of this practice, the Health Department warned the hospitals to stop. Several Catholic nursing homes had forms which patients could sign indicating that they no longer wanted certain medical treatment. This was a revelation to Mr Taylor.²⁷ A written policy was developed by a nine-member ethics committee at Southern Cross Homes WA (Inc), which runs four retirement villages, four hostels and three nursing homes in the metropolitan area. The Not For Resuscitation order sets out strict guidelines for medical staff on the withholding of life-prolonging measures where recovery is deemed impossible or treatment overly burdensome to the patient. A Refusal of Treatment

²⁶ See Appendix 1: *Medical Care of the Dying Bill (1995)* Clause 4(3) and Sections 11 and 12.

²⁷ Let them die policy for old folks' homes. (1995 April 2). *The Sunday Times*, p. 3. Committee Chairman and Southern Cross board member, Dr Frank Prendergast, said the policy was written after worried nursing staff disagreed on the treatment for severely ill elderly residents. Father Walter Black said the no-resuscitation policy had been more than two years in the drafting. Graham Kierath supported such a policy.

certificate that can be signed by patients to cover them in the event of a seizure is mooted by Southern Cross Homes.

Mr Taylor described the Committee Stage as taking a good idea that could be "lured into a committee and strangled". Although he had the numbers to stop that happening, it went to Committee and languished there.²⁸ Upon reflection, he believed that if he had been there it would not have happened. He said his Bill had been "done to death" and the Legislative Assembly did not need such a Committee to examine the Bill clause by clause. Some MPs wanted a Select Committee that would call for further public submissions and then report its findings to parliament. Mr Taylor resisted that process because much of the consultation and lobbying activity had already occurred. In many ways it was a compromise Bill which had majority support from the MPs. However, it went to the Committee Stage on Wednesday 15 May 1996.²⁹

Mr Taylor believed the ALP member for Ashburton, Fredrick Riebeling's amendments were too bold and unworkable for the legislation to pass through parliament.³⁰ Mr Reibelings

²⁸ Western Australia Parliamentary Debates, 1 November 1995, p. 10240.

²⁹ Western Australia Parliamentary Debates, 15 May 1996, p. 2027. Dr Watson was Chairperson of the Bill with Mr Ainsworth as Deputy Chairperson. Mr Day was the Deputy Chairman of Committees. There was one sitting and members were: Mr Prince, Dr Gallop, Dr Hames, Mr Pental, Mr Ripper, Mr Bloffwitch and Dr Turnbull. The Committee automatically ceased existence upon parliament's prorogation on 14 November 1996.

Phillips, H. C. J. (1991). *Second Reading Parliamentary Government in Western Australia*. Perth: Ministry of Education, p. 46 and 49. During Committee Stage of a Bill, it is discussed in detail, often clause by clause and amendments may be suggested. To become an Act of Parliament, a Government Bill or a Private Member's Bill must be passed in the same form by both houses before being given the Governor's assent and proclaimed.

³⁰ Western Australian Parliamentary Debates. 23 August 1995, p. 7118.

amendments included an introduction of a living will for both competent and incompetent persons; affirmation and protection of the rights of terminally ill persons to refuse unwarranted medical treatment; the appointment of an agent by enduring power of attorney; allowance of an agent or guardian to refuse medical treatment on behalf of the incompetent patient; protection of the agent, guardian, the medical practitioner and other health professionals and dealing with related purposes.

In a calculated political manoeuvre, Mr Taylor aimed to "get the Bill through the first hoop". He considered the heroism if his Bill had dealt with the issues of incompetent terminally ill incompetent people. The Guardianship Tribunal legislation was under review in 1995 and advice Mr Taylor received from the Tribunal was that the issue would be better dealt with under the Guardianship Legislation than as a separate Bill.³¹ Mr Taylor accepted the advice.

Well-known pro-euthanasiast and ALP member for Kenwick, Dr Judyth Watson, took over the Bill during Committee as Mr Taylor surrendered his seat in State politics to contest the 1996 Federal election. Mr Taylor was sure Dr Watson would not be able to change the Bill's intent because of the nature of the legislation, that is, to turn a Bill which did not allow for euthanasia into a Bill which allowed for euthanasia. Such a practice is not allowed

³¹ Office of the Public Advocate. (1996). *Proposed Changes to the Guardianship and Administration Act 1990 Discussion Paper*. Perth: Western Australian Government. The report's main concern is the appointment of an enduring power of attorney - and the *Medical Care of the Dying Bill (1995)* did not address the issue of loss of capacity.

under Parliamentary Standing Orders as one can not turn a Bill "on its head"; a separate Bill must be introduced in order to achieve a different outcome.

Mr Taylor said that Health Minister, Mr Kierath, claimed he had a similar Bill to his "ready to go", but Mr Taylor challenged the statement. Furthermore, Mr Kierath said he had the report of a working group on "dying with dignity", set up by former Health Minister, Peter Foss in December 1993 and had drafted legislation to reflect the recommendations. Mr Kierath had expected to release the report and the draft in October 1995, but believed Mr Taylor had pushed ahead with his Bill to try to pre-empt that process.³² Mr Kierath never released his Bill to the public.

The Conscience Vote and Lobby Power

Mr Taylor would not have taken the Bill to parliament unless his colleagues had a free vote.³³ Mr Taylor could not remember having had a conscience vote during his 14 years in parliament. Furthermore, he could not predict the effect of his Bill if MPs were given a free vote.³⁴ An editorial in *The West Australian* summed up the debate:

Politicians will be lobbied by both sides of the debate and assessed on how they vote and the quality of their responses. Without the constraint and protection of party policy, they will be exposed to a purer form of democracy than is usually practised in WA.³⁵

³² Survey of MPs backs principle. (1995 August 26). *The West Australian*, p. 4.

³³ Free vote likely on Taylor death Bill. (1995 August 24). *The West Australian*, p. 46.

³⁴ *Ibid.* p. 46.

³⁵ Bill on dying will test politicians. (1995 August 28). *The West Australian*, p. 12.

This situation afforded a unique opportunity for pressure groups to lobby MPs. Mr Taylor described the decision:

Every man and woman in the caucus supported the proposal that we have a conscience vote on this Bill. We supported that because we were of the view that this legislation is not of a political nature, but in many respects relates to the moral, philosophical, ethical and religious position of individuals.³⁶

Mr Taylor called on the public and community leaders to join the debate. The lobby groups emerged and became an influential and vocal force. However, Mr Taylor said individuals and groups should not be intimidated by vocal groups, such as the Right to Life Association of Western Australia.³⁷ Mr Taylor explained:

I have been contacted by very senior people in the Catholic Church, I have even worked with some of these people on this particular legislation and I know they support it. But I do not think that they feel intimidated by groups like the Right to Lifers. I think you have to stand up to those groups occasionally.

The findings of this thesis can be applied to similar conscience-vote situations where the outcomes from lobbying can be considerable. The Legislative Assembly vigorously debated the Bill and it is hard to imagine that the Bill "ran aground" in the Committee Stage as Mr Taylor changed careers. What is interesting to look out for is the surge in the debate where the swell is highest when it comes to MPs "under the influence" of lobby groups. It is notable that as soon as the Bill was introduced, controversial amendments were asked for by Fredrick Riebeling asking for

³⁶ Western Australia Parliamentary Debates, 24 May 1995, p. 4069.

³⁷ Free vote likely on Taylor death Bill. (1995 August 24). *The West Australian*, p. 46.

third party judgements for incompetent patients - just what Mr Taylor and the Catholic Church didn't want. It seems the elastic nature of the debate could come back and sting those groups who initially supported the legislation, only to watch it change shape, which was something the L. J. Goody Bioethics Centre feared and the Catholic Church Archbishop Barry Hickey articulated in his statement about the concerns of the Taylor Bill that "*The Medical Care of the Dying Bill* needs to be treated with great caution lest it have unintended consequences."

CHAPTER FOUR
THE PARLIAMENTARY DEBATE

... there will not be a more important piece of legislation before this House this year than this Bill.

Liberal member for Jandakot, Michael Board¹

Community response to the *Medical Care of the Dying Bill* (1995) was one of keen interest, given the frequent mass media coverage the debate attracted. The moral, religious and ethical argument was a complex issue and it occupied considerable parliamentary time. However, the conscience vote meant that there was intense lobbying from pressure groups which was either welcomed or endured by MPs. This chapter focuses on the parliamentary debate, the significance of the conscience vote and pressure group influence. Polls were often referred to by MPs to support their viewpoint.

The *Medical Care of the Dying Bill* (1995) was one of 107 Bills introduced into the Western Australian Legislative Assembly in 1995-1996. It was one of 18 Private Members' Bills presented in the Legislative Assembly and one of the 30 Bills which lapsed.² Twenty-nine MPs debated during the second reading, which included 12 ALP, 14 Liberal Party, one National Party and two Independent Liberals. The ALP member for Maylands, Dr Judith Edwards, Liberal member for Dianella, Dr Kim Hames and National Party member for Collie Dr Hilda Turnbull, provided physicians' viewpoints on the Bill.

¹ Western Australian Parliamentary Debates. 1 November 1995, p. 10233.

² *Parliamentary Digest*. (1995). Legislative Assembly, Vol. 23. Perth: State Law Publisher, p. 39 and 41.

In mid August 1995 *The West Australian* contacted 76 of the 91 MPs in both the Legislative Assembly and Legislative Council and found that 44 either backed Mr Taylor's Bill or supported the concept. Only nine were against it. Fifteen had not made up their mind and eight refused to give a view. Most of those who agreed with the concept backed Mr Taylor's Bill as it stood. Others said that they would like to see minor amendments and some did not know the details of the proposal, but supported the concept.³ The Western Australian Legislative Assembly passed Mr Taylor's *Medical Care of the Dying Bill* on 1 November 1995 by 34 votes to 17 at the second reading stage.⁴

The key factor that determined political support for the Bill was the media coverage, particularly the press coverage which would have encouraged the public and influenced decision-makers. Also the support from the L. J. Goody Bioethics Centre with Catholic Church links and the Australian Medical Association. The success of the Bill was based on the acceptance of the Bill by these two institutions as they have enjoyed a long tradition of respect and community acceptance. The medical community did not oppose the Bill because if enacted, it would make their jobs easier and less risky. Having Caucus approval was a key factor in securing political support, as was being granted a conscience-vote.

³ Survey of MPs backs principle. (1995 August 26). *The West Australian*, p. 4.

⁴ See Table 4.1, page 120.

What was needed for the successful passage of the Bill was enough MP support to get the numbers required to pass the Bill. This chapter attempts to explain both the MPs support and opposition to the Bill. Meantime, it is worthwhile noting key features of the new framework of the Bill, bearing in mind that it took account of developments in other States. The Bill was based on recent consultation with medical and palliative care groups, the Catholic Church through the L. J. Goody Bioethics Centre, various pressure groups and government agencies in Western Australia. There was a long period for public submissions and these were recorded, collated and examined by Mr Taylor and various government departments. Mr Taylor's further consultation and analysis of the draft *Medical Care of the Dying Bill (1995)*, which mostly was with medical groups and the L. J. Goody Bioethics Centre resulted in the final Bill. These factors combined to give strong political support. The following issues provided the framework for the Bill:

- The legislation was seen as necessary in order for terminally ill patients to have the right to refuse treatment and to protect doctors who may be in fear of prosecution for withdrawing treatment that no longer benefits the patient.
- Palliative care would be excluded from the medical treatment which may be refused.
- A Refusal of Treatment Certificate provided proof of the terminally ill patient's understanding of their medical treatment decision.

The strongest opposition came from Right to Life Groups, such as the Coalition for the Defence of Human Life, who saw the Bill as being a precursor to active euthanasia. Here a refusal of treatment bill was widely promoted by the international Right to Die movement, (e.g. the Australian Voluntary Euthanasia Societies), as a precursor to the legalising of death by lethal injection. Many opposing MPs saw the Bill as being unnecessary and flawed, and they were circumspect about the moral outcomes of the legislation.

Initially it appeared the Bill had bipartisan support in the Legislative Assembly of Western Australia. At the time, members enjoyed the detour from party politics because of the conscience vote, which "livened up" the House from the more formalised, disciplined, adversarial role that the Legislative Assembly usually adopts. The ALP member for Kalgoorlie, Mr Taylor, said the conscience vote would give parliament the opportunity to have a totally free and open debate. Mr Taylor explained that the best part of the debate was that the members were able to express their personal points of view, which was a rare opportunity in the House.⁵ Furthermore, he noted:

Perhaps one of the smaller lessons gained from such legislation is that this place would be better off - as individuals we would be better off, and certainly the legislation produced would be better- if we had the opportunity more often to exercise a conscience vote.⁶

Mr Taylor acknowledged the assistance from people in the medical area - doctors, nurses and other health professionals who gave him:

⁵ Western Australian Parliamentary Debates. 1 November 1995, p. 10238.

⁶ *Ibid.* p. 10238.

a great deal of advice and support over the past couple of years in putting together this Bill. In many ways the Bill is for them rather than anyone else.⁷

The first reading was on 28 March 1995. The second reading⁸ on 24 May 1995 began with Mr Taylor's explanation of the Bill as:

An Act to affirm and protect the rights of terminally ill persons to refuse unwanted medical treatment, to protect medical practitioners and other health professionals and for related purposes.⁹

He said that the *Medical Treatment for the Dying Bill* (1993) was a controversial Bill in the community because it allowed for third party substituted judgements for incompetent persons. He left this out of his 1995 Bill.¹⁰ During the years 1993 - 1995 Mr Taylor consulted with the community on the legislation. As a result of the lobbying from pressure groups, Mr Taylor crystallised the *Medical Care of the Dying Bill* (1995).

When Mr Taylor left the job as Leader of the Opposition, he took up the *Medical Care of the Dying Bill* (1995). An ALP discussion paper was circulated among a range of interested groups in the community. Some controversial points in the

⁷ Western Australian Parliamentary Debates. 24 May 1995, p. 4069.

⁸ The second reading is considered to be the most important stage in a Bill's passage.

⁹ Western Australian Parliamentary Debates. 24 May 1995, p. 4062.

¹⁰ Cabinet delays over aid for dying. (1998, June 20). *The West Australian*, p. 54.

The 1998 version is almost certainly a modification of Ian Taylor's 1993 Bill. Democrat MLC Norm Kelly said the *Medical Care of the Dying Bill* (1998) had been through eight separate drafts and should be ready for debate. The Australian Medical Association said doctors would like to see the Medical Care of the Dying Bill debated.

1993 Bill were abandoned to ensure the success of the 1995 Bill.¹¹

It is worth noting that Mr Taylor supported the decision-making role of patients and palliative care.¹² His emphasis on palliative care resulted from the information he received from the Silver Chain Nursing Association, the L. J. Goody Bioethics Centre and the Australian Medical Association (WA Branch). Mr Taylor said the Silver Chain Nursing Association and other Western Australian hospices provided world-class palliative care. He believed the Bill reflected sound ethical principles for the delivery of such care.¹³

Mr Taylor visited St Christopher's Hospice in London, one of the first hospices established in the world and spoke to Dr Robert Dunlop, a leading hospice carer who said:

... he believed strongly that legislation which recognises that people have a right to die with dignity is generally worthy of support.¹⁴

The Silver Chain Nursing Association's approach was to have Mr Taylor visit terminally ill people. As a result of this, he concluded that people had the ability to die with dignity.¹⁵ Mr Taylor said that although many people felt the Bill did not go far enough, it was long overdue legislation which could have a proper place in Western Australian society.¹⁶

¹¹ Western Australian Parliamentary Debates. 24 May 1995, p. 4063.

¹² *Ibid.* p. 4063.

¹³ Western Australian Parliamentary Debates. 24 May 1995, p. 4069.

¹⁴ *Ibid.* p. 10238.

¹⁵ Western Australian Parliamentary Debates. 1 November 1995, p. 10239.

¹⁶ Western Australian Parliamentary Debates. 24 May 1995, p. 4070.

The impact of pressure groups on the Bill's passage is described:

The attitudes of a wide variety of groups and organisations in the community now favour the adoption of measures designed to enhance and protect the rights of terminally ill patients in order to ensure that they are allowed to die with dignity. Professor Peter Baume¹⁷ has stated that laws are required to give patients the right to refuse medical treatment and to protect doctors who comply with a patient's wishes not to receive medical treatment. The Australian Nurses Federation recently announced its support for the introduction of legislation to allow terminally ill patients to choose to refuse medical treatment and to protect medical staff who honour those wishes.¹⁸

Consideration of pressure group influence is contained in Mr Taylor's speech:

The original Bill considered by Caucus also provided for the situation where a patient is not able to make decisions about medical treatment because of incompetence. I have deleted these provisions because of objections from some groups as to the difficulty of dealing with this issue of people making life or death decisions on behalf of another person.¹⁹

Mr Taylor said that it was not just doctors who were concerned about legal action for not continuing with medical treatment. Nurses did too. It was the Refusal of Treatment certificate that provided protection.²⁰ Mr Taylor concluded his speech at the end of the second reading on 1 November 1995. He praised the ALP member for Ashburton Mr Fredrick Reibeling's courage in placing amendments to deal with incompetent patients on the Notice

¹⁷ Professor Peter Baume is also a member of the NSW Voluntary Euthanasia Society.

¹⁸ Western Australian Parliamentary Debates. 24 May 1995, p. 4065.

¹⁹ Western Australian Parliamentary Debates. 24 May 1995, p. 4066.

²⁰ Western Australian Parliamentary Debates. 24 May 1995, p. 4067.

Paper affirming the Guardianship Tribunal's desire for parliament to deal with the issue of medical power of attorney.²¹

Mr Taylor referred to the "important press release" from which the ALP member for Nollamara, Mr John Kobelke, quoted. The release was prepared in co-operation with the L. J. Goody Bioethics Centre. The combined statement was from the Catholic Doctors Association, the Catholic Health Care Association, St John of God Health Care Assistance, St Anne's hospital, Southern Cross Homes and Catholic Homes. The statement concluded that the *Medical Care of the Dying Bill (1995)* was not promoting euthanasia and was worthy of support.²²

The key issues which influenced the MPs decision making processes in determining their political support and opposition were varied. The ALP member for Maylands, Dr Judith Edwards, said the Bill was an intensely personal issue. This made political support for the Bill less certain. Being a Private Member's Bill, political participation was greater and many MPs were open to persuasion. Pressure group persuasion was a factor in gaining political support for the Bill from MPs.

²¹ *Ibid.* p. 10239.

Office of the Public Advocate. (1996). *Proposed Changes to the Guardianship and Administration Act 1990 Discussion Paper*. Western Australian Government, p. 13. At that time in Western Australia, it was not possible for a person to give lawful authority to another person to make medical decisions on their behalf in the event that they are unable to make those decisions for themselves. The issue of loss of capacity was not addressed in Mr Taylor's Bill.

²² Western Australian Parliamentary Debates. 1 November 1995, p. 10240.

From an Aboriginal perspective, the ALP member for Kimberley Mr Earnest Bridge, said the Aboriginal perception would be one in which the Bill could allow for a white doctor to kill a black person. He refused to support the Bill. The Liberal member for Warren, Mr Paul Omodei, agreed saying he too feared this line of thinking in Aboriginal people. The ALP member for Perth, Diana Warnock's support relied on her world-view gained from the West Australian Voluntary Euthanasia Society and her understanding of the medical profession's acceptance of the Bill. This was a significant factor in her support of the Bill and she said it was a "serious philosophical issue", in which the community battled.

The ALP member for Kenwick, Dr Judyth Watson indicated the polls' support for euthanasia and the right of individual's to make choices about their own bodies. She said the Victorian Parliament had passed similar legislation. She appeared to indicate that she had a greater understanding of the issue because of her involvement in the West Australian Voluntary Euthanasia Society, and her previous role as a nurse.

The Independent member for Floreat, Dr Elizabeth Constable provided an articulate account of the issues in which the Bill dealt. She supported the Bill because it gave individuals dignity in controlling their own death. She also said that the legislation should not progress further into enabling euthanasia.

The ALP member for Victoria Park, Dr Geoffrey Gallop's speech is evidence that the L. J. Goody Bioethics Centre

achieved his political support, as it provided him with the information he needed in order to make an informed decision. He challenged those politicians who opposed the Bill to indicate "how we can deny such a right [to a dying person] and preserve the dignity of a human being?"

The Liberal member for Greenough, Mr Kevin Minson supported the Bill, after seeking the advice he needed from Christian groups. He agreed with their response that the Bill needed to advocate for better palliative care for the sick and frail. The Medical Treatment Certificate was an obstacle for political support by the NPA member for Avon, Mr Maxwell Trenorden - he saw it as a futile exercise, together with the fact that people may change their minds after they sign a document.

The Liberal member for Riverton, Mr Graham Kierath opposed the Bill as he felt it was "flawed" and therefore sought a better drafted Bill. He said the key in the complex legal issues resided in whether the patient was competent or incompetent. The Liberal member for Scarborough, Mr George Strickland, the Liberal member for Jandakot, Mr Michael Board and the Liberal member for Cottesloe, Mr Colin Barnett offered tentative support. The Liberal member for Helena, Mrs Rhonda Parker did not support the Bill due to its many weaknesses. The NPA member for Collie, Dr Hilda Turnbull did not see the need for the Bill as to date no doctor had been charged. She believed the Medical Treatment Certificate posed problems of a legal nature as it provided a mechanism where a medical professional could subsequently be charged.

The Liberal member for Vasse, Mr Barry Blaikie felt that he needed more time and more information before he would consider supporting the Bill. He sought a joint select committee on the matter.

Other influential factors in gaining political support were the Law Reform Commission of Western Australia Report on Medical Treatment for the Dying, which found there was a strong case for the introduction of such a Bill in Western Australia. Also the fact that medical science had progressed and that the law had not kept up with the progression.

Allowing for medical treatment decisions by third parties of incompetent patients was a barrier to political support; so, too, was the possibility of the Bill allowing for euthanasia. Dr Judyth Watson said that ultimately an individual's behaviour could not be legislated. Support for this third version of the Bill was greater than for antecedent Bills. The ALP platform acknowledged that people have the right to die in a peaceful and dignified manner. The Bill allowed for this and so drew further support. The Bill was opposed to euthanasia and did not affect the operation of the Criminal Code.

Mr Taylor was certain that groups in the community wanted to improve the rights of the terminally ill, to ensure that such patients could die with dignity. There was overwhelming support from the medical community, palliative care groups and the Catholic Church. However, opposition came from the Royal Australasian College of Physicians which warned that the Bill addressed an issue which was

complicated. Initially the West Australian Voluntary Euthanasia Society opposed the Bill but later changed its mind.

Having significant lobby group support from the Australian Medical Association and the L. J. Goody Bioethics Centre, gave politicians ample reason to vote for the Bill. These groups' thoughtful analyses of the issue in the early stages of the Bill's formation ensured strong political support. By far the most powerful submission was from the L. J. Goody Bioethics Centre with its statement on the sanctity of human life and the role of the Catholic Church. Mr Pandal alluded to this saying:

If the real issue is that question of sanctity, this Bill is capable of being supported. Even people who have no religious persuasions or persuasions other than those of the Roman Catholic Church would acknowledge that there is no harsher critic anywhere in the world of measures of this kind than that organisation;²³

Furthermore, Catholic Archbishop Hickey gave cautious support to the Bill in a written statement. The L. J. Goody Bioethics Centre's submission used a combined statement from Doctors which became a powerful political motivator for MP support. It is worth noting that acceptance of the Bill came from politicians on both sides of the "ideological fence" on the matter of euthanasia. The ALP member for Ashburton, Mr Fredrick Riebeling wanted to take the Bill an irresistible "one step further". There was little support from other MPs to do this. Yet many MPs supported the Bill because it clarified a "grey" area in the medical treatment of the terminally ill.

²³ Western Australian Parliamentary Debates. 23 August 1995, p. 7124.

Mr Fredrick Riebeling congratulated Mr Taylor on his community consultation and offered amendments to:

1. Introduce the living will for both competent and incompetent persons.
2. Affirm and protect the rights of terminally ill persons to refuse unwarranted medical treatment.
3. Allow the appointment of an agent by enduring power of attorney.
4. Allow an agent or guardian to refuse medical treatment on behalf of the incompetent patient.
5. Protect the agent, the guardian, the medical practitioner and other health professionals.
6. Deal with related purposes.²⁴

Mr Riebeling said the parliament had an opportunity "to go one step further" and that is why he offered the amendments.²⁵

Liberal member for Dianella, Dr Kim Hames, supported the principles of the Bill and said his views were his own, not his party's.²⁶ From a physician's perspective he said, Mr Taylor's observations had occurred in medical practice for a long time.²⁷ The complexities of health-care decisions were addressed and Dr Hames stated support for the Bill because it clarified the present situation. However, he urged members not to support amendments to the Bill and warned:

In the last part [of the Bill] where injections for the terminally ill are mentioned there is nothing to dictate in any sense what quantity of drug is acceptable. If members are talking about this creeping into euthanasia, this is one area in which that possibility exists.²⁸

²⁴ Western Australian Parliamentary Debates. 23 August 1995, p. 7118.

²⁵ Western Australian Parliamentary Debates. 23 August 1995, p. 7120.

²⁶ Western Australian Parliamentary Debates. 23 August 1995, p. 7121.

²⁷ *Ibid.* p. 7121.

²⁸ Western Australian Parliamentary Debates. 23 August 1995, p. 7122.

Dr Hames said he noticed support from many areas in the medical profession.

Independent Liberal member for South Perth, Mr Phillip Pandal, stated that the legislation before the house was the most important piece of legislation of recent note.²⁹

Significantly, pressure group influence was upon Mr Pandal when he said:

It is true to say that it is little short of extraordinary that the Bill before the House has support from such disparate groups and the Western Australian Voluntary Euthanasia Society on the one hand and leading Roman Catholic ethicists and philosophers on the other. I understand but totally reject the ultimate agenda of WAVES, which was outlined in the latest letters to members although I respect their right to express a view but make it clear that I do not agree with their ultimate agenda. One of the people I consulted was Father Walter Black, who is the head of the L. J. Goody Bioethics Centre in Western Australia. Apart from having a fine mind and being a leading ethicist in his own right he is also a consultant to the Australian Medical Association on such topics. Father Walter Black takes the view that the Bill drafted by the member for Kalgoorlie represents, expresses and reflects what he says are sound and traditional medical ethics. I understand that it was not always the case that the member for Kalgoorlie's Bill was in its current form, because in its original form it talked about the rights of patients whereas that has been refined to deal with the rights of terminally ill persons. That is reflected in clause 5 of the Bill. It did not mention before the refusal of treatment "when that medical treatment is futile or is excessively burdensome." For those who want to maintain support for the Bill the retention of clause 12 is crucial to the whole affair.³⁰

Mr Pandal would withdraw his support if Mr Reibelings' amendments were passed.³¹ On the role of palliative care he said:

²⁹ Western Australian Parliamentary Debates. 23 August 1995, p. 7123.

³⁰ *Ibid.* p. 7123.

³¹ Western Australian Parliamentary Debates. 23 August 1995, p. 7124.

... it is essential to distinguish between: euthanasia; control of pain and other symptoms; and withholding or discontinuing life-prolonging treatments. One must never confuse these three different types of clinical judgments and activities.³²

He explained the differences between euthanasia and pain control procedures quoting extensively from the *European Journal of Palliative Care* (1994):

...that prolonging life at all costs, especially at the cost of unbearable suffering, is not the right thing to do. That is the point of the evolving ethic of allowing the dying to die, and in doing everything possible and justifiable to help them die in peace and without pain ... that is the point of palliative care.³³

Mr Pental referred to the influence of Father Walter Black of the L. J. Goody Bioethics Centre director endorsing the Bill. Mr Pental explained:

In fact, Father Black goes further and says in his conversations with me, which he knows I will repeat here, that the Bill stands as a protection against euthanasia in Western Australia.³⁴

After quoting from Pope Pius XII, Mr Pental urged a slow procession of the Bill and "to allow the sort of community debate that has been going on at a certain level in the past couple of months."³⁵ Mr Pental said he was given a copy of Catholic Archbishop Hickey's statement:

Given the current push for euthanasia in Australia, any legislation that contains provisions for the terminally ill must be subjected to the closest scrutiny ... Unless

³² *Ibid.* p. 7124. The L. J. Goody Bioethics Centre supplied the article to Mr Pental.

³³ Western Australian Parliamentary Debates. 23 August 1995, p. 7125.

³⁴ Western Australian Parliamentary Debates. 23 August 1995, p. 7124.

³⁵ Western Australian Parliamentary Debates. 23 August 1995, p. 7126. That "certain level" must surely refer to the lobbying and media attention the Bill received.

the concerns are addressed ... what claims to be a Bill to prevent euthanasia legislation might in fact pave the way for it.³⁶

ALP member for Maylands Dr Judy Edwards, as a physician, reflected on the medical aspects of the Bill. She said that the Bill affirmed and protected the rights of the terminally ill to refuse unwanted medical treatment. The Bill also protected medical practitioners and other health professionals who assisted in the refusal of medical treatment. She explained her perception of community opinion:

This is a step in a very important debate and one which the community is now signalling it wants held in this Chamber.³⁷

"I feel very strongly about this Bill and why it is extremely important that this Bill is before this parliament." Dr Edwards said.³⁸ Later she mentioned another source of influence:

... some people who have been closely involved with the system, usually with relatives who have died, tell me that they do not think the situation has changed in the way which they want to see, and they are screaming out for a Bill such as this which spells out that people can refuse unwarranted medical intervention.³⁹

Dr Edwards warned:

... the law can be a very blunt instrument in circumstances which are not black and white and which are not amenable to a blunt instrument approach.⁴⁰

³⁶ *Ibid.* p. 7126.

³⁷ *Ibid.* p. 7127.

³⁸ *Ibid.* p. 7127.

³⁹ *Ibid.* p. 7127.

⁴⁰ Western Australian Parliamentary Debates. 23 August 1995, p. 7130.

Dr Edwards desired the medical profession's input into the Bill:

There is no doubt that palliative care physicians have gained a lot of wisdom over the years, and I hope that wisdom can come through in Bills like this.⁴¹

Furthermore, she believed the community was asking parliament to look at the issue. She said people were more attuned to how they wanted to die and quoted Peter Baume:

The withdrawal of curative treatment from the terminally ill and the continuation only of symptomatic relief is not what many of us call euthanasia - it is just good medicine. ... Neither is the inadvertent shortening of life by the giving of symptom relief (e.g. with adequate doses of narcotics) what we call euthanasia.⁴²

The ALP member for Kimberley Mr Ernie Bridge, said the Bill was one of the most significant matters on which the members were called upon to pass judgment. Having strong links with the large number of Aboriginal constituents he represents, Mr Bridge considers such people to be a significant force:

... a perception could be put forward by the Aboriginal people that, in their eyes, this legislation is a rose by any other name which would smell as sweet. It could be interpreted by them as empowering a white doctor to kill a black person.⁴³

Such empowerment over death was a significant issue of the legislation and a powerful part of Aboriginality.

⁴¹ Western Australian Parliamentary Debates. 23 August 1995, p. 7128.

⁴² Western Australian Parliamentary Debates. 23 August 1995, p. 7130. Peter Baume is a patron of the NSW Voluntary Euthanasia Society, a former Liberal senator and Health Minister.

⁴³ Western Australian Parliamentary Debates. 23 August 1995, p. 7131.

He vehemently opposed the Bill and concluded he would have no part of it. He said:

I know what I think and I believe I neither have, nor was ever given, the right to use this measure of empowerment. I will never depart from that rule whatever might be the opposing forces and the mass of opinion ... The duration of life, regardless of what course it might take and whatever the circumstances, is outside the realm of the human race to determine.⁴⁴

He was even clearer:

I do not care what the Pope, the bishops, other members who spoke on this Bill or you think, Mr Acting Speaker. I will not depart from that rule whatever might be the opposing forces and the mass of opinion.⁴⁵

The ALP member for Perth, Ms Diana Warnock, reflected the views of the pressure group known as the West Australian Voluntary Euthanasia Society. Ms Warnock supported the legislation and also presented a petition on behalf of the group on Thursday 26 October 1995.⁴⁶ The petition conformed to the Standing Orders:

We the undersigned, request that because the Criminal Code law in Western Australia is such that suffering people have no legal right to be allowed or helped to die, no matter what their degree of suffering nor the urgency of their plea for release by death, the Legislative Assembly, in Parliament assembled, should enact legislation that makes the right to be allowed or, if necessary, helped to die a legal option on the request of persons who are suffering more than they wish to bear; and that other persons participating in the fulfilment of such legal options shall not be subject to legal, professional or social action.

⁴⁴ Western Australian Parliamentary Debates. 23 August 1995, p. 7132.

⁴⁵ *Ibid.* p. 7132.

⁴⁶ Western Australian Parliamentary Debates. 26 October 1995, p. 9884. Ms Watson presented a petition to the Legislative Assembly on behalf of the West Australian Voluntary Euthanasia Society. It was the 11th petition to be presented for the group since 1988 and it was the largest, bearing 3,967 signatures.

Ms Warnock said it was rare for the Chamber to engage in a philosophical debate and that members mainly dealt with practical issues along ideological party lines.⁴⁷ Ms Warnock referred to the strength of representations made to her by people with strong religious views.⁴⁸

Advocates made representations for the disabled and others who have taken an entirely different view on the debate.⁴⁹ She referred to a number of groups who contacted her regarding the "slippery slope"⁵⁰ argument. Furthermore, she received material which stated that the Bill did not go far enough for many people and that included members of the lobby group, the West Australian Voluntary Euthanasia Society. She explained that the group based its philosophical views on individual choice, and claimed that its views were shared by almost four out of five Australians. She said, "I have seen that mentioned in many surveys". Ms Warnock then quoted from the material sent to her from the group:

WAVES welcomes his Bill, which seeks not only to safeguard the right of terminally ill patients to refuse undesired treatment but also to provide long overdue protection for professional carers who act upon such refusal. We strongly urge you to support these provisions.⁵¹

In the same letter from the West Australian Voluntary Euthanasia Society, the group stated that more radical

⁴⁷ Western Australian Parliamentary Debates. 23 August 1995, p. 7132.

⁴⁸ Western Australian Parliamentary Debates. 23 August 1995, p. 7133.

⁴⁹ *Ibid.* p. 7133.

⁵⁰ Pollard, B. (1994). *The Challenge of Euthanasia*, Crows Nest: Little Hills Press, Crows Nest, p. 134. The slippery slope argument engenders fear based on the claim that there can be a slide of lesser moral infringement to the greater.

⁵¹ Western Australian Parliamentary Debates. 23 August 1995, p. 7134.

action should be taken. The letter indicated the group's tacit support for Mr Riebeling's amendments and the group were disappointed the Bill did not allow for living wills.⁵²

The Liberal member for Albany, Mr Kevin Prince, hoped that the debate would be non-political and that it would produce different and considered views.⁵³ As a lawyer he practiced in the area of deceased estate administration and was chairman of the Albany Hospice (Inc.) before he entered parliament.⁵⁴ Mr Prince said he was a long-standing member of the Anglican Church and Diocesan Advocate to the Bishop of Bunbury, and a member of the national Synod.

Mr Prince quoted from poet Arthur Clough: "Thou shalt not kill, but needest not strive officiously to keep alive".⁵⁵ He warned that the poem's simple theme was not simple in modern reality. He supported the Bill because it would protect medical and other professionals from breaking the law.

The ALP member for Nollamara, Mr John Kobelke supported the Bill. He said it was appropriate to withdraw treatment on the request of the patient and that it reflected

⁵² *Ibid.* p. 7134.

⁵³ Western Australian Parliamentary Debates. 27 September 1995, p. 8741.

⁵⁴ Western Australian Parliamentary Debates. 27 September 1995, p. 8738.

⁵⁵ Western Australian Parliamentary Debates. 27 September 1995, p. 8739. The quoted couplet from an ironic poem by the nineteenth century poet Arthur Hugh Clough, entitled *The Latest Decalogue*, is often used in the literature on death and dying. Frequently it is taken out of context when it is quoted.

traditional Christian ethics.⁵⁶ He applauded Mr Taylor's consultation process:

He recognised that the law has not kept up with the needs of society and, through a thorough consultation process, he has ensured that the Bill addresses a real problem in a moderate and sensible way.⁵⁷

Mr Kobelke quoted from a joint statement issued by the L. J. Goody Bioethics Centre to all MPs, which stated:

The science and art of palliative care has made such great advances that our doctors and nurses can now keep patients virtually pain-free until they die. It may indeed sometimes be the case that recourse to proper palliative care and pain control may foreseeably but unintentionally somewhat shorten the life-span of the patient. Hence, when there is no intention to deliberately cause death, the shortening of life is understood as a side-effect of proper palliative care. Such procedures for the benefit of the patients are morally justifiable and should be free of any legal restrictions.

This is not euthanasia.⁵⁸

The statement helped Mr Kobelke clarify his thoughts.

West Australian Voluntary Euthanasia Society member and the ALP member for Kenwick, Dr Judyth Watson, began with: "I shall make a brief contribution in support of the legislation," then recorded one of the longest speeches in the debate. Dr Watson hoped for euthanasia legislation.⁵⁹

Dr Watson supported the aims and objectives of the West Australian Voluntary Euthanasia Society. She also favoured a living will. Dr Watson quoted from an opinion poll which

⁵⁶ Western Australian Parliamentary Debates. 18 October 1995, p. 9354.

⁵⁷ *Ibid.* p. 9354.

⁵⁸ Western Australian Parliamentary Debates. 18 October 1995, p. 9355.

⁵⁹ Western Australian Parliamentary Debates. 18 October 1995, p. 9356.

indicated "Seventy-three per cent of Australians believe in euthanasia for an elderly person who is hopelessly ill and in great pain."⁶⁰

The Independent Liberal member for Floreat Dr Elizabeth Constable articulated the entire spirit of the Bill in her concise speech. She said:

By its very nature the bill raises complex legal, religious and ethical issues. It is not a political issue, but for members of parliament a matter of conscience when it is finally put to the vote.⁶¹

Dr Constable said the community wished to debate the issues raised in the Bill; a finding she had made during her wide community consultation with her electorate on the matter.⁶²

She also quoted from Morgan Gallup polls to indicate changing public opinion on the acceptance of euthanasia.

Dr Constable said:

Many people without looking at the Bill have gone too far in their assessment of what the Bill is about. A number of people have mistakenly concluded that this Bill will permit euthanasia. It must be said over and over again that that is not the case ... In fact, it is about allowing people who have a terminal illness to die with dignity and in a humane and comfortable way.⁶³

She explained that the legislation would enable terminally ill patients over the age of 18 to refuse medical treatment when that treatment would be over-burdensome or futile.

The decision to refuse medical treatment must be well informed and made voluntarily. There are three provisions in protecting patients that:

⁶⁰ Western Australian Parliamentary Debates. 18 October 1995, p. 9356.

⁶¹ Dying with dignity. (1995, September). *The Western Review*, p. 6.

⁶² Western Australian Parliamentary Debates. 18 October 1995, p. 9359.

⁶³ *Ibid.* p. 9359.

1. there is no intention to cause the patient's death;
2. the patient consents to the treatment; and
3. the treatment is reasonable⁶⁴

The legislation affirms existing law for the treatment of the dying by protecting patients, medical practitioners and nurses. Under current law, a person of sound mind may refuse medical treatment and that refusal terminates the legal duty of the practitioner to the patient. On the other hand, under current law a doctor who treats a person without consent commits a trespass or assault.⁶⁵ Dr Constable said it was right that a refusal of treatment certificate did not cover a refusal of palliative care that included pain relief, food and water. The Law Reform Commission of Western Australia's 1991 report stated:

that under the current Western Australian law, there is no means by which people can give legally binding directions about withholding or withdrawing treatment should they become incompetent, nor is it possible for a person to appoint someone to make treatment decisions on his or her behalf.⁶⁶

The Bill was not about euthanasia, living wills, assisting suicide or about denying people proper treatment. Dr Constable said the Bill was about allowing people who have a terminal illness to die with dignity and in a humane and comfortable way. She believed the Bill had gone far enough, and agreed it was necessary that the legal duties and responsibilities of doctors and nurses be spelt out, in legislation. Dr Constable said medical or health care

⁶⁴ *Ibid.* p. 9359.

⁶⁵ *Ibid.* p. 9359.

⁶⁶ *Ibid.* p. 9359.

workers should not fear the threat of legal action when they carried out their duties.⁶⁷

Supporter of the Bill, ALP member for Victoria Park Dr Geoffrey Gallop, said he had received a significant submission signed off by Dr Michael Quinlan. Mr Taylor and Mr Pandal had both referred to the submission which was from a series of Catholic organisations on palliative care matters. Dr Gallop paraphrased the submission.⁶⁸ He said a closer look at the legislation's wording would be undertaken in the Committee Stage.⁶⁹

Liberal member for Warren Mr Paul Omodei, disagreed with the Bill and said the Bill had created a great deal of interest for MPs who would vote as they saw fit.⁷⁰

The public statement issued to members by Dr Michael Quinlan sparked Mr Omodei's conversation with Dr Quinlan in which they discussed concerns about the issue and the attempts around Australia to legalise euthanasia. If passed, Mr Omodei said the legislation would lead to the further possibility of euthanasia legislation and that would be the thin edge of the wedge. He quoted from the statement:

We all have the responsibility to take reasonable care of health and life. But in a situation of terminal

⁶⁷ Western Australian Parliamentary Debates. 18 October 1995, p. p. 9359-9360.

⁶⁸ The L. J. Goody Bioethics Centre sent the document to MPs. Signatories included: the Catholic Doctors Association, the Catholic Health Care Association, St John of God Health Care System, St Anne's Hospital, Southern Cross Homes (WA) Inc., Catholic Homes Inc. It is clear the submission influenced his thinking.

⁶⁹ Western Australian Parliamentary Debates. 1 November 1995, p. 10220.

⁷⁰ *Ibid.* p. 10220.

illness, when a person is dying with no hope of a cure or improvement of condition, then any aggressive medical treatment may well be quite futile and excessively burdensome to the person ... The purpose of [palliative care] is to free patients from the pain and intense discomfort that dominates consciousness and leaves no psychic space available for the personally important things people want to think about, say and do before they die ...⁷¹

Mr Omodei quoted extensively from a report⁷² which gave the history of hospital and palliative care in Western Australia. He referred to the work of the Silver Chain Nursing Association.⁷³

He quoted from a submission from the Australian Nursing Federation:

The Bill in its current construction makes no distinction between persons with chronic terminal illness and those with acute/traumatic illness. With the former the person is generally afforded time for substantial consideration of his/her condition and outcome whilst the latter situation might not allow for such consideration.⁷⁴

Then he quoted from a letter sent to MPs from the Coalition for the Defence of Human Life:

⁷¹ *Ibid.* p. 10220.

⁷² Baird, M. (1993). *Planning for Palliative Care in Western Australia: Report of the State Planning Committee on Palliative Care to the Commissioner of Health, Western Australia.* Perth.

⁷³ Western Australian Parliamentary Debates. 1 November 1995, p. 10221.

⁷⁴ Western Australian Parliamentary Debates. 1 November 1995, p. 10222. Hospital death rules sought. (1996, October 16) *The West Australian*, p. 48. The Australian Nursing Federation spokesperson Helen Attrill said there could be a serious mix-up if hospital staff continued to make ethical decisions about death in a vacuum and without strict guidelines. She said ethical problems occurred every day where patients in great pain had been given large doses of analgesics, which risked depressing respiratory function and assisting death. Hospital staff could also make a mistake about the survival of a patient and assist in speeding up death in a way which was totally against the wishes of the family or the individual.

Our Coalition accepts the traditional ethical position that patients may choose freely to refuse proportionately burdensome medical treatment and that there is, naturally, no obligation to undergo treatment that is likely to be futile.⁷⁵

"To exercise a conscience vote is not something that should be taken lightly," said the Liberal member for Cottesloe Mr Colin Barnett. He supported the second reading but conceded it was not perfect.⁷⁶

The Liberal member for Scarborough Mr George Strickland, predicted there would be interesting debates in honing definitions in the Committee Stage - and how right he proved to be!

"I will not support his legislation," said the Liberal member for Roleystone Mr Frederick Tubby. He had spoken to people in his electorate and recounted:

... a number of elderly people have spoken to me at some length about it and have expressed their concerns and fears. If we are going to generate fear among our senior citizens, we must look closely at where we are going.⁷⁷

The Liberal member for Geraldton, Mr Bob Bloffwitch said he had read the statistics on euthanasia and explained why he would not support the Bill:

when a survey of over 75 year olds was held in one of the countries where 80 per cent of the population was in favour of euthanasia, 95 per cent of them were against it.⁷⁸

⁷⁵ Western Australian Parliamentary Debates. 1 November 1995, p. 10222.

⁷⁶ Western Australian Parliamentary Debates. 1 November 1995, p. 10226.

⁷⁷ Western Australian Parliamentary Debates. 1 November 1995, p. 10228.

⁷⁸ Western Australian Parliamentary Debates. 1 November 1995, p. 10228.

The National Party of Australia member for Collie Dr Hilda Turnbull, a physician and palliative care specialist said no case had been raised of a person who did not have dignity when dying in Western Australia. She said a Bill containing administrative formalities would not make much difference and she said there was no need for it.⁷⁹ Dr Turnbull said the Bill was not about medical care but about administrative formalities, and once that line was drawn the opportunity for legal action could eventuate.⁸⁰

The Liberal member for the Darling Range, Mr John Day, supported the second reading. He said that a definition of a "terminally ill patient" was needed. Professor David Allbrook, a palliative care doctor for the Silver Chain Nursing Association, lobbied Mr Day and said:

... although the intent of the Bill is well worthwhile, the detail needs to be closely considered, and that perhaps a better way to deal with the situation would be to introduce a Bill to amend the Criminal Code in order to remove the possibility of doctors being prosecuted - whether that possibility is real or perceived.

The Liberal member for Helena Mrs Rhonda Parker, predicted that if the Bill went to Committee Stage with extensive amendments, it would become an unwieldy piece of legislation and more problems would be created than be resolved. She was right.

A new title to the Bill: "*The Removal of Medical Care to Hasten the Death of People*", was sardonically offered by the Liberal member for Vasse, Mr Barry Blaikie, because he considered that to be the end result of the Bill. One

⁷⁹ Western Australian Parliamentary Debates. 1 November 1995, p. 10230.

⁸⁰ Western Australian Parliamentary Debates. 1 November 1995, p. 10228.

reason he did not support the Bill was that it had insufficient regard for the moral dilemma resulting from the legislation, and that Mr Taylor had not canvassed the moral grounds. This was despite the ALP supporting a conscience vote in Mr Taylor's second reading:

... because we were of the view that this legislation is not of a political nature, but in many respects relates to the moral, philosophical, ethical and religious position of individuals.⁸¹

People had raised such concerns with him and he was not satisfied that there were good moral reasons for proceeding with the Bill.⁸² Mr Blaikie asked, "With regard to the religious position of individuals, have ministers of the clergy of the various denominations indicated where they stand on this matter?" Mr Omodei replied, "they have made responses and they are strongly opposed to it."

However, Mr Blaikie said there was an amount of caution in the wider community and:

If ever there were an occasion on which the Parliament should be better advised, this is it. It is important for the Parliament to be advised on the moral, social, ethical, philosophical and religious areas surrounding this subject. A joint select committee of both Houses of Parliament should be established to seek advice from the wider community and in due course report to the Parliament. Members of Parliament would then be far better informed than they are now ... I have yet to hear comments made on the basis of research and knowledge. I certainly do not have access to this researched information.⁸³

⁸¹ Western Australian Parliamentary Debates. 1 November 1995, p. 10234.

⁸² *Ibid.* p. 10234.

⁸³ *Ibid.* p. 10234. Making such a statement, Mr Blaikie is inviting pressure group lobbying.

Health Minister and Liberal member for Riverton Mr Graham Kierath noted that the debate recorded one of the highest numbers of members to have spoken on any legislative proposal before the House.⁸⁴ He said:

The issues have been canvassed far and wide. Members have put different points of view. The regime promoted in the Bill is flawed. I honestly believe this legislation would create more legal uncertainty than it would resolve.⁸⁵

He gave an indication of what would be ahead in the Committee Stage when the Bill would be debated clause by clause. Some of the "sticking points" were definitions: "which a terminally ill person considers to be burdensome", "excessively burdensome" and "considers".⁸⁶ Either these problems were solved in the Committee Stage or the Bill should be withdrawn, he told journalists.⁸⁷

He did not support the Bill because of its flawed nature but supported the principles.⁸⁸ Mr Kierath participated in discussion groups on the right of an enduring power of attorney and although the idea did not have unanimous support, it had majority support.⁸⁹ Mr Kierath said he would leave treatment decisions in his wife's hands and that there should be some facility to cover that situation.⁹⁰ Mr Kierath revisited Mr Taylor's opening speech and supported the idea of an enduring power of

⁸⁴ *Ibid.* p. 10234

⁸⁵ Western Australian Parliamentary Debates. 1 November 1995, p. 10237.

⁸⁶ Western Australian Parliamentary Debates. 1 November 1995, p. 10235.

⁸⁷ Death Bill moves closer. (1993, November 2). *The West Australian*, p.3.

⁸⁸ Western Australian Parliamentary Debates. 1 November 1995, p. 10237.

⁸⁹ Western Australian Parliamentary Debates. 1 November 1995, p. 10235.

⁹⁰ Western Australian Parliamentary Debates. 1 November 1995, p. 10236.

attorney. Mr Kierath invited Mr Taylor to work with him to produce a Bill that would receive majority support.⁹¹

The busy 1995 parliamentary agenda caused the Bill to run out of time and it was debated in the Committee Stage in 1996. Perhaps unfortunately for the fate of the Bill, Mr Taylor left State politics to stand for the House of Representatives at the 1996 Federal Election. Dr Judyth Watson assumed responsibility for the Bill in the critical Committee Stage. The definition of "terminally ill" was put into the amendments on the Notice Paper, then debated in the Committee Stage. Further amendments were proposed.

Committee Stage

Dr Judyth Watson commented on the favourable media coverage and correspondence regarding the way in which members conducted themselves. The amendments allowed for the *Medical Care of the Dying Bill (1995)* to include all people, not just the terminally ill. She said the community wanted the Bill to become an Act:

I remind members that we were committed to working together to see this legislation passed for the benefit of the people described in the long title of the Bill as those terminally ill people who refuse unwanted medical treatment, and to protect medical practitioners and other health professionals.⁹²

Insertion in page 2 of definitions of "board", "hospital" and "licence holder" was already on the Notice paper prior to the second reading. The Health Department's legislation

⁹¹ Western Australian Parliamentary Debates. 1 November 1995, p. 10237.

⁹² Western Australian Parliamentary Debates. 15 May 1996, p. 2027.

team provided non-contentious definitions. The amendment was put and passed.⁹³

Dr Watson said the definition of "terminally ill person" should be the first from which other definitions flow. Dr Hames' proposal would then be cast in the context of the "medical treatment" definition followed by the schedule for the patient's signature. Dr Watson said it was important that palliative care be defined separately in the Bill, so that people were not given the option of refusing palliative care, nutrition and fluid intake. She said the definition in the schedule should match paragraph (c) definition.⁹⁴

Dr Watson moved an amendment to define a terminally ill person as part of clause 3. After discussion, members determined that it was within Assembly rules to complete the debate on clause 3. Lines 16 and 17⁹⁵ would be recommitted at the end of the Committee Stage.

Her subjective definition of terminally ill read:

... a person who has a current illness or condition which, unless medical treatment which that terminally ill person considers to be excessively burdensome is applied, is likely to result in the death of that person.⁹⁶

Dr Hames' next amendment was contingent upon the passage of the above amendment. Dr Hames' objective definition read:

⁹³ Western Australian Parliamentary Debates. 15 May 1996, p. 2028.

⁹⁴ Western Australian Parliamentary Debates. 15 May 1996, p. 2030.

⁹⁵ See Appendix 1: Medical Care of the Dying Bill No. 35-1B, clause 3(c).

⁹⁶ Western Australian Parliamentary Debates. 15 May 1996, p. 2031.

... when a medical practitioner decides the administration of further treatment would not be useful in a medical sense and there is no hope of recovery or even control of the disease.⁹⁷

Dr Watson referred to other treatments which may be burdensome.⁹⁸ Several members and the Liberal member for Albany Mr Kevin Prince agreed that legislators were not alone in over-describing certain terms in legislation to make a point. She quoted correspondence from Father Walter Black to Mr Taylor which described "excessively burdensome":

It is good and wise law to protect the rights of any patient, but especially of the terminally ill to be able to refuse any such treatments as involve disproportionate hardship, which are futile or excessively burdensome.⁹⁹

Dr Watson said the key word was "futility". Father Black had previously explained "ordinary means" and "extraordinary means".¹⁰⁰ Dr Watson conceded that the long

⁹⁷ Western Australian Parliamentary Debates. 15 May 1996, p. 2032.

⁹⁸ The definition has been widened to include any person and any condition - not just a terminally ill person who considers the medical treatment to be burdensome.

⁹⁹ Western Australian Parliamentary Debates. 15 May 1996, p. 2033. Groups unite against die Bill. (1995, May 25). *The West Australian*, p. 25. L. J. Goody Bioethics Centre Director Father Walter Black, said it was ethically desirable not to prolong a dying person's life if there was no chance of improvement or recovery or if the treatment was unreasonably traumatic, expensive and painful. The Roman Catholic Church - though apolitical, said its guidelines were similar to those in the Bill.

¹⁰⁰ These two concepts are critical to the debate. In an interview with the author on 30 September 1997, Father Walter Black said that ordinary measures of patient care are recognised as elements of essential care. They represent obligatory, proven and justified therapies and procedures. They are denoted by the fact that the patient himself can obtain them and put them to his own use. They further represent measures which he can reasonably undergo with only minimal or moderate danger and maximal effectiveness. Such measures are also not an impossible or excessive burden. Extraordinary measures are complicated methods. They are impossible for the patient to use or apply to himself and present a costly and difficult burden. In addition, they represent a high level of danger and the results

title of the Bill was not perfect. Definitions were seldom perfect, but she believed it went a long way to affirm and protect the rights of people with a terminal illness. The amendment would, in turn, protect medical practitioners and other health professionals when making decisions. The emphasis was not on competence, as the person must be competent to sign the refusal of treatment certificate. People who are not competent would not be approached to sign the certificate. Dr Watson wanted both amendments to be moved to enable a fruitful debate.¹⁰¹ She hoped the Bill would progress to the third reading and thanked Mr Prince for offering to commit resources to redraft the Bill.

Mr Prince referred to definitions of "medical treatment" and "considers burdensome" in clause 3. He said "burdensome" meant oppressive duty, obligation, expense or emotion. Burdensome medical treatment for the terminally ill can vary enormously and was an inappropriate subjective term giving rise to litigation.¹⁰² But such litigation would often involve a dead patient as a witness. Because the words "consider" and "burdensome" were used, experts could arrive at totally different views. Clause 5(1)(a) used the definition "excessively burdensome".

Mr Prince asked why the Bill did not utilise the recommendations found in the Law Reform Commission of

expected are not predictable. That is, the effectiveness is minimal or moderate while the dangers are maximal. Extraordinary measures sustain life artificially at the level it is found.

¹⁰¹ Western Australian Parliamentary Debates. 15 May 1996, p. 2033.

¹⁰² Western Australian Parliamentary Debates. 15 May 1996, p. 2028.

Western Australia's report, that palliative care be included as a medical treatment.¹⁰³

The term "considers to be burdensome" raised problems because it required a cognitive function in a patient. Not all people in the terminal stage of illness were capable of such a process. Mr Prince offered a definition of burdensome:

that medical treatment means the carrying out of an operation, the administration of a drug or other like substance or any other medical procedure - full stop.¹⁰⁴

He said it was essential that the definition of any other medical procedure be consistent with the definition in clause 3. The Bill was inconsistent because it referred to two inconsistent and interchangeable terms "burdensome" in clause 3 and "excessively burdensome" in clause 5(1)(a)(ii):

... for a current condition when that medical treatment is futile, or is excessively burdensome;

Mr Prince wanted "excessively" taken out of the Bill or the deletion of all the words after "medical treatment":

... means a person who has a current illness or condition which, unless medical treatment is applied, is likely to result in the death of that person.¹⁰⁵

Mr Prince hoped the members would accept Dr Hames' amendment. However, Mr Prince objected to the excessive

¹⁰³ See *Appendix 1: Medical Care of the Dying Bill No. 35-1B*, clause 3 p. 2.

¹⁰⁴ *Ibid.* p. 2029.

¹⁰⁵ Western Australian Parliamentary Debates. 15 May 1996, p. 2032.

language in Dr Watson's amendment. He said they were writing law, not prose.¹⁰⁶

Referring to clause 4(1): "Subject to section 12" this should also be inserted in clause 4(2). This puzzled him because he could not see why clause 4 should be subject to clause 12. There seemed to be no statutory interpretation, logic or reason for this. Mr Prince could not see why legal rights should be subject to clause 12 saying it was superfluous. Instead he offered:

... this Act does not affect any right of any terminally ill person under any Act or law to refuse medical treatment.¹⁰⁷

Clause 4(3) page 3 of the Bill was contrary. Mr Prince concluded the legislation required much debate and due to drafting inconsistencies, the Bill should not advance in its present form and should not return to the House until those problems discussed had been addressed.¹⁰⁸

The ALP member for Victoria Park, Dr Geoffrey Gallop, agreed with Mr Prince on the need for clear definitions. He said an amendment to the amendment by Dr Hames would overcome the problem, giving objective reference points. Dr Gallop said definitions should objectively explain medical treatment. He supported the amendments of Drs Watson and Hames.¹⁰⁹

¹⁰⁶ Western Australian Parliamentary Debates. 15 May 1996, p. 2034.

¹⁰⁷ Western Australian Parliamentary Debates. 15 May 1996, p. 2035.

¹⁰⁸ Western Australian Parliamentary Debates. 15 May 1996, p. 2036.

¹⁰⁹ Western Australian Parliamentary Debates. 15 May 1996, p. 2035.

The Liberal member for Dianella, Dr Kim Hames, confessed that he was confused with some of Dr Gallop's reasoning.¹¹⁰ A detailed debate over logic and reasoning on the word "consider" ensued. Dr Hames asked for Dr Gallop's alternative legal view on the word "considers". He said there was a purist view of "considers" and a logical view. People in any state of mind could consider a matter, regardless of whether it was done in a pure sense or to a lesser extent. "Consider" therefore, can be variable.

Dr Hames agreed with the NPA member and Deputy Chairman for Roe Mr Ross Ainsworth, that clause 3 should be revisited at a later stage. The definition of medical treatment should also be read according to the second page of the schedule.¹¹¹

Then, Dr Hames asked if clause 3 be postponed and debated in the definition of terminal illness:¹¹²

I seek leave of the Chamber to move an amendment to the amendment which would give the Committee the opportunity to debate the member for Kenwick's amendment and my amendment conjointly.¹¹³

With leave granted he moved the amendments to Dr Watson's amendment at page 3 after line 5:

"terminally ill person" means a person who has a current illness or condition which, unless medical treatment which that terminally ill person considers to be excessively burdensome is applied, is likely to result in the death of that person.¹¹⁴

¹¹⁰ Western Australian Parliamentary Debates. 15 May 1996, p. 2028.

¹¹¹ Western Australian Parliamentary Debates. 15 May 1996, p. 2031.

¹¹² *Ibid.* p. 2031.

¹¹³ Western Australian Parliamentary Debates. 15 May 1996, p. 2033.

¹¹⁴ Western Australian Parliamentary Debates. 15 May 1996, p. 2031.

Line 1 of the amendment - To delete the word "means" and substitute the following - means -

- (a) Line 3 of the amendment - To delete "person" and substitute the following - person; and
- (b) one who has reached the stage where the administration of therapeutic care has become medically useless to bring about eventual recovery or even effective control of the disease.¹¹⁵

The importance of the amendment to the amendment was that the original definition of terminally ill person included any person, such as a depressed person or one on dialysis who may wish to end their life. Under Dr Watson's definition of terminally ill, they would have the right to refuse treatment and could, in effect, commit suicide. Thus, it was important for the members who did not support the Bill to make sure they supported the amendment to the amendment. Lobby groups had ample time to analyse the Bill.¹¹⁶

Mr Phillip Pandal said he was reluctant to support amendments made "on the run" because that was heading for trouble. He would support clause 3(c) as it was written. He said that if certain words were excluded at the last moment, then there would be no chance to consult other people. Mr Pandal would not support any changes to the clause and said a vote should be on the clause as it stood.¹¹⁷ He asked to reconvene within the month to consider and seek advice (from relevant pressure groups) on the proposed amendment.

He disagreed with Dr Watson's agreement to continue the debate on clause 3 and recommit part of it (lines 16 and

¹¹⁵ Western Australian Parliamentary Debates. 15 May 1996, p. 2033.

¹¹⁶ Western Australian Parliamentary Debates. 15 May 1996, p. 2035.

¹¹⁷ Western Australian Parliamentary Debates. 15 May 1996, p. 2030.

17). He wanted to continue the debate of the definition of "terminally ill".

He also had difficulty with Mr Prince's invitation to Dr Watson to "amend on the run", by the removal of the word "excessively." He said he made no apologies that he took advice from Father Walter Black. Father Black would make the point that by itself Dr Watson's definition was not adequate and that it was absolutely imperative that the words of Dr Hames' amendment be added.¹¹⁸

Support for Dr Watson's amendment without any further amendment on her part would be forthcoming, so long as members then added to her amendment the words outlined by Dr Hames. Members were not allowed to talk about Dr Hames' amendments at that point, other than his amendment reflected the Canadian definition, which was well regarded.¹¹⁹

Debate continued regarding the administration of therapeutic care by a medical practitioner. The NPA member for Collie Dr Hilda Turnbull, said this should be put beyond doubt. Due to time constraints, Mr Pandal opposed Dr Turnbull's amendment. He believed her concern was catered for in the clause:

where the administration of therapeutic care has become medically useless.¹²⁰

¹¹⁸ Western Australian Parliamentary Debates. 15 May 1996, p. 2032.

¹¹⁹ *Ibid.* p. 2032.

¹²⁰ *Ibid.* p. 2032.

Furthermore, he quipped that the amendment was excessively burdensome!

Mr Eric Ripper did not want to convene again because private members' time was scarce. He wanted swift progress, to continue the discussion and vote on the amendment. Dr Watson would give a commitment that she supported recommittal of the Bill at the third reading stage so that members could go back into the Committee Stage to deal with clause 3. He said consultation with the public could then be achieved.¹²¹ He asked if they could debate Dr Watson's amendment and postpone clause 3.

The Deputy Chairman said that they could pass over clause 3 and revert to it.¹²² He asked if clause 3, as amended, could be agreed to.

The amendment for the inclusion or otherwise of the word "excessively" was awkward and would be debated again. The entire clause 3 would then be recommitted at the end of the Committee Stage. He said that if the amendment before the Chamber is put and agreed to it would preclude Dr Hames from moving his amendment to the amendment. Thus, Dr Hames should move his amendment before the vote was taken on Dr Watson's amendment.

Mr Ainsworth reassured the Chamber that:

any matters which cause members concern about the wording of clause 3, regardless of whether it deals with the clause as printed in the Bill, the amendment or the

¹²¹ *Ibid.* p. 2032.

¹²² *Ibid.* p. 2032.

amendment on the amendment, can be dealt with when the clause is recommitted.¹²³

Dr Hilda Turnbull attempted to offer her many amendments on Dr Hames' amendment. She debated such points saying that the Chamber could not pass the Bill without the following amendment which took into consideration who had made the judgment that a person was terminally ill:

... by inserting after "(b) one who" the words "in the opinion of a medical practitioner."¹²⁴

This amendment was unpopular and she withdrew it. The other amendments were then put and passed.

Conclusion

The Bill never progressed to the third reading stage or the Legislative Council. The third session of parliament resumed on 15 May 1996 and the Bill was debated once.¹²⁵ Nine members participated in the Committee Stage debate.

In order for the successful passage of the Bill, the entire process which occurred in the Legislative Assembly would need to be duplicated in the Legislative Council, with a third reading before the Bill could be sent to the Governor for signature. Even then it was likely that the major pressure groups opposing the legislation would petition the Governor requesting him to deny his assent or eventual

¹²³ Western Australian Parliamentary Debates. 15 May 1996, p. 2034.

¹²⁴ *Ibid.* p. 2034.

¹²⁵ Western Australian Parliamentary Debates. 15 May 1996, p. 2027. Dr Watson took charge of the Bill with Mr Day as the Deputy Chairman of Committees.

proclamation of the Act. Of course these stages were never reached.¹²⁶

It should be noted that although the Bill was a conscience Bill the support for the measure was much firmer from Labor party members. Only Kimberly MP Ernie Bridge, who became an Independent on 27 July 1996, voted with the noes. Three Labor MPs Norm Marlborough, Michelle Roberts and David Smith abstained. Likewise, the preponderance of the noes came from Liberal Party members. Liberal Premier Richard Court abstained, while National Party members were evenly divided with three voting for the Bill and three voting against the Bill.¹²⁷

¹²⁶ Although they had to be negotiated two years later when the Abortion Bill (also a conscience Bill) passed through all the parliamentary stages before receiving assent and proclamation by the Governor.

¹²⁷ It should be noted Premier Richard Court was absent in Japan and was one of the five members to miss the vote in the Legislative Assembly on the controversial Abortion Bill. The Bill was given a third reading in the Legislative Council and granted royal assent on 26 May 1998. See Western Australian Parliamentary Debates. 1 April 1998, p.p. 1351-1352.

Table 4.1 Voting Results in the Legislative Assembly

RESULTS					
Ayes	Party		Party		Party
Mr Ainsworth	NP	Mr Graham	ALP	Mr Pandal	In.Lib
Mr C. J. Barnett	Lib.	Mr Grill	ALP	Mr Prince	Lib.
Mr M. Barnett	ALP	Mrs Hallahan	ALP	Mr Riebeling	ALP
Mr Board	Lib.	Dr Hames	Lib.	Mr Ripper	ALP
Mr Brown	ALP	Ms Henderson	ALP	Mr Strickland	Lib.
Mr Catania	ALP	Mr House	NP	Mr Taylor	ALP
Dr Constable	In.Lib	Mr Kobelke	ALP	Mr Thomas	ALP
Mr Cowan	NP	Mr Lewis	Lib.	Ms Warnock	ALP
Mr Cunningham	ALP	Mr Marshall	Lib.	Dr Watson	ALP
Mr Day	Lib.	Mr McGinty	ALP	Mr Leahy	ALP
Dr Edwards	ALP	Mr Minson	Lib.	(Teller)	
Dr Gallop	ALP	Mr Osborne	Lib.		
Noes					
Mr Blaikie	Lib.	Mr Nicholls	Lib.	Mr Tubby	Lib.
Mr Bradshaw	Lib.	Mr Omodei	Lib.	Dr Turnbull	NP
Mr Bridge	ALP	Mrs Parker	Lib.	Mrs van de Klashorst	Lib.
Mrs Edwardes	Lib.	Mr Shave	Lib.	Mr Wiese	NP
Mr Kierath	Lib.	Mr W Smith	Lib.	Mr Bloffwitch	Lib.
Mr McNee	Lib.	Mr Trenorden	NP	(Teller)	
Abstentions					
Mr Clarko	Lib.				
Mr Court	Lib				
Mr Johnson	Lib.				
Mr Marlborough	ALP				
Ms Roberts	ALP				
Mr D. Smith	ALP				

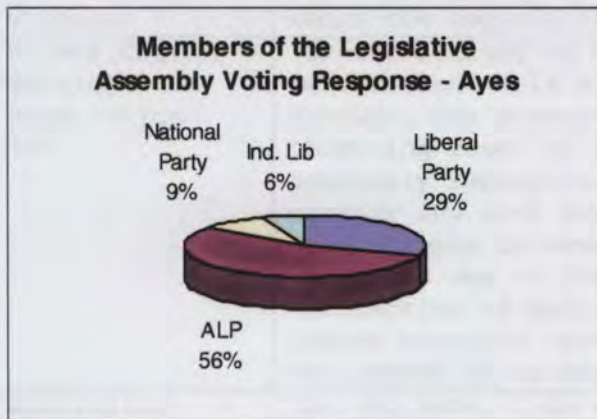


Table 4.2. Members' Affirmative Voting Response.

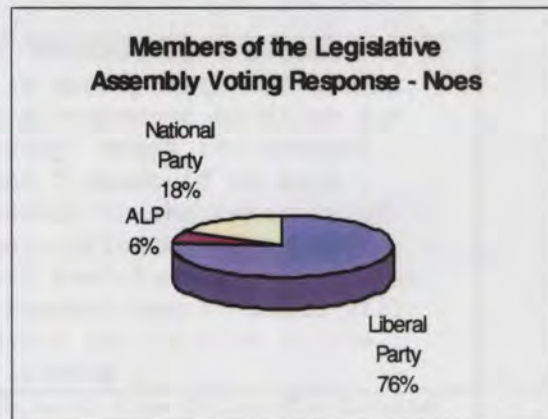


Table 4.3. Members' Negative Voting Response.

CHAPTER FIVE

PRESSURE GROUP PARTICIPATION AND CLASSIFICATION

*Pressure groups are political. Their reason for existence is to influence politics and policy-making. To do so, they undertake political activities.*¹

Dean Jaensch

The *Medical Care of the Dying Bill (1995)* cultivated the shape of the lobby. Some of the key groups were identified in the *Hansard* debate. Their positions are summarised below:²

Group	Comments/Position
Royal Australasian College of Physicians	"Consensus was that although the Bill appears to be well intentioned and formulated it addresses an issue that is much more complicated than it appears superficially."
Royal Australasian College of Surgeons	"I have sent a copy to our central office to see if there is any specific College policy but from my own [Chairman] personal view, I have no qualms about the legislation."
Silver Chain Nursing Association Inc.	"In the setting up of a 'Refusal of Treatment Certificate' this Bill is appropriate and clear. However, the absence of a component to allow for 'Enduring Power of Attorney' makes the concept generally impractical and I doubt if it will provide any real improvement in the capacity of dying people to have their opinions taken into account. One of the very positive aspects if the 'Protection of Medical Practitioners' which will remove possible uncertainty for Doctors in the management of terminal illness."
Australian Medical Association (WA Branch)	"As you know, I do agree with the principle behind the Bill. Fortunately in most circumstances the uncertainties in the law have not prevented appropriate medical care of the dying in this State. The AMA has not obtained its own legal advice on the likelihood of current medical practice exposing a doctor to criminal or civil liability in relation to the care of dying

¹ Jaensch, D. (1994). *Parliament, Parties and People*, second edition. Melbourne: Longman Cheshire, p. 171.

² Western Australia Parliamentary Debates. 24 May 1995, p. p. 4067-4069.

	<p>patients. If however, that potential exists, then there may well be value in proceeding with this legislation ... My other concern is with the penalty for the offence of medical trespass. I believe this is unnecessary and to some extent, provocative. I do not believe that there would be any likelihood of a Doctor even now ignoring a patient's decision to decline treatment, and the establishment of such a penalty seems entirely unnecessary."</p>
<p>Urological Society of Australasia</p>	<p>"First of all, could we please compliment you on your effort to address the situation here in W.A. and we are fully supportive of such moves. We would fully concur that euthanasia should in no way be included in such legislation and are fully supportive of the view outlined in your preliminary explanatory notes."</p>
<p>Australian Nursing Federation</p>	<p>"At the outset I should make it clear that the ANF, while welcoming the introduction of such Bills and the debate created in the community, is of the view that any legislation in this area should be uniform across the states. The nursing profession is a highly mobile profession and should inconsistencies in legislation exist across the states enforcement and/or adherence to the legislation would become difficult ... the profession is supportive of the Bill ... The Bill in its current construction makes no distinction between persons with chronic terminal illness and those with acute/traumatic illness. With the former the person is generally afforded time for substantial consideration of his/her condition and outcome whilst the latter situation might not allow for such consideration. It might be appropriate to consider differentiating between the two illness scenarios." Mr Taylor could find no way to bring that matter into the Bill.</p> <p>Mr Taylor said one of his main reasons for drafting the Bill was a plea to the State Health Department in 1993 by a group of nurses concerned at the lack of guidelines on medical care procedures for the dying.³</p>
<p>Coalition for the Defence of Human Life</p>	<p>"Our Coalition accepts the traditional ethical position that patients may choose freely to refuse proportionately burdensome medical treatment and that there is, naturally, no obligation to undergo treatment that is likely to be futile. We also uphold the existing legal framework which prohibits doctors (other than in emergencies or where a patient is otherwise unable to consent) from treating patients without their consent. Unfortunately, it is our considered view that the <i>Medical Care of the Dying Bill 1995</i> fails to</p>

³ Talks on dying Bill changes. (1995 September 19). *The West Australian*, p. 24.

	achieve its intended goal and has a number of serious defects."
Western Australian Voluntary Euthanasia Society (Inc)	<p>"It had, of course, been understood that the aims of your Bill were far less than the legislation of full active voluntary euthanasia for which the Society has campaigned since it was founded in 1980."</p> <p>The group objected strongly to the changes to the provisions of the <i>Medical Treatment for the Dying Bill 1993</i>. For the Bill to operate properly according to its present intentions it would require amendment. For it to operate to the West Australian Voluntary Euthanasia Society's requirements regarding passive voluntary euthanasia, it would require considerable alteration.⁴</p>
L. J. Goody Bioethics Centre	<p>This group dealt with a variety of issues and made suggestions about treatment that might be considered to be futile or excessively burdensome. Mr Taylor took into account this group's suggestions and received the advice from Father Walter Black, the director of the Centre. Mr Taylor adopted most of Father Black's recommendations for the 1995 Bill, including the naming of the Bill.</p> <p>Father Black told MP Phil Pental, that the Bill stands as a protection against euthanasia in Western Australia.⁵</p>

The above table provides evidence of effective lobbying. It demonstrates that effective lobbying depends upon how well each group researches an issue, how informed it is on the issue and its understanding of the political process. Importance is also on attracting the "ear" of parliamentarians and appearing to be a credible source. Providing useful information to MPs is effective.

In discussing in depth the participation of the key pressure groups, the requirement of expert knowledge is paramount. The NPA member for Collie, Dr Hilda Turnbull, said as a physician she had the knowledge on the issue of

⁴ The day we took to the streets. (1995, December). *WAVES News*, p. 5.

⁵ Western Australian Parliamentary Debates, 23 August 1995, p. 7124.

the Bill and that no amount of lobbying would have changed her perspective. She said the more strident the pressure groups became the more entrenched the politicians were. However, she said that pressure groups have value when they adopt an educative role.⁶

1. West Australian Voluntary Euthanasia Society (Inc.) Strategies⁷

Initially this group opposed the Bill. They later changed their minds and lent political support based on their interpretation of the importance of patient autonomy. The Bill enhanced part of their concept found in the right to die. They saw the opportunity to lobby for voluntary euthanasia.

The West Australian Voluntary Euthanasia Society (Inc.) is a member of the World Federation of Right to Die Societies. From its formation in Western Australia in March 1980 with an initial membership of 35, it has grown today to 1,400 members. Its disparate membership is mostly over 50 years of age and predominantly female. Members represent religious denominations, professions - including medical and nursing, several politicians such as the ALP member for Kenwick, Dr Judyth Watson, and the ALP member for Perth Diana Warnock. These members have recorded in *Hansard* their support for voluntary euthanasia legalisation.⁸ The organisation claims it has no religious, professional or political affiliations; however, it aligns itself with the

⁶ Dr Hilda Turnbull, interview with the author, 9 September 1998.

⁷ Dr Ralph White, past President of the West Australian Voluntary Euthanasia Society and current committee member. Interview with the author, 26 September 1997.

⁸ Our aim. (1997, June). *WAVES News*, p. 1.

ALP platform on euthanasia. High profile voluntary euthanasia academic, Dr Helga Kuhse, acts in a consulting role to the group. Regular newsletters maintain communication to the membership on the group's lobbying activities.

By 1984 the group was one of four established Voluntary Euthanasia Societies in Australia. Two were formed in 1974, in Victoria and New South Wales and a third in 1983, in South Australia. Two New Zealand Societies emerged in 1978, in Auckland and Wellington. The group's key concept is of autonomy of the patient in medical decision-making.

During 1995, as a result of publicity from the *Medical Care of the Dying Bill (1995)*, a surge of membership was recorded. Funding is from subscriptions, bequests and donations. The group's aim is to influence public and political opinion so that suffering people need not be subjected to unnecessary and unwanted treatment; but can, if they so wish, be allowed or helped to die, with proper assistance.⁹

The West Australian Voluntary Euthanasia Society is a political, lobby pressure group that seeks to influence public, professional and political opinion to bring about euthanasia law reform. Without outside professional help, the group conducted its own lobbying on the *Medical Care of the Dying Bill (1995)*. To "get the ball rolling", the group asked Attorney General Joseph Berinson in 1986 to investigate the right to die issue. The group was active in lobbying the Attorney-General's office from that time to

⁹ *Ibid.* p. 1.

the 1991 release of the Law Reform Commission of Western Australia report.¹⁰

As the group approved the refusal of treatment approach, it was hoped a natural progression to voluntary euthanasia would eventuate. The group also wanted the community debate which arose on treatment for the dying, to result in public acceptance of legal voluntary euthanasia. In its submission to Mr Taylor's *Medical Treatment for the Dying Bill (1993)*, the group called for treatment-advice papers, drawn up in advance by patients, to be recognised as legal documents. These are called "living will" directives. Such directives would become legal documents and the group hoped physicians had less power than the patient did when it came to witnessing a Refusal of Treatment Certificate. The group also sought a more acceptable interpretation of the WA Criminal Code with respect to physicians continuing treatment against the patient's wishes. Physicians would also be liable to a charge of unlawful killing if they hastened a patient's death by withholding treatment, even at the patient's request.¹¹

The West Australian Voluntary Euthanasia Society believed the Law Reform Commission's 1991 report was fundamentally flawed.

Its newsletter¹² reported that the *Medical Care of the Dying Bill (1995)* would be attractive to the medical

¹⁰ Thompson, J. A. (1991). *Report on Medical Treatment for the Dying*, Project No. 84. Perth: Law Reform Commission of Western Australia.

¹¹ Correspondence from the West Australian Voluntary Euthanasia Society to MLC Attorney General, Joseph Berinson, October 1991. See sections 268 and 273 of the WA Criminal Code.

¹² Waves comments. (1995, December). *Waves News*, p. 10.

profession. However, Dr White said it was most unattractive as far as incompetent, acutely terminally ill patients and chronic sufferers were concerned. As proponents of voluntary euthanasia, this group contends that the right of patients to forego life-sustaining medical treatment should include a right to voluntary euthanasia.

The past president, Dr White, claimed his organisation offered Mr Taylor limited support due to Mr Taylor's limitations on the Bill. The group deplored the weakness of the Bill because it excluded voluntary euthanasia, rejected living wills, advance directives and made no allowance for incompetent people. The group supported the withdrawal of medical treatment and the allowance for massive doses of palliative medicine.

Dr White said Mr Taylor's legislation was hypocritical as a patient could die without peace or dignity, as a direct result of the withdrawal of treatment. That patient could then die as a result of voluntary euthanasia - just what Mr Taylor was hoping to avoid. Dr White took issue that a patient could refuse medical treatment but not palliative care, as some people might not like the idea of palliative care - thus advocating forced treatment. This was stated in the group's parliamentary submissions which sought to have the Bill amended.

In 1995 this organisation lobbied the Northern Territory Parliament. It arranged for funding and submissions to support the *Rights of the Terminally Ill Bill (1995)*. As a result of this, lobbying was limited to the *Medical Care of*

the Dying Bill (1995), as resources were limited. Mr White conceded that lobbying on the Taylor Bill was directly at MPs, not the political parties. Activities included paid advertising in *The West Australian* and community newspapers, public and member meetings, letters to the editor of *The West Australian* and *The Sunday Times* and speaking engagements to Rotary, Lions, schools, church groups and social groups. Activities were part of a public education campaign. *The Sunday Times* offered a 600 word editorial opportunity to the group but they rejected it because they wanted more space for their article, rather than to write a "knee jerk" article. Most of all, Dr White said that they preferred to advertise. The West Australian Voluntary Euthanasia Society was delighted with Dr Judyth Watson's speech in the Legislative Assembly on Wednesday 18 October 1995.

When the group advertised and held a public rally on 25 October 1995, more than 100 mainly elderly citizens (the ABC recorded 60, Channel 10 said 90), marched to Parliament House. Dr White said the rally was a success but scorned the antics of the lobby group, the Coalition for the Defence of Human Life. He speculated that had the Coalition stayed away, the media might not have covered the rally, thus it was good that the "opposition" had showed up on the day. The West Australian Voluntary Euthanasia Society had a permit for the rally but the Coalition for the Defence of Human Life did not.¹³ A member of the group Mrs White, described the hectoring scene in *The West Australian*:

¹³ Another unedifying spectacle. (1995, November 2). *The West Australian*, p. 12.

In the forecourt of Parliament House the orderly proceedings were suddenly interrupted by a group of mainly young people led by Richard Egan, ... thrusting placards at the older people and shouting down elderly speakers. Mr Egan and his followers had no permit to be there and were surely in contempt of Parliament in endeavouring to hinder or prevent a petition to Parliament. Police did not stop them, saying it was the responsibility of parliamentary officers. In the end it was left to an elderly lady with a walking frame to attempt to defend the old against the onslaught of Richard Egan and his ilk. It was a microcosm of the present situation.

The high point of the rally was the presentation of a petition with 3,967 signatures supporting voluntary euthanasia, which MP Diana Warnock presented as petition number 162 on 26 October 1995.¹⁴ Ms Warnock quoted from the group's submission in *Hansard*.¹⁵ Furthermore, the group supported MP Fredrick Riebeling's amendments.¹⁶

A 1980 booklet written by Dr White: *The Case for Voluntary Euthanasia* was put to good use as a handout during the lobbying of MPs. A grassroots letter-writing campaign was orchestrated directed at MPs.

Other alliances the West Australian Voluntary Euthanasia Society made were with the Doctors Reform Society and the AIDS Council. The Humanist Society of Western Australia (Inc) also printed an editorial from Dr and Mrs White on end of life medical treatment issues.

¹⁴ Western Australia Parliamentary Debates, 26 October 1995, p. 9884.

¹⁵ Western Australia Parliamentary Debates, 23 August 1995, p. 7134.

¹⁶ Living will type legislation is directed at authorising non-treatment. Living will advance-directives legislation excludes the intention to cause death from end of life decision-making. The empowering of agents to make refusal of treatment decisions for noncompetent people who have never given any advance health directive flies in the face of this group's belief in patient autonomy.

The West Australian Voluntary Euthanasia Society (Inc.) spokesperson Dr White, admitted that the group would not have changed its tactics or lobbied any differently. He believed the group's public relations activities and political participation were a positive contribution to the debate. The Bill offered the group an opportunity to promote its aims and objectives to the community.

2. Coalition for the Defence of Human Life Strategies¹⁷

This group took the "no compromise" view of the Bill. It vehemently opposed the Bill based on the grounds that it was unnecessary and they felt that the legislation could be dangerous because elderly people may be deprived of treatment. The Coalition for the Defence of Human Life believed the patients may "sign away" their right to proper medical care. They viewed under-treatment as the problem, not over-treatment.

Other reasons why the group opposed the Bill were based on their belief that the Bill could be a precursor to active euthanasia and it deliberately confused pain relief with patient killing, that is, confusion in the treatment and delivery of palliative care. The implication of the Bill was that refusal of simple, available treatment may be suicidal, and therefore, indemnifying doctors did not make sense.

In 1988 the Coalition for the Defence of Human Life was established in response to ALP moves to progress an

¹⁷ Richard Egan, Secretary of the Coalition for the Defence of Human Life, interview with the author, 15 September 1997.

abortion Bill. The organisation seeks to promote, preserve and defend the sanctity of human life from fertilisation to natural death and to oppose the destruction of human life by embryo experimentation, IVF, abortion, infanticide and euthanasia. The Coalition for the Defence of Human Life is supported and endorsed by Catholic, charismatic, evangelical, orthodox and pentecostal churches. Its affiliate membership consists of the:

Albany Pregnancy Problem Group	Life Ministries Inc.
Australian Family Association	National Civic Council
Bibleway Life Churches	Parents & Friends Federation
Christian Democratic Party	Pregnancy Assistance
Catholic Women's League	Pregnancy & Life Education
Concerned Citizens Movement	Ministries
Crisis Pregnancy Care	Pregnancy Problem House
Endeavour Forum	Reformed Churches of Australia
Festival of Light	Right to Life Australia
Knights of the Southern Cross	Thomas More Centre
	Women Hurt by Abortion

The size of these affiliations varies. The Coalition for the Defence of Human Life merged with ideologically compatible groups with a pre-determined organisational outcome. The Coalition for the Defence of Human Life board members are representative of the groups. The group is issue-oriented, deliberately constructed and goal-focused. Its activities are issue-based. There are a large number of youth members.

Funds are drawn from affiliation fees, donations, church service offerings and creative fundraising opportunities. All lobbying is conducted in-house.

The group studied the lobbying strategies of the Victorian Right to Life when the *Victorian Medical Treatment Act 1988*

was drafted and debated. The similarities between that Bill and the *Medical Care of the Dying Bill (1995)* were most helpful when the group formed its arguments. The Coalition for the Defence of Human Life responded to the Law Reform Commission's advertisements, providing a thoroughly researched submission.

The group opposed the Bill and rejected the idea of the Refusal of Treatment Certificate with its absolute, binding legal status. The Coalition for the Defence of Human Life saw the possible misuse of the certificates under circumstances that may lead to the unnecessary and tragic deaths of old, depressed, disabled or marginalised members of the community. In such an event there would be no legal remedy because the Bill provided liability exemptions for physicians.

Mr Taylor's proposed amendments to the Bill broadened its scope to include patients who were not terminal cases. Existing laws would be overturned prohibiting assisting and counselling suicide in patients. Contrary to popular belief, the Coalition for the Defence of Human Life has never stated that life should be sustained at all costs. The group supports the right to refuse treatment as upheld in common law. Furthermore, the group believed the Bill would result in lowering standards of medical practice.

The Coalition for the Defence of Human Life objected to the refusal of the food and water definition in the Law Reform Commission of Western Australia 1991 report because stroke, comatose and "persistent vegetative state" patients were not terminally ill. The refusal of food and water on

behalf of such a patient could be construed as an act of homicide.

Other flaws in the Bill included the lack of a definition of terminal illness. The Bill could be expanded to include other illnesses and certain remedies such as antibiotic treatments. Objections to *Part II - Refusal of Treatment* clause 5, was recorded by the group because a treatment or non-treatment decision relied upon the implied understanding of an independent witness when completing the Refusal of Treatment certificate, as shown in Schedule 1 of the Bill.

Group spokesperson, Richard Egan, recalled questions asked at a public meeting at the University of Notre Dame by Professor Ian Thompson. Professor Thompson explained that the Bill has a "what's the point?" argument and any sensible use of the Bill would be a misuse. He said certificates could be completed by two kinds of people; one kind for whom there were useful treatments available and the other kind for whom there was only futile or burdensome treatment available.

Richard Egan explained that 20-30 per cent of patients die following lengthy degenerative diseases and that the Bill would be irrelevant for the 70-80 per cent who die following acute illnesses or accidents. The Bill was offering the patient a certificate which allowed a physician to state, as Richard Egan surmised: "There is nothing we can do for you but for a certain treatment - which won't work anyway. Would you like to sign this form saying you don't want it?".

Such a certificate indemnifies a physician. "Difficult" patients could then be offered the option to sign a Refusal of Treatment form. According to the group, physicians can be persuasive and not all are altruistic. The Bill offered no parameter to measure the patient's understanding of a medical diagnosis. Consider in Australia that almost half of all adults lack basic reading and writing skills. What of the million Australians who need help to fill out forms or read information from government agencies and businesses?¹⁸ The Bill assumes literacy and comprehension skills are inherent to a patient.

Richard Egan said the whole *raison d'être* of the Bill was based on a complete furphy: that the medical profession was in fear of being prosecuted for making, what everybody agreed, was a reasonable medical decision. The group relied on sound legal counsel during its lobbying and found that in Western Australia, there was little confusion in the current law and therefore no need for such a Bill. The group believed, instead of medical treatment legislation, that an education campaign for physicians on the appropriate legal requirements would be sufficient.

This pressure group wrote their own version of the Bill which "zeroed-in" on the two areas of concern; however, their Bill was not promoted. Advice in the drafting was taken from Professor John Finnis, who emphasised that a

¹⁸ Half adults lack basic reading skills. (1997, September 9). *The West Australian*, p. 6. Results taken from an Australian Bureau of Statistics comprehensive adult literacy survey in "Aspects of Literacy" conducted between May and June 1996.

physician was not liable, nor was there any criminal liability in respect of a patient's refusal of treatment.

Richard Egan was puzzled over other pressure groups' claims that palliative care treatment could kill or hasten death of a patient during the administration of pain relief. Mr Egan explained that if possible treatment side effects hasten or cause death by a couple of hours or days, then it did not meet the definition of homicide.

The Coalition for the Defence of Human Life focussed its lobbying activities on MPs because of the conscience vote afforded to the members. After the group had sought legal opinion, it drafted a research brief for submission to all MPs. The group encouraged prominent citizens who shared the organisation's views to write to MPs, organised a grassroots letter-writing campaign and lobbied the Health Minister, Graham Kierath. Personal visits to key members and frequent spontaneous lobbying in the corridors of parliament took place.

Meetings and newsletters facilitated internal group communication. The group's lobbying efforts depended upon the affiliate members' understanding of the Bill. Efforts were made to inculcate the group's leaders and membership on the complex issue. This had the desired percolating effect.

The media's role was an important one for the group. The campaign's success depended to a large extent on the publicity that the group attracted. The Coalition for the Defence of Human Life sought every opportunity for media

exposure and monitored the media for timeliness in submitting media releases and gauging the newsworthiness of the issues involved. Media involvement extended to letters to the editor of *The West Australian* and *The Record*, talk-back radio spots, television appearances and debates with Ian Taylor, on current affairs program, *Today Tonight*.

A successful public meeting was held at the University of Notre Dame where Right to Life lawyer, Karin Clark, presented a paper. The group "gatecrashed" the West Australian Voluntary Euthanasia Society's march on 25 October 1995 to Parliament House which achieved television coverage. The Coalition for the Defence of Human Life's policy is to appear when counter-lobby groups appear.

Members of the group sat in the public gallery and watched the debate throughout the night, impressing the media and MPs with their commitment and tenacity. As a result, the group's members had many contact opportunities with politicians and aides and, of course, the media within the "corridors of power" - the Parliament House lobby. The group was proud of the ALP member for Kimberley, Ernie Bridge's speech.

The group's submissions to the Health Department of Western Australia and the Law Reform Commission of Western Australia ran the message of "vulnerable people most at risk". This counteracted their opponent's the West Australian Voluntary Euthanasia Society's argument, of "patient autonomy".

The Coalition for the Defence of Human Life became "side-tracked" when an altercation between key members and the L. J. Goody Bioethics Centre developed, which weakened the position of the group and lobbying of ALP members. The group "fell out" with Father Walter Black of the L. J. Goody Bioethics Centre. Both groups viewed the Bill differently and this thwarted the Coalition's lobbying efforts. Father Black's position is translated in the wording of the Bill. The Coalition for the Defence of Human Life struggled by not having Father Black's support.

In the end members of the Liberal Party voted against the Bill, despite the group's persistent lobbying. When West Australian Voluntary Euthanasia Society member and ALP Member for Kenwick, Dr Judyth Watson, got carriage of the *Medical Care of the Dying Bill (1995)* in Committee Stage, the Bill began to lose support from several MPs. It was feared the legislation would lose its definition and facilitate euthanasia or suicide. Richard Egan said that, despite members being persuaded on the issue at the end of the second reading, when the Bill went to the Committee Stage it lost the moral unanimity and fell into a morass of confusion, which added to its demise. In its lobbying, the group was sensitive to politicians rejecting the incremental argument- one of creeping acceptance of euthanasia. The Coalition for the Defence of Human Life dismissed this argument from its lobbying, instead focused on the issues in the Bill and the abuses that could occur.

The Coalition for the Defence of Human Life considered enlisting the support of disabled advocacy groups but decided against this. Neither did they use a petition,

considering it to be potentially unsuccessful. However, in 1997 the Coalition for the Defence of Human Life presented a petition opposing the 1997 Euthanasia Bill put forward by MLC Democrat, Norm Kelly.

The Coalition for the Defence of Human Life hoped for the Archbishop's support in a public statement, which would help them with their problem with the L. J. Goody Bioethics Centre. A cautiously worded statement from Archbishop Hickey was finally made, but the group felt it arrived too late to help support its lobbying of MPs.¹⁹

The group was pleased that the Bill ran out of time even though there was pressure on the government to give it more time. Other factors which influenced the *Medical Care of the Dying Bill (1995)* unsuccessful passage through parliament were Mr Taylor's retirement and Health Minister Graham Kierath's opposition. Add to this the confusion of the suggested amendments in Committee Stage, which contributed to a "stalled" Bill. Richard Egan was pleased these events occurred. He also said MP's understanding of the Bill was based on death and dying, rather than the outcome of the legislation. He summed the group's lobbying thus:

¹⁹ MP Doctor Let Dying Patients Refuse Therapy. (1995, August 25). *The West Australian*, p. 3. Catholic Archbishop Barry Hickey said that in view of the push for euthanasia in Australia, the Bill needed close scrutiny. He said ambiguities in the Bill had to be addressed carefully to prevent it from being used for purposes for which it was not intended.

The disagreement between the Coalition for the Defence of Human Life and the L. J. Goody Bioethics Centre was complex and involved the nuances of Catholic moral theological terms and appropriate moral outcomes, natural law language about disproportionate, ordinary, extraordinary, burdensome treatment and the right to refuse treatment. The Coalition for the Defence of Human Life believed the practical outcome of the *Medical Care of the Dying Bill (1995)* would not be morally acceptable.

I don't think we would have had the same result if we had done nothing. With the benefit of hindsight, we would have lobbied differently, we would have pulled out more stops and secured the Archbishop's statement earlier. We would have tried more and earlier approaches to decision-makers because they really were the opinion makers.

3. Australian Medical Association (WA) Branch Strategies²⁰

The Australian Medical Association's political support was based upon its understanding of the Bill as one which did not allow for euthanasia. It was important that the Association and the Catholic Church accepted the Bill and both had a pivotal role in its formulation and drafting stages. The Australian Medical Association approved the protection that the Bill would give to Medical Practitioners and the priority it gave to the consideration and importance of palliative care.

The Australian Medical Association State vice-president, David Roberts, said he supported the principle of the Bill. He said it would give people the legal right to die gracefully. It was very different from the new Northern

²⁰ The Australian Medical Association (WA Branch) interview with the author, 22 October 1997. Conditional interview granted on the basis that the spokesperson be unidentified. Only the President is the authorised public spokesperson. Given the sensitivity of the Bill and the draft *Medical Care of the Dying Bill (1998)*, under development, the Association declined disclosure of its lobbying activities. The Association adheres rigorously to issues of principle from a medical professional standard and the associated confidences. Should sensitive information be divulged then sources of information may be jeopardised. There is a degree of confidentiality in the processes of lobbying. The politicians and stakeholders are keen to see matters of mutual respect based on confidentiality, particularly in the circumstances of the Taylor Bill.

Territory laws which allowed euthanasia.²¹ Author W. J.

Byrt wrote on the background of the group:

The Australian Medical Association is an important professional association which represents approximately 80-85 per cent of the medical profession in Australia. It has been a most effective pressure group: influencing courses of study; restricting entry into the profession; influencing government legislation at both State and Commonwealth level; maintaining the earnings of medical practitioners at a high level ... there has been a good deal of criticism of the Australian Medical Association, by the press, politicians, groups interested in the provision of health services and even by members of the medical profession ... However, the medical profession contains some of the great and powerful of Australian society and enjoys the admiration and respect of the country's political, social and industrial elite. Accordingly, the Australian Medical Association is able to shrug off criticism and remain a powerful pressure group.²²

The Australian Medical Association (WA Branch) is a significant force as a pressure group, which, by its nature, enjoys "insider" status to government. Branches of the British Medical Association were formed in the Australian colonies from 1879. The Australian organisation was granted autonomy from the British Medical Association in England in 1933 and in 1961 its name was changed to the Australian Medical Association.²³ The Western Australian branch was established in 1897. The community and legal fraternity has high expectations and interest in the group.

The Australian Medical Association (WA Branch) is affiliated with the Australian Medical Association federal body to represent the medical profession in a political,

²¹ MP doctor let dying patients refuse therapy. (1995, August 25). *The West Australian*, p. 3.

²² Byrt, W. J. (1985). *The Framework of Consensus Government, Business & Trade Unions*. Sydney: The Law Book Company, p. 159.

²³ Matthews, T. (1973). *Australian Pressure Groups* in Mayer, H. and Nelson, H. (Eds) *Australian Politics, third reader*, Melbourne: Cheshire Publishing, p. 477.

industrial and professional sense. In addition, it is affiliated with all other Western Australian medical associations and colleges and some overseas groups. There are approximately 4,000 registered and registrable physicians. Funding is from the membership base.

The Australian Medical Association (WA Branch) gave its support in principal to the Bill but had concerns with some aspects of the Bill as it was debated in parliament. Of concern were patients in a persistent vegetative state, medical power of attorney, Refusal of Treatment certificates and advance directives. The penalty for offence for medical trespass was viewed as provocative. The group saw the need to look at each case based on its merits and what was best for the patient, without making said patient's life and condition more burdensome and futile.

With respect to the care of severely and terminally ill patients, the Australian Medical Association conceded that the issues are complex and:

... continues to encourage open and frank discussion of all aspects of death and dying within the profession and the wider community ... While doctors have an ethical obligation to preserve health, death should be allowed to occur with dignity and comfort when death is inevitable and when treatment which might prolong life appears futile. Under such circumstances, the Australian Medical Association believes withholding or withdrawing treatment, or refraining from resuscitation procedures, may well be in the patient's best interests and should not be regarded as professional misconduct if the doctor is acting in good faith and within the boundaries of established medical practice ... The Australian Medical Association endorses the rights of patients to refuse treatment and the right of a severely and terminally ill patient to have relief of pain and

suffering, even when such therapy may shorten the patient's life ...²⁴

It was in the early 1980s that the issues relating to medical care for the dying became apparent. The Australian Medical Association (WA Branch) supported the intent of the Bill because it addressed the ethical problems of physicians and advocated care of terminally ill patients. The group sought federal advice on the Bill to ensure continuity of Federal Australian Medical Association policy. Consideration was sought from members regarding the content of the Bill and the branch sought to have the Bill passed. It was not satisfied with the outcome of the Bill. The branch sought to influence all parties, to facilitate understanding of the issue by clear channels of communication.

Having given its approval to the *Medical Care of the Dying Bill (1995)*, the Bill's passage through parliament was made easier. However, the Australian Medical Association (WA Branch) serves its members first and lobbying is only one facet of its role. As a professional association, its political role developed as government increasingly intruded on the practice of medicine.

While the Australian Medical Association (WA Branch) does not campaign on ethical issues, its concern is for clear legislation of the medical profession's legal obligations under medical trespass laws. The Federal and State Australian Medical Association secretariats have employed

²⁴ Handbook of Resolutions, April 1997 Canberra: Australian Medical Association Federal Council, p. p. 89-90.

very shrewd and capable negotiators and industrial relations staff.²⁵

While the debate over euthanasia is not new, the Australian Medical Association has taken the position of unequivocal rejection. It eschews popular surveys promulgated by the media as being the wrong approach to the treatment of death and dying issues. The Australian Medical Association is conservative in nature because it deals in matters of life and death.

It became clear that the Australian Medical Association (WA Branch) had good relations and communications with the L. J. Goody Bioethics Centre during the drafting of the Bill and subsequent debate. The Association also had open lines of communication with Mr Ian Taylor and other key figures and statutory bodies, which no doubt enhanced its lobbying success.

4. Australian Nursing Federation (WA Branch) Strategies²⁶

Two key issues for the Australian Nursing Federation's political support of the Taylor Bill were based upon the legal protection of nursing personnel when carrying out medical instructions for terminally ill patients and the acceptance and inclusion of the Medical Treatment Certificates.

The Australian Nursing Federation is the principal nursing union in Australia and the Western Australia branch was

²⁵ Handbook of Resolutions, April 1997 Canberra: Australian Medical Association Federal Council, p. 17.

²⁶ Helen Attrill, interview with the author, 2 October 1997.

established in 1908. The group was established with a national council consisting of representatives from each state. It is affiliated at the state level with the Trades and Labour Council and at the national level with the Australian Council of Trade Unions and the Commonwealth Nurses Federation.

The Western Australian Branch provides services to members, sets fees for nurses' services and wages, regulates their training, education and examination and keeps a register of trained nurses. It also offers professional and industrial assistance to nurses. Membership is approximately 7,500 and consists of nurses in different categories. Funding is from subscriptions.

The Australian Nursing Federation frequently lobbies at state and federal levels. As a sectional group it aims its lobbying resources and focus directly at issues which affect the group's members. The *Medical Care of the Dying Bill (1995)* fell slightly short of that sectional interest.

Australian Nursing Federation (WA Branch) Secretary Helen Attrill said Mr Taylor's legislation was needed to provide strong safeguards to ensure patients were given all available information before they refused medical treatment. Legislation which protected health care workers from criminal action was welcome, but the Bill did not go far enough - offering legal protection only to physicians and not to nurses. Ms Attrill explained it was nurses who are were at a patient's bedside 24 hours a day.

The Federal Australian Nursing Federation reported in a 1991 survey of more than 900 nurses in Victoria, Monash University found that nearly half had faced requests from terminally ill patients to help them die. Helen Attrill said voluntary euthanasia legislation should allow medical staff to make decisions about helping a patient die.²⁷

That statement, made one month before the first reading of the *Medical Care of the Dying Bill (1995)*, brought criticism from surprised members of the public who were astonished at the group's position. The Australian Nursing Federation (WA Branch) had no formal policy on euthanasia. The group said it supported national voluntary euthanasia legislation as some nurses already helped patients to die.²⁸

The Australian Nursing Federation warned there could be a serious mix-up, if hospital staff continued to make ethical decisions about death in a vacuum and without strict guidelines.²⁹ Although the Australian Nursing Federation (WA Branch) backed Mr Taylor's Bill, it wanted amendments and was disappointed with the outcome.

The Australian Nursing Federation (WA Branch) lobbied on the first draft of the Bill in 1993. Conversations, meetings and submissions occurred. The group was represented on the Health Department of Western Australia's Dying with Dignity committee in establishing health guidelines in 1994-95. During this time Mr Taylor approached the Australian Nursing Federation (WA Branch)

²⁷ Nurses support euthanasia move. (1995, February 4). *The West Australian*, p. 46.

²⁸ *Ibid.* p. 46.

²⁹ Hospital death rules sought. (1996, October 16). *The West Australian*, p. 48.

asking them what issues they saw as important and he went away and drafted the *Medical Care of the Dying Bill (1995)*. The group read the draft and responded with a written submission.

The wording of the Bill raised concern for the Australian Nursing Federation (WA Branch). Whilst the physician was the person ordering treatment, the physician was not necessarily the people carrying out those orders - this was a surprising omission in the Bill. The main focus of concern about the Bill was whether it had the potential to extend the protection to nurses. The group supported the signed consent of the certificates. The Australian Nursing Federation Federal Office supported the Bill by writing to Mr Taylor, welcoming the introduction of the Bill and the debate it created in the community and called for uniform legislation across the States.

The group's members were informed via group newsletters. By 1995, the Australian Nursing Federation (WA Branch) chose not to actively pursue lobbying of the *Medical Care of the Dying Bill (1995)*. The group took the position that nothing much would happen with the 1995 Bill - given the politically divided nature of it. They believed the Bill was not high enough on the political agenda. The group would have lobbied differently if they thought the Bill was "going somewhere". They took a minimalist approach, which was a gamble.

Issues that relate to protecting the rights of the dying are difficult for the Australian Nursing Federation (WA Branch) because of the divided membership position on the

issue. However, consensus among members was one of support for the Bill as it was certainly less controversial than the Northern Territory's *Rights of the Terminally Ill Bill*. The group made media releases to that effect.

The Australian Nursing Federation (WA Branch) believed that end of life medical treatment decisions were matters for wider community debate. Whatever the outcome of that debate, nurses felt that they should have an "out" clause as a result of their conscience or values belief. A policy is due to be presented at the next national delegates meeting that will make clear the Australian Nursing Federation's position.

5. L. J. Goody Bioethics Centre Strategies³⁰

This pressure group's prime political support for the Bill was based on the fact that they saw the Bill as being an instrument which would not allow for euthanasia. The L. J. Goody Bioethics Centre believed that the Bill had a good title which adequately explained key issues of a critical moral, ethical and philosophical nature. They also considered the Bill was better than preceding Bills as it avoided substituted medical decision making. The group believed legislation was needed to clarify Common Law in order to keep up with medical practice and technology. Furthermore, the L. J. Goody Bioethics Centre considered that the Bill allowed for appropriate palliative care, and did not allow for suicide. They felt that it should include the group's definition of "terminally ill".

³⁰ Father Walter Black, interview with the author, 30 September 1997.

The L. J. Goody Bioethics Centre is part of the Archdiocese of Perth. It was named after a previous Archbishop of Perth, His Excellency Sir Lancelot Goody. Founded in 1985, it has been established in Glendalough since 1990. The Bioethics Centre is accountable to the Archbishop, has a constitution and is classified as a tax-exempt public benevolent institution. The Centre is privately funded.

The L. J. Goody Bioethics Centre is "head office" for the Catholic Doctors Association of Western Australia and the newly formed L. J. Goody Nurses Association, the Archbishop's Council of Priests and many other Archdiocese groups and Committees. The Committee for Family and for Life, Catholic Health Care Association, St John of God Health Care System, Mercy Hospital, Southern Cross Homes (WA) Inc, Catholic Homes Inc., are associated with the Centre. Director and ethicist, Father Walter Black, worked closely with members of the Australian Medical Association (WA Branch). Discussions began in 1988 about medical care for the dying, when Father Black asked to have an appointment with the Assistant Commissioner of Health and with senior members of the Health Department of Western Australia.

The L. J. Goody Bioethics Centre, together with the Catholic Church, adopts a non-confrontational and co-operative lobbying approach instead of throwing "brickbats", attacking politicians and the government. Rather than being on the counter-attack as is the Right to Life lobby, the Centre aims to place itself in a consultative role. Father Black is often approached by both sides of the House and Independents for advice and is

invited to serve on Government Boards; which he sees as a far more powerful position.

The Centre has an open-door policy to MPs and the executive arm of government who may wish to use the Centre's library and resources enabling research before legislation reaches parliament. The L. J. Goody Bioethics Centre provides expertise consults on draft legislation for MPs.

Physicians, hospitals and parish priests refer numerous moral questions to the centre. Inquirers receive information about Catholic teaching on a wide range of health care matters, such as the ethical issues involved in care for the terminally ill. The Centre offers lectures, seminars and workshops for all public hospitals; provides guidance to the State Government and is a research centre for student physicians, nurses, teachers and lawyers.

Father Black is a member of ethics committees for the St John of God Health Care System, Mercy Hospital, and the WA Reproductive Technology Council. He was also a member of the 1991 working party who drafted the *Charter of Patients Rights and Responsibilities* for the Health Department of Western Australia.

Father Black's involvement in the Bill's formation began as a result of a public meeting at John XXXIII College, where a spirituality and justice group called INIGO, conducted a meeting. This group invites guest speakers to discuss various topics and Father Black addressed the meeting on the ethics of the care for the terminally ill. After the meeting, treatment difficulties were discussed with a member of the group called Tess. She asked Father Black if he had talked with Mr Taylor about such treatment

difficulties when Ian Taylor drafted his 1993 Bill. Father Black told her he did not offer unsolicited criticism to MPs. He considered approaching MPs first as "poor lobbying". Tess asked if she could mention her conversation with Father Black to her son, the leader of the ALP, Jim McGinty. Not long after that conversation, Father Black received a call from Ian Taylor. Father Black told Mr Taylor he would like to help draft the Bill rather than marshalling the Archbishop to start "throwing bricks" at it when it was on the floor of parliament.

Father Black does not deny his group's unique position with the government and MPs. The group rejected Ian Taylor's 1993 draft Bill because it gave legislative approval to any patient to refuse any medical treatment. The 1993 legislation was scrapped and Mr Taylor drafted the 1995 Bill with the help of the L. J. Goody Bioethics Centre. Father Black's view that *section 12 - Protection of medical practitioners - pain control* was a needed revision of the law in Western Australia. The group endorsed the spirit of the Bill which provided physicians with greater legal certainty.

The group considered the Bill was a good solution to the turn of the century laws which Father Black called "the ulcer" in Western Australian law. It would now give a dying person proper palliative care or keep them pain free, even if foreseeably or unintentionally that person's lifespan was shortened.

The L. J. Goody Bioethics Centre formed a working party and prepared a submission with powerful signatories. They

comprised the Catholic Doctors Association; Catholic Health Care Association; St. John of God Health Care System; Mercy Hospital, Mt Lawley; Southern Cross Homes (WA) Inc; Catholic Homes Inc; with Dr Michael Quinlan as the contact person. This statement was sent to State MPs.

On 4 May 1995 Father Black offered to arrange a seminar at the University of Notre Dame. All MPs were invited to hear a presentation of how the Centre viewed the Bill and how it could be improved by aligning the legislation with sound medical ethics. Ian Taylor was happy to be part of a panel chaired by Dr Robert Pye, Surgeon Frank Prendergast, Dr Michael Quinlan, with Father Black as the ethicist.

It was pointed out to Mr Taylor that the Centre would support his Bill if he re-wrote it, reflecting the distinction in ethical principles of "ordinary means of medical treatment". Thus building on the distinction in classical medical ethics: such that when the duty to take responsible care for life and health extends to the use of "ordinary means", no obligation exists to employ "extraordinary means". These are crucial terms in understanding the Bill. Treatments are "ordinary" if they are reasonably available, beneficial and supportable. If the treatment is "extraordinary", in the sense of a moral category, not a medical description; a matter of medico-moral prudential judgement, not reducible to the physical features or mode of operation of the equipment. He said one was entitled to refuse extraordinary means of medical treatment but one was not entitled to refuse ordinary means. The 1993 draft Bill allowed for ordinary means and that was tantamount to legalising suicide.

Following the seminar, Mr Taylor left his first draft and asked Father Black to produce the wording of the *Medical Care of the Dying Bill (1995)*. Mr Taylor was expecting a hostile seminar gathering, however he received support. Clause 5 in the Bill reflected the group's position. At the request of Mr Taylor, Father Black produced a definition of "terminally ill" yet Mr Taylor did not include this definition in the Bill. He later placed it on the Notice Paper and it was put as an amendment by Dr Watson in the Committee Stage on 15 May 1996, as Mr Taylor had resigned from State politics on 4 February 1996 and then lost his seat at the Federal Election.³¹

The L. J. Goody Bioethics Centre made several submissions to the Law Reform Commission of Western Australia, which pre-dated the Bill. Articles appeared in the weekly Catholic paper *The Record* and letters to the editor in *The West Australian*. Father Black supported Independent MLA Dr Elizabeth Constable's speech³² and her subsequent article in the local community paper *The Western Review*.³³ He wrote congratulating her saying that what she had said was good. She was pleased to receive the correspondence and handed it to Ian Taylor. The L. J. Goody Bioethics Centre trickled information to MPs and its lobbying was more of an information-dissemination role. This involved sending a euthanasia statement drawn up by all the Catholic Health Care entities in Perth, sent to State MPs. The statement was "lifted" from an article in the *European Journal of Palliative Care*, Vol 1 No. 1, "Regarding Euthanasia".

³¹ Western Australian Parliamentary Debates. 15 May 1996, p. 2031.

³² Western Australian Parliamentary Debates. 18 October 1995, p. 9359.

³³ Dying with dignity. (1995, September). *The Western Review*, p. 6.

Several MPs wrote to the group thanking them for the article!

Whenever an objection to the *Medical Care of the Dying Bill* (1995) was raised, the group was directly quoted in *Hansard*. In fact, much of Ian Taylor and Independent MLA, Phil Pandal's debate involved quotes from Father Black in *Hansard*.

The Coalition for the Defence of Human Life criticised aspects of the Bill because it could allow for euthanasia. Despite this, Father Black believed the Bill would remove the ground for euthanasia, negating any foreseeable euthanasia legislation.

Father Black disapproved of the lobbying approaches taken by the Coalition for the Defence of Human Life. Each group claimed support from Archbishop Hickey. The Archbishop's dilemma was such that, if he made a public statement in support of the Bill, and it went into the Committee Stage where there were amendments to the amendments, the Bill would no longer be what he had approved. Father Black conceded the Coalition for the Defence of Human Life had good intentions, but their approach often weakened their position.

The L. J. Goody Bioethics Centre was not satisfied with the Bill's outcome, particularly the Committee Stage debate. The amendments attempted to remove all aspects of the *Medical Care of the Dying Bill* (1995) that the Centre had lobbied for and had turned the Bill into one which allowed for suicide. The Bill could be interpreted as giving a

legal right to a patient to refuse any treatment for any reason.

How did this agreeable lobbyist, Father Black, respond when faced with the lobby from opposite sides of the ideological spectrum? He said he had been to public meetings and sat on panels in seminars with the West Australian Voluntary Euthanasia Society past president, Dr White, and it was a well-worn joke that *not everything is Black and White*.

6. Silver Chain Nursing Association Inc. - Hospice Care Service Strategies³⁴

The Silver Chain Nursing Association found agreeable the key issues with which the Bill dealt. They lent political support because it promoted palliative care; more importantly, the Bill excluded palliative care from medical treatment practices, which could otherwise be refused under the terms of the Medical Treatment Certificate. Of course, this group did not object to the Bill because it did not allow for euthanasia. According to the group's spokesperson, the legislation was needed.

The Silver Chain Nursing Association Inc. assists those in need to live in the community. With annual 1996 revenue of \$58.9 million and over 2,900 staff and volunteers, the group is one of the major providers of community health services in Western Australia. It is a non-political, non-sectarian, not-for-profit organisation that has a policy not to lobby.

³⁴ Dr Kevin Yuen, Medical Director and founding Member of International Hospice Institute. Interview with the author, 7 October 1997.

Eighty per cent of the Silver Chain Nursing Association's funding comes from the Home and Community Care Program and the Government of Western Australia. In 1995, \$11 million came from non-Government resources. From the mid 1980s, federal funding for palliative care became available through the Medicare Agreement. In June 1982, the group commenced a pilot project providing a home support service in the metropolitan area and later a rural service. It has a Board of Management which comprises ten members of whom seven, including the President, are non-executive. This ensures independence and objectivity in governing the Association's affairs. The Silver Chain Nursing Association is well established with the Cancer Foundation and various grief support services medical associations in the community.

Hospice care is a service arm of the group which provides home based support for the terminally ill. It is a non-denominational organisation that provides a support network for both the patient and the family. The Hospice Care Service aims to provide a high standard of care and relief in the family home through a team of nurses, physicians, chaplains, counsellors, care aides and volunteers. Membership comprises mostly nursing staff, 29 physicians and a number of part-time consultants.

It was in 1991 that the Hospice Care Service began monitoring the progression of Ian Taylor's *Medical Care of the Dying Bill* (1995). Medical Director, Dr Kevin Yuen, invited Mr Taylor to speak to the organisation's physicians and present the guidelines of the Bill. The group had

previously sent a submission to the Law Reform Commission of Western Australia *1988 Discussion Paper on Medical Treatment for the Dying*. It was agreed that the Bill provided reasonable and acceptable guidelines for the care of the dying and did not allow for euthanasia; however, Dr Yuen regarded the Bill as a "grey zone" area where much public confusion existed with respect to passive and active euthanasia.

Dr Yuen said the Bill attempted to recognise what already existed already in medical practice - a patient's right to terminate treatment. Mr Taylor sought the group's position in correspondence and by telephone. The Silver Chain Nursing Association sent letters in support of Mr Taylor and gave submissions which provided feedback on the draft Bill. There were no clauses which the group objected to; however, it supported the promotion and definition of palliative care. The group has not lobbied on any similar legislation but has adopted a consultative lobbying approach.

The Hospice Care Service sought opinions from other groups with respect to the Bill. They hoped the Bill would be passed and were puzzled and disappointed that it did not gain successful passage.

The lobbying efforts were principally directed towards Mr Taylor rather than to parties or the Health Department of Western Australia. Dr Yuen said if Ian Taylor had asked him or his colleagues to write to other key MPs who were uncertain about aspects of the Bill, Dr Yuen would have complied. Upon reflection, Dr Yuen would have lobbied

issue groups within the Catholic Church, to mount support for the Bill.

Emeritus Professor David Albrook, one-time professor of anatomy at the University of Western Australia, is a consultant palliative care physician for the Silver Chain Nursing Association. He pioneered the Hospice Care Service. Professor Albrook lobbied his local MP, Mr Day, and made the point that although the intent of the Bill was well worthwhile, the detail needed to be closely considered. He said that a better way to deal with the situation was to introduce a Bill to amend the Criminal Code in order to remove the possibility of physicians being prosecuted.³⁵ Professor Albrook said Mr Taylor's legislation was widely misunderstood and that the legislation was desirable.

7. Uniting Church in Australia, Synod of Western Australia Strategies³⁶

The Uniting Church did not find sufficient reason to lend either political support or opposition to the Bill. The reasons for this are explained later. It offered preliminary submissions to government but found itself neutral on the issue.

The Western Australian Moderator of the Uniting Church, the Reverend John Dunn, is part of the executive and has extensive experience working with individuals and groups both inside and outside the Church. He is qualified in

³⁵ Western Australian Parliamentary Debates. 1 November 1995, p. 10230.

³⁶ Rev. John Dunn, consultant for Mission and Justice, interview with the author, 6 October 1997.

theology, management and counselling. The Uniting Church was established in 1977 from the union of three churches: Methodist, Presbyterian and Congregational. State membership is approximately 15,000. The Uniting Church is one of the biggest providers of services to the government in Western Australia: Wesley Mission, Uniting in Care, Good Samaritan Industries, Crossroads, homes for the aged, prison and outreach ministries, as well as schools and colleges. Funding comes from its 84 parishes and the Uniting Church Investment Fund.

Due to a lack of research base within the Synod it was felt that the issue addressed in the *Medical Care of the Dying Bill (1995)* was not of great significance as it dealt with a "grey area" on which the Church could not decide its position. Prior to this however, the Church had made a preliminary submission on the June 1988 *Discussion Paper on Medical Treatment for the Dying*. The Church's position was such that it chose not to be prescriptive on the issue. Any lobbying on the Bill was left to individual members to undertake if they felt compelled to do so.

Whenever the Church lobbies, activities include presentations to public inquiries and production of information kits. The Church Synod conducts all lobbying after thorough research. The Church has a trained educator and public relations consultant, Judith Amey. The Publicity is often gained through radio talk-back and via media releases. Reverend Dunn often addresses public rallies and encourages members to write and contact their local MPs on various issues.

The church joined with the National Council of Churches in Australia in making a public statement regarding euthanasia at its meeting of 24-25 July 1995. It did not make a public statement regarding the *Medical Care of the Dying Bill (1995)*. The Church was active in 1995 on issues such as woodchipping, poverty, gambling and gaming legislation. The members of the Uniting Church Bioethics Committee seek to hold together a diversity of opinion within the Christian faith, yet have not arrived at a common mind in regard to euthanasia. The members of the Committee understand and respect the integrity of those who arrive at different conclusions, just as the Committee has three positions: one of opposition, one of qualified support and one of caution. It is a different sort of Church in that way, which is the strength of the Uniting Church and its weakness. The Committee believed that the Church needs to continue to wrestle with the complex issues raised by euthanasia.

The National Synod believed that its members should understand the *Victorian Medical Treatment Act 1988* and the Church encourages that Bill's appropriate use. When matters relating to death and dying are involved, the Church would like to see the community adopt a simple, efficient, cost-effective way of making known a patient's wishes to family and health care professionals. However, to that end and to date, the Uniting Church in Western Australia has not politically advanced that view.

8. Anglican Church of Australia Strategies³⁷

The Anglican Church of Australia's political support was grounded in Mr Taylor's consultative approach which resulted in an agreeable Bill that dealt with the appropriate treatment of terminally ill people. Archbishop Carnley said they would have "sprung into action" had the Bill begun to take a different form in the Committee Stage. It naturally disapproves of euthanasia and would never condone a Bill which allowed for same.

In 1829 the Church began its colonial chaplaincy, but it was not until 1872 that the first Synod was held in Perth. The Anglican Church of Australia operates schools and colleges and many community outreach affiliations: Anglicare, Anglican Homes, Meath Care Inc, Kinway, Anglican Marriage Encounter, Anglican Caring Organisation Network, St. Bartholomew's House, Parkerville Children's Home, Thornlie Church Hostel, Anglican Board of Missions and chaplaincy to schools and hospitals. There are approximately 400,000 Anglicans in Western Australia. Funding is drawn from parishioners and church investments.

Archbishop Peter Carnley³⁸ considered the Bill in the context of the national euthanasia debate and his position was the official Church's position. Ian Taylor's Bill was welcomed by the Church as a moderate approach to the treatment difficulties of terminally ill patients, given that it did not endorse the active killing of persons. The

³⁷ Theo Mackaay, Nigel Leaves, Linda Kurti and Archbishop Peter Carnley. Interviews with the author 29 October 1997, 1 November 1997, 4 November 1997. Files were also made available to the author.

³⁸ Archbishop Peter Carnley, interview with the author, 4 November 1997.

Church believed the Bill provided protection to the medical fraternity and that the general principle was sound. The Church focused its lobbying on the national arena and the Northern Territory, because of the *Rights of the Terminally Ill* Bill. However if the *Medical Care of the Dying Bill* 1995 had been radically altered at any stage of its passage through parliament; to become a form of enabling euthanasia or suicide, then the Church was prepared to lobby hard. The press approached the Archbishop to make a comment on the Bill - which he did. The Bill seemed to be right, he said, and he hoped the Bill would be passed.

The Anglican Church believed that the various religious traditions should play a part in public policy formation because religion occupies a central place in most Australian lives; particularly at times of birth, marriage and death. It maintains a vigilant stance against the manipulation of power at all levels of the social decision-making strata. The Church concedes that the political process is often determined by pressure group tactics, media manipulation, money and personal influence, of which the ballot box is only a small part.³⁹

In June 1986 the Law Reform Commission of Western Australia wrote to the Archbishop of Perth seeking the Church's preliminary views as to whether the present law was possibly inadequate and to identify areas of reform. The correspondence stated that there would be a further opportunity for more detailed submissions at a later stage

³⁹ Social Responsibilities Commission (1997) *Euthanasia: a position paper* Perth: Anglican Social Responsibilities Commission, p. 1.

after the Commission's Discussion Paper was published and circulated.

The Anglican Churches Social Responsibilities Commission sought assistance by way of written comments on the issue from groups and individuals such as: Anglican Homes, Chaplains from Royal Perth Hospital and Sir Charles Gairdner Hospital, Silver Chain Nursing Association Inc. A submission was then drafted and presented to the Law Reform Commission of Western Australia.

The Law Reform Commission of Western Australia invited the Church to make known its views on the questions raised in the paper or on any other matter within the terms of reference. The Church provided the Commission with a submission. A "think-tank" meeting was arranged with an impressive guest list, which included Sir G. M. Bedbrook of the Conference of Churches of Western Australia. This conference comprised the following Churches: Anglican, Coptic Orthodox, Greek Orthodox, Roman Catholic (Archdiocese of Perth), Salvation Army, Society of Friends, and the Uniting Church. Conversations took place between Ian Taylor, Reverend Canon Les Goode and others in the Social Development Commission. Canon Goode said he was not in favour of the Bill. He said he could not understand the necessity for the law, given that no prosecution of a physician had taken place in Western Australia regarding the applications referred to in the Bill. The right to opt out of active treatment is already practiced and patients exercise free choice. Canon Goode explained palliative care as an effective, distinctive form of treatment and an appropriate and effective option for people. He did not

doubt Mr Taylor's sincerity to remove any doubts that may have existed in the law.

The facilitatory role the church took on was one of informer. Linda Kurti of the Anglican Church said she was pleased that the Bill was halted because more time was needed for the public to fully understand the issue.

The Church actively researched issues referred to in the Bill. Its Social Development Commission of the General Synod produced a draft discussion paper by Dr Bruce Kay to consider the matter of dealing with the value and sacredness of human life and dignity. In terms of social policy, the health and social fabric of Australia is dependent upon legislation that is workable in particular circumstances and on the highest possible respect for the preservation of human life. The Commission made submissions to the Law Reform Commission of Western Australia in 1988 and 1991 and discussed the issues raised in its newsletter, *Justice Perspectives*.

The Anglican Church of Australia Diocese of Perth, W.A. 1996/97 *Yearbook*, affirms the value of human life and urges all parishes to promote study on euthanasia and related issues, in order for Anglicans to be well informed and able to apply understanding to public debate on the issue. The Synod encourages Anglicans to support the development and resourcing of effective and available palliative care for all people with terminal illness.⁴⁰

⁴⁰ *Ibid.* p. 1.

Summary

A more detailed tabulation of the strategies employed, coupled with a broad classification of pressure group type, is presented in Appendix 4.

CHAPTER SIX
TOWARDS A PRESSURE GROUP PRESCRIPTION
FOR CONSCIENCE-VOTE ISSUES

Author Daniella Gobetti explained that political participation allows groups to exercise control over the social forces that shape and mould lives.¹ This thesis concludes that pressure group activity moulded Ian Taylor's legislation and contributed to the outcome. The pressure group activity formed the shape of the debate and singularly influenced many MP's during the Legislative Assembly debate. To an extent Ian Taylor waited to be dictated to by pressure groups. It should also be recalled that the Independent member for South Perth, Phil Pandal, wanted more time in the Committee Stage to consult with the L. J. Goody Bioethics Centre. It is clear that this group was a key organisation in the debate and monopolised significant political influence. Another plausible conclusion is that had there not been any lobbying the *Medical Care of the Dying Bill (1995)* would have passed without incident.

"Politics," began Glenda Jackson in chapter one, "is the only way to achieve change, you can't do it from the outside. You have to be in the process." Despite the inability of Mr Taylor to achieve legislative change, this thesis posits that powerful change, or the thwarting of change, can be achieved from the domain of "outside" i.e., where pressure group activity takes place. This activity

¹ Gobetti, D. (1992). *Private and Public*. London: Routledge, p. 160.

positions pressure groups "in the political process". Such interchangeability is a pressure group strength.

It is certain that modern pressure groups, as they form, merge and often collide over "gaining the ear" of parliament when a conscience-vote is offered. Conscience-votes provide the richest lobbying opportunities. Mostly, debate was enriched by pressure groups educating and providing suggestions to parliament, from their very early involvement by submissions, to their silent observations in the Committee Stage, long after Mr Taylor voiced the prophetic - "that his good idea would be lured into a cul-de-sac and strangled."

In Western Australia there is a bicameral legislature with State Constitution, allowing for lobbying to be directed at the legislature or the administration. Should a pressure group enjoy good relations with the political parties, its lobbying efforts will, in all likelihood, receive due attention from political leaders. However, once legislation reaches parliament the chances of major changes involving policy shifts are usually slight.² The *Medical Care of the Dying Bill* (1995) was an exception.

Media Influences and Pressure Groups

As evidenced in the media and during the author's discussions with Ian Taylor, it was clear that he practiced a seemingly commendable, two-way symmetrical communication

² Tymson, C. and Sherman, B. (1989). *The Australian Public Relations Manual*. Sydney: Millennium Books, p. 83.

modus operandi that facilitated the consultation and lobbying process which is described thus:

This "ideal state" describes the management of communication to ensure that an organisation communicates, asks for feedback and then uses that feedback to come to a mutual understanding with the other party in the communication process.³

Lobbyist Peter Cullen writes in his book *No is not an Answer, Lobbying for Success*, that there are very few ventures in political lobbying which do not have a public relations element such as promotion, publicity and use of the media.⁴

Expensive advertising campaigns did not occur, nor were they needed, as lobby groups maintained a public profile by publicity using opportunities provided in the "free" press or media. Only the West Australian Voluntary Euthanasia Society paid for its advertising.

The media was one means of informing, and possibly persuading, public opinion towards awareness of the right to die issue, and autonomy of terminally ill patients in selecting or refusing medical treatment. A general observation was the media played a key part in reporting the issue fairly despite the linking of the *Medical Care of the Dying Bill (1995)* to euthanasia. Groups were able to receive publicity because they were identified in the

³ Quarles, J. and Rowlings, B. (1993). *Practising Public Relations*. Melbourne: Longman Cheshire, p. p. 4 and 8.

Based on Professor James Grunig's 1984 definition which emphasises the importance of two-way communication. Grunig is a United States professor and a leading theorist in public relations.

⁴ Cullen, P. (1991). *No is not an Answer, Lobbying for Success*. North Sydney: Allen & Unwin, p. 43.

debate and in the media. The press coverage may have energised potential supporters and influenced decision-makers.

Euthanasia opinion polling was occasionally cited in the press and during the *Hansard* debate. Mr Taylor told the author that opinion poll findings showed support for euthanasia but he clarified this by adding that it was more widely understood that people should not suffer unnecessarily. Euthanasia protagonists such as the ALP member for Perth, Diana Warnock, and the ALP member for Kenwick, Dr Judyth Watson, cited polls in their speeches to uphold euthanasia and support for the *Medical Care of the Dying Bill* (1995).⁵ The Independent member for Floreat, Dr Elizabeth Constable, also quoted from Morgan Gallup polls which indicated changing community acceptance for euthanasia.⁶ The Liberal member for Geraldton, Bob Bloffwitch, used survey findings to challenge Mr Taylor's Bill.

It is significant that three years later with another conscience-vote issue, the controversial *Acts Amendment (Abortion) Act 1998*, the passage of the legislation depended, to a very large extent, on the findings of opinion polls referred to by parliamentarians. The constant reference to such opinion polls was a means of

⁵ Western Australian Parliamentary Debates. 23 August 1995, p. 7134. MP Diana Warnock said, "This society bases its philosophical views on individual choice, and claims that its [the West Australian Voluntary Euthanasia Society] views are shared by almost four out of five Australians. I have seen that mentioned in many surveys."

Western Australian Parliamentary Debates. 18 October 1995, p. 9356. MP Dr Judyth Watson quoted from a 1988 Morgan Gallup poll finding that "73 per cent of Australians believe in euthanasia for an elderly person who is hopelessly ill and in great pain."

⁶ Western Australian Parliamentary Debates. 18 October 1995, p. 9360.

justifying the parliamentarians' vote on the matter. Poll results clearly shaped the outcome of the abortion legislation.⁷

It is interesting to note that the Returned & Services League, Australia's largest and most successful pressure group, considers media responses vary according to the issue reported. For example, the RSL is one of the biggest welfare groups in the country but the media are not interested in reporting the group's views.⁸ On the other hand as the Victorian State President, Bruce Ruxton, explained, on contentious issues the media are interested in the RSL's opinion. Mr Ruxton attributed this to the fact that the media is dominated by the "left wing". It is a view which would be disputed in many quarters. However, what needs to be remembered is that not all issues necessarily gain media exposure. Conscience-votes, such as the *Medical Care of the Dying Bill (1995)*, do create interest and gain media attention. This media focus may prompt a major pressure group, which at first instance may not be involved in the lobbying process, to mobilise its resources for the public debate and legislative process.

⁷ Phillips, H. and Black, D. (1998) Parliament beyond 2000 one House or two, a unique bicameral exercise: the 1998 Western Australian abortion legislation. *Australasian Study of Parliament Group 20th Annual Conference* (p. 14). Hobart, Tasmania: Edith Cowan University. See page 14: Most MPs preferred to accept the accuracy of the polls as a measure of constituency opinion on changes to the abortion law. One Liberal MLA, Arthur Marshall, was reported as saying that since "opinion polls showed most women wanted choice", this would be the direction of his vote.

⁸ Bruce Ruxton, interview with the author, 8 January 1999.

Manufactured Consent?

In chapter two, Noam Chomsky referred to consent being "manufactured" when mainstream coverage of issues mobilised public support for special interests that dominate government. It cannot be asserted that the main media organisations in Western Australia attempted to "manufacture consent" in the terms represented by Noam Chomsky. However, the media, on several occasions, referred to euthanasia polls - whether they were relevant or not - when reporting or commenting on the *Medical Care of the Dying Bill (1995)*. It is possible that a degree of "manufactured consent" exists with the controversial issue of euthanasia in the media. Poll findings reported by MPs in the media and in *Hansard*, were used to support the view taken by each member.

Notwithstanding this, the media was an integral component in both the groups' lobbying activities and in attracting and maintaining public interest. Media publicity raised the profile of each of the eight groups selected for this study. Favourable coverage from a sympathetic media no doubt fuelled the debate and facilitated a superficial understanding of the right to die issue. Ian Taylor's Bill was one step towards social reform on the way Western Australians viewed death and the treatment of dying people. Mr Taylor said he had been determined to bring in legislation of this type. Labor MLC, Cheryl Davenport, on her previously mentioned, highly contentious *Acts Amendment (Abortion) Act 1998*, shared a similar determination.⁹

⁹ Phillips, H. and Black, D. (1998) Parliament beyond 2000 one House or two, a unique bicameral exercise: the 1998 Western Australian abortion

There is no doubt that legislating in "grey" moral areas is difficult, as this thesis testifies. Given the extent of media coverage and the influence of opinion polling, the views of the MPs were swayed by pressure groups in the most direct way. Note however, the views of NPA member for Collie, Dr Hilda Turnbull, who explained "The more strident the pressure groups became the more entrenched the politicians were."¹⁰ It is certain that pressure groups can strategically influence and educate MPs, yet there are some politicians who solidly reject any form of persuasive argument, no matter how it is couched.

Pressure Group Evaluation

This case study of conscience-vote legislation provides a prescription for other pressure group situations, particularly where MPs are exposed to pressure group activity. Enumerating pressure group activity assists in gaining a perspective and an anticipation of the mines in the battlefield ahead, as specified in *Appendix 4: Pressure Group Strategy Hierarchy*. The groups had one thing in common - they lobbied for change. Interestingly, not one group employed the services of an independent lobbyist, although each group was actively lobbying various parliamentarians. Technology is impacting upon the methods of lobbying in some quarters, however, this case study did not reveal widespread use of email or the Internet being employed by the pressure groups to increase their

legislation. *Australasian Study of Parliament Group 20th Annual Conference* (p. 13). Hobart, Tasmania: Edith Cowan University.

¹⁰ Dr Hilda Turnbull, interview with the author, 21 August 1998.

influence. The "human factor" was a major lobbying strategy.

Chapter one described the common pressure group lobbying techniques such as media releases, letters to newspapers, correspondence, paid advertising, petitions, telephone calls, television appearance and a rally. These are effective traditional lobbying techniques coupled with communicating direct with politicians by generating and distributing quality information. The Returned & Services League Victorian State President, Bruce Ruxton said recent lobbying involved the group's frequent approach of writing a factual letter to every MP on the particular issue. Delegations were also sent to MPs.¹¹ The RSL typically lobbies all parties and both Houses of Parliament by mail. This was also the approach taken in this case study, and by far the most effective.

The West Australian Voluntary Euthanasia Society's lobbying objective was to educate and influence. As Dean Jaensch wrote, "an organisation of one interest has a tendency to produce the organisation of a counter-interest"¹² which saw the rise of the Coalition for the Defence of Human Life serving that interest. Its lobbying objective was simply to maintain a presence - publicly and privately. This group demonstrates what can be done when striving for omnipresence.

¹¹ Bruce Ruxton, interview with the author, 8 January 1999.

¹² Jaensch, D. (1994) *Parliament, Parties and People*, second edition. Melbourne: Longman Cheshire, p. 172

The Australian Medical Association (WA Branch) lobbying approach was quietly persuasive. Lobbying was largely a private affair with "silent" links with the L. J. Goody Bioethics Centre. The Australian Medical Association is a determined group which survives on its pivotal strategic position with government and generally high rating of community approval and acceptance.

The Australian Nursing Federation (WA Branch) activity was strategic. Its lobbying was less effective because other, more important "industrial" issues distracted its efforts. However, its strategy of applied pressure when Mr Taylor was drafting his Bills was only in part successful, as nurses did not receive the same treatment as medical practitioners in the Bill. They were a firm ally with Mr Taylor, and like all the groups, were involved in the first critical stage of lobbying.

The L. J. Goody Bioethics Centre is a powerful, "insider" group whose style is non-confrontational and co-operative with government and parliament. It not only offers government its considerable resources but more importantly, it educated the politicians, not just on the topic of the *Medical Care of the Dying Bill (1995)*. It also maintains its profile and availability at all times. The group's powerful political influence is attributed to its religious, historical roots ingrained in Judeo-Christian western democracy together with the acceptance and credibility that the Catholic religion has in society. A strength of the L. J. Goody Bioethics Centre is its networking and nurturing of relationships at strategic political levels. Father Walter Black's relationship with

Ian Taylor, from the very early stages of the Bill through to their involvement at the end of the Second Reading, made the group very successful in achieving its desired outcome. The group had established relationships with key political players such as Phil Pandal, who said:

Even people who have no religious persuasions or persuasions other than those of the Roman Catholic Church would acknowledge that there is no harsher critic anywhere in the world of measures of this kind than that organisation;¹³

Mr Pandal relied upon Father Black's advice. It could be stated that Walter Black together with Ian Taylor successfully steered the Bill through the Lower House, but that it "lost its way" during the Committee Stage in Mr Taylor's absence.

Father Walter Black is a strong advocate for the Catholic faith through the L. J. Goody Bioethics Centre. This pressure group offers resources, advice, education and practical assistance. In its public statement to MPs, they supplied much information to hopefully persuade the politicians to decide in favour of the Bill. The L. J. Goody Bioethics Centre had the long tradition of religion and medicine and well argued moral reasonings to support its view. It is a clear case demonstrating that the provision of well timed, supportive information can win favour and religion and medicine are two strongly ingrained and influential forces. This case study illustrates the effective, professional, strategic communication skills the L. J. Goody Bioethic Centre (read Catholic Church) has in offering a high level of integrated services to

¹³ Western Australian Parliamentary Debates. 23 August 1995, p. 7124.

politicians. The role played by the group was one of strategist, which assisted the MPs by providing them with a clear plan and brief, thereby allowing them to do what they do best - to debate and decide on the issue.

The lobbying of the Silver Chain Nursing Association Inc. - Hospice Care Service was informal as the group have a restrictive policy towards lobbying. Indeed, its co-operative role with Mr Taylor was influential but it could have been more powerful if it had sought to be so. Perhaps its intervention was timely.

The Uniting Church, had it chosen to lobby, would not have had any difficulty gaining media coverage. Its outspoken position on other matters such as female ordination and approval of homosexuality, gains frequent media coverage. Placing a low priority on the issue of medical care for the dying resulted in its low media profile - had they entered into the debate and lobbied using the vigour they mustered for woodchipping and sexual discrimination, it would have added an interesting component to this thesis.

Similarly, the Anglican Church of Australia was committed to lobbying in the Northern Territory during debate and proclamation of the *Rights of the Terminally Ill Act* (1995). The strategic decision to concentrate on combating euthanasia legislation elsewhere left lobbying opportunities unexplored in Western Australia. Meanwhile, the *Medical Care of the Dying Bill* (1995) went to Committee Stage and was fast evolving into a confused piece of legislation that would apply to any person suffering any

form of illness. It was a far cry from Mr Taylor's intended legislation.

Illustrated below is a pressure group sampling, which indicates the groups' strategic lobbying:

The West Australian Voluntary Euthanasia Society	Politically astute, overt.
Coalition for the Defence of Human Life	Organised, energetic, omnipresent.
Australian Medical Association (WA Branch)	Collaborative, powerful, covert.
L. J. Goody Bioethics Centre	Co-operative, educative, informative.
Australian Nursing Federation (WA Branch)	Strategic.
Silver Chain Nursing Association (Inc.) Hospice Care Services	Timely.
The Uniting Church in Australia (WA Synod)	Indecisive, ineffective.
The Anglican Church of Australia	Certainty of focus, distracted.

Jaensch said that a pressure group's combination of size, wealth, sense of unity and clear and distinct aims is the basis for a powerful pressure group:¹⁴ what if that list was added to? What if a pressure group arises possessing Jaensch's qualities and also has qualities from *Table 6.1*?

Chapter one described Jaensch's five access points to decision-makers for pressure groups. This case study indicates that most pressure was applied to parliament, the Executive and the electorate through channels of the media and public opinion polling. Star lobbying performers were clearly the Australian Medical Association and the L. J. Goody Bioethics Centre in terms of achieving favourable lobbying outcomes.

¹⁴ *Ibid.* p. 179.

Moving on from 1995

Four years on from the debate, the Coalition State Government has decided to shelve its Medical Care for the Dying Bill indefinitely.¹⁵ Apparently, it is too difficult to legislate in this area. The Government's reticence in releasing its draft Bill for the community to debate is contrary to the approach adopted by Ian Taylor.¹⁶ Now that the Coalition has shelved the 1998 Bill, the lobby groups have been silenced.

Dr Scott Blackwell, former State President of the Australian Medical Association, said he could understand the decision of the party room to shelve the legislation, given the emotional 1998 abortion debate.¹⁷ The State government needs a clear "grasp of the nettle" to resolve the perceived medical care of the dying problem. This seems remote. In broad terms, it will take a determined political will to solve the problem, in competition with other, urgent issues facing government. Meantime, pressure groups will need to pay close attention in the months ahead. In all likelihood pressure groups will prove once more that they are a major force in the Western Australian polity.

In 1997, Coalition members were not given a conscience-vote over a Bill in the Legislative Assembly to lower the age of consent for homosexual men to 16. The reason for this? The two parties possibly believed such a vote would put

¹⁵ Doctors urge dying Bill. (1998, September 14) *The West Australian*, p. 35.

¹⁶ *Ibid.* p. 35.

¹⁷ *Ibid.* p. 35.

individual MPs under too much pressure from gay lobbyists.¹⁸ These "pressures" can take the form of traditional lobbying procedures such as meetings with constituents, responding to correspondence, telephone calls, facsimile transmissions to new lobbying procedures such as e-mails and potential internet use. Moral issues which are subject to conscience-votes such as abortion, euthanasia or prostitution continue to enter the floor of parliament; this thesis therefore, provides an indication of the pressure group activity which is likely to transpire. When parliament makes moral decisions, MP's can become exhausted as concentrated extended media and pressure group attention may cause stress to members and the government.¹⁹

Furthermore, this thesis concludes that pressure group lobby activity is stimulated and energised by a conscience-vote with MPs rather than the Executive, as a target of such activity. Graham Maddox said that it would take a large volume [of literature] to analyse the activities of interest and pressure groups.²⁰ It appears his assumption was correct. Unfortunately, because of the difficulty of this exercise there is a dearth of literature and case studies of pressure group activity. This thesis goes some

¹⁸ Consent Bill defeat looms. (1997, November 7). *The West Australian*, p. 10.

¹⁹ Cabinet delays over aid for dying. (1998, June 20). *The West Australian*, p. 54. Legislation giving the terminally ill the right to refuse medical treatment has been delayed indefinitely because government members have grown nervous about the pace of social reform. Coalition backbenchers wanted the *Medical Care of the Dying Bill 1998* delayed because members did not want to embark on a sensitive social debate so soon after the controversial abortion debate, *Acts Amendment (Abortion) Act 1998*.

²⁰ Maddox, G. (1996) *Australian Democracy in Theory and Practice*, third edition. Melbourne: Longman Australia, p. 417.

way in understanding the pressure group environment and provides warnings about the traps and difficulties which are likely to be encountered on conscience issues facing the legislature.

All groups shared levels of motivation and self-interest in the *Medical Care of the Dying Bill* (1995) debate. Each group was presented with an equal opportunity to raise their public profile by entering into pressure group activity. This can frequently be beneficial to a group's cause or purpose.

The parliamentary debating sessions often became distracted and wearisome with irrelevancies. As chapter four testifies, there were marked differences between speakers. It was the ALP member for Kimberly, Ernest Bridge, who rose at a critical point and made a daring and impassioned speech:

The matter before the House is very significant. It is perhaps one of the most significant matters on which we are called upon to pass judgement.

We are talking about legislating about the empowerment of the human race, if we pass this legislation. That empowerment will give people some capacity to determine the duration of life.

In this debate, however, a perception could be put forward by the Aboriginal people that, in their eyes, this legislation is a rose by any other name which would smell as sweet. It could be interpreted by them as empowering a white doctor to kill a black person.²¹

This study also illustrates the connection, an "eternal triangle" collaboration between three powerful, influential

²¹ Western Australian Parliamentary Debates, 23 August 1995, p. p. 7130- 7131.

institutions: government, religion and medicine - the staple of many moral, conscience-type issues.

A Summary: Tips and Traps for Pressure Group Activists

Successful lobbyists (including the army of unpaid persons) should be anchored in the knowledge and wisdom of the political masters on citizen participation and group theory. Wisdom provided by the great masters of Locke, Rousseau, Paine, Madison, de Toqueville and Mill should not be ignored. Introduced in chapter one, these thinkers have contributed to modern, participative democracy and all recognised the "potency" of groups. John Locke agreed that political matters should be settled according to the will or wishes of the "majority".

Jean-Jaques Rousseau viewed groups as a threat to the "General Will". Thomas Paine and James Madison recognised the necessity of pressure groups in a representative democracy. De Tocqueville and John Stuart Mill feared the tyranny of the majority. Importantly, Mill's thoughts have direct application to this thesis when he claimed:

pressure groups frustrate proper representative government, for they attempt to gain advantages and benefits for one particular group in society rather than considering the 'greatest happiness of the greatest number'."²²

Those frustrations contributed to the fatigue status and "strangulation" of the right to die Bill. Not only did the

²² Phillips H. C. J. and Rielly, C. W. (1982). *Key Concepts in Politics*. Melbourne: Thomas Nelson Australia, p. 128.

Bill run out of parliamentary time, many of the protagonists and antagonists also grew weary.

Significantly, too, this thesis also attests to Mill's view that:

the elected legislature [was the] 'fulcrum' of the political system.²³

For the Legislative Assembly was indeed the fulcrum of the debate.

To avoid legislative strangulation, parliamentarians may take heed of strategies which have been described in this thesis. They are worthy of careful consideration for future conscience-type issues. If a successful outcome for a conscience-vote issue is desired, then surveillance of the pressure group environment should be conducted and documented. Consideration and anticipation of the objectives and strategies pressure groups may employ are key factors.

Can it be that moral conscience-vote issues may have a greater chance of successful outcome if the legislation is initiated in the Upper House?²⁴ Perhaps MPs are not subject to the same electoral pressure in the Upper House due to the proportional representative voting system and multi-member constituencies? They can, in fact, treat a conscience-vote without the same electoral problems and

²³ *Ibid.* p. 70.

²⁴ *Ibid.* p. (p.p. 2, 4, 17). There are no staggered terms and all the members of the Legislative Council face the electors at the same time. The multi-member constituency factor with proportional representation also has ramifications for members.

party ramifications that can transpire in the Legislative Assembly. Notwithstanding this, whether legislation is introduced into the Upper House or the Lower House, it still has to negotiate and pass through the Lower House.

The "fatigue factor" saw the *Medical Care of the Dying Bill* (1995) slowly deflate. Winning a Second Reading vote was not enough. The Bill took its toll on individuals and groups involved in the debate. Anticipating delays may avoid pitfalls and downtime in a Bill's successful legislative passage, yet it can be the nature of the debate and not the steering of it, which can cause the fatal "fatigue factor".

Gaining an understanding of the type and nature of a pressure group may give a keen observer an insight into the possible type of lobbying behaviour that a group may display. Knowing how the media may treat the issue can be an advantage. Is the matter newsworthy and capable of being self-sustaining? Consider lobbying activities based on good media relations and planned media activity. Determining a pressure group's relationship with the media and government can be a good gauge in assessing whether there will be favourable or unfavourable media coverage and the extent of this coverage. If consent is going to be "manufactured" then a pressure group should carefully resolve its position and reinforce its media message. Seizing the opportunity to lobby can be a double-edged sword for a pressure group - consider the persuasive lobbying task at hand and take the opportunity to improve on the group's public profile and media relations.

Consideration of the effect of public opinion polling on the outcome of the issue²⁵ is a significant point. The *Medical Care of the Dying Bill (1995) Hansard* debate was punctuated with reference to euthanasia polls. Pressure groups used poll findings to support their views. What was necessary was concrete evidence of overwhelming support by way of public opinion polls. As Professor Ian Maddocks told the author in an interview, it is crucial nowadays that poll questions are framed thoughtfully, fairly and truthfully. However, opinion poll references were not as marked in this thesis. The protagonists said the Taylor Bill was not euthanasia yet it tapped into the euthanasia support base, and quoted from euthanasia polls.

It can be seen that pressure groups overcoming the obstacles, gaining the support of MPs was only a part of the conundrum. If groups were prepared to modify their behaviour, then they may have had more chance of success. Acting differently, in a calculated way, may have improved lobbying outcomes.

Nevertheless, it cannot be over-stated that possessing a deep understanding and knowledge of the issue and providing an educative role to MPs can be one of the greatest roles a pressure group can play. Also, analysing and evaluating the constant perspective changes of MPs during the *Hansard* debate can be a powerful leverage mechanism.

²⁵ *Ibid.* p. 14.

This paper found that the constant reference to opinion polls by parliamentarians as a means of justifying their vote was a feature of the abortion debate. Despite the fact that MPs reported a substantially greater magnitude of correspondence emanating from pro-life groups, they mostly preferred to accept the accuracy of the polls as a measure of constituency opinion on changes to the abortion law.

The "right to die" issue will possibly come again, rather like a slide-show carousel revolving. It's just taking its turn for the next public viewing and debate. In the long run the pressure group picture may have slightly altered, the media treatment may be different particularly if euthanasia legislation takes a form in the shape of the Medical Care of the Dying Bill in other states of Australia or in other countries.

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