



5 April 2011

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The Honourable Stephen Wade MP
Shadow Attorney-General
Parliament House
North Terrace
ADELAIDE SA 5000

Dear Mr Shadow Attorney-General

***Criminal Law Consolidation (Medical Defences – End of Life Arrangements) Amendment Bill
2011***

I refer to the email of 16 March 2011 from your Adviser, Mr Biar, referring the above Bill to the Society for comment. We provide the following comments.

The Society has not taken a policy position on 'voluntary euthanasia' and is not likely to do so given the very personal and sensitive nature of the issue.

As with other draft legislation of similar or related content on which the Society has recently commented, the primary concern in relation to this Bill is around clarity and certainty, that those who are intended to 'benefit' from its effect can assess their position as confidently as possible and provide assistance in end of life arrangements with the impunity Parliament intends.

The Bill decriminalises the recognised offences of murder, manslaughter, assisted suicide and voluntary euthanasia in certain circumstances outlined in the Bill. To that extent, there are some significant public policy issues associated with the Bill. It appears to be a compromise solution to the difficult question of the legalisation of voluntary euthanasia. We comment specifically as follows

1. The Bill proposes a defence to a charge of an offence "*against this Division*" if certain criteria are met.
2. A defence is available if the death to which the charge relates resulted, or was intended to result, from the administration of "*drugs*" (a term which is not defined).
3. If that is the case, then the defence is available if the defendant proves (on the balance of probabilities) that:
 - (a) the defendant was a treating medical practitioner of the person (which is defined as a practitioner "*who is currently treating*" the person for their qualifying illness – being an

As no antecedent period of treatment is indicated, it might be reasonably argued that "currently treating" would be satisfied by the "offending conduct", ie the administration of drugs.

This is an important issue, because the existence of the relationship is a fundamental element of the defence;

- (b) the defendant believed on reasonable grounds that:
 - (i) the person was adult;
 - (ii) the person was of sound mind;
 - (iii) the person was suffering from an illness, injury or other medical condition that irreversibly impaired the person's quality of life; and
 - (iv) that the impairment was such that life had become intolerable to that person;
- (c) the conduct to which the charge relates occurred at the express request of the person;
- (d) the conduct to which the charge relates was in all the circumstances a reasonable response to the suffering of the person.

A number of issues arise:

- (a) Does "*intolerability*" have a temporal aspect, eg can acceding to the "*request*" be at precisely the same time as the person first perceives life to have become intolerable, or must/should there be some antecedent to that – such as in previous Bills which required certain information/assessment processes to have been undertaken before an "end of life decision" could be made?

Some illnesses may be periodic. Some might be able to be managed by medication, yet there is no obligation on a person to minimise their discomfort. In short, this provision extends to many types of conditions that may not justify the termination of a life. Whether life has become "intolerable" is very subjective.

- (b) In S13B(1)(b), the basis for the belief on "reasonable grounds" is not outlined. Would "*reasonable grounds*" be satisfied if the person stated that life had become intolerable – even under heavy medication? It may be that the defendant was informed of such by the person and verily believed it was so. That would therefore place the defendant, a medical practitioner, in no different position to a lay person. This provision could be expected to require the defendant to have formed a view after a thorough examination. However it does not require any level of examination – it only assumes that an examination has been conducted;
- (c) S13B(1)(d) – this provision seeks to introduce an element of objectivity, but it fails given the subjective basis of s13B(1)(b). We question how a reasonable response to the suffering of a person can be measured when a person insists that life is intolerable. Section 13B(5) does not assist in this regard.

- (d) Only one medical person is required to form a view. This leaves the provision open to abuse in that a person may seek out pro-euthanasia practitioners.
- (e) S13B(1)(c) – this is ambiguous. One interpretation of the provision is that the conduct to which the charge relates is the administration of the drug. There does not appear to be any requirement that there be an express request for life to be terminated.
- (f) As above for s13(1)(a) and (b)
- (g) As above for s13B(2)(c) An added concern is that an implied request is sufficient.
- (h) S13B(3)(a) – the mere acquittal of the medical practitioner should not act as a bar to liability. There could be a myriad of reasons why a person is acquitted that do not bear upon the actions of the aider and abettor, including identity. The common law reflects this by providing that the principal offender need not be charged or convicted in order for the aider to be liable;
- (i) S13B(3)(b) – as above;
- (j) the stated requirement is the “conduct” be at the “express request”. Does this mean that the practitioner must receive specific instructions regarding the drug(s), the amounts to be administered and when? In short, it is unclear how close the co-relation must be between the conduct and the request;
- (k) in the proposed new section 13B(5) the Bill elaborates on whether particular conduct was “a reasonable response” to the suffering. In that regard the court is required to have regard to the intention of Parliament that:

“... conduct bringing about the end of a person’s life is a reasonable response to such suffering in exceptional circumstances, including where palliative care measures have not relieved the person’s suffering to a level acceptable to the person.”

With respect, this seems to confuse the concept of the intolerability with the nature of the conduct in response.

The conduct to which the charge relates will be around the administration of drugs which have the effect of causing death. The defence requires that this conduct be a reasonable response – and the obvious question must be ‘by whose standard?’ The issue of reasonableness of the conduct is only a matter to be considered if all other criteria have been satisfied, including intolerability, request etc. Surely the reasonableness should then focus on the means – not create a further qualifying criteria?

Yet that is what section 13B(5) seems to require – ie that somehow the administration of drugs must be “in all the circumstances” a reasonable response – and that this is met only in “exceptional circumstances”.

Certainly, Parliament is legislating a moral/ethical position of ‘reasonableness’ – without which the argument could be mounted that the administration of lethal drug dosages could never be considered reasonable. In doing so, however, it creates a ‘catch-all’ qualifying criteria – which it states can only be reached in “exceptional circumstances” thereby creating a curious juxtaposition of terms, ie “reasonable” must be “exceptional”.

It further seems to suggest that this test can only be met if there is no other alternative relief available.

In summary, the impression given is that Parliament wishes there to be some exercise of judgement co-relating the conduct causing/advancing death and the available means to alleviate suffering. It is suggested this could be very much clearer – rather than relying on the necessary existence of “*exceptional circumstances*”.

4. The proposed section 13B(2) entitles a defendant to advance a defence to a charge of aiding, abetting or counselling suicide (or attempted suicide) if similar criteria are met.

The requirement of the conduct being a “*reasonable response*” to the suffering is also present here – although the conduct may be quite diverse, because there is no qualifying criteria that the death result from the administration of drugs.

Would then the provision of a weapon with which to self harm be a reasonable response to the suffering? Some may answer affirmatively and some may not – Parliament has expressed its view that conduct bringing about the end of life may be reasonable having regard to the person’s prognosis and available alternatives. It says nothing in this context about the paradigm of means and this is an area on which it should provide some guidance for clarity.

5. Finally, the Bill proposes a defence to those who might be charged with supporting or assisting a medical practitioner in relation to the death of a person.

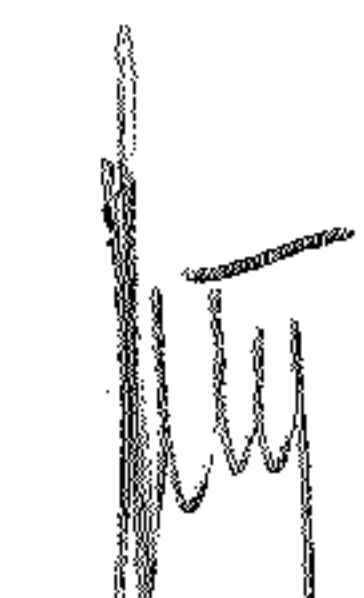
The defence criteria are met if the medical practitioner is acquitted “*under this section*” or if the person proves, on balance, the conduct was in good faith in the ordinary course of employment and the conduct of the medical practitioner was in all the circumstances a reasonable response to the suffering.

It would seem to be a very difficult defence for an assistant to make out – without the necessary knowledge and training to assess the alternatives, but reliant on the judgement of the practitioner as to whether “*exceptional circumstances*” were present. Simply put, if the medical practitioner fails on this issue, then so does the assistant – irrespective of the skills, knowledge and capacity (or lack thereof) of the assistant and without any consideration permitted to surrounding circumstances.

Consideration should be given to the basis of incorporating this criteria and why good faith and the conduct being in the ordinary course of employment are not sufficient for a defence in this instance.

I trust these comments are of assistance. Please do not hesitate to contact me, should you wish to discuss this matter.

Yours sincerely



Ralph Bönig
PRESIDENT

cc Hon S Keys MLC
The Attorney-General