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“Such is Life”: Euthanasia and capital punishment in Australia: consistency or contradiction?

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“Such is Life”: Euthanasia and capital punishment in Australia: consistency or contradiction?

Abstract

Lawful euthanasia involves State endorsed termination of human life. Apart from a period of less than 9 months, in the Northern Territory, euthanasia has been illegal in Australia. Many of Australia’s parliaments have regularly considered introducing the practice and they continue to do so. In this context, this paper considers another type of State endorsed termination of human life: capital punishment. These took place in Australia from 1788 to 1967. The practice was abolished nationwide by 1985 and the Commonwealth passed laws, in 2010, to prevent its reintroduction. This paper does not consider all of the arguments for or against euthanasia or capital punishment and nor does it argue that the two practices are identical. Instead, it argues that introducing euthanasia without careful consideration of the arguments and experiences of capital punishment would risk repetition of past mistakes. The paper considers whether introducing euthanasia would be inconsistent with arguments accepted as grounds for the abolition of capital punishment. It focuses, on the irrevocable argument. This is the argument that death is irrevocable and that the risk of an innocent person being executed should never be taken. The paper argues that, any criteria which might be adopted by the State as sufficient to justify euthanasia, would run the risk of people outside that criteria being euthanised. The paper argues that capital punishment and euthanasia each pose disproportionate risks to minority and vulnerable groups. The paper also argues that, the evidence of pain and suffering endured by the condemned in their execution require careful consideration in relation to arguments for euthanasia as a means to a quick and pain free “good death.” It considers the evidence that demonstrates that, like execution, euthanasia in practice can be slow and painful. The paper then argues that requiring health professional to administer lethal injections in acts of euthanasia would be inconsistent with the approach taken in Australia and the United States to the identification of those willing to administer the death penalty. The paper concludes that many of the key arguments which resulted in the abolition of the death penalty in Australia support the continued prohibition of euthanasia in Australia and ought to be addressed by proponents of change but its primary aim is to encourage further examination of the extent to which learnings relevant to the current euthanasia debate can be gained by examining the arguments and experience of capital punishment.

Cover Page Footnote

"Such is life."¹ Euthanasia and capital punishment in Australia: consistency or v contradiction?

Michael Quinlan

"So stay awake, because you do not know either the day or the hour."²

Introduction

Lawful euthanasia and capital punishment involve State endorsement of the deliberate, premeditated and intentional termination of a human life. Whilst there has been a worldwide movement to abolish capital punishment it remains a means of punishment in most countries.³ Capital punishments were carried out in Australia between February 1788 and February 1967. They were abolished in the States, Territories and Federally, in Australia, between 1922 and 1985. Australians have since demonstrated increasing opposition to the practice overseas.⁴ By contrast, euthanasia is prohibited in most countries in the world.⁵ Despite persistent attempts

¹ Whilst there is controversy about the last words of the Australian bushranger Edward (Ned) Kelly, he is said to have uttered these words (or in another version "Oh well, I suppose it has come to this then") as his final words before he was hanged at the Melbourne gaol on 11 November, 1880. See John V. Barry, 'Kelly, Edward (Ned) (1855–1880)', *Australian Dictionary of Biography*, National Centre of Biography, Australian National University, <http://adb.anu.edu.au/biography/kelly-edward-ned-3933/text6187>, published first in hardcopy 1974, accessed online 6 October 2016.

² Matthew 25:1 (New Jerusalem Bible).

³ Michael Victory, *End of The Line Capital Punishment in Australia*, (Victoria: CIS Publishers, 1994) 3, 57 Although capital punishment is available in most of the world's nations most of the executions take place in very few countries.

⁴ In 2005 the execution of convicted heroin smuggler Nguyen Tuong Van in Singapore led to a renewed focus and concern in Australia about the use of capital punishment: David Indermaur, "Changing Attitudes to the Death Penalty: An Australian Perspective," *Current Issues in Criminal Justice* 17 (2006): 444. As Indermaur observes, Van's funeral on 7 December, 2005, at St Patrick's Cathedral in Melbourne, attracted a congregation and levels of grief in excess of many state funerals. In 2015, a concerted attempt was made to persuade Indonesia not to execute two Australians who were convicted drug smugglers: Andrew Chan and Myuran Sukumaran. Their funerals were equally well attended and one Australian law school named a scholarship after them: Adam Gartnell, "Andrew Chan and Myuran Sukumaran deserved a second chance" *Sydney Morning Herald*, May 3, 2015, <http://www.smh.com.au/federal-politics/political-opinion/andrew-chan-and-myuran-sukumaran-deserved-a-second-chance-20150430-1mwzdm.html#ixzz42BxLt0sh>; Tom Attard, "Bali nine: Hundreds farewell Myuran Sukumaran at Sydney funeral" *Sydney Morning Herald*, May 3, 2015, <http://www.smh.com.au/national/bali-nine-hundreds-farewell-myuran-sukumaran-at-sydney-funeral-20150508-ggxsda.html#ixzz42ByLay13> and "ACU Mercy Scholarships" Australian Catholic University, https://www.acu.edu.au/connect_with_acu/newsroom/news/media_releases/year/2015/acu_mercy_scholarships. For the background to the crimes, arrest, prosecution and sentencing of Chan, Sukumaran and the other members of the Bali Nine see Lorraine Finley, "Exporting the Death Penalty? Reconciling International Police Cooperation and the Abolition of the Death Penalty in Australia," *Sydney Law Review* 33 (2011): 95, 96-102.

⁵ Euthanasia was not recognised as medical treatment for 2,400 years: Margaret Somerville, *Bird on an Ethics Wire* (Mc-Gill Queen's University Press, 2015), 166. It is however now permitted in the Netherlands, Belgium and Luxembourg. Doctor assisted suicide, in which a doctor provides the means of death to a patient, is permitted in the Netherlands and Luxembourg and in the US States of Oregon, Washington, Montana, Vermont and (since 5 October 2015) California. Assisted suicide (which need not involve a doctor) is permitted in Switzerland: see Jose Pereira, "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls," *Current Oncology* 18 (2011): 2, esp. 38 Euthanasia and doctor assisted suicide (together called physician assisted death or PAD) are now permitted in Canada following the Supreme Court of Canada's decision in *Carter v Canada* [2015] 1 S.C.R. 331 (Can).. For discussion of the Canadian position see College of Physicians and Surgeons of Ontario, Policy Statement #1-16 "Interim Guidance on Physician- Assisted Death" 2. <http://eol.law.dal.ca/wp-content/uploads/2016/05/ON-MAID-Guidelines.pdf>

to introduce lawful euthanasia, it has always been unlawful in Australia, apart from a period of less than 9 months, in the Northern Territory.

The aim of this paper is not to examine all of the arguments for or against euthanasia or capital punishment or to argue that the two practices are identical.⁶ Rather this paper argues that introducing euthanasia without careful consideration of the arguments and experiences of capital punishment would risk repetition of past mistakes. This paper considers the consistencies and contradictions in some of the arguments accepted for the abolition of the death penalty and put by advocates for the legalisation of euthanasia in Australia. Part I provides some definitions before providing a brief history of these practices and of their popularity in Australia. Part II examines the arguments for the abolition of capital punishment grounded on the irrevocable nature of death.⁷ This Part argues that similar difficulties, to those experienced in ensuring that only those who fit the criteria set for execution, arise in ensuring that only those who satisfy the criteria set by a State to permit access to euthanasia. Part III considers the risks posed by capital punishment to minority and vulnerable groups and argues that similar risks beset euthanasia. Part IV considers arguments against capital punishment based on the pain and suffering endured in capital punishment and argues for more transparency in the examination of evidence as to the experiences of euthanasia. Part V looks at the need for individuals to administer capital punishment and euthanasia and argues that requiring health professional to administer lethal injections in acts of euthanasia would be inconsistent with the approach taken in Australia and the United States to the identification of those willing to administer the death penalty. The paper concludes that many of the key arguments which resulted in the abolition of the death penalty in Australia support the continued prohibition of euthanasia in Australia and must be carefully considered as part of any consideration of law reform.

When dealing with capital punishment and euthanasia, it is important to remember that the decisions a nation takes on these issues are not matters of academic interest alone as they effect real people. Case studies can assist in recognising the personal impacts of such laws.⁸ For this reason this paper includes a number of case studies.

⁶ It does not, for example, examine arguments for euthanasia grounded on personal autonomy: see House of Lords Select Committee On The Assisted Dying For The Terminally Ill Bill, Vol 1: Report (2005) 5,11 [8], 20-28 [39]-[68], Michael Douglas, "An absurd inconsistency in law: Nicklinson's case and deciding to die", 21 *Journal of Law & Medicine* 627 (2014). Significantly in the context of the issues that this paper does address, most States which permit euthanasia introduce limits on access to euthanasia by reference to legislated criteria and so place limits on the personal autonomy of citizens who may wish to access the procedure. Where the State restricts access to the procedure it is asserting that the State has an interest in continuing to prohibit euthanasia (and the free exercise of personal autonomy in relation to a decision as to when a person might lawfully request or require another person to terminate their life) in all other contexts. See Legal and Social Issues Committee, Legislative Council, Parliament of Victoria, *Inquiry Into End of Life Choices Final Report*, June 2016 [8.4.1]

⁷ This is the argument that the death penalty is irrevocable and that the risk, albeit small, of an innocent person being convicted and executed should never be taken. In this paper where reference is made to "the irrevocable argument" it refers to this argument.

⁸ They are regularly called upon by proponents of euthanasia in support of their position See for example, Juliet Rieden, "Andrew Denton: I watched my father die an agonising death" *Australian Women's Weekly*, 19 April, 2016, <http://www.aww.com.au/latest-news/in-the-mag/andrew-denton-i-watched-my-father-die-an-agonising-death-26670>, Anonymous, "There Has to Be A More Humane Way" in Helga Kuhe (ed), *Willing To Listen Wanting To Die* (Ringwood Penguin, 1994) 43-48, anonymous, "Dying Without Dignity" in Kuhne 49-55, Sue Harper, "Terminal Care In Nursing Homes" in Kuhne 97-114.

I. Some Definitions and a Brief History

A. Definitions

In this paper the term capital punishment is used to refer to state sanctioned executions of human beings.⁹ The term euthanasia is used to refer to what, are in fact, many different things and this is the cause of much confusion.¹⁰ This paper is exclusively concerned with voluntary euthanasia. The term euthanasia will be used in this paper to refer to voluntary euthanasia as defined by the Australian and New Zealand Society of Palliative Medicine:

Euthanasia is the act of intentionally, knowingly and directly causing the death of a patient, at the request of the patient with the intention of relieving intractable suffering. If someone other than the person who dies performs the last act, euthanasia has occurred.¹¹

B. A Brief History of Capital Punishment in Australia

The death penalty arrived in Australia with the first fleet in January 1788.¹² The first execution occurred on 27 February 1788.¹³ Apart from the Australian Capital Territory (ACT), all States and Territories of Australia enforced capital punishment. Executions occurred regularly, with Tasmania and New South Wales carrying out the greatest number. The number of executions declined substantially after Federation.¹⁴ The last executions occurred in Queensland in 1913, New South Wales in 1940, Tasmania in 1946, the Northern Territory in 1952, South Australia and Western Australia in 1964 and Victoria in 1967.¹⁵ Capital punishment was abolished in Queensland in 1922, Tasmania in 1968, the Commonwealth, the ACT and Northern Territory in 1973, Victoria in 1975, South Australia in 1976, Western

⁹ As Potas and Walker note "The term 'capital punishment' is derived from the Latin *caput*, meaning 'head'. It originally referred to death by decapitation, but now applies generally to state sanctioned executions." Ivan Potas and John Walker, 'Trends and Issues in Crime and Criminal Justice No.3 Capital Punishment' (Report, Australian Institute of Criminology, February 1987) 1.

¹⁰ Nargus Ebrahimi, "The ethics of euthanasia," *Australian Medical Student Journal* 3 (2012):73; Rex Adhar, "The Case Against Euthanasia and Assisted Suicide" (forthcoming) *New Zealand Law Review* 3 (2016): 1-3, Michael Douglas, "An absurd inconsistency in law: Nicklinson's case and deciding to die", 21 *Journal of Law & Medicine* 627 (2014) 628-629 . Lorana Bartels and Margaret Otowski, "A right to die? Euthanasia and the law in Australia," 17 *Journal of Law & Medicine* 532 (2010) 532--533 and see also Iain Benson, "Some Aspects of the Euthanasia Debate" (paper presented at the Catholic Educators Conference, Holy Cross Regional High School, Surrey, British Columbia, Canada, February 17, 1995). It is also one of the factors bedeviling the reliability of opinion polls.

¹¹ Australian and New Zealand Society of Palliative Medicine Inc, "Position Statement: The Practice of Euthanasia and Assisted Suicide" (approved 31 Oct 2013 reviewed October 2016) accessible at <http://palliativecarewa.asn.au/site/wp-content/uploads/2014/03/ANZSPM-Position-Statement-on-Euthanasia-and-Assisted-Suicide.pdf>

¹² The practice was known in the early English common law where a mandatory sentence was the punishment for almost any felony offence: Paul Marcus, "Capital Punishment in the United States and beyond," *Melbourne University Law Review* 31 (2007) 837 - 838. At that time the English penal code included over 160 offences for which the punishment was hanging: Victory, *End of The Line Capital Punishment in Australia*, 11.

¹³ Thomas Barrett was the first to be executed in Australia. He was arrested for stealing and he was hanged on the same day: Victory, *End of The Line Capital Punishment in Australia*, 11.

¹⁴ For example, between 1820 and 1967, 1648 prisoners were hanged in Australia, of these 784 were hanged in New South Wales and 501 were hanged in Tasmania. All but 128 of these executions occurred prior to Federation in 1901: Potas and Walker, 'Trends and Issues in Crime and Criminal Justice No.3 Capital Punishment', Table 1, 2.

¹⁵ Victory, *End of The Line Capital Punishment in Australia*, 18, Table 2.2.

Australia in 1984 and New South Wales in 1985.¹⁶ In 2009, the Commonwealth amended its 1973 legislation to extend the abolition of capital punishment to the States to “ensure the death penalty cannot be reintroduced anywhere in Australia.”¹⁷ The history of the abolition of capital punishment in Australia is not a history of the nation’s parliaments responding to opinion polls but to the slow process of parliamentary debates, discussion and analysis of the issues sometimes in the face of contrary public opinion.¹⁸ Given the current state of Federal, State and Territory legislation it is inconceivable that capital punishment could return in Australia.

C. A Brief History of Euthanasia in Australia

Euthanasia was legal in the Northern Territory during the operation of the *Rights of the Terminally Ill Act 1995* (NT) (*NT Act*). The *NT Act* was overridden by the Commonwealth Parliament.¹⁹ Since then there have been many unsuccessful attempts to introduce voluntary euthanasia in various states and territories and to amend the Commonwealth legislation to restore the operation of the Northern Territory legislation.²⁰ The issue remains on the agenda

¹⁶ Victory, *End of The Line Capital Punishment in Australia*, 18 Table 2.2. Note that New South Wales had abolished capital punishment for all crimes other than piracy and treason in 1955.

¹⁷ Explanatory Memorandum, Crimes Legislation Amendment (Torture Prohibition and Death Penalty Abolition) Bill 2009 (Cth) 2. The legislation means that if a State wished to reintroduce capital punishment, after the State parliament had passed the relevant legislation it would then need to pass both houses of the Federal Parliament. The Commonwealth has also signed and ratified the *International Covenant on Civil and Political Rights* and the *Second Optional Protocol to the International Covenant on Civil and Political Rights, Aiming at the Abolition of the Death Penalty* and on 18 December 2007 voted for the *Moratorium on the use of the Death Penalty* in the United Nations: see discussion in Finley “Exporting the Death Penalty? Reconciling International Police Cooperation and the Abolition of the Death Penalty in Australia,” 101-102, 107-111 and in George Williams, “Chances of return to death penalty remain almost nil,” *Sydney Morning Herald*, June 18, 2013 <http://www.smh.com.au/comment/chances-of-return-to-death-penalty-remain-almost-nil-20130617-2oeie.html>.

¹⁸ There was vigorous debate in the parliaments and strong support for retention which extended beyond politicians and the general public. For example, in October 1986, the 30-member council of the Police Federation of Australia voted unanimously to seek to persuade the State and Federal governments to hold a referendum on the reintroduction of capital punishment: Potas and Walker, ‘Trends and Issues in Crime and Criminal Justice No.3 Capital Punishment’, 2. Particularly when especially vicious crimes, or the murders of young children occur, support for the return of capital punishment, to the extent, at least that this can be accurately measured by opinion polls, can be very strong: Victory, *End of The Line Capital Punishment in Australia*, 19. For example, the Australian Public Opinion Poll conducted in January 1985 revealed 70% support for the reintroduction of capital punishment for crimes such as child-murder, rape-murder or gang war murder. In January 1986, 95% of the 48,000 callers to a Sydney television station poll, conducted after a well-publicised and gruesome sex-crime, supported the reintroduction of capital punishment: Potas and Walker, ‘Trends and Issues in Crime and Criminal Justice No.3 Capital Punishment’, 3. Morgan Gallup Polls conducted in 1980 and 1986 showed a 43% support for the reintroduction of the death penalty for murder: Potas and Walker, ‘Trends and Issues in Crime and Criminal Justice No.3 Capital Punishment’, Table 3, 3. A *Sunday Age* poll of 1500 Victorians conducted in 1988, but released in 1990, showed that 44% of those polled supported the return of capital punishment: Victory, *End of The Line Capital Punishment in Australia*, 20, Table 2.3. Australian National Institute for Public Policy polling at the Federal election in 1993 showed 68% support for the return of capital punishment for murder although this declined to 45% at the 2010 Federal election: Williams, “Chances of return to death penalty remain almost nil”.

¹⁹ By amendments to the *Northern Territory (Self-Government) Act 1978* (Cth). The *NT Act* commenced operation on 1 July 1, 1996 and, prior to the passage of the Commonwealth legislation, had survived a challenge to its validity before the Full Bench of the Northern Territory Supreme Court which ruled by 2:1 in favour of validity on July 24, 1996. See discussion in Ged Williams, “Voluntary euthanasia legislation: Practicalities of the Northern Territory’s Rights of the Terminally Ill Act 1995” *Australian Critical Care* 9 (1996): 92 and for a history of the legislation and its operation see Patrick Quirk, “Euthanasia in the Commonwealth of Australia” *Issues in Law & Medicine* 13 (1998): 425.

²⁰ It would be beyond the scope of this paper to list all of the many pieces of draft legislation which have been proposed in the various States and Territories of Australia to legalise euthanasia let alone to attempt any analysis

with support from the Greens, Democrats and the Liberal Democratic Party. Opinion polls have shown support for voluntary euthanasia in Australia growing from slightly below a majority in 1962 (47%) to between 60 and 80%.²¹ Whilst the media, proponents of law reform and politicians can afford public polling on issues much significance, Indermaur argues that one-line public opinion polls are likely to misrepresent and seriously distort the truth and provide an inaccurate measure of public attitudes.²² As a result, he argues that they provide a poor basis for legislating in policy areas such as capital punishment.²³ As noted above, abolition occurred despite strong support for capital punishment. Similarly, since the overruling of the *NT Act*, Australia's parliaments have consistently rejected euthanasia.²⁴

of the contents of those Bills however some examples (to at least demonstrate the number and frequency of such bills) are Restoring Territory Rights (Dying with Dignity) Bill 2016 (Cth), Voluntary Euthanasia Bill, 2016 (SA), Restoring Territory Rights (Assisted Suicide-Legalisation) Bill 2015 (Cth), Voluntary Euthanasia Bill 2015 (SA), Criminal Law Consolidation (Medical Defences-End of Life Arrangements) Amendment Bill, 2011 (SA), Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008 (Cth) and the Medical Treatment (Physician Assisted Dying) Bill 2008 (SA.) According to an adjournment Speech made in the NSW Legislative Council, a cross-party working group is developing a euthanasia bill for debate in NSW. New South Wales, *Parliamentary Debates*, Legislative Council, 12 November 2015, 5801 (Lynda Voltz).

²¹ Williams, "Voluntary euthanasia legislation: Practicalities of the Northern Territory's Rights of the Terminally Ill Act 1995," 92; Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," (June 2008) 3, 37-38. For example, a 2012 Australia Institute poll of 1400 people showed 71% approval to the proposition that a doctor should be allowed to help a person experiencing unbelievable and incurable suffering: Australian Capital Territory, *Parliamentary Debates*, Legislative Assembly, 17 February 2016, 518 (Simon Corbell). A Newspoll conducted in the same year found 82% support among respondents for people whose suffering had become unbearable and where there were no medical interventions available to alleviate their suffering being given the choice to end their life: South Australia, *Parliamentary Debates*, House of Assembly, 11 February 2016, 4229 (S.W. Key).

²² Indermaur, "Changing Attitudes to the Death Penalty: An Australian Perspective," 447-448. He observes that respondents to opinion polls often respond to questions put to them with top of the head" or "expressive" views which may not equate to their considered opinion if given "more time and information: Indermaur, "Changing Attitudes to the Death Penalty: An Australian Perspective," 447 esp. n 7 and n8. See also Iain Benson, "Some Aspects of the Euthanasia Debate" [8].

²³ "The basis of much public opinion is thought to derive from elite opinion and also the political flavour of certain positions. Many will be prepared to look to church leaders for the position to take on social issues, but there is an even more significant psychological process at work that will determine the position on social issues adopted by an individual. This concerns our desire to be part of the mainstream. Studies of public attitude consistently point to the way decisions on which opinion to embrace are shaped by what respondents believe is a 'socially desirable' view. Most people, it seems, want to have an opinion that is in keeping with the majority, particularly in relation to subjects where there is a risk of social isolation from proclaiming an, unfashionable or unpalatable view." Indermaur "Contemporary Attitudes to the Death Penalty: An Australian perspective," 448. If Indermaur's comments, about many Australians looking to church leaders for guidance, was true of the position in Australia in 2006, the author questions whether it would be true today, although this does depend on what is meant by "many". A discussion of the declining influence of religion in Australia is beyond the scope of this paper but see generally Roy Williams, *Post God Nation? How religion fell off the radar in Australia – and what might be done to get it back* (Sydney: ABC Books, 2015), esp. 279-280.

²⁴ Pollard has argued that misunderstandings about the meaning of euthanasia bedevil such polls: Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," (June 2008) 38 [4.21].

II. The Irrevocable Nature of Death

A. Capital Punishment

The irrevocable argument was one of the key arguments for the abolition of the death penalty in Australia and for the 2009 extension of the Commonwealth legislation to the States.²⁵ Sheehan put the argument in this way:

That the death penalty is irrevocable. Though the odds against an innocent person's being convicted of murder and hanged may be very great, the risk should never be taken. The death penalty is irreparable, and an irreparable judgement should never be pronounced except by an infallible tribunal. If an innocent person is hanged no redress is possible. Death admits of no compensation. Further, in executing the person, the mainspring of any movement to reverse the verdict is destroyed.²⁶

The irrevocable argument was powerful, even in an Australian criminal justice system with a well-developed system of law. An accused, in Australia, could expect an independent judiciary, trial by jury, an advocate speaking on their behalf and other processes which seek to protect the rights of accused persons and to provide them with means of appeal in the event of trial error.²⁷ The irrevocable argument does not rely on evidence of the execution of the innocence for its force. Sheehan refers to no such case. He could not do so. Whilst some Parliamentarians referred to cases involving the inadvertent execution of innocent persons overseas capital punishment was not abolished in Australia because there was a consensus that any innocent person had been executed in Australia.²⁸ It was abolished for all – even those who had

²⁵ Indeed, Victory describes the irrevocable argument as “the most powerful argument against capital punishment.”: Victory, *End of The Line Capital Punishment in Australia*, 28. The significance of the irrevocable argument to the passing of the Crimes Legislation Amendment (Torture Prohibition and Death Penalty Abolition) Act 2009 (Cth) is evident from the House of Representatives Crimes Legislation Amendment (Torture Prohibition and Death Penalty Abolition) Bill 2009 (Cth) Second Reading Speeches of 11 February 2010 see Alex Hawke MP (1193) and the Second Reading Speeches of 22 February 2010 see Robert McClelland MP (1357), Melissa Parke MP (1281-1282), Luke Simpkins MP (1284), Rob Oakeshott MP (1291), Tony Zappia MP (1286-1287), Janelle Saffin MP (1292), Shayne Newmann MP (1299), Maria Vamvakinou MP (1333), Mark Dreyfus MP (1341), Jill Hall MP (1348), Laurie Ferguson MP (1354-1355) and the Senate Second Reading Speeches of 11 March 2010 see Sen Gary Humphries (1641).

²⁶ NSW Legislative Assembly, Crimes (Amendment) Bill Second Reading Speech, W.F. Sheehan, 23 March, 1955 (3225). W. F. Sheehan made this argument as Attorney General during the 1955 debates in the New South Wales' parliament which led to the abolition of capital punishment for most crimes, including murder and rape.)

²⁷ Leaving aside the early years of the colonies. The trial and execution of Thomas Barret which, as noted above, both occurred on the same day (27 February 1788) and the inconsistencies in the evidence and late appointment of the defence lawyer (5 days before trial) in the trial of the Tasmanian Aborigines, Bob and Jack, who were the first people publicly hung in Melbourne on 20 January 1842 suggest that the full protections of the criminal justice system were inadequate at these times: see Victory, *End of The Line Capital Punishment in Australia*, 12, 14-15.

²⁸ NSW Legislative Assembly, Crimes (Amendment) Bill Second Reading Speech, Mr Pelly (3258-3260), Victory, *End of The Line Capital Punishment in Australia*, 28. This does not mean that it never, in fact occurred. There have certainly been doubts raised as to the guilt of some of those executed, including Ronald Ryan: Victory, *End of The Line Capital Punishment in Australia*, 28, 42-45 and see Barry Jones, “The decline and fall of the Death Penalty in the English-speaking world” in *The penalty is death*, ed. Barry Jones (Melbourne: Sun Books, 1968) 244-284, 265-270. Jones argues that there was clear evidence of insanity in the case of Ernest Williams, who was executed in NSW in 1943 (Jones, “The decline and fall of the Death Penalty in the English-speaking world,” 256) and that Arnold Sodemann (executed in Victoria in 1936) and Thomas Johnstone (executed in the same State in 1939) appear to have been insane (Jones, “The decline and fall of the Death Penalty in the English-speaking world,” 261). There have also been cases of Australians being wrongly convicted for crimes which once attracted the death penalty. Perhaps the most famous of these was the wrongful

confessed to the most violent of murders or volunteered for capital punishment.²⁹ Even volunteers may be innocent.³⁰ The very small risk that an innocent person may be executed was considered unacceptable.³¹

conviction of Lindy and Michael Chamberlain for the murder of their daughter Azaria: see Victory, *End of The Line Capital Punishment in Australia*, 28. The wrongful conviction of Edward Splatt is another Australian example (see Potas and Walker, 'Trends and Issues in Crime and Criminal Justice No.3 Capital Punishment', 5) as is the case of Frederick Lincoln Mc Dermott who was convicted of murder in 1947 and found, by a Royal Commission, to have been wrongly convicted in January 1952 (Barry Jones, "The decline and fall of the Death Penalty in the English-speaking world," 258). In other countries, in which capital punishment was or is still practised, there are many examples of convicted prisoners being exonerated whilst awaiting execution. For example, in the period 1973-1998 an average of 2.96 prisoners were exonerated in the US and in the years 1998-2003 this rose to an average of 7.6 exonerations per year: Indermaur, "Changing Attitudes to the Death Penalty: An Australian Perspective," 448 esp. fn 10. In other countries executed prisoners have also later been established to have been innocent.

²⁹ At many points during the criminal justice process an accused has the opportunity to make decisions which may impact on the likelihood of execution: for example, an accused can confess, an accused can instruct his or her lawyers not to argue particular defences or an accused, who has been convicted of a crime which may attract the death penalty, may opt for it or instruct their lawyers not to present any evidence in mitigation. See discussion in Adam Thurschwell, "Ethical Exception Capital Punishment in the Figure of Sovereignty" in *States of Violence War, Capital Punishment and Letting Die*, eds. Austin Sarat and Jennifer L. Culbert (New York: Cambridge University Press, 2009) 271-296, 288. Many defendants, on trial for capital offences, decide at some time during the criminal justice process, to waive their right to argue against execution: Thurschwell, "Ethical Exception Capital Punishment in the Figure of Sovereignty," 288-289. Whilst many then change their mind, 11% of prisoners (132 of 1146) executed in the United States between 1976, when the death penalty was reinstated in the United States, and 2009, were volunteers who abandoned their defence and asked to be executed: Thurschwell, "Ethical Exception Capital Punishment in the Figure of Sovereignty," 288-289. Gary Gilmore was the first in this period to opt for execution. In Australia, Adrian Bayley, who raped and murdered ABC employee Jill Meagher, in a Brunswick laneway in 2013, may have similarly volunteered if not for abolition. After admitting his guilt, he said to the police "I hope they bring back the death penalty before I get sentenced. I have no life left. They should bring back the death penalty for people like me." Quoted in Williams, "Chances of return to death penalty remain almost nil".

³⁰ As Thurschwell observes the fact of volunteering is deeply troubling for some: "The fundamental legitimacy of the state, which stands or falls in most people's eyes first and foremost on the manner in which it chooses to go about killing its own citizens, has been placed in the hands of an individual, indeed, one who, has already been convicted of abusing that ultimate power—a murderer." Thurschwell, "Ethical Exception Capital Punishment in the Figure of Sovereignty," 290. Mental illness, depression and prison conditions may all be factors, which prompt an innocent accused to plead guilty or to waive rights which might have prevented execution: Victory, *End of The Line Capital Punishment in Australia*, 7, 8, 28.

³¹ Significantly this argument prevailed despite infamous cases of recidivism. One of the most infamous is the case of the artist Lionel Keith Lawson. Lawson was sentenced to death in May 1954 for tying up and raping a number of models. His sentence was commuted to life and, as he was an ideal prisoner, he was released in 1962. Within weeks of his release he had murdered a school mistress and a student. See discussion in Jones, "The decline and fall of the Death Penalty in the English-speaking world," 258. It is beyond the scope of this paper to consider the impact of the fear of recidivism in the opposite trend in relation to dangerous animals. Whilst the legislation differs in each jurisdiction their provisions include destruction of dangerous dogs in the event of unprovoked attack or failure by an owner to comply with muzzle, notice or fencing requirements: e.g. *Companion Animals Act, 1998* (NSW) Pt 5, Div. 3, 4; *Animal Management (Cats and Dogs) Act 2008* (Qld) Ch 5 Pt 4; *Dog and Cat Management Act, 1995* (SA) s 51; *Dog Control Act 2000* (Tas) Pt 3, Div 4, 5; *Domestic Animals Act 1994* (Vic) Pt 7A, Divs 2, 6, s 84P; *Dog Act 1976* (WA) Pt 7; *Domestic Animals Act 2000* (ACT) Pt 2, Div 2.7 and see discussion Cao, Sharman and White, *Animal Law in Australia*, 184-186 [6.190]. Contrasts between the treatment of human beings and animals in the context of euthanasia are made by proponents of euthanasia: For example Mr Bob Dent, the first person to die in Australia under the *NT Act*, wrote in his final letter: "If I were to keep a pet animal in the same condition I am in, I would be prosecuted. If you disagree with voluntary euthanasia, then don't use it, but don't deny the right to me to use it." (quoted in The World Federation of Right to Die Societies, "Euthanasia and Assisted Suicide in Australia" accessed October 18, 2016, <http://www.worldrtd.net/euthanasia-and-assisted-suicide-australia>). In an interview with the BBC given on September 17, 2013 physicist Stephen Hawking said: "I think those who have a terminal illness and are in great pain should have the right to choose to end their lives and those that help them should be free from prosecution.

B. Euthanasia

The irrevocable argument, if applied to euthanasia, would suggest that euthanasia should remain prohibited if even a very small risk existed that a person might be euthanised in error or euthanised in circumstances beyond the criteria which the state specifies as those permissible for access to the procedure. This could occur where those charged with determining that the relevant criteria are satisfied incorrectly conclude that the criteria is satisfied.³² It could also occur if an individual opted for euthanasia when misdiagnosed, inadequately informed about treatment or palliative care options, suffering from untreated pain, lacking the mental capacity to consent, suffering from an untreated illness, particularly a mental illness such as depression or when overborne or pressured by another. It could also occur if patients were euthanised without their consent. Whilst proposals for the legalisation of euthanasia in Australia all include safeguards of some form or other,³³ none involve the rigour of the processes which were applied in capital cases in Australia.³⁴ As noted above, even with this rigour, the irrevocable argument was a major element of the decision of parliaments in Australia to abolish capital punishment.

Whilst there were no definitive instances of innocent prisoners being executed, over the 196 year history of capital punishment in Australia in the brief period in which euthanasia was lawful in the Northern Territory, 2 out of the 7 patients who sought euthanasia were provided with inadequate information of their true medical condition and of their treatment options.³⁵ Unlike the criminal justice system, with its system of judicial appeals, under the *NT Act*, if a doctor found that the patient did not meet the criteria for access to euthanasia, the patient (or his or her advisers) could approach an unlimited number of other doctors until one could be

We don't let animals suffer, so why humans?"(quoted in Strinic, "Arguments in Support and Against Euthanasia," 7). See also Bianca Salter, "Canada's embrace of euthanasia applauded" *Australian Nursing and Midwifery Journal* 22 (2015): 55. For this reason the fact that dangerous animals and dangerous humans are treated so differently under Australian law warrants further consideration.

³² It can be difficult for doctors to determine the expected life span of a patient where that forms part of the criteria as it does in Oregon: Inga Peulich MLC, "End of Life Choices Inquiry: Minority Report" in Legal and Social Issues Committee, Legislative Council, Parliament of Victoria, *Inquiry Into End of Life Choices Final Report*, June 2016 [4.6.3].

³³ Under the *NT Act*, for example, a person could only request assistance from a medical practitioner to end his or her life, if the person was terminally ill, experiencing pain, suffering and distress to an unacceptable level. In that event, the doctor needed to be satisfied, on reasonable grounds, that the illness was terminal and in the normal course would lead to death and that there were no medical procedures which could cure the ailment which were acceptable to the patient. The doctor was required to certify that the person was making the decision voluntarily, freely and after due consideration and that he or she was of sound mind. The doctor's opinion that the illness was terminal and the prognosis of the person then needed to be confirmed by a specialist in the relevant illness. The person was also to obtain information on palliative care from a specialist in that area. The person was also to be seen by a psychiatrist who was required to confirm that the person was not clinically depressed. The *NT Act* also contained a requirement for a 7-day period to pass between initial inquiry and the completion of an informed consent form and a further 48 hours to pass before the person could be euthanised. See the discussion in DW Kissane, A Street and P Nitschke, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia." *The Lancet* 352 (9134) (1998): 1097-1098 and Williams, "Voluntary euthanasia legislation: Practicalities of the Northern Territory's Rights of the Terminally Ill Act 1995," 92-93.

³⁴ In particular, none involve, judicial processes or juries or advocates speaking in favour or against the termination of the life in question. Involving Court processes to protect applicants for euthanasia is very rare internationally. Note however that pending the introduction of the euthanasia legislation in Canada following the decision in *Carter* patients must obtain a Court order to access physician assisted death. See discussion in College of Physicians and Surgeons of Ontario Policy Statement #1-16, 2.

³⁵ Kissane, Street and Nitschke, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia," 1098-1101.

found who would give the required opinion.³⁶ This situation arose during the brief operation of the *NT Act* in Case 4. When there was no consensus that the patient's condition satisfied the *NT Act*'s requirements, among oncologists, the patient made an appeal on national television. An orthopaedic surgeon, who had no expertise in her condition as the *NT Act* required, provided the certification that the patient's condition was terminal and she was euthanised.³⁷ In Kissane's opinion:

The voluntariness of her choice for euthanasia was influenced by her not being informed of the availability of effective treatment for depression nor being given the opportunity to have her suffering alleviated.³⁸

In Case 5, a patient was jaundiced and suffering from a bowel obstruction but was not advised of the palliative care³⁹ and medical treatment available.⁴⁰ In Kissane's view:

Given the level of error rate that does occur in medical practice, this experience [of the operation of the *NT Act*] suggests it would be impossible to safely legislate for doctors to kill.⁴¹

The evidence, of euthanasia occurring in the absence of explicit consent and in the absence of underlying illness, from other jurisdictions,⁴² also supports the irrevocable argument against euthanasia. For example, a 1995 review of euthanasia in the Netherlands found that 0.7% of such deaths had occurred without explicit consent from the patient.⁴³ Pereira has noted that: in the Netherlands in 2005 1 in 5 people euthanised had not given explicit consent and that a Flemish study revealed that 32% of the euthanasia cases studied occurred in the absence of request or consent because the patients were comatose (70%), had dementia (21%), because the physician decided it was "clearly in the patient's best interest" (17%) or because the

³⁶ This feature of patients seeking multiple opinions similarly forms part of the process recommended for Canada by the College of Physicians and Surgeons of Ontario at the various stages of the process – from the first request to the second consulting physician: College of Physicians and Surgeons of Ontario Policy Statement #1-16, 6-7. See also Inga Peulich MLC, "End of Life Choices Inquiry: Minority Report" in Legal and Social Issues Committee, Legislative Council, Parliament of Victoria, *Inquiry Into End of Life Choices Final Report*, June 2016 [4.6.4].

³⁷ Kissane, Street and Nitschke, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia," 1100 - 1101; David W. Kissane, "Case Presentation: A Case of Euthanasia, The Northern Territory, Australia," *Journal of Pain and Symptom Management* 19 (2000): 472.

³⁸ David W. Kissane, "The Challenge of Informed Consent," *Journal of Pain and Symptom Management* 19 (2000): 473.

³⁹ Palliative care is "care that provides coordinated nursing, medical and other allied services for people with a terminal illness." Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008" (Report, Standing Committee on Legal and Constitutional Affairs, June 2008) 42 fn 55.

⁴⁰ Kissane, Street and Nitschke, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia," 1100. Although this was required by s7(1)(e) of the *NT Act*.

⁴¹ Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," 82.

⁴² In Switzerland, a recent study found that approximately 16% of those helped to die, by Dignitas and other organisations that provide such assistance, had no underlying illness: Nicole Steck et al. "Suicide assisted by right-to-die associations: a population based cohort study," *International Journal of Epidemiology* 43 (2014): 1–9.

⁴³ Kissane, Street and Nitschke, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia," 1101; Pereira, "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls," esp. 39.

physician has determined that discussing it with the patient would be harmful to the patient (8%).⁴⁴

Psychiatric illnesses and depression raise issues about a patient's mental capacity to provide informed consent.⁴⁵ These conditions also raise issues about access and adequacy of treatment as most patients respond to treatment.⁴⁶ Studies have established the association between depression and a wish to die and that treatment often sees that wish disappear.⁴⁷ Of the 7 patients, who sought to access euthanasia under the *NT Act*, 4 showed symptoms of depression.⁴⁸ Many studies confirm the prevalence of depression among those seeking euthanasia or PAS.⁴⁹ An Oregon study of 58 patients, who had requested assistance in dying, found that 3 of the 18, who were approved to be assisted to die, were suffering from undiagnosed but treatable clinical depression at the time they were assessed as being suitable

⁴⁴ Pereira, "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls," esp. 39. Some Dutch doctors do not recognise the right of a patient who has opted for euthanasia to change their mind: see Celeste McGovern, "Belgium's Euthanasia Slippery Slope: Now It's For Grief," *National Catholic Register*, February 10, 2016, <http://www.ncregister.com/daily-news/euthanasia-doctor-in-belgium-i-dont-have-to-justify-myself-to-anyone-i-deci/>.

⁴⁵ Levene and Parker argue that: "Depression is a concern in requests for euthanasia/PAS because it is potentially reversible and may affect the patient's competency, particularly in the relative weighting they give to positive and negative aspects of their situation and possible outcomes. Depressed patients can be viewed as a vulnerable population in this context as their request for death may be part of their illness, with the correct response being treatment rather than assistance in dying." Michael Levene and Ilana Parker, "Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: a systematic review," *Journal of Medical Ethics* 37 (2011): 205. Emmanuel et al observe that: "psychological distress including depression and hopelessness, are significantly associated with patients' interest in hastening their own death through euthanasia and/or PAS." Emmanuel et al., "Depression, euthanasia and improving end-of-life care" *Journal of Clinical Oncology* 23 (2005): 6456; Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," 84. See also Iain Benson, "Some Aspects of the Euthanasia Debate" (paper presented at the Catholic Educators Conference, Surrey, British Columbia, February 17, 1995) [5]-[6] esp. fn 34.

⁴⁶ RANZCP New Zealand National Committee, "Submission to Health Committee investigation into ending one's life in New Zealand," 2, 3. This is a particular concern because many current and proposed euthanasia regimes permit access to patients whose sole illness is a psychiatric one. For example, California's 2015 *End of Life Option Act*. Similarly, the criteria to be applied in the Canadian regime, which the *Carter* decision requires be in place by June 6, 2016, does not limit its operation to physical ailments. It requires that the candidate be a consenting, competent adult with "a grievous and irremediable medical condition (including an illness, disease or disability)" that the applicant "[e]xperience enduring suffering that is intolerable to the individual in the circumstances of his or her condition." See discussion in College of Physicians and Surgeons of Ontario, Policy Statement #1-16 "Interim Guidance on Physician-Assisted Death" 3-4 see also Inga Peulich MLC, "End of Life Choices Inquiry: Minority Report" in Legal and Social Issues Committee, Legislative Council, Parliament of Victoria, *Inquiry Into End of Life Choices Final Report*, June 2016 [4.8]

⁴⁷ Kissane, Street and Nitschke, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia," 1101 and fns 11 to 16; Linda Ganzini, Elizabeth R Goy and Steven K Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey," *British Medical Journal* 337 (2001): 1682; Ilana Levene and Michael Parker, "Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: a systematic review," 205-211, 205, 209 and *Washington v Glucksberg* 521 U.S. (1997) 730-731.

⁴⁸ Kissane, Street and Nitschke, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia," 1101.

⁴⁹ Studies in the US and Canada found 50-55% of those seeking euthanasia/PAS were suffering from "severe depression or depressed mood" or diagnosed depression: In studies conducted in the Netherlands "severe depression" was identified in 4-47% of people requesting euthanasia/PAS, 2-10% of those whose request for euthanasia/PAS was granted were classified as depressed and 5-25% of people granted euthanasia described depression as a motivating factor in their request. A Swedish study also found a high level of apparent depression in granted PAS requests: Levene and Parker, "Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: a systematic review," 206-208.

candidates for doctors' assistance to die.⁵⁰ There are risks of a lack of diagnosis particularly as, non-psychiatrically trained doctors, fail to recognise up to 50% of cases of major depression in the ill.⁵¹ There are also risks of a lack of treatment.⁵² For example, in Oregon, none of the people who died by lethal ingestion in 2007, had been evaluated by a psychologist or psychiatrist.⁵³ Part of the risk here appears to be a lack of training of physicians in the recognition of mental illness and a lack of appreciation of this fact.⁵⁴ For example, in 2005 Dr Nitschke observed, in relation to identifying depression in candidates for euthanasia that "common sense is a good enough indicator. It's not that hard to work out whether you are dealing with a person who is able to make rational decisions or not."⁵⁵ Delirium, dementia, addiction and traumatic brain injury make it difficult to diagnose competence and doctors who are not-trained psychiatrically may fail to recognise such conditions in patients who are otherwise medically ill.⁵⁶ The reality is that diagnosing major depression in gravely ill patients is extremely difficult.⁵⁷

Even where euthanasia legislation mandates a psychiatric assessment⁵⁸ depressed patients remain at risk. There are doubts about the ability of psychiatrists to act as gatekeepers to protect those afflicted by depression and other forms of mental illness, whilst assessing the capacity of a candidate for euthanasia. This is outside a psychiatrist's traditional role which involves a true doctor/patient dialogue as part of a properly multidisciplinary team aimed at assessing and providing appropriate care to a patient. Part of the problem is that depressed patients who have determined to seek euthanasia and see any mandated psychiatric assessment as an impediment to obtaining that outcome, are unlikely to disclose their full histories to a psychiatrist. For example, during the operation of the *NT Act* one candidate, who was alienated

⁵⁰ Ganzini, Goy and Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey," 1682. Oregon's *Death With Dignity Act* only requires a patient to be referred to a psychologist or psychiatrist if a concern exists that the patient's judgment may be impaired by a psychiatric disorder including depression.

⁵¹ Christopher J. Ryan, "Depression, decisions and the desire to die," *Medical Journal of Australia* 165 (1996): 411; see also Ganzini, Goy and Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey," 1682.

⁵² For example, a candidate for euthanasia under the *NT Act* was being treated for depression but consideration was not given to changing the dosage or form of medication or to psychotherapeutic management: Kissane, Street and Nitschke, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia," 1101.

⁵³ Ganzini, Goy and Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey," 1682.

⁵⁴ Ganzini, Goy and Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey," 1682.

⁵⁵ Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," 84. Ganzini, Goy and Dobscha found that family members, physicians and hospice professionals of patients who sought to access physician assisted suicide in Oregon did not believe that depression influenced choices to seek to access the legislation: Ganzini, Goy and Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey," 1682.

⁵⁶ RANZCP New Zealand National Committee, "Submission to Health Committee investigation into ending one's life in New Zealand" (Submission, RANZCP New Zealand National Committee, 1 February 2016) 2.

⁵⁷ C Ryan, "Depression, decisions and the desire to die," *Medical Journal of Australia* 165 (1996): 411; see also Ganzini, Goy and Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey," 1682.

⁵⁸ With the aim of protecting those suffering from clinical depression or other forms of mental illness, as the *NT Act* sought to do.

from one child and had endured the death of another, withheld that relevant information from the psychiatrist charged with her assessment. She was subsequently euthanised.⁵⁹

People in pain want that pain to stop. Death can seem desirable when in pain.⁶⁰ In a small percentage of cases suffering and pain cannot be relieved by even high quality palliative care⁶¹ but many euthanasia candidates change their mind when provided with pain relief and palliative care.⁶² For example, an Oregon study found that nearly half of those requesting PAS changed their mind when they were treated for pain or depression or referred to a hospice.⁶³ Adequate training of physicians in pain management and access to such services remain issues in Australia.⁶⁴ A failure to appropriately control a patient's pain or to provide access to palliative care can result in requests for euthanasia which cannot properly be termed voluntary.⁶⁵ The experience of the American, Sidney Cohen is illustrative. After being diagnosed with cancer, Mr Cohen was bed-ridden, suffering agonizing pain and had been given a prognosis of three months to live. Whilst in this situation, Mr Cohen asked for euthanasia. As euthanasia was illegal, rather than being euthanised, he was placed into hospice home care. Eight months later Mr Cohen was enjoying a full life and opposed to euthanasia.⁶⁶ Mr Cohen's experience is not unique. In her book *Death Talk*, Margaret Somerville tells the story of her own father's death. She describes being telephoned from Australia and told that her father was in his final days. On arrival she found him in great pain and incoherent. He told her that he wanted to live as long as he could but not with such terrible pain. She insisted on his being seen by a pain specialist. Following a change to his pain relief his lucidity returned and he lived almost pain free for a further nine months.⁶⁷

Whilst some might argue that the irrevocable argument against euthanasia could be overcome in Australia through legislation with better safeguards and monitoring compliance, this defies the experience in the Northern Territory and other jurisdictions where euthanasia is lawful. If the safeguards provided in Australia's criminal justice were not sufficient to overcome the irrevocable argument against capital punishment it is very difficult to conceive of a euthanasia regime which could ensure that there was no risk of error.

⁵⁹ Kissane, Street and Nitschke, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia," 1101; Kissane, "The Challenge of Informed Consent," 473.

⁶⁰ Somerville, *Bird on an Ethics Wire*, 138.

⁶¹ Hal Swerissen and Stephen Duckett, "Dying Well" (Report No 2014-10, Grattan Institute, 2014) 2, 15. See discussion in Adhar, "The Case Against Euthanasia and Assisted Suicide," 31-33

⁶² Somerville, *Bird on an Ethics Wire*, 128.

⁶³ Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," 44.

⁶⁴ Margaret Somerville, Dr Brian Pollard and others have noted that pain control has been available to deal with pain across a wide spectrum of diseases for decades but that most doctors are poorly educated in the area. Swerissen and Duckett identify deficiencies with the availability of palliative care in Australia: Swerissen and Duckett, "Dying Well," esp. 17-19.

⁶⁵ Somerville and others argue that those in pain have a "fundamental human right" to reasonable access to pain management: Somerville, *Bird on an Ethics Wire*, 235-240.

⁶⁶ Visnja Strinic, "Arguments in Support and Against Euthanasia," *British Journal of Medicine and Medical Research* 9 (2015): 4.

⁶⁷ Margaret Somerville, *The Ethical Canary: science, society and the human spirit*, (Ringwood: Penguin, 2000), 138-139.

III. Risks to Minority and Vulnerable Groups

A. Capital Punishment

One of the arguments for the abolition of capital punishment is that it is disproportionately enforced against vulnerable groups such as those suffering from mental illness, the less educated, racial minorities and members of lower socio-economic groups.⁶⁸

B. Euthanasia

Euthanasia appears to similarly impact disproportionately on the vulnerable, those suffering from mental illness, the elderly, the poor and indigenous Australians. Such people may feel they are a burden to their families or to society as a whole⁶⁹ and there is evidence that vulnerable groups are more likely to be euthanised.⁷⁰ Kissane concluded that "the gatekeeper roles designed by [the *NT Act*] failed to protect depressed, isolated and demoralized patients."⁷¹ He noted that of the 7 people who sought to be euthanised, under the *NT Act*, 3 were socially isolated and 4 had displayed symptoms of depression.⁷² However the impact of euthanasia on the vulnerable is not measured simply by numerical analysis. As euthanasia deaths represent a small number of total deaths, in those places where it has been introduced,⁷³ it is the potential for euthanasia to discourage the vulnerable from seeking needed medical attention and any

⁶⁸ House of Representatives Crimes Legislation Amendment (Torture Prohibition and Death Penalty Abolition) Bill 2009 (Cth) Second Reading Speeches of 11 February 2010 see Laurie Ferguson MP (1355) and of 22 February 2010 see Melissa Parke MP (1281) and Maria Vanakinou MP (1333), Victory, *End of The Line Capital Punishment in Australia*, 24-28, 52; Paul Litton, "Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of Their Relationship," *Journal of Law, Medicine & Ethics* 1 (2013): 333, 346. See also Marcus, "Capital Punishment in the United States and beyond," 858-861. As Victory has put it: "When the ability to obtain good legal representation becomes one of the most important factors in determining the outcome of a trial, questions of race, class and poverty can have a considerable effect on administration of justice." Victory, *End of The Line Capital Punishment in Australia*, 32.

⁶⁹ Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," 57-58, Jeremy Prichard, "Euthanasia: A reply to Bartels and Otlowski" *Journal of Law and Medicine*, 610 (2012) 616-617, 620-621.

⁷⁰ RANZCP New Zealand National Committee, "Submission to Health Committee investigation into ending one's life in New Zealand" (Submission, RANZCP New Zealand National Committee, 1 February 2016) 4. This Submission notes that the highest suicide rate in New Zealand is of men aged 85 or above. An Oklahoma programme which operated between 1977 and 1982 made use of a "quality of life" formula in assessing which babies born with spina bifida should be allowed to live. Poorer children were given a more negative outlook than wealthier children. 24 babies died: Diane Coleman, "Not Dead Yet" in *The Case Against Assisted Suicide: For the Right to End-of-Life Care* eds. Kathleen Foley and Herbert Hendin (Baltimore: John Hopkins University Press, 2002), 229. A 2007 report which looked at evidence from the experience of PAS in Oregon and euthanasia and PAS in the Netherlands concluded from what the report identified as robust data that there was evidence of people with AIDS dying at a disproportionate rate from euthanasia but found that this was not true of the elderly, women or the uninsured. As the report observed it did not consider the impact of access to euthanasia or PAS to minority or vulnerable groups. The analysis was also limited to a consideration of the proportion of those euthanised from particular identified groups rather than a consideration of the broader risks to the vulnerable: Margaret P Battin et al., "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in 'vulnerable' groups," *Journal of Medical Ethics* 33 (2007): 591-597. See also Jeremy Prichard, "Euthanasia: A reply to Bartels and Otlowski" *Journal of Law and Medicine*, 610 (2012) 619-621.

⁷¹ Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," 82.

⁷² Kissane, Street and Nitschke, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia," 1098, 1100.

⁷³ From around 0.2% of all deaths in Oregon, Washington and Vermont to 3% in the Netherlands: Hal Swerissen and Stephen Duckett, "Dying Well," 15.

dampening of palliative care resourcing which may impact the vulnerable in greater numbers.⁷⁴ Many indigenous organisations have expressed concerns about the impact of euthanasia on Aboriginal health.⁷⁵ There is anecdotal evidence to support these concerns which describe indigenous patients leaving hospitals and refusing immunisations during the operation of the *NT Act* out of fear of euthanasia.⁷⁶

IV. Pain and Suffering

The pain and suffering endured in capital punishment was an argument employed in the debates for the extension of the Commonwealth prohibition laws across Australia.⁷⁷ Whilst all executions in Australia took the form of hanging, this argument continues to be made against capital punishment in jurisdictions which have introduced lethal injection as a more humane form of execution.⁷⁸ Given that euthanasia is also effected by injecting drugs, to bring about a person's death, the paper now considers the evidence of complications occurring in the context of capital punishment and euthanasia.

A. Capital Punishment

The execution protocol used in many jurisdictions in the United States involves injection by a continuous intravenous line: a barbiturate (sodium thiopental or pentobarbital) to cause a loss of consciousness, a muscle relaxant (pancuronium bromide) to stop breathing followed by potassium chloride to cause cardiac arrest.⁷⁹ Each of the drugs used in this

⁷⁴ Strinic, "Arguments in Support and Against Euthanasia," 5, 8.

⁷⁵ Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," 35. Indigenous concerns about the *NT Act* were also aroused by its contradiction of indigenous cultural law and this concern was expressed in a "Letter Strick" delivered to the Commonwealth Parliament by the Yolnu Nation/States within East Arnhem land: Quirk, "Euthanasia in the Commonwealth of Australia," 425, fn 22.

⁷⁶ Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," 58. Note however that a report prepared in 1997 indicated that there was no evidence from patient travel data or hospital separations to confirm that the *NT Act* affected the willingness of indigenous Australians to attend hospitals for treatment: Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," 59.

⁷⁷ House of Representatives Crimes Legislation Amendment (Torture Prohibition and Death Penalty Abolition) Bill 2009 (Cth) Second Reading Speeches of 22 February 2010 see Melissa Parke MP (1281),

⁷⁸ Teresa A Zimmers et al., "Lethal Injection for Execution: Chemical Asphyxiation?" *PLoS Medicine* 4 (2007): 646 - 653. Between 1976 and October 2014, 1389 executions took place in the United States with 1212 (87.3%) of those by lethal injection: "The Death Penalty US Executions Since 1976" The Clark County Prosecuting Attorney, <http://www.clarkprosecutor.org/html/death/usexecute.htm>.

⁷⁹ Amnesty International has described the process in this way: "Execution by lethal injection involves the continuous intravenous injection of a lethal quantity of a short-acting barbiturate in combination with a chemical paralytic agent. In Texas, USA, three drugs are used together...the first of these is a barbiturate which makes the prisoner unconscious, the second is a muscle relaxant which paralyses the diaphragm, and thus arrests the motion of the lungs, and the third causes cardiac arrest." Amnesty International, *When the State Kills: The death penalty v human rights*, 58. Litton describes a typical lethal injection protocol in this way: "The execution team inserts a primary intravenous line, either as a peripheral (arms, legs, hands or feet) or central (neck, chest or groin) venous line, and then, if possible, an additional peripheral line. Saline solution is then sent through the lines to confirm proper functioning. If the department director approves, a barbiturate – either sodium thiopental or pentobarbital – is injected through the lines, followed by more saline solution. After at least three minutes from the start of the barbiturate injection and after the team confirms the inmate is unconscious, a team member injects pancuronium bromide, a paralytic agent, followed again by saline solution. Finally, a team member injects potassium chloride to stop the inmate's heart. If the electrocardiograph, attached to the prisoner's chest detects electrical activity after five minutes, additional potassium chloride is sent through the prisoner." Litton,

protocol, in sufficiently high dosages, can cause death and executions using these drugs invariably succeed.⁸⁰ However, as thiopental has no analgesic effect, unless sufficient analgesics are given, there is a risk of a prisoner waking paralysed by the pancuronium, unable to breathe and dying slowly conscious and in pain feeling potassium-induced burning.⁸¹ Pentobarbital shares many of the problems of thiopental.⁸²

Capital punishment by lethal injection and euthanasia, depend on the abilities of the person inserting the needle and in calculating the type and correct quantity of drugs to be used. The fact that both prisoners and the terminally ill may be long-term drug users and may have developed toxicity tolerance as a result is one of the variables that can result in complications. As data is not recorded, it is not possible to provide statistics on the percentage of executions by lethal injection in which complications have occurred.⁸³ As challenges to capital punishment are brought to courts in the United States, including Constitutional challenges which are heard in the United States Supreme Court, and there is public interest and proponents for and against abolition in the United States, there is significant media attention on executions. The press often attends. As a result there is considerable knowledge of the complications which have occurred in such executions. These have included death taking up to 17 minutes, delays of 45 minutes whilst twenty-three attempts were taken to insert an intravenous catheter, an instance of the tube attached to the needle being found to be leaking, a prisoner experiencing "sudden and extreme" convulsive movements 3-4 minutes into the execution and another whose chest and abdomen convulsed in more than 30 heaving movements before death.⁸⁴ Some explanation for these complications may lie in the drugs or protocols used, a lack of knowledge by those involved in administering the lethal injection and the absence of adequately trained physicians.⁸⁵ Some specific examples of the complications which have arisen

"Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of Their Relationship," 333 - 335.

⁸⁰ Zimmers et al., "Lethal Injection for Execution: Chemical Asphyxiation?" 647.

⁸¹ This could occur if an insufficient dosage of thiopental sodium is given before the paralytic agent is administered or if, when injected, as is not uncommon in clinical practice, the thiopental sodium were to infiltrate the surrounding tissue: Truog and Brennan, "Participation of Physicians in Capital Punishment," 1347; Litton, "Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of Their Relationship," 333, 335; Zimmers et al., "Lethal Injection for Execution: Chemical Asphyxiation?" 647, 650; Nathaniel A.W. Crider, "What You Don't Know Will Kill You: A First Amendment Challenge To Lethal Injection Secrecy," *Columbia Journal of Law and Social Problems* 48 (2014): 1, 8-9 and *Baze v Rees* 553 U.S. 35 (2008), 53.

⁸² Crider, "What You Don't Know Will Kill You: A First Amendment Challenge to Lethal Injection Secrecy," 10-11.

⁸³ Zimmers et al., "Lethal Injection for Execution: Chemical Asphyxiation?" 647.

⁸⁴ Crider, "What You Don't Know Will Kill You: A First Amendment Challenge To Lethal Injection Secrecy," 11-13; Zimmers et al., "Lethal Injection for Execution: Chemical Asphyxiation?" 648; Robert D Truog and Troyen A Brennan, "Participation of Physicians in Capital Punishment," *The New England Journal of Medicine* 329 (1993): 1346, 1347; Victory, *End of The Line Capital Punishment in Australia*, 5

⁸⁵ Zimmers, et al., "Lethal Injection for Execution: Chemical Asphyxiation?" 647. For example, executioners in most executions by lethal injection have not received anaesthesia training. Some of these problems may have been caused or contributed to by the fact that executions by lethal injection are not always supervised by doctors. For, example no doctor was present at the execution of John Autry: Truog and Brennan, "Participation of Physicians in Capital Punishment," 1347. Whilst most medical societies proscribe participation in capital punishment by their members, doctors and other medical personnel nevertheless do so: Litton, "Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of Their Relationship," 336. Concerns about the process of dying by lethal injection have lead one prisoner awaiting execution in Florida to request that his execution occur by way of electric chair. A number of states in America now use barbiturate overdoses to execute prisoners with the aim of eliminating the risks of suffocation and painful death posed by the typical lethal injection protocol described above: Mark Berman, "Death row inmate in Florida asks to be executed by electric chair rather than lethal injection in state first," *The Independent*,

are Ricky Ray Rector and John Autry. Rector was executed in Arkansas in January 1992 after person staff, supervised by a former military medic, took 45 minutes to insert an intravenous catheter by surgical cut down and percutaneously. John Autry who was executed in Texas in March 1984 was conscious, in pain and moving about for about 10 minutes before dying. According to the doctor, who pronounced Autry dead, diluted drugs or clogging of the intravenous tubing were the probable reasons.⁸⁶

B. Euthanasia

There is an assumption made, by many proponents of euthanasia that the process of euthanasia will involve patients painlessly drifting off into a never ending sleep. This is at the very heart of the “good death” some proponents seek.⁸⁷ As capital punishment and euthanasia both involve injecting drugs to cause death, it is not self-evident that euthanasia would or could be free from the complications which bedevil capital punishment by lethal injection. Unlike capital punishment, euthanasia does not normally occur in the presence of journalists or opponents of the process. Doctors and family members, who are involved in the decision making process of the person who has accessed euthanasia, are likely to support that decision. They are not likely to come forward to identify problems with the procedures. Nevertheless, such evidence as there is suggests that complications are common.⁸⁸ A 2000 study of 535 cases of euthanasia in The Netherlands found that technical problems (such as difficulties in finding a vein to inject the lethal injection, problems with the intravenous catheter or difficulties administering an oral drug) occurred in 4.5% (24) of cases, complications (such as spasm or sudden, involuntary jerking of muscles (myoclonus), skin turning blue (cyanosis), nausea or vomiting, hiccups, perspiration and extreme gasping) occurred in 3.7% (20) of the cases and problems with completion (where the time of death took longer than expected or the patient did not become comatose or after becoming comatose awoke) occurred in 5.2% to 10% (28-51) of the cases. This study relied on data obtained in two studies of euthanasia in The Netherlands conducted in 1990 and 1991 and in 1995 and 1999. In one case, a patient who had been administered drugs intended to result in coma sat upright. In cases where the death took longer than had been anticipated by the physician, death took between 5 minutes and 7 days with 3 hours being the median time it took for the patient to die.⁸⁹ In a Flanders study, in 5 out of the 11 cases, where information of the time between last drug dosage and death was available, 5 patients took more than 3 hours to die. The Flanders study found that the drugs given with the intention to cause euthanasia probably had no such effect in 3 of the 16 cases, in which there was sufficient information to form a view on whether the drugs given were effective to euthanise the patient. The same study observed that the terminal phase of dying may be lengthened rather than shortened by administering increasing doses of opioids and that

October 25, <http://www.independent.co.uk/news/world/americas/death-row-inmate-in-florida-asks-to-be-executed-by-electric-chair-rather-than-lethal-injection-in-a6707341.html>.

⁸⁶ Truong and Brennan, “Participation of Physicians in Capital Punishment,” 1347.

⁸⁷ Or avoiding dying a “bad death” including death by suicide: see Legal and Social Issues Committee, Legislative Council, Parliament of Victoria, *Inquiry Into End of Life Choices Final Report*, June 2016 [7.1.2]-[7.1.3],[A7.4.3].

⁸⁸ Two 1992 studies from the Netherlands, found that doctors working in nursing homes and general practitioners reported complications in 12% of euthanasia cases; Johanna H Greonewoud et al., “Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in The Netherlands,” *The New England Journal of Medicine* 342 (2000): 551, 555-556 n 14, 15. See also Inga Peulich MLC, “End of Life Choices Inquiry: Minority Report” in Legal and Social Issues Committee, Legislative Council, Parliament of Victoria, *Inquiry Into End of Life Choices Final Report*, June 2016 [4.6.8].

⁸⁹ Greonewoud, et al., “Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in The Netherlands,” 555 Tables 4 and 5; R.H. Vander Stichele et al., “Drugs used for euthanasia in Flanders, Belgium,” *Pharmacoepidemiology and Drug Safety* 13 (2004): 89, 91, 93.

there is a widespread but incorrect belief among doctors and their patients of the lethal effects of even small doses of morphine.⁹⁰ As one study observed "[s]uch cases may have been painful experiences for patients, families and physicians."⁹¹

Occasionally relatives do speak of their adverse experiences of the procedure. One such case is the death of Tine Nys, who was euthanised by lethal injection in Belgium on April 24, 2010 at 38 years of age, which is described below:

The day of her death was immensely distressing for the family. The doctor was so incompetent that he failed to bring bandages to hold fast the needle for the lethal injection. Instead, he asked Tine's father to hold it on her arm. There was no place to hang the infusion bag with the toxic drug so the doctor placed it on the arm of Tine's armchair. To the dismay of her grieving family, it plopped onto her face as she died. Then the doctor asked her parents to use his stethoscope to see that she was well and truly dead.⁹²

Some explanation for the complications experienced in euthanasia may lie in the drugs or protocols used, a lack of knowledge by those involved in euthanizing patients and the absence of adequately trained or caring physicians. Each of these factors warrant consideration. The suggested drug regime for use under the *NT Act* resembled the first two stages of the lethal injection protocol for capital punishment described above. It recommended first administering drugs, such as barbiturates or benzodiazepine in large doses, to induce coma followed by a neuromuscular blocking agent to stop the patient breathing. Significantly, given the adverse experiences discussed above, it also gave doctors latitude to account for the individual patient's needs and idiosyncrasies.⁹³ Dr Nitschke, who euthanised all patients, euthanised under the *NT Act*, preferred euthanasia drug is the barbiturate pentobarbital also known by the brand name Nembutal.⁹⁴ This drug is used for executions by lethal injection in Oklahoma, Arizona and Texas.⁹⁵ Guidelines issued in the Netherlands in 1998 (Dutch Guidelines) also recommend a protocol which resembles the first two stages of the lethal injected protocol referred to above. The Dutch Guidelines recommended the induction of a coma by intravenous administration of sodium thiopental followed by a bolus [a concentrated mass] of pancurium hydrochloride or vecuronium hydrochloride to stop breathing.⁹⁶ A 2000 study showed that this sequence was the most commonly used in the Netherlands. In some cases, potassium chloride was also used. As noted above this is the third drug introduced in the lethal injection protocol. However, these

⁹⁰ Vander Stichele et al., "Drugs used for euthanasia in Flanders, Belgium," 89, 91, 93.

⁹¹ Vander Stichele et al., "Drugs used for euthanasia in Flanders, Belgium," 91.

⁹² Michael Cook, "A peek behind Belgium's euthanasia curtain," *Careful*, February 8, 2016, www.mercatornet.com/careful/view/a-peek-behind-belgiums-euthanasia-curtain/17572.

⁹³ Williams, "Voluntary euthanasia legislation: Practicalities of the Northern Territory's Rights of the Terminally Ill Act 1995," 95. This situation may be replicated in Canada if the recommendation of the College of Physicians and Surgeons of Ontario that "[p]hysicians must exercise their professional judgment in determining the appropriate drug protocol to follow to achieve physician-assisted death" is adopted: see College of Physicians and Surgeons of Ontario, Policy Statement #1-16 "Interim Guidance on Physician-Assisted Death" 7.

⁹⁴ Greg Kelton, "Nitschke wins right to use euthanasia drug," *The Advertiser*, 26 September, www.news.com.au/national/nitschke-wins-right-to-use-euthanasia-drug/story-e6frfkur-1226146549923. Dr Nitschke used a veterinary version of Nembutal, in the Northern Territory prior to the passing of the *NT Act*: Kelton, "Nitschke wins right to use euthanasia drug: Kelton, "Nitschke wins right to use euthanasia drug."

⁹⁵ Kelton, "Nitschke wins right to use euthanasia drug".

⁹⁶ These protocols were issued in Dutch by the Royal Dutch Society for the Advancement of Pharmacy and the Scientific Institute of Dutch Pharmacists and this paper relies on the description of their content contained in Vander Stichele et al., "Drugs used for euthanasia in Flanders, Belgium," 90.

protocols are not always followed and practitioner flexibility and discretion is a common feature of euthanasia design notwithstanding the fact that most doctors who administer euthanasia are not trained anaesthetists. As a result, a wide range of drugs are used to administer euthanasia. In the 2000 study opioids, insulin and other drugs and drug combinations were used in 17% of the cases studied.⁹⁷ A study published in 2003 of the drugs used in 22 cases of euthanasia in Flanders showed that a wide range of drugs, doses and methods of delivery used alone or in combination to euthanise patients including morphine, opioids, insulin, pentothal, mivacurium, potassium chloride, lidocaine, pentazocine and lorazepam.⁹⁸

As noted above executions by lethal injection are not always carried out by doctors. The same is true of euthanasia. Although all lethal injections given under the *NT Act* were given by Dr Nitschke, doctors do not always administer euthanasia overseas despite legislative requirements for them to do so. For example, one study found that a doctor was not continuously present, from the time of administration of the lethal drugs until death, in 28% of cases and that in 2% the doctor was not present at all with the procedure being conducted by a nurse or colleague. It also found that a nurse, rather than a doctor, administered the lethal drugs in 4% of the cases and that someone other than a doctor or nurse, usually a family member, administered those drugs in 1% of the cases.⁹⁹ The presence or absence of a doctor appears to be no guarantee of a quick and painless death. A Flanders study observes that the odds of an individual doctor (particularly a GP) being involved in an act of euthanasia, in those jurisdictions where it is lawful, are very low.¹⁰⁰ Studies also show that many doctors are not well informed about using lethal drugs and that the drugs recommended for the purpose of euthanasia are not always used.¹⁰¹ Given that a similar protocol and drugs may be used for capital punishment and euthanasia and doctors experienced in administering lethal injections may not carry out either procedure a similar rate of complications might be expected in each procedure. Complications in administering capital punishment by lethal injection are unacceptable. It must however be remembered that the purpose of capital punishment is primarily the death of the convicted criminal. One of the *raison d'être*s of euthanasia is different. It is securing a "good death." This means that complications in administering euthanasia are not only unacceptable; where this is the procedure's objective, they undermine its foundational purpose. Forty years of capital punishment by lethal injection and the international experience of euthanasia by this means suggest that complications may be inevitable and militate against the legalisation of euthanasia in Australia for this reason.

⁹⁷ Greonewoud et al., "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in The Netherlands," 553.

⁹⁸ Vander Stichele et al., "Drugs used for euthanasia in Flanders, Belgium," 91, 93.

⁹⁹ Greonewoud et al., "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in The Netherlands," 553 esp. Table 2. Similarly, the Flanders study found that in seven out of the 322 cases studied a doctor did not administer the drugs and in at last 4 of those cases the doctor was not present when the patient was euthanised: Vander Stichele et al., "Drugs used for euthanasia in Flanders, Belgium," 91. See also Inga Peulich MLC, "End of Life Choices Inquiry: Minority Report" in Legal and Social Issues Committee, Legislative Council, Parliament of Victoria, *Inquiry Into End of Life Choices Final Report*, June 2016 [4.6.5]

¹⁰⁰ Vander Stichele et al., "Drugs used for euthanasia in Flanders, Belgium," 94.

¹⁰¹ Greonewoud et al., "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in The Netherlands," 556. The same was found to be so in Flanders in the study by Vander Stichele et al., "Drugs used for euthanasia in Flanders, Belgium," 93-94.

V. Identifying Persons To Administer

The paper now considers society's role in identifying the persons to carry out euthanasia and capital punishment with State endorsement or permission.

A. Capital Punishment

Historically, executioners were hired specifically to carry out that role. In Australia, as capital punishment was carried out by hanging, executioners needed to have knowledge of medicine and anatomy and other skills. This is because they had to assess the strength of a condemned prisoner's neck muscles, gauge his or her weight, and (taking those factors into account) determine the length and strength of rope required and tie the approved submental knot. This knot was designed to deliver a short sharp blow to the prisoner's neck on the release of the trap. To carry out this role, hangmen were required to regularly visit the cells of the condemned.¹⁰² Those who accepted an appointment as a state executioner, rarely revealed their identity, plied their trade anonymously or were despised.¹⁰³ At least some of those who accepted the role were adversely affected by it.¹⁰⁴ Importantly, hangmen played no part in the State's decision on whether or not to execute a prisoner and were clearly not in any relationship of trust or fiduciary relationship with the prisoner. This remains so in those places where capital punishment is effected by lethal injection although some such executions are carried out by medical professionals. The role of doctors, nurses and pharmacists in the prescription and administering of the necessary drugs poses ethical dilemmas.¹⁰⁵ Doctors are normally in a position of trust and a fiduciary relationship with their patients. Whilst a doctor tasked with administering a lethal injection will, no doubt, not consider a condemned prisoner to be a patient, the nature of the relationship may be quite unclear to the condemned prisoner. As Victory has put it, "[d]octors are trained to preserve and protect life, not destroy it."¹⁰⁶ This understanding of the proper role of doctors has led to the proscription of doctors from participating in capital punishment by every large humanitarian and medical organisation that has considered the issue.¹⁰⁷ Truog and Brennan argue that doctor involvement in capital

¹⁰² Victory, *End of The Line Capital Punishment in Australia*, 13.

¹⁰³ Victory, *End of The Line Capital Punishment in Australia*, 9. Alexander Green, who was the public executioner in Sydney for almost 30 years fell into the latter category: Victory, *End of The Line Capital Punishment in Australia*, 13-14.

¹⁰⁴ For example, Alexander Green was frequently drunk and dirty and went mad: Victory *End of The Line Capital Punishment in Australia*, 13-14. Involvement in the process also affects prison guards, police officers, prosecutors and judges: Amnesty International, *When the State Kills: The death penalty v human rights*, (London: Amnesty International Publications, 1989) 67-70.

¹⁰⁵ Truog and Brennan, "Participation of Physicians in Capital Punishment," 1349; Daniel J. Cobourg, "Opposing pharmacists' participation in capital punishment: The right thing to do" *American Journal of Health-System Pharmacists* 72 (2015): 1355; Litton, "Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of Their Relationship," 333-349 and Amnesty International, *When the State Kills: The death penalty v human rights*, 77-82.

¹⁰⁶ Victory, *End of The Line Capital Punishment in Australia*, 5, see also Litton, "Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of Their Relationship," 333; Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," (June 2008) 51 and Somerville, *Bird on an Ethics Wire*, 37, 151, 162-166.

¹⁰⁷ Including the American Medical Association, World Medical Association, General Assembly, American College of Physicians, American Public Health Association, American Society of Anaesthesiologists, the American College of Physicians and Physicians for Human Rights: see Truog and Brennan, "Participation of Physicians in Capital Punishment," 1349 and Litton, "Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of Their Relationship," 335-336. For example, it underpins the American Medical Association (AMA)'s "Opinion 9.73 - Capital Punishment" which contains the following

punishment is “removed from the legitimate sphere of medicine.”¹⁰⁸ They also argue that it involves “medicalized killing” which is “subversive to the core of medical ethics”¹⁰⁹ and was the “crucial step” in the Nazi prosecution of the “final solution.”¹¹⁰ As Litton explains:

[p]hysician involvement does lend moral support to the practice. This fact explains why death penalty proponents – at last initially – sought physician involvement and increased medicalization of executions. Their aim was to make the public as comfortable as possible with executions. Presumably, physician involvement can strengthen or maintain public support for executions by creating the image of a caring doctor overseeing hospital-type procedure in which an inmate peacefully falls asleep.¹¹¹

Guidry observes the potential negative consequences to public trust arising from the participation of medical practitioners, in capital punishment, giving rise to fear and lack of trust. He argues that:

[t]he more the execution looks like an anaesthetic, the less comfortable patients are likely to be with anaesthesia. Surgery is already a frightening time and one in which patients need to trust their anaesthesiologist. The last thing patients need is to equate the [operating room] with a death chamber, to equate anaesthetic drugs with death drugs, or to have in their subconscious the spectre of the anaesthesiologist as an executioner.¹¹²

B. Euthanasia

These arguments might equally be applied to the participation of medical practitioners in euthanasia. This has led some to argue that only non-doctors should deliver euthanasia.¹¹³ As

proscription of doctor participation in capital punishment: “An individual’s opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution. Physician participation in execution is defined as actions that fall into one or more of the following categories: (1) Would directly cause the death of the condemned; (2) Would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) Could automatically cause an execution to be carried out on a condemned prisoner. “American Medical Association, “Opinion 9.73 Capital Punishment” (adopted in June 2016) <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>

¹⁰⁸ They also argue that doctor involvement in execution is “prostituting medical knowledge and skills to serve the purposes of the state and its criminal justice system” Truog and Brennan, “Participation of Physicians in Capital Punishment,” 1349.

¹⁰⁹ Truog and Brennan, “Participation of Physicians in Capital Punishment,” 1349.

¹¹⁰ Truog and Brennan, “Participation of Physicians in Capital Punishment,” 1349.

¹¹¹ Litton, “Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of Their Relationship,” 344.

¹¹² Orin F Guidry, “Message from the President: Observations Regarding Lethal Injection” *American Society of Anaesthesiologists* (online) June 2006, <http://monitor.pubs.asahq.org/article.aspx?articleid=2489872>.

¹¹³ Strinic, “Arguments in Support and Against Euthanasia,” 6; Somerville, *Bird on an Ethics Wire*, 37, 151 where Somerville argues that a specially trained group of lawyers rather than physicians ought to be tasked with the role of administering euthanasia. These arguments also inform the AMA’s proscription of doctor participation in euthanasia which reads in part that: “Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient’s life. Euthanasia could also

noted above, prevailing fears of the medical profession among some members of the Northern Territory's indigenous population may have been exacerbated by the introduction of the *NT Act*. These concerns and the approach taken, at least in Australia and in the United States, to seeking volunteers to take on the role of executioner would suggest that, if euthanasia were to be legalised, participation by medical practitioners (or others given authority by the State to euthanise) would be voluntary.¹¹⁴ This in itself may create issues of concern, as advocates for euthanasia may be most attracted to take up that role. Indeed, in the brief period of operation of the *NT Act*, the euthanasia campaigner Dr Nitschke administered euthanasia to all of those who accessed the procedure. Some such doctors may consciously or unconsciously have a preference for euthanasia. This may result in an actual or, at least, perceived conflict of interest particularly given the fiduciary relationship of trust that exists between a doctor and patient.¹¹⁵ Quite unlike a hangman or executioner administering a lethal injection, a doctor who administers euthanasia will have a clear doctor-patient fiduciary relationship.¹¹⁶ Such a doctor may well have been involved in assisting the patient to decide on the course of euthanasia and

readily be extended to incompetent patients and other vulnerable populations. Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. "Opinion 2.21 – Euthanasia" American Medical Association, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion221.page> and "Opinion 2.211 - Physician-Assisted Suicide" American Medical Association, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page> are to the same effect. Some medical practitioners nevertheless argue that doctor participation in euthanasia, but not capital punishment, is ethical: Truog and Brennan, "Participation of Physicians in Capital Punishment," 1348.

¹¹⁴ Note though that in Canada a number of recommendations have been made to oblige doctors with a conscientious objection to euthanasia to act against their conscience by referring their patients to a doctor who they know does not share their objection. See e.g. College of Physicians and Surgeons of Ontario, Policy Statement #1-16 "Interim Guidance on Physician-Assisted Death" 4-6 and Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, 'Final Report' (Report, Provincial-Territorial Expert Advisory Group, 30 November 2105), 43-45. This would put Canadian doctors with a conscientious objection to euthanasia in the same position as many doctors with a conscientious objection to abortion in the Australian states of Victoria and New South Wales: see *Abortion Law Reform Act, 2008* (Vic) (the Victorian Act) s 8 and the NSW Government Ministry of Health, "*Policy Directive Pregnancy – Framework for Terminations in New South Wales Public Health Organisations*". http://www.health.nsw.gov.au/policies/pd/2014/pdf/PD2014_022.pdf (the NSW Policy). These require such conscientious objectors to refer (Victorian Act) or direct (NSW Policy) their patients to a doctor who they know does not share their objection. There are many objections to compelling doctors to act against their conscience. A full analysis of those issues is beyond the scope of this paper. For an analysis of these issues in the context of abortion see Michael Quinlan, "The religious freedom implications of the referral and direction obligations of health practitioners in Victoria and New South Wales" (forthcoming) (November 2016) *Brigham Young University Law Review Law and Religion Issue*. In contrast to the position, advocated in the Canadian reports, the RANCP argues that medical practitioners with a conscientious objection to euthanasia should be allowed to abstain from providing services or advice to those seeking the service: RANZCP New Zealand National Committee, "Submission to Health Committee investigation into ending one's life in New Zealand" (Submission, RANZCP New Zealand National Committee, 1 February 2016) 3.

¹¹⁵ Such a perception may be exacerbated by additional involvement by such a doctor in a legislated process of approval of the administering of euthanasia: see Standing Committee on Legal and Constitutional Affairs, "Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008," (June 2008) 83.

¹¹⁶ See College of Physicians and Surgeons of Ontario, Policy Statement #1-16 "Interim Guidance on Physician-Assisted Death" 2 although not all would agree with the particular emphasis this Policy Statement puts on what this relationship means for prioritising patient interests in the context of euthanasia. For example, Litton observes that physicians regularly place personal and family interests ahead of those of their patients without complaint when they set visiting hours, take holidays etc.: see Litton, "Physician Participation in Executions, the Morality of Capital Punishment, and the Practical Implications of Their Relationship," 341. See also Bridget Campion, "The health Care Professional as Person: The Place of conscience," *Bioethics Matters* 14 (2016): 2, 4.

have facilitated the achievement of that objective. For example, during the brief operation of the *NT Act*, Dr Nitschke paid for the fees of one of the psychiatrists who signed off on the availability of euthanasia for one of his patients.¹¹⁷ Like executioners, some medical practitioners can suffer adversely from participating in euthanasia.¹¹⁸

Conclusion

This paper has considered a number of the arguments accepted for the abolition of the death penalty and put by advocates for the legalisation of euthanasia in Australia. It reviewed the history of the abolition of capital punishment and noted that abolition occurred often in spite of the popularity of capital punishment in Australia. It argued that similarly popularity is not a sufficient reason to legislate euthanasia. The paper considered the irrevocable argument, the risks posed to minority and vulnerable groups and the cruelty of capital punishment. Each of these arguments was found to militate against the legalisation of euthanasia. Finally the paper looked at the need for individuals to administer capital punishment and euthanasia and identified the dangers of medicalising either procedure. Taking these factors into account the conclusion that the current position in Australia in which the death penalty and euthanasia are both prohibited is the only logically consistent approach to these issues. Introducing euthanasia without careful consideration of the successful arguments for the abolition of capital punishment and the experience of that procedure in practice would risk repetition of past mistakes. Further examination of the extent to which learnings relevant to the current euthanasia debate can be gained by examining the arguments and experience of capital punishment is necessary.

¹¹⁷ Standing Committee on Legal and Constitutional Affairs, “Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008,” (June 2008) 68.

¹¹⁸ RANZCP New Zealand National Committee, “Submission to Health Committee investigation into ending one’s life in New Zealand” (Submission, RANZCP New Zealand National Committee, 1 February 2016) 2. This would be a particular concern if conscientious objection were not to be respected and medical practitioner participation by prescribing or administering a lethal injections or providing a referral to someone who would be willing to do so. There is growing evidence that requiring health practitioners to act against their conscience can lead to physical and mental symptoms known as ‘moral distress’ and to desensitising of conscience. This particularly affects health practitioners who consistently act against their conscience. These practitioners are left at greater risk of developing indifference to patients and “doubling” or “compartmentalization” which leads to a weakened ability to make the types of ethical decisions critical for health practitioners: Rachael Wong, “Professional Conscientious Objection and Referrals in Medicine” (Aug. 10, 2015) (unpublished LLM dissertation, University of Otago) (on file with author) 24-27, Brigid McKenna, “Conscience and the Healthcare Professional” in *Foundations of Healthcare Ethics* 174, 178 (Jānis T. Ozoliņš & Joanne Grainger eds., 2015), 180-181., Michael Burleigh, *Death and Deliverance* (New York: Cambridge University Press, 1994) 154.