

Finding the Meaning of Euthanasia and Its Safeguards

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ABSTRACT

Some people around the globe may be still debating whether euthanasia should be regulated or forbidden. Some countries, in the other hand, have legislated euthanasia a few years ago. Arguments from allies and opponent have been analysed before the legislators, but the euthanasia legislations differ in several provisions. These differences may generate potential abuses. Thus, a clear definition of euthanasia and proper safeguards for it are hoped eliminating the abuse. The objective of this paper is to obtain the clear meaning of various euthanasia terms and to present the notions of safeguarding for euthanasia legislation related to a vulnerable patient and any medical practitioner who is involved in administering euthanasia.

Key Words: euthanasia

Introduction

Some opponents may believe that euthanasia is wrong. This opinion is normally based on the traditional moral norm that intentionally taking a person's life cannot be justified.¹ The norm forbids killing and encourages maintaining life. Another argument is the religious perspective. The attempt to end a person's life is not a human's autonomy and thus it means challenging God's will.² Moreover, "the slippery slope" argument has been presented against voluntary euthanasia legalisation. This argument believes that there is a good indication to believe that "the legislation of morally permissible act of euthanasia would in fact lead to the performance of morally impermissible act of euthanasia".³ In other words, it means that legalisation of voluntary euthanasia would lead to legalisation of involuntary euthanasia in cases where it is morally unacceptable.

On the other hand, based on the compassionate desire to end unbearable pain under hopeless conditions and to grant a request from patient who is experiencing terminal illness by a doctor to accelerate death in the most humane manner, proponents of euthanasia seek to legalise it. Currently, for example, in Australian, the Western Australian, Tasmanian, and South Australian parliaments have introduced bills related to active voluntary euthanasia. Before these jurisdictions, many others have legalised voluntary euthanasia such as the Netherlands, Belgium, and Oregon. This trend is predicted to continue with guarantees that the legislation contains proper safeguards. Potential abuses will be always appear when euthanasia is legalised.⁴ Therefore, an important issue that could be raised in the legalisation of euthanasia is protecting against abuse by incorporating proper safeguards.⁵

There may not be any legislation that is able to eliminate all kinds of abuse.⁶ Nevertheless, these proper safeguards could

¹ Rachael Patterson and Katrina George, "Euthanasia and assisted suicide: A liberal approach versus the traditional moral view" (2005) 12 (4) *Journal of Law and Medicine* p. 504.

² Craig Paterson, *Assisted suicide and euthanasia: a natural law ethics approach* (Ashgate Publishing Limited, 2008) p. 16.

³ Hallvard Lillehammer, "Voluntary euthanasia and the logical slippery slope argument" (2002) 61 (3) *The Cambridge Law Journal* p. 545.

⁴ Victoria Hiley, 2008, *In Pursuit of a Good Death: Responding to Changing Sensibilities in the Context of the Right to Die Debate*, SJD Thesis, University of Sydney, Sydney, p. 229.

⁵ *Ibid*, p. 228.

⁶ Stephen W. Smith, Some Realism about End of Life: The Current Prohibition and the Euthanasia Underground (2007) 33 (1) *American Journal of Law & Medicine* p. 57.

secure potential patients from the risk of error and abuse of voluntary euthanasia.⁷ Ferguson emphasises that "whether or not one agrees that individuals have a right to die, clearly any rule must have standards to protect those who cannot protect themselves".⁸ Moreover, the constitutional safeguard must be based on humane and painless principles. Also, "euthanasia is a remedy of last resort".⁹

If the discourse of the legalisation of euthanasia is as an attempt to minimise abuses, it is required to be what euthanasia is and what proper safeguards for it. The objective of this paper is to obtain the clear meaning of various euthanasia terms and to present the notions of safeguarding for euthanasia legislation related to a vulnerable patient and any medical practitioner who is involved in administering euthanasia. This paper will initially define the euthanasia terms, particularly the meaning of the sort of euthanasia which is globally used. Next, it will identify and analyse crucial issues which must be provided by a voluntary euthanasia legislation to protect against potential abuses. This paper will focus on two main issues related to the requirements of the patient who may potentially request voluntary euthanasia and the obligation of the medical practitioner in the process of assisting euthanasia.

Definition of Euthanasia

The definition of euthanasia and its facets must be clearly described in order to eliminate the confusions around the debate of the meaning euthanasia. The debate recently includes what euthanasia is and what it is not.¹⁰ There are a few terms which have been commonly used such as voluntary, non-voluntary and involuntary euthanasia, active and passive voluntary euthanasia, and assisted suicide. Determining which euthanasia is acceptable to be legalised, is an important

aspect of the debate for supporters and opponents parties of euthanasia.

The term euthanasia stems from Greek words: *eu* meaning good and *thanatos* meaning death,¹¹ and thus it means "a gentle and easy death".¹² The Cambridge dictionary defines euthanasia as "the act of killing someone who is very ill or very old so that they do not suffer any more".¹³ Also, the Oxford dictionary identifies euthanasia as "the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma".¹⁴ These definitions seem trying to contrast euthanasia to homicide, where the difference is in the motive of third party killing the person. In euthanasia the motive is to relieve pain or suffering. However, these definitions do not deal with patients' consent, where the consent might distinguish euthanasia from homicide. It may also become apparent that "euthanasia is a species of the class homicide".¹⁵

On the other hand, some definitions have been presented to obtain more explanation what euthanasia is. Euthanasia is defined by the World Medical Association as "the deliberate ending of a person's life at his or her request, using drugs to accelerate death".¹⁶ Also, Bamgbose defines euthanasia as "the termination of life by a physician at the express wish of the patient".¹⁷ A comprehensive definition has been provided by the Western Australian Bill, it defines euthanasia as "a gentle and peaceful death achieved through the deliberate administration of a recognised drug to an applicant by that applicant's medical practitioner in concentrations that will and is intended to cause the death of the applicant, where the applicant knows and intends that what is done

⁷ Dieter Birnbacher and Edgar Dahl (eds), *Giving Death a Helping Hand: Physician-assisted Suicide and Public Policy An International Perspective* (Springer 2008) p. 62.

⁸ John E. Ferguson, *The Right to Die* (Infobase Publishing 2007) p. 43.

⁹ Victoria Hiley, *op. cit.*, p. 230.

¹⁰ Colleen Cartwright, the right of terminally ill act revisited, (2008) 17 (1&2) *Australian Health Law Bulletin*, p. 3.

¹¹ Oluyemisi Bamgbose, Euthanasia: Another Face of Murder, (2004) 48 (1) *International Journal of Offender Therapy and Comparative Criminology* p. 112.

¹² Craig Paterson, *op. cit.*, 11.

¹³ Cambridge Dictionaries Online, euthanasia, <<http://dictionary.cambridge.org/dictionary/british/euthanasia>> at 20 May 2013

¹⁴ Oxford Dictionaries, euthanasia <<http://www.oxforddictionaries.com/definition/english/euthanasia>> at 20 May 2013

¹⁵ Craig Paterson, *op. cit.*, p. 11.

¹⁶ Colleen Cartwright, *op. cit.*, p. 3.

¹⁷ Oluyemisi Bamgbose, *op. cit.*, p. 114

or omitted to be done will cause his or her death".¹⁸ Accordingly, it can be seen that euthanasia could be defined as the termination of life if it covers three elements: a request from the patient, conducted by a physician and administered by drugs. If one of these elements is not fulfilled, the termination must not be categorized as euthanasia.

However, these definitions may be similar with the term of voluntary euthanasia. An act can be called voluntary euthanasia when carried out at the request of the patient. Young defines voluntary euthanasia when a patient makes the request to a physician to end his or her life by such methods as administration of a drug.¹⁹ Moreover, Bamgbose emphasizes that voluntary euthanasia must be performed with a voluntary request where it must be carefully considered and repeatedly expressed.²⁰ Also, the patient must be aware of the consequences of his or her request.²¹ Such a request may contrast euthanasia to voluntary euthanasia. Therefore, the main distinction between euthanasia and voluntary euthanasia is in the request which is voluntary expressed by the patient after considering the consequences of the request.

Other terms usually used in relation to euthanasia are involuntary euthanasia and non voluntary euthanasia. Involuntary euthanasia is referred to an action to end the life of a patient who is capable of consenting, when the action is performed without his or her consent.²² In this case, the third party administers euthanasia without any consent from the patient or the patient does not make a request. For instance, such a patient may be in a persistent vegetative state. Non voluntary euthanasia is defined as the intentional killing of a patient who is not capable of consenting. The example of the case is where a newborn baby experiences a critical medical condition. However, both terms, based on the definitions

of euthanasia, should not be categorized as euthanasia. The absence of patients' consent in euthanasia may constitute homicide. In criminal law, the consent seems play a crucial role. Any medical treatment treated under patient's consent is lawful.²³

Other terms commonly used in relation to euthanasia are active euthanasia and passive euthanasia. Commonly, in order to contrast these terms, often the words "killing" and "letting die" are used.²⁴ Active euthanasia is performed when the third party "active" killing a patient. A physician, for example, intentionally kills a patient by injecting a lethal dose of drugs such as potassium chloride or morphine through the vein of the patient. Practically, in the Netherlands, there are at least two kinds of drug administration in voluntary euthanasia, which are legally recognised. Voluntary euthanasia could be administered by a doctor injecting a patient or when a doctor gives a deadly drug for the patient to swallow.²⁵

However, the administering of drugs in increasing amounts to relieve a patient's pain is generally referred to as "the doctrine of double effects" and this is not voluntary euthanasia.²⁶ The condition of this doctrine is where the drugs given are intentionally administered to reduce or relieve pain, but unexpectedly it may result in the death of the patient. On the other hand, some jurisdictions have legalized this doctrine, such as the United Kingdom, Canada and the United States. Patterson and George suggest that the doctrine may be morally acceptable if the following conditions are satisfied:

- a. "the bad consequences occur only as side-effects to the intended purpose (that is, whilst the actor must not intend the bad consequences, he or she may foresee them);
- b. the intended purpose must itself be morally good or (at the very least) morally neutral;

¹⁸ *Voluntary Euthanasia Bill 2010* (WA) s 3

¹⁹ Robert Young, *Medically Assisted Death* (Cambridge University Press 2007) p. 20.

²⁰ Oluyemisi Bamgbose, *op. cit.*, p. 114.

²¹ Joanna Sikora and Frank Lewins, 'Attitudes concerning euthanasia: Australia at the turn of the 21st Century' (2007) 16 (1) *Health Sociology Review* p. 68.

²² Colleen Cartwright, , *op. cit.*, p. 3.

²³ Oluyemisi Bamgbose, *op. cit.*, p. 118.

²⁴ Joanna Sikora and Frank Lewins, *op. cit.*, p. 68.

²⁵ Dieter Birnbacher and Edgar Dahl (eds), *op. cit.*, p. 77.

²⁶ Colleen Cartwright, *op. cit.*, p. 3.

- c. the bad consequences must not be a means of achieving the good end (that is. the intended purpose); and
- d. the bad consequences must not be so serious as to outweigh the good effect".²⁷

On the other hand, passive euthanasia is referred to as a circumstance where a third party "passively" kills a patient. Passive euthanasia is often associated with withholding and withdrawing life support system. A physician, for example, withdraws a ventilator machine of the patient who is unable to breathe due to dependence on the ventilator. However, it is still debatable whether or not this "letting die" method is euthanasia. Cartwright believes that this method is not euthanasia, because this merely prolongs the dying process.²⁸ Moreover, in 2003 the Victorian Supreme Court came to a decision that it is lawful and not euthanasia if a physician withdraws artificial nutrition from a seriously demented patient.²⁹ Although, Birnbacher and Dahl state that the "letting die" method has smaller opportunity to abuse rather than other methods.³⁰ This method may have a problem related to the insurance that euthanasia must be humane and painless. This is because withholding or withdrawing a medical treatment could take several days to result in death. This is may be why that The Dutch statistics show that the number of patients who are requesting withdrawing recent treatment is much smaller than the number of patients who may be eligible for assisted suicide.³¹

Sikora and Lewins cite that the "letting die" method sustainably conducted, may be based on the notion that there are modern medical treatments that could reduce the pain and suffering and increase life expectancy.³² However, such modern medical treatment may

not reduce all kinds of pain and suffering.³³ Reducing deathly pain and suffering may require sophisticated medical treatment, and there is no insurance that it will totally reduce the pain and suffering. "Hence if withdrawal of treatment brings on suffering, 'mercy killing' should be preferred".³⁴

In a moral view, there is a conventional claim in the euthanasia debate which is known as the "difference principle". This claims that there is a moral difference between killing and letting die, where "killing a person is morally worse than letting a person die".³⁵ The proponents of this claim believe that allowing a patient to die is sometimes permissible and intentionally killing a patient is always prohibited. However, the difference principle has been argued based on these notions:

- a. "active euthanasia is in many cases more humane than passive euthanasia;
- b. it leads to decisions concerning life and death on irrelevant grounds;
- c. the doctrine rests on a distinction between killing and letting die that itself has no moral importance; and
- d. the most common arguments made in support of the doctrine are invalid".³⁶

Therefore, it can be seen that letting die is not euthanasia, but it may be permissible. Another term used in association with euthanasia is "assisted suicide". Livings states that "'Assisted suicide' is just one facet of euthanasia".³⁷ This term attempts to emphasize the third party's role in the suicide of another person.³⁸ Here, the act of killing is not conducted by the third party or the assister. Usually, the assister provides a lethal means or knowledge for committing suicide. The term is commonly known as physician assisted suicide (PAS). If it is compared with active voluntary euthanasia, the most distinction is in the PAS a physician only provide a means and knowledge and does not

²⁷ Rachael Patterson and Katrina George, *op. cit.*, p. 509.

²⁸ Colleen Cartwright, *op. cit.*, p. 3.

²⁹ Lindy Willmott and Ben White, "Private Thoughts of Public Representatives: Assisted Death, Voluntary Euthanasia and Politicians" (2003) 11 *Journal of Law and Medicine* p. 77.

³⁰ Dieter Birnbacher and Edgar Dahl (eds), *op. cit.*, p. 5.

³¹ *Ibid.*

³² Joanna Sikora and Frank Lewins, *op. cit.*, p. 68.

³³ Robert Young, *op. cit.*, p. 23.

³⁴ Joanna Sikora and Frank Lewins, *op. cit.*, p. 70.

³⁵ Rachael Patterson and Katrina George, *op. cit.*, p. 495.

³⁶ Rachael Patterson and Katrina George, *op. cit.*, p. 495.

³⁷ Ben Livings, 'A Right to Assist? Assisted Dying and the Interim Policy' (2010) 74 (1) *Journal of Criminal Law* 32.

³⁸ Craig Paterson, *op. cit.*, p. 9.

commit the act which results in the patient's death. On the other hand, it has been argued that in the moral perspective there is no difference between active voluntary euthanasia and PAS.³⁹ The reason is that the purpose and result in both actions is the same. Both actions have a purpose and result to end an individual's life. Hiley emphasizes that between active voluntary euthanasia and physician assisted suicide there is no "bright dividing line".⁴⁰

However, according to some euthanasia legislation and bills both active voluntary euthanasia and PAS are permissible. For instance, according to the Northern Territory legislation, *the Rights of the Terminally Ill Act*, where the act was repealed by the Euthanasia Laws Act 1997 (Cth),⁴¹ that termination of a patient's life are allowed to be performed in some manners, includes the prescribing of a substance, the preparation of a substance and the giving of a substance to the patient for self administration, and the administration of a substance to the patient.⁴² The same provision also is provided in the Tasmanian Bill.⁴³ Moreover, the South Australia Bill legalises withholding or withdrawing medical treatment.⁴⁴ Therefore, it seems that even though letting die method may not be classified as euthanasia, it would be treated the same as active voluntary euthanasia in the light of euthanasia legislation.

The Netherlands, Belgium and Oregon legislations have legalised physician assisted suicide, whereas the Switzerland legislation regulates that assisted suicide, with or without the involvement of a doctor, is legal.⁴⁵ Importantly, a euthanasia legislation must be performed with proper safeguards in order to eliminate potential abuses. There are two main issues which must be considered in euthanasia

legislation, related to the patient who may potentially request for voluntary euthanasia and the obligation of the medical practitioner in the process of assisting euthanasia.

Patients

There are at least three conditions which must be fulfilled by the patients before requesting voluntary euthanasia. The patient must be an adult and mentally competent, they must be a local resident and finally must be suffering from a terminal illness. These conditions seem to be regulated in order to ensure that voluntary euthanasia is administered to the invulnerable people.

1. Adult and Mentally Competent

An individual's competence seems to be a significant factor in determining how the law should treat a euthanasia case.⁴⁶ Consent given by a competent person could determine that an action is categorised as voluntary euthanasia or murder.⁴⁷ This is because voluntary euthanasia could be justified if "the competent nature of the person making the decision has been established"⁴⁸ or if it does not so "the authority and legitimacy of a decision is vitiated"⁴⁹.

The determination of whether a patient is adult or not, might be based on the notion that an adult is competent to request euthanasia, because in common law believes that adults are competent.⁵⁰ However, the determination of when an individual has reached adult age or not, has been debated for the past decades. It can be seen in several legislation and bills that they are not in the same design to determine what the exact age for people to request euthanasia. The Oregon legislation, South Australian Bill and Tasmanian Bill regulate that the patient must

³⁹ Colleen Cartwright, *op. cit.*, p. 3.

⁴⁰ Victoria Hiley, *op. cit.*, p. 3.

⁴¹ John I. Fleming, 'Death, Dying, and Euthanasia: Australia versus the Northern Territory' (2000) 15 (3) *Issues in Law & Medicine* p. 302.

⁴² *Rights of the Terminally Ill Act* (NT) s 3.

⁴³ *Dying with Dignity Bill 2009* (Tas) s 3.

⁴⁴ *Voluntary Euthanasia Bill 2010* (SA) s 11(2).

⁴⁵ A. Chapple, S. Ziebland, A. McPherson and A. Herxheimer, 'What people close to death say about euthanasia and assisted suicide: a qualitative study' (2006) 32 (1) *Journal of Medical Ethics* p. 706.

⁴⁶ Cameron Stewart, Carmelle Peisah and Brian Draper, 'A test for mental capacity to request assisted suicide' (2011) 37 (1) *Journal of Medical Ethics* p. 37.

⁴⁷ Dieter Birnbacher and Edgar Dahl (eds), *op. cit.*, p. 60.

⁴⁸ Craig Paterson, *op. cit.*, p. 107.

⁴⁹ Kumar Amarasekara and Mirko Bagaric, 'The Vacuousness of Rights in the Euthanasia Debate' (2002) 6 (1) *The International Journal of Human Rights* p. 21.

⁵⁰ Cameron Stewart, Carmelle Peisah and Brian Draper, *op. cit.*, p. 34.

be age 18 or older, whereas the Western Australian Bill determines that the patient must be age 21 or over. In other words, the patient must be legally competent.

The personal competency is not only determined by age, but also by mental condition. A patient is competent if he or she must be able to "comprehend and retain treatment information; weigh the information and reach a decision; and communicate the decision".⁵¹ It ensures that a patient's decision has been well considered based on satisfactory ability, particularly the risk of the decision. "Well considered" is when the request is continuing and that the decision is made based on complete information and understanding about the patient medical condition.⁵² Moreover, the Oregon Act requires that the patient must be 'capable' that means "a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available".⁵³ Also, the qualified patient for PAS must be able to appreciate:

- a. His or her medical diagnosis;
- b. His or her prognosis;
- c. The potential risks associated with taking the medication to be prescribed;
- d. The probable result of taking the medication to be prescribed; and
- e. The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

The New South Wales Act provides indications when an individual is qualified as incompetent:⁵⁴ "...a person is incapable of giving consent to the carrying out of medical or dental treatment if the person:

- (a) is incapable of understanding the general nature and effect of the proposed treatment, or

- (b) is incapable of indicating whether or not he or she consents or does not consent to the treatment being carried out.

Some euthanasia legislations explicitly require that the patient must be mentally competent or "of sound mind". However, the term 'of sound mind' has been criticised. The term seems 'meaningless' and is not commonly used in any modern psychiatric text book.⁵⁵ The important is that the legislation must provide provision which contain the indication that whether a person is mentally competent or not. Some indications have been presented in some legislation and bill. The indications are that the person must be able to weigh the pros and cons of presented medical treatment and palliative care options, understand the benefits and risks of the request for assistance to end his or her life and make a decision freely or voluntarily. The most important that the person realises that death is "the inevitable consequence of the action".⁵⁶ Therefore, the requesting of euthanasia will not be able to be granted to incompetent people such as children, mentally impaired people, people who are unconscious over a long period and people who are in a persistent vegetative state.⁵⁷

The determination of whether a person is competent or not, must also be established in order to eliminate doubtful competent person.⁵⁸ Some patients who experience terminal illness may request voluntary euthanasia because they feel depression or to reduce financial impact on family or they feel that they have become a burden.

The patient's decision must be voluntary made and free from undue influence. The decision is voluntary made when there is no pressure from other people and the patient is competent.⁵⁹ The doctor who will assist the patient must ensure that the request made by the patient's autonomy. Patterson and George state "The principle of

⁵¹ *Ibid.*

⁵² H M Buiting, J K M Gevers, J A C Rietjens, B D Onwuteaka-Philipsen, P J van der Maas, A van der Heide and J J M van Delden, "Dutch criteria of due care for physician-assisted dying in medical practice: a physician perspective" (2008) 34 (1) *Journal of Medical Ethics* p. 1.

⁵³ *Death with Dignity Act 1994* (Oregon) s 127.800 §1.01 (3).

⁵⁴ *Guardianship Act 1987* (NSW) s33.

⁵⁵ Kumar Amarasekara and Mirko Bagaric, *op. cit.*, p. 5.

⁵⁶ Dieter Birnbacher and Edgar Dahl (eds), *op. cit.*, p. 60.

⁵⁷ Kumar Amarasekara and Mirko Bagaric, *op. cit.*, p. 6.

⁵⁸ Robert Young, *op. cit.*, p. 53.

⁵⁹ H M Buiting, J K M Gevers, J A C Rietjens, B D Onwuteaka-Philipsen, P J van der Maas, A van der Heide and J J M van Delden, *op. cit.*, p. 1.

autonomy provides that humans have the right to non-interference and self-determination when making decisions about themselves" and thus it will respect patient's rights, privacy and liberty.⁶⁰

2. Local Resident

The fact that people may travel to a jurisdiction where legalising euthanasia is "a real one in an age of global travel".⁶¹ Smith also states that this provision tends to lead to discrimination, because only particular patients are able to access the professional lethal medications as "suicide tourism".⁶² Moreover, in 1999, Dignitas, a non-profit body in Switzerland, reported that it had facilitated more than 800 assisted suicides for non-local residents.⁶³ It seems that "suicide tourism" becomes closer to the discrimination practice. Therefore it seems that the provision related to the requirement for the patient who is able to request euthanasia must be a local resident, should be established in order to eliminate the opportunity of "suicide tourism". Oregon legislation, for example, regulates that the evidence of the patient is a local resident, if he or she is able to demonstrate particular documents such as Oregon driver license; registration to vote in Oregon; evidence that the person owns or leases property in Oregon; and Oregon tax return for the most recent tax year.⁶⁴ Also, the Tasmanian Bill requires that the patient must be domiciled or ordinarily resident in the State and had settled minimal 12 months⁶⁵ and even minimal 3 years in the Western Australian Bill.⁶⁶

A case related to this issue was *Local Authority v Z*,⁶⁷ where since this case about 100 Britons have travelled to Switzerland for

seeking euthanasia.⁶⁸ Mrs Z decided to travel from Britain to Switzerland to seek euthanasia because she was suffering from cerebellar ataxia. Mr Z helped her to travel to Switzerland. There was no undue influence from Mrs Z's family and she completely understood the risk of her decision. The judge considered to Mr Z's proposal as assisting suicide. However, in the judge's finding there was no obligation to prevent Mrs Z from travelling.

3. Terminal Illness

Terminal illness is the most significant condition which must be met for administering voluntary euthanasia. Many definitions have been presented to describe when an illness can be called terminal. The South Australian Bill, for example, defines that it can be terminal illness when "the illness is causing the person to suffer pain which the person finds unbearable and which cannot be alleviated to a degree the person finds acceptable by pain relief methods offered to the person".⁶⁹ It also defined by Westerns Australian Bill that terminal illness means a medically diagnosed illness or condition that will result in the death of the applicant within 2 years of the date on which the request was made.⁷⁰ From these current definitions, it can be noted that terminal illness is indicated by unbearable pain or intolerable suffering, the absent of alternative pain relief methods and the illness will result in death.

However, related to the prediction of when a terminal illness will result in the death of the patient, has been criticised by Young, he said that "medical professionals cannot always be sure that a particular patient will die within a specified period of time".⁷¹ An example is motor neurone disease, where this disease is fatal but sufferers are difficult to determine when they will die.⁷² Similarly, a patient who is depending on a respirator sometime is not terminally ill. Nevertheless, the important factor is that the illness will

⁶⁰ Rachael Patterson and Katrina George, *op. cit.*, p. 501.

⁶¹ Brendon Murphy, 'Human rights, human dignity and the right to die: Lessons from Europe on assisted suicide' (2009) 33 *Criminal Law Journal* p. 348.

⁶² Stephen W. Smith, *op. cit.*, p. 70.

⁶³ Richard Huxtable, 'The Suicide Tourist Trap: Compromise Across Boundaries' (2009) 6 (3) *Journal of Bioethical Inquiry* p. 329.

⁶⁴ *Death with Dignity Act 1994* (Oregon) s 127.860 s3.10.

⁶⁵ *Dying With Dignity Bill 2009* (Tas) s 9.

⁶⁶ *Voluntary Euthanasia Bill 2010* (WA) s 6.

⁶⁷ *Local Authority v Z*. EWHC 2817, 2004.

⁶⁸ Cameron Stewart, Carmelle Peisah and Brian Draper, *op. cit.*, p. 36.

⁶⁹ *Voluntary Euthanasia Bill 2010* (SA) s 4(2).

⁷⁰ *Voluntary Euthanasia Bill 2010* (WA) s 3.

⁷¹ Robert Young, *op. cit.*, p. 17.

⁷² Victoria Hiley, *op. cit.*, p. 231.

result to the death of the patient, and thus medical practitioners, who will assist euthanasia, must ensure that the illness will result in the death

Furthermore, the patient decision for requesting euthanasia must be consistently expressed over time with past. This requirement will ensure that the patient has fully considered all information given and knew and understood the consequences of his or her decision. The Western Australian Bill requires that a second request must be expressed at least 14 days from the first request.⁷³ The medical practitioner administering euthanasia, consequently, must assess the second request to ensure that all requirements the same as the first request, have been met.

Medical Practitioners

As what has been discussed above that the discourses of active voluntary euthanasia is commonly related to physician assisted suicide (PAS). It means that legal euthanasia must be administered by a qualified physician or medical practitioner. Magnusson believes that "the key to the euthanasia debate lies in how best to regulate what doctors do".⁷⁴ There are some important medical practitioner's obligations when administering euthanasia. These obligations are related to their competency and before, during and after administering of euthanasia.

The simple indication that whether a medical practitioner is competent or not, is from their level of medical experience. Tasmanian and Western Australian Bills for example, requires that a practitioner must have at least 5 years experience. A psychiatrist may be required to assess whether the patient is mentally competent or not in order to identify conditions such as depression. However, Kissane and Kelly argue that a psychiatrist's ability to accurately assess a patient's motivation and their competence in decision making are doubtful.⁷⁵ This is because

the success of comprehensive psychiatrists' assessment must be based on satisfied management plans which refer to appropriate safeguards.⁷⁶ It is difficult to prove that such safeguards have been established by current legislations.⁷⁷ However, psychiatrists with their educational background are a better party to assess patients' mental conditions rather than other medical practitioners.⁷⁸

Before administering euthanasia, the partitioner must satisfy that the patient is mentally competent and experience terminal illness. The General Medical Council (GMC) of Great Britain provides guidance for doctors to consider a voluntary euthanasia request, at least if the patient is an adult; has the capacity to make the decision; is not subject to undue influence; make the decision on the basis of adequate information about their choice.⁷⁹ Moreover, the medical practitioner must inform the patient of the diagnosis and prognosis of the patient's illness and the risks associated with the procedure, includes that it may result in serious harm for the patient.⁸⁰ The medical practitioner must follow this procedure, because the aim of the procedure is "to make sound decisions that respect human life and recognise a patient's right to make informed decisions about requesting or refusing treatment".⁸¹ Moreover, the practitioner has rights to refuse a request from potential patient. It will ensure that there is no medical practitioner who would feel pressured when assisting a patient to do so.⁸²

Furthermore, before performing active voluntary euthanasia, a medical practitioner should formally consult with an independent and knowledgeable other medical

⁷³ *Voluntary Euthanasia Bill 2010* (WA) s 10.

⁷⁴ R S Magnusson, "Euthanasia: above ground, below ground" (2004) 30 (1) *Journal of Medical Ethic* p. 441.

⁷⁵ David W. Kissane and Brian J. Kelly, 'Demoralisation, depression and desire for death: problems with the Dutch guidelines for euthanasia of the mentally ill',

(2000) 34 (2) *Australian & New Zealand Journal of Psychiatry* p. 328.

⁷⁶ *Ibid*, p. 329.

⁷⁷ *Ibid*.

⁷⁸ Malcolm Parker, 'Medicine, psychiatry and euthanasia: an argument against mandatory psychiatric review' (2000) 34 (2) *Australian & New Zealand Journal of Psychiatry* p. 322.

⁷⁹ Andrew Lu, 'A new guidance for doctors on end of life treatment and care', *Australian Health Law Bulletin* (online), 7 August 2010, p. 101.

⁸⁰ *Ibid*, 101.

⁸¹ *Ibid*, 100.

⁸² Lorana Bartels and Margaret Otlowski, "A right to die? Euthanasia and the law in Australia" (2010) 17 (4) *Journal of Law and Medicine* p. 532.

practitioners.⁸³ The aims of this consultation are not only to fulfil the related provision in euthanasia legislation, but also to verify the diagnosis and to ensure that administering euthanasia is a remedy of last resort. A remedy of last resort is when there is no other alternative palliative care that will reduce the patient's pain to the acceptable level of pain; and when all safeguards have been fulfilled.⁸⁴

When administering euthanasia, a medical practitioner must be guided by appropriate medical standards and guidelines. This standard could eliminate potential errors, such as improper dosage of drugs, malpractice of procedure and lack of professionalism. Smith indicates that the biggest problems affecting euthanasia are related to lack of professionalism of its participants and administering on a trial and error basis.⁸⁵ Particular drugs may work differently, quickly or slowly. A patient may request euthanasia with lethal injection where he or she hopes that it will result in death quickly. However, there is no guarantee that the injection will result as hoped. Although, a drug has been produced through a research, but sometimes it fails.⁸⁶ The practitioner must be present during administering of euthanasia. The presence of these medical practitioners constitutes "important safeguards to minimise the risk of error or abuse".⁸⁷

It has been emphasized that the administering of euthanasia must be humane and painless or "do no harm"⁸⁸. However, this may be difficult to establish in a case if euthanasia will be administered by withholding or withdrawing a treatment. This kind of killing may take several days to end a life, while lethal injection method may take several hours. This therefore becomes an essential concern by the Australian Medical Association.

It is noted in its code of ethics that medical practitioners' obligation is to maintain life, but "where death is deemed to be imminent and where curative or life-prolonging treatment appears to be futile, try to ensure that death occurs with dignity and comfort."⁸⁹

After administering euthanasia, the medical practitioner must keep all related documents and report the event to the authorised body. The practitioner must indicate that all conditions that are required under the legislation have been established. As the evidence, the related documents, such as the requests of patient, the record of the medical practitioner opinion on the patient's condition and the opinion from another independent practitioner. This procedure may also ensure that a slippery slope would not exist by providing adequate information.

These all safeguard must be acceptably constructed. However, if safeguards are "too safe", where it means so complex and bureaucratic, and thus there is no vulnerable patient who could ever qualify for euthanasia, another aim of the legislation may fail.⁹⁰ The aim is to eliminate illegal practices. There are some research proving that "underground" euthanasia practices had been existed in USA, England and Australia.⁹¹ A positive provision has been stated by South Australian Bill to monitor the implementation of voluntary euthanasia. The bill regulates that the Minister must establish a Voluntary Euthanasia Monitoring Committee, which consist of the people from various organisation and society.⁹² The functions of the committee are to monitor and report to Minister the implementation of the Act; and produce recommendation related to amendment and improvements to the Act.

CONCLUSION

From the previous discussion and analysis, it can be concluded that there is confusion terms used in relation to euthanasia

⁸³ Bregje D Onwuteaka-Philipsen and Gerrit van der Wal, "A protocol for consultation of another physician in cases of euthanasia and assisted suicide" (2001) 27 (1) *Journal of Medical Ethics* p. 331.

⁸⁴ Victoria Hiley, *op. cit.*, p. 230.

⁸⁵ Stephen W. Smith, *op. cit.*, p. 90-91.

⁸⁶ *Ibid*, p. 91.

⁸⁷ Lorana Bartels and Margaret Otowski, *op. cit.*, p. 533.

⁸⁸ David W. Meyers and J.K. Mason, *Physician Assisted Suicide: A Second View from Mid-Atlantic* (1999) 28 (3) *Anglo-American Law Review* p. 268.

⁸⁹ *Australian Medical Association Code of Ethics 2004* <<https://ama.com.au/position-statement/ama-code-ethics-2004-editorially-revised-2006>> at 26 May 2013.

⁹⁰ R S Magnusson, *op. cit.*, p. 444.

⁹¹ *Ibid*, p. 442.

⁹² *Voluntary Euthanasia Bill 2010* (SA) s 19(1).

terms. Sometimes they overlap and have no "bright dividing line". However, in the light of euthanasia legalisation, it can be noted that active voluntary euthanasia, physician assisted suicide (PAS) and letting die methods are that the sort of euthanasia is globally accepted. Legal euthanasia exists when there is a voluntary request from the patient. It is conducted by a competent physician and it is administered by strict standards. These significant conditions must be ensured by regulation of proper safeguards. The safeguards will eliminate potential abuses.

The requirements of the patient who may potentially request voluntary euthanasia and the obligation of the medical practitioner in the process of assisting euthanasia, seem to be crucial issues which must be focused in the safeguarding of the process. An adult patient will allowed for requesting euthanasia if he or she is mentally competent by showing that he or she is able to comprehend and retain treatment information; fully consider the information and achieve a decision; and communicate the decision. Related to the decision, it must be free from undue influence and consistent over time with past. Furthermore, a competent medical practitioner must ensure that all information related to the patient's illness has been satisfactory informed to the patient. Formal consultation with an independent and knowledgeable other medical practitioners must be conducted to ensure that administering euthanasia is a remedy of last resort. The administering euthanasia must be guided by appropriate medical standards and guidelines. Finally, the medical practitioner must report the event to the legal appointed body. Importantly, the factor that must be emphasised is that these safeguards will be convincingly established, if there is an adequate control by the government how the safeguards performed.

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