A minimalist legislative solution to the problem of euthanasia

such a reform will preserve the requirement that doctors remain legally accountable for their actions

Summary

- Intense debate has continued for many years about whether voluntary euthanasia or assisted suicide should be permitted by law.
- The community is bitterly divided and there has been vigorous opposition from medical practitioners and the Australian Medical Association.
- Despite differences of religious and philosophical convictions and ethical values, there is widespread community agreement that people with terminal illnesses are entitled to adequate treatment, and should also be allowed to make basic choices about when and how they die.
- A problem with the current law is that doctors who follow current best practice cannot be confident that they will be protected from criminal prosecution.
- We propose simple changes to Commonwealth and state legislation that recognise community concerns and protect doctors acting in accordance with best current practice.
- This minimalist solution should be widely acceptable to the community, including both the medical profession and those who object to euthanasia for religious reasons.
- Important areas of disagreement will persist that can be addressed in future debates.

In Australia and elsewhere, there has been a continuing, intense debate over many years about whether voluntary euthanasia or assisted suicide should be permitted by law.[1] Passionate views have been expressed on both sides. While some sections of the community strongly favour the option of assistance to die in some circumstances, others, including the Australian Medical Association and other professional associations, remain implacably opposed to the legalisation of euthanasia in any form.[2]

In the latest rounds of the debate, a Senate committee has called for a conscience vote when the matter is next presented to the Australian Parliament,[3] a view unexpectedly supported by the Prime Minister,[4] while the Medical Board of Australia has suspended the medical registration of a prominent euthanasia activist.[5] Sadly, despite the frequent, forceful and ongoing expressions of views, little progress appears to have been made, with impassioned calls from one side for the enactment of formal "right to die" legislation being matched by an equally resolute defence by the other of what are regarded as the traditional values and practices of the medical profession.

The issues at stake are undoubtedly deep and important, and it is not hard to understand why many members of the community view the prospect of institutionalised processes that promote killing, whatever the context, with apprehension. Widely held religious and philosophical convictions about the nature of death and ethical responsibility also reflect memories of the tragic experiences of the Second World War and Nazism. While it has been argued that the outcomes of euthanasia laws enacted in overseas jurisdictions are reassuring,[6,7] not all agree with this assessment,[8,9] and it must at least be accepted that the concerns of opponents are by no means frivolous. The possibility that the need to respond to critical shortages in health budgets resulting from an ageing society might lead to nightmarish outcomes (explored as a hypothetical in my novel *Riding a crocodile: a physician's tale*[10]) cannot be summarily dismissed. Many doctors remain understandably nervous about the implications for their profession of what they see as a radical reversal of some of its most enduring precepts.

Removing uncertainty from considerations of best practice

The often strident and acrimonious tone of the debate has obscured the fact that there is widespread community agreement on two fundamental principles: that people suffering from terminal illnesses are entitled to adequate treatment of their symptoms, and that they should also be allowed to make key decisions about when and how they die.[11] In addition, a genuine and abiding problem with the current legal situation remains unresolved: doctors who follow current best practice by providing whatever care is needed to alleviate pain and suffering cannot be confident that they would be protected from criminal prosecution for murder, manslaughter or aiding and abetting suicide should they be actively involved in the death of their patient. Although there have been no prosecutions of Australian doctors for these offences, these have occurred in other jurisdictions, and it is widely accepted that the law in Australia remains unclear.[12] This view is reinforced by the lack of certainty among doctors themselves about what is acceptable practice and what would be regarded as euthanasia.[13]

We believe that recognition of the broad community agreement as well as the need for action in relation to specific legal questions might allow the prevailing social deadlock to be broken and genuine progress to be made in bringing about meaningful reform. One precondition for such progress would be a shift in focus away from higher-level — and inherently insoluble — abstractions about the "right to die" and the "sanctity of life" to more practical issues that demand urgent attention. This could be achieved with modest changes to existing legislation and would preserve well tested and widely supported legal principles and ethical values.

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A simple change consistent with current principles and practice

We propose that legislation be enacted to amend relevant Commonwealth and state criminal legislation to provide a defence to a charge of homicide or manslaughter when a doctor has prescribed or administered a drug that has hastened or caused the death of a patient with a terminal disease. This defence would be allowed if the doctor: (a) reasonably believed that it was necessary to prescribe or administer the drug to relieve the pain or suffering of the patient; or (b) prescribed or administered the drug with the intention of relieving such pain or suffering.

A simple legislative change to this effect would explicitly affirm the legal doctrines of necessity and double effect that are well established in common law,[14] even if, in medical contexts, they have rarely been tested in the courts. It would ensure that people facing serious illness would be confident that their needs could always be met, and that doctors following accepted best practice in providing for the needs of their patients would be able to do so without the threat of criminal conviction. By clearly stating the conditions and limits of the law, such a reform would preserve the requirement that doctors remain legally accountable for their actions — a principle that few members of the profession would want to abandon. Protection for older and vulnerable members of the community would be undiminished. End-of-life decision making would remain where it should: in dialogues between patients, their families and their medical carers. Accepted, high-quality medical practice would be respected and formally acknowledged by the law, and the harmony between the two restored.

This minimalist solution should be widely acceptable to the community, including those who remain disquieted by attempts to purify death of its untidiness, uncertainty and risk. The direct reliance on the traditional Catholic doctrine of double effect should satisfy some of the most trenchant opponents of end-of-life legal reform. The preservation of well tested safeguards against excesses and of the importance of clinical dialogues should satisfy individual practitioners and their representatives in professional associations.

Questions for the future

Important areas of disagreement would, of course, persist. In particular, cases in which patients with severe chronic but not terminal illnesses ask for help with dying will remain problematic. Further, attention will need to be given to the potential of accepted treatments to hasten death. How these dilemmas will be resolved remains uncertain, but the public debate will at least deal with them in a fresh and constructive social environment.

We believe that it is time to move from the repetitive, unproductive, circular discussions about euthanasia and end-of-life decision making of the past to a more pragmatic approach that preserves well tested legal principles and reflects the prevailing widespread social consensus.

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References are available online at www.mja.com.au.

1 Komesaroff PA, Charles S. Let's not over-complicate euthanasia debate. *The Age* 2014; 21 Nov. http://www.theage.com.au/comment/lets-not-overcomplicate-euthanasia-debate-20141120-11qbbe.html (accessed Dec 2014).

2 Australian Medical Association. Position statement on end of life care and advance care planning 2014 https://ama.com.au/position-statement/position-statement-end-life-care-and-advance-care-planning-2014 (accessed Dec 2014).

3 The Senate Legal and Constitutional Affairs Legislation Committee. Medical Services (Dying with Dignity). Exposure draft bill 2014. http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Dying_with_Dignity/Report (accessed Dec 2014).

4 Hagan K. Tony Abbott commits to free vote on euthanasia. *Sydney Morning Herald* 2014; 19 Dec. http://www.smh.com.au/national/tony-abbott-commits-to-free-vote-on-euthanasia-20141219-12ayc7.html (accessed Dec 2014).

5 Medical Board of Australia. Medical Board confirms suspension [media release]. 24 Jul 2014. http://www.ahpra.gov.au/News/2014-07-24-media-release-Dr-Nitschke.aspx (accessed Dec 2014).

6 Rietjens JA, van der Maas PJ, Onwuteaka-Philipsen BD, et al. Two decades of research on euthanasia from the Netherlands. What have we learnt and what questions remain? *J Bioeth Inq* 2009; 6: 271-283.

7 Battin MP, van der Heide A, Ganzini L, et al. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups. *J Med Ethics* 2007 33: 591-597.

8 Walker RM. Physician-assisted suicide: the legal slippery slope. *Cancer Control* 2001; 8: 25-31.

9 American Medical Association. Ethical statement, E-2.21 Euthanasia (adopted 1991), revised 1996, reaffirmed August 22, 2005. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion221.page (accessed Apr 2015).

10 Komesaroff PA. Riding a crocodile: a physician's tale. Perth: University of Western Australia Publishing, 2014.

11 The Australia Institute. Survey results — attitudes to voluntary euthanasia (released 6 Jan 2011). http://www.tai.org.au/node/1316 (accessed Dec 2014).

12 Cica N. Euthanasia — the Australian law in an international context. Part 2: Active voluntary euthanasia. Canberra: Department of the Parliamentary Library, 1996. (Parliamentary Research Service, research Paper no. 4 1996–97). http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/RP9697/97rp4 (accessed Mar 2015).

13 Neil DA, Coady CA J, Thompson J, Kuhse H. End-of-life decisions in medical practice: a survey of doctors in Victoria (Australia). *J Med Ethics* 2007; 33: 721-725.

14 Charles S. Dying with dignity. *Victorian Bar News* 2014; issue 155 (winter): 38-42. ■