

Euthanasia and the Quality of Legislative Safeguards

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INTRODUCTION

Moved by a compassionate desire to end unbearable pain and to grant self-determination to an incurable patient by enabling that person to request a doctor to accelerate death, the *Rights of the Terminally Ill Act 1996* of the Northern Territory (hereafter, the Act) seeks to ensure that the request is voluntary, the condition is hopeless and that a permanent end is brought about after due reflection and in the most humane manner. The Act is mindful of the potential for abuse in decriminalising the intentional killing of an innocent person and it installs a variety of safeguards as a consequence.

An analysis of those safeguards is fundamentally important because one jurisdiction, though not bound by the success or failure of another to decriminalise some form of euthanasia, will be obliged to consider the concrete provisions of the Act. Hardly anyone will argue that euthanasia should be legalised without any controls. The danger that the power to accelerate the termination of life may be exploited and abused is as obvious as it is great.

Attempts to win over the opponents of legalised euthanasia as well as the need to minimise abuse by interested persons is part of the motivation for setting limits on decriminalisation. Unless these restrictions are scrutinised closely, the ideological divide will remain as wide as ever. An evaluation of the Northern Territory's legislative constraints will help both in drafting or avoiding future legislation. It will also pose a challenge to either of the absolutist claims that voluntary euthanasia is incorrigibly flawed or that voluntary euthanasia has invincible merit.

This article analyses the adequacy of measures taken to cope with the dangers of legalising voluntary euthanasia, and it expresses concern that the benefits of decriminalising euthanasia will be negated by adverse results flowing from the pioneering efforts of the legislation.

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Current Status, Definitions and Forms

The Act was proclaimed on 1 July 1996; its validity was upheld by the Supreme Court of the Northern Territory in *Wake v Northern Territory of Australia*¹ but a federal constitutional challenge to the legislation has succeeded. The *Euthanasia Laws Act 1997* (Cth), which originated as a Private Member's Bill, (the Andrews Bill), removes the power of the Australian Capital Territory, the Northern Territory and Norfolk Island to enact laws which permitted euthanasia and mercy killing or the assisting of a person to terminate his or her life. The Commonwealth legislation repeals the *Rights of the Terminally Ill Act 1995* (NT) (*RTI Act*) but does not retrospectively invalidate anything done under that Act before the Andrews Bill came into force. The Andrews Bill, as amended, prohibited the intentional killing of a person but permitted the withdrawal or withholding of treatment for prolonging life and the provision of palliative care for a dying patient. It empowered a patient to appoint an agent with authority to decide whether to withdraw or withhold treatment. Attempted suicide was decriminalised.

The Bill was debated on non-party lines and a conscience vote was allowed. It was passed in the Commonwealth House of Representatives by a majority of 88 votes to 35 and in the Senate by 38 to 34. The Governor-General's Assent was given on 27 March 1997.

Unlike the three Territories, Australian States are not within the provenance of the Andrews Bill. A private member's Bill has been introduced in the South Australian Upper House to legalise voluntary euthanasia — and will be debated in June 1997. It is certain that the Act will influence many speakers. A High Court challenge to the *Euthanasia Laws Act 1997* (Cth) is also under consideration. Accordingly, it is premature to regard the *RTI Act* as a mere historical event that has no relevance to the present or future.

In this article the provisions of the *Rights of the Terminally Ill Act 1995* (NT) will be discussed in the present rather than the past tense, on the assumption that the Act will continue to be a significant component of the euthanasia debate and of future legislation on that subject.

The Act legitimises assisted suicide by permitting a doctor to provide the means whereby the patient brings about his or her death. There have so far been four cases of accelerated termination (two men and two women) after the Act was proclaimed. All of them involved a terminally ill patient using a machine devised by a doctor to self-administer a lethal injection which brings about a rapid death.

In Canada a majority of the Supreme Court held that a complete ban on assisted suicide was necessary and that the interests of the State in protecting its vulnerable citizens superseded the individual rights of a citizen who sought

¹ (1996) 124 FLR 298; 109 NTR 1. Application for special leave to appeal to High Court adjourned: *Wake v Northern Territory*, High Court of Australia, No. D10 of 1996, transcript of proceedings, 15 November 1996, p4.

it.² In the United States of America the legality of physician assisted suicide is under review. State laws in New York and Washington which had banned physician assisted suicide were held by the Federal Appeal Courts to be an unconstitutional violation of the right to liberty or equal protection.³ The appeals are pending before the US Supreme Court. In Oregon a voter-initiated referendum resulted in the *Death with Dignity Act* 1994 which permits doctors to assist their patients to commit suicide, but does not permit them to perform active euthanasia. The US District Court held that ban to be a violation of the Fourteenth Amendment and Equal Protection clause because it prevented recourse by terminally ill patients to the protection accorded to others.⁴

The Act also provides for voluntary active euthanasia, which involves a competent patient making a free and deliberate request to a doctor to effect an accelerated termination of his or her life. That may be done by a consenting practitioner who administers a lethal substance to the patient under specified conditions. This is euthanasia *stricto sensu*, whether the definition used is emotive⁵ or whether it stipulates an intention to kill.⁶

The Act does not provide for a wider ranging notion of euthanasia as 'killing someone, where on account of his distressing physical or mental state this is thought to be in his own interests'.⁷ Assisted suicide and voluntary active euthanasia are decriminalised only if there is physical pain in a terminal illness and not in any situation of mental illness or distress.⁸

² *Rodriguez v A-G for British Columbia* [1994] 85 CCC (3d) 15; see M Somerville, 'Death Talk in Canada: The Rodriguez Case' (1994) 39 *McGill JL* 602; B McSherry, 'The Right to Die' (1994) 1(3) *JLM* 138; P Thompson, 'The Law on Active Euthanasia: Whose Life is it Anyway?' (1995) 2 *J of L & Med* 233.

³ *Compassion in Dying v State of Washington* 79 F 3d 790 (1996). Argued before the US Supreme Court on 8 January 1997 under the name *State of Washington v Glucksburg* No. 96-110 US Supreme Court, Oct. 1996; *Quill v Vacco* US App Lexis 6215 (1996), argued before the US Supreme Court on 8 January 1997 as *Vacco v Quill* No. 95-1858 US Supreme Court, Oct. 1996 term.

⁴ *Gary Lee v State of Oregon* 891 F Supp 1429 (D OR) (1995). See H Lee and S Tolle, 'Oregon's Plans to Legalize Suicide Assisted by a Doctor' (1995) 310 *BMJ* 613; A Alpers and B Lo, 'Physician Assisted Suicide in Oregon' (1995) 274 *JAMA* 483. The appeal against the Oregon State Law, mandated at referendum as Measure 16, was dismissed by a Federal Appeal Court on 27 February 1997; Australia, *Senate Legal and Constitutional Committee's Consideration of the Euthanasia Laws Bill 1996 referred to the Committee* (1997) (hereafter, the Australian Senate Committee Report) 109, 180. 'Federal Appeals Court Dismisses Challenge to Oregon Assisted-Suicide Law', *Washington Post*, 28 February 1997, A10.

⁵ 'Assisting a person to die in a humane manner'; see Northern Territory, *Report of the Northern Territory Select Committee on Euthanasia* (Vol 1, 1995) 5.

⁶ 'An action or an omission which of itself or by intention causes death in order that all suffering may be eliminated': The Roman Catholic Church, *Declaration of Euthanasia* (1980) 6; P Mullen, 'Euthanasia: An Impoverished Construction of Life and Death' (1995) 3 *JLM* 121, 122, which adopts the definition used by the House of Lords in the Report by the Select Committee on Medical Ethics; United Kingdom, *House of Lords Report by the Select Committee on Medical Ethics* (1994) Vol 1, 10, 'a deliberate intervention undertaken with the express intention of ending a life of intractable suffering'.

⁷ J Glover, *Causing Deaths and Saving Lives* (1977) 182.

⁸ M Bagaric argues that Glover's definition is not tendentious unlike the others cited above; M Bagaric, 'Euthanasia, Morality and the Criminal Law', unpublished Master of Laws thesis, Jan. 1997, page 5, Monash Law Faculty.

Active euthanasia is practised in Holland without the legislative fiat given in the Northern Territory but without prosecution by the State (see later 'The Dutch Experience').

The Act makes no provision for other forms of euthanasia such as passive euthanasia which occurs where treatment is withdrawn, not initiated, or limited.⁹ Nor does the Act deal with non-voluntary euthanasia which involves terminating the life of a person whose irreversible coma or persistent vegetative state makes that person unable to communicate. In passive euthanasia the patient is usually but not invariably unable to express a preference for life or death, while in non-voluntary euthanasia the person is non-sentient.¹⁰

Involuntary euthanasia occurs where the termination of life is contrary to the person's wishes and has no place in the Act.

In decriminalising active voluntary euthanasia the Act makes a radical departure from existing law. Thus consent is not normally a defence to causing serious injury or death.¹¹ Similarly, the fact that death was imminent makes no difference to a charge of murder.¹² A humanitarian motive to end pain does not justify intentional killing because the interest of the State in preserving life overrides the otherwise all powerful interest of patient autonomy.¹³ The Act also decriminalises abetment of suicide which is an offence in some jurisdictions.¹⁴ Injunctions have been refused where to grant them would have abetted suicide.¹⁵

The magnitude and number of these changes to the criminal law are other grounds which make it necessary to assess whether the safeguards and limitations contained in the Act are adequate.

⁹ United Kingdom, *Report of the House of Lords Select Committee on Medical Ethics* (1994) Vol 1, 10–11.

¹⁰ 'a competent person is put to death without the person's request or consent' Northern Territory Legislative Assembly, *Report of the Inquiry by the Select Committee on Euthanasia* (1995) Vol 1, 5.

¹¹ *R v Brown* [1994] 1 AC 212; *R v Coney* (1882) 8 QBD 534; *R v Donovan* [1934] 2 KB 498. Exceptions are made in cases of sport, religious rituals, tattooing and informed consent to surgery and medical procedures; *R v Wilson* [1996] 3 WLR 125; *Pallante v Stadiums Pty Ltd (No. 1)* [1976] VR 331; I Freckleton, 'Masochism, Self Mutilation and the Limits of Consent' (1994) 2 JLM 48.

¹² H Palmer, 'Dr Adams Trial for Murder' [1957] *Crim LR* 365; P Devlin, *Easing the Passing: The Trial of Dr John Bodkin Adams* (1985).

¹³ *Airedale NHS Trust v Bland* [1993] AC 789, per Lord Mustill at 893. However, if the intention is to relieve pain, then neither the incidental shortening of life nor the foresight of the risk of death amounts to murder; *R v Adams* [1957] *Crim LR* 365; *R v Cox* (unreported 18 September 1992, Ognall J); *Airedale NHS Trust v Bland* [1993] AC 789, 867; *Auckland Area Health Board v AG* [1993] 1 NZLR 235, 248.

¹⁴ *Crimes Act 1958* (Vic) s 6B(2); *Crimes Act 1900* (NSW) s 31C. Reasonable force may be used to prevent a suicide: *Crimes Act 1958* (Vic) s 463B; *Crimes Act 1900* (NSW) s 574B.

¹⁵ Force feeding a prisoner on a hunger strike: *Schneidas v Corrective Services Commission* (1983) 7 *Crim LJ* 353, and operating on a man to prevent a suicide attempt from succeeding: *In re Kinney*, unreported, SC of Victoria, Fullagar J, 23 December 1988; L Skene, 'The Fullagar Judgment' (1989) 14 *Legal Service Bulletin* 42, were held to be lawful.

DISCRIMINATION AND THE ACT

One of the conditions under which a medical practitioner may assist a patient to die is that the patient has to be at least 18 years old (although the Certificate of Request does not stipulate age, s 7(1)(a) of the Act mentions this fact). As other preconditions are predicated on the patient's voluntariness, knowledgeability and sound judgment, a minimum age requirement supposedly guarantees these. Sanity is another prerequisite. The practitioner should have reasonable grounds to be satisfied that the patient is of sound mind and that the decision to end life has been made freely, voluntarily and after due consideration.¹⁶ A second practitioner must share that opinion after discussing the case with the first practitioner prior to co-signing and witnessing the Certificate of Request.¹⁷

The phrase 'of sound mind' has been criticised as 'meaningless' and is not used in any modern psychiatric text book or manual. A subjective assessment by the practitioner will be called for, given the vacuous nature of the statutory test.¹⁸ To ascertain whether the patient's request was made freely a useful analogy lies in the law of confessions.

The inquiry into the voluntariness of a confession is a searching one. The case law and learned writing on the proof of voluntariness are notable for their bulk as well as their acuity.¹⁹ The rationality and voluntariness of a request to be killed are not tested by the Act with the same sophistication and sustained rigour that the law requires for the admissibility of an accused person's confession.

A capacity to understand a medical prognosis and to make an informed decision is required. The doctor must inform the patient about the nature and likely outcome of the illness and the medical treatment that is available, including palliative care, counselling, psychiatric support and extraordinary measures for keeping the patient alive. After that information is conveyed, the patient must indicate to the doctor that a decision to end life has been made by her or him.²⁰

An onus is placed on the practitioner to be satisfied that the patient has considered the possible implications of the decision to the patient's family.²¹ A similar duty should be placed on the practitioner to inform the family of the request and the proposed date and time of the termination. Regulation 8 and Schedule 1 of the Rights of the Terminally Ill Act Regulations 1996 (NT) cover some aspects of the medical practitioner's duty to notify the patient's family about the request.

The information that must be given to a patient is predicated not only on the sanity but also on the capacity of a patient to make a reasoned choice

¹⁶ *Rights of the Terminally Ill Act* 1995 (NT) s 7(1)(h).

¹⁷ *Rights of the Terminally Ill Act* 1995 (NT) s 7(1)(k).

¹⁸ Dr D Mendelson, 'Medico-Legal Aspects of the Right to Die Legislation in Australia' (1993) 19 MULR 112, 117.

¹⁹ See the wealth of material discussed by PK Waight and CR Williams in *Evidence: Commentary and Materials* (4th ed. 1995) 783-845.

²⁰ *Rights of the Terminally Ill Act* 1995 (NT) s 7 (1)(e) & (f).

²¹ *Rights of the Terminally Ill Act* 1995 (NT) s 7(1)(g).

between the requested termination and life. It is essential that information on the availability of palliative care should be given either by the patient's medical practitioner if qualified in that field, or if not, then by any other practitioner with special qualifications in palliative care.²²

It becomes a duty to give this information only after the request for assistance has been communicated to the doctor by the patient. It is doubtful that the knowledge so acquired will be useful to a patient who has already decided to terminate life or to one who is so weakened by pain or illness that the ability to choose between assisted suicide and palliative care is nominal. However, the legal and ethical imperative to obtain the informed consent of the patient makes the information indispensable.

It is difficult to detect whether a desire for suicide, assisted or not, is the result of a disordered mood or of a measured, well thought out decision. A practitioner may empathise with a suffering patient to the extent that a detached judgment of the patient's voluntariness may be obscured.²³

The requirements of sanity, age, understanding, capacity to make a free choice and the voluntariness of the decision discriminate in favour of the mature, sentient, intelligent person. A child, a mentally impaired person or one who is unconscious over a long period or in a persistent vegetative state cannot seek assisted suicide.

This limitation has the salutary aim of ensuring the personal autonomy of a competent patient in coping with pain and a terminal illness. It allows the sufferer to choose death without implicating a doctor who assists in carrying out this choice.

However it opens a door to the argument of inequality of opportunity. Why, it will be asked, should one person have to suffer the ravages of an incurable illness when another person may have it lawfully terminated?

The anticipated movement from voluntary to non-voluntary euthanasia or the 'slippery slope' prognosis may appear to some as alarmist and as a doomsday prophecy. That movement will gain an impetus from arguments based on equal opportunity and discrimination. There is indirect discrimination because the preconditions for assisted termination 'disproportionately affect members of a disadvantaged group' by excluding many persons who are terminally ill as well as others who desire accelerated termination but fall outside the limitations of the Act.²⁴

²² *Rights of the Terminally Ill Act 1995* (NT) s 7(3).

²³ P Mullen, op cit (n 6) 126. However, a desire to commit suicide is not evidence per se of an irrational or insane mind: L Gillam, 'Euthanasia, The Current State of the Debate' in J McKie (ed) *Active Voluntary Euthanasia: The Current Issues* (1994) 5, 7; *Shorter v Hodges* (1988) 145 NSWLR 698.

²⁴ See the discussion by B Gaze and M Jones on indirect discrimination in *Law, Liberty and Australian Democracy*, (1990) 416; see also Article 7 of the *Universal Declaration of Human Rights* (1948) and Article 26 of the *International Covenant on Civil and Political Rights* (1966) which guarantee equality before the law and protection against discrimination. Discrimination has been defined as 'any practice that makes distinctions between individuals or groups so as to disadvantage some and advantage others': *Australian and New Zealand Equal Opportunity Law & Practice*, CCH, 5132 para 4-200.

To treat people differently when they are similar in the relevant respects or to treat them similarly or equally when they are different in the relevant respects is discriminatory.²⁵ Discrimination 'implies not merely difference or distinction but unequal treatment and carries a very strong pejorative flavour against the person practising it'.²⁶ These definitions reinforce the view that if the basis of decriminalising euthanasia is compassion it is discriminatory to deny a request for accelerated termination to those who experience pain, otherwise than in the course of a terminal illness. The fact that one source of pain is terminal and the other is not is not a relevant distinction. Both types of pain can be equally agonising and equally worthy of compassion.

If the basis of the Act is autonomy, then every person who is capable of making an autonomous decision about dying should be able to invoke the Act, because terminal illness and pain are irrelevant to the capacity to make an autonomous decision.

Once voluntary euthanasia is available to sane, terminally ill and conscious adult persons, it becomes more difficult to withhold it from incompetent persons. The notion of voluntariness will recede before the twin onslaught of compassion for, and non-discrimination against, minors, the intellectually impaired and those in a vegetative state. For example, it is unlawful for a supplier of services to refuse to supply those services to another by reason of race, colour or national or ethnic origin of that other.²⁷ That principle could be invoked and the analogy pursued where a medical practitioner refused a request for assisted termination because a patient's condition did not satisfy the criteria of the Northern Territory's legislation.²⁸

Fair minded observers will argue that a burdensome inequality has been created. The agony of pain is felt by minors and the intellectually impaired, even if the insentient and comatose cannot feel it. The knowledge that an illness is terminal can be conveyed to a minor and the gravity of that state may be comprehended by him or her. Many who observe it will wish to rectify the disparity between those who have access to legalised euthanasia because they can choose it, and those who cannot make a choice to obtain the relief available to others. Popular moves against discrimination and in favour of parity of status will find an ideal lobby on behalf of those who are disqualified from requesting termination.

The permanent relief of pain by death will be argued to have a greater value when available universally than when subjected to conditions of voluntariness and consent which favour only a part of society. The 'transformation of ethical sensibility' resulting from legalised voluntary euthanasia for the

²⁵ L Katzner, 'Is the Favouring of Women and Blacks in Employment and Educational Opportunities Justified?' in J Feinberg and H Gross (eds), *Philosophy of Law* (4th ed 1991) 468.

²⁶ *Comalco Ltd v ABC* [1985] 64 ACTR 1, 31.

²⁷ *Racial Discrimination Act 1975* (Cth) s 13.

²⁸ Gaze and Jones point to the inherent discrimination in not recognising the specific needs of people with disabilities and assert that 'Australian anti-discrimination laws all focus on equality of opportunity'; B Gaze and M Jones, op cit (n 24) 408 and 412; see also the *Disability Discrimination Act 1992* (Cth).

terminally ill is likely to make the extension of the panacea to many other categories of persons virtually irresistible.²⁹

The arguments for non-voluntary euthanasia appear attractive when founded not merely on compassion for suffering and pain and on personal autonomy, but when fortified by notions such as equality and fairness. Two meanings have been attributed to the notion of equality. One is equality before the law in enforcing legal rules; the other is equality in law in the content of legal rules.³⁰ When voluntary euthanasia is made available only to some, and when the grounds for permitting accelerated termination of the lives of terminally ill patients apply to particular cases but not to others, then equality is unavailable under the Act.

The obvious distinction between non-voluntary and voluntary euthanasia lies in the choice available to those who seek the latter. Informed consent is said to justify the termination of life unlike the imposed termination that is distinctive of non-voluntary euthanasia. That distinction is likely to be overridden in the move to achieve equality between the impaired and unimpaired persons who feel that same pain. Compassion for suffering³¹ will be a common factor between those who favour voluntary euthanasia and those prepared to legitimise euthanasia in order to achieve equality. The element of choice will not be crucial when it can be supplanted by consensus or by the agreement of a committee consisting of relatives, friends and experts. Alternatively, a decision by a court of law that non-voluntary euthanasia is justified will be considered an adequate or even better substitute than a choice of assisted termination made by a person who is seriously debilitated.

Moves to legalise non-voluntary euthanasia are already evident in the case of deformed or severely handicapped infants and patients in a persistent vegetative state. Professor Peter Singer suggests that transplanting organs from amencephalic infants who are permanently insensate because of the absence of a cerebral cortex is morally justifiable.³² In the *Prins* case from Holland a gynaecologist killed a brain damaged spina bifida infant after consultations with colleagues and the infant's family. The ensuing murder conviction was upheld but no punishment was imposed.³³

Withholding futile treatment and depriving a patient of nutrition and hydration are trends in the same direction. In *Airedale NHS Trust v Bland*³⁴ the House of Lords held that withdrawal of treatment did not amount to

²⁹ R Manne, 'The Slippery Slope is a Life and Death Argument' *The Age*, 14 June 1995, p17.

³⁰ W Sadurski, 'Equality Before the Law: A Conceptual Analysis' (1986) 60 ALJ 131.

³¹ As in the dissenting judgment of Cory J in *Rodriguez v A-G for British Columbia* (1994) 85 CCC (3d) 15, 85 'State prohibitions that would force a dreadful painful death on a rational but incapacitated terminally ill patient are an affront to human dignity'.

³² P Singer, *Rethinking Life and Death* (1994) 46-56; cf P Sundstrom, 'Peter Singer and "Lives Not Worth Living" — Comments on a Flawed Argument from Analogy' (1995) 21 *Jo. of Medical Ethics* 35; H Pauer-Studer, 'Peter Singer on Euthanasia' (1993) 76 *The Monist* 135; J Teichman, 'Humanism and Personism' *Quadrant* (December 1992) 26.

³³ 'Dutch Doctor Convicted but not Punished for Euthanasia of Infant' (1995) 14(3) *Monash Bioethics Review* 5; 'Dutch Court Convicts Doctor of Murder' (1995) 310 *BMJ* 1028.

³⁴ [1993] AC 789.

euthanasia and that euthanasia was unlawful.³⁵ One distinction lies in the difference between an act (the administration of a lethal injection) and an omission (discontinuing treatment, nutrition and hydration).³⁶ The decision is in line with authority that the withdrawal of life support is not the cause of death where the original cause is a substantial and subsisting one.³⁷ Bland was crushed in a stampede at a soccer match and his cerebral cortex had 'resolved into a watery mass'.³⁸ On existing principles that cause was not interrupted or superseded by the withdrawal of life support.

However, the decision establishes that the continuance of life in a persistent vegetative state is futile and that the preservation of life is not essential in every case. The sanctity of life is questionable if conduct which foresees the certainty of death and an omission to preserve life are lawful.³⁹ *Bland* diminishes the sanctity of life by legitimising passive, non-voluntary euthanasia. The Act devalues it further by legalising active voluntary euthanasia. In both cases treatment is futile because recovery from a persistent vegetative state or from a terminal illness is exceptional. However, a doctor's lethal injection will bring about death with a greater certainty and greater speed. It will eliminate the possible benefits of medical discoveries and unforeseen cures.

Bland is also open to the criticism that the distinction between acts and omissions is controversial⁴⁰ and that it could seem hypocritical to proscribe a lethal injection while legitimising a discontinuance of nutrition and hydration.⁴¹

³⁵ *Id.*, 859 per Lord Keith, 865 per Lord Goff, 892–93 per Lord Mustill.

³⁶ *Id.*, 858–9 per Lord Keith, at 865 to 866, 873 per Lord Goff, at 887, 897–8 per Lord Mustill.

³⁷ *R v Kinash* (1981) 5 A Crim R 240; *R v Malcherek & Steel* [1981] 2 All ER 422, 427 ff.

³⁸ *Airedale NHS Trust v Bland* [1993] AC 789, at 856 per Lord Keith.

³⁹ P Singer 'Presidential Address: Is the Sanctity of Life Ethic Terminally Ill?' (1995) 9 *Bioethics* 327, 337–42; P Singer, *Rethinking Life and Death* (1994) 57–80; JM Finnis, 'Bland: Crossing the Rubicon?' (1993) 109 *LQR* 329, 335; JM Finnis 'A Philosophical Case Against Euthanasia' in J Keown (ed) *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (1995), 23, 30–4; R Magnusson, 'The Future of the Euthanasia Debate in Australia' (1996) 20 *MULR* 1108, 1115–20.

⁴⁰ *Cruzan* 497 US 261, 297; 111 L ed 2d 224, 253–4 (1990), per Justice Scalia; *Compassion in Dying v State of Washington* 79 F 3d 790; 1996 US App Lexis 3944, 110–11 per Reinhardt J; *Quill v Vacco* 1996 US App Lexis 6215 at 40–1 per Miner J.

⁴¹ *Bland* [1993] AC 789 at 865; see B McSherry, 'Death by the Withholding of Medical Treatment and Death by Lethal Injection: Is There a Difference?' (1993) 1 *JLM* 71; I Freckelton, 'Withdrawal of Life Support: The Persistent Vegetative State Conundrum' (1993) 1 *JLM* 35; cf M McQueen and J Walsh, 'The House of Lords and the Discontinuation of Artificial Nutrition and Hydration: An Ethical Analysis of the Tony Bland Case' (1991) 35(4) *Catholic Lawyer* 363, 370 and 377. Some judges have doubted that *Bland* is a case of euthanasia because no positive action was taken to cause death; Sir Thomas Bingham in the Court of Appeal in *Bland* [1993] AC 789, 808, and because there was no external agency of death; Hoffmann LJ id 856.

THE DUTCH EXPERIENCE WITH EUTHANASIA

The ease with which voluntary euthanasia coexists with non-voluntary euthanasia has been demonstrated in Holland where a survey by a government commission reported that in 1970 there were 1000 cases of involuntary euthanasia, 2300 cases of voluntary euthanasia and 400 cases of assisted suicide.⁴²

The 1000 cases of involuntary euthanasia represented 27% of doctors who admitted that these lives were ended without consent.⁴³

These figures must be placed in the context of Article 293 of the Dutch Penal Code which makes the intentional killing of a person at his or her express and serious request an offence. However, a defence of necessity is available to a doctor who follows specified guidelines in cases of euthanasia and assisted suicide.⁴⁴

In practice, a doctor who performs euthanasia is not prosecuted if the patient had intolerable suffering, with no prospect of improvement and had made a free, informed and durable request to die after other forms of treatment were found to be inadequate. The doctor should have consulted with an independent medical practitioner who had experience in the field. It has been claimed that these guidelines are strict and precise,⁴⁵ but a leading Dutch lawyer who supports euthanasia concedes that 'unbearable pain' and similar concepts within the guidelines are subjective and not open to precise definitions.⁴⁶

Although the guidelines require deliberation and persistence by the patient in requesting euthanasia, a survey has shown that in 7% of cases, euthanasia was administered by some nursing home physicians in less than a day after the

⁴² The van der Maas survey in PJ van der Maas et al, 'Euthanasia and Other Medical Decisions Concerning the End of Life' *Elsevier* 1992. A summary of the survey appears in (1991) 338 *Lancet* 669. See Dr J Keown, 'Some Reflections on Euthanasia in the Netherlands' and 'Further Reflections on Euthanasia in the Netherlands in the Light of the Rummelink Report and the van der Maas Survey' in L Gormally (ed) *Euthanasia, Clinical Practice and the Law* (1994) 193, 219.

⁴³ Dr J Keown, 'The Law and Practice of Euthanasia in the Netherlands' (1992) 108 *LQR* 51; cf PJ van der Maas et al, 'Dances with Data' (1993) 7 *Bioethics* 323 who claim that their findings have been misinterpreted. See the response by Dr J Keown, 'Euthanasia in the Netherlands: Sliding Down the Slippery Slope?' in Dr J Keown (ed) *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, op cit (n 39) 273, (hereafter, Keown, 'Slippery Slope').

⁴⁴ The Royal Dutch Council, KNMG, collaborated with the National Association of Nurses to set out guidelines for lawful euthanasia; see 'Guidelines for Euthanasia' translated by W Lagerwey (1988) 2 *Issues in Law and Medicine* 429. On the defence of Necessity or *force majeure* see the Press Release by the Netherlands Ministry of Foreign Affairs, 'The Termination of Life by a Doctor in the Netherlands' May 1995; B Sneiderman and M Verhoff, 'Patient Autonomy and the Defence of Medical Necessity: Five Dutch Euthanasia Cases' (1996) 34 *Alberta Law Review* 374.

⁴⁵ H Rigter, 'Euthanasia in the Netherlands: Distinguishing Facts from Fiction' (1989) 19(1) *Hastings Centre Report* 31 (Special Supplement).

⁴⁶ HJJ Leenen, 'The Definition of Euthanasia' (1984) 3 *Medicine and Law* 333, 334.

first discussion with the patient, and in 35% of cases, less than a week after the first request.⁴⁷

More safeguards have been introduced recently. From 1 June 1994 a doctor is obliged to report on a decision to terminate the life of a terminally ill patient. Fifty criteria have been set out as guidelines and the report is verified by a pathologist. The State prosecutor then decides whether the doctor may rely on a defence of necessity.⁴⁸

Other empirical evidence suggests that there is popular acceptance of non-voluntary euthanasia where voluntary euthanasia is practised openly. A poll conducted in 1986 in Holland showed that 77% of the population supported non-voluntary euthanasia.⁴⁹ Euthanasia for certain groups was supported by 90% of economics students as against 93% of patients in nursing homes who opposed it.⁵⁰

At least two criticisms have been offered of the finding that there were 1000 cases of involuntary euthanasia. It is argued that the van der Mass survey of voluntary euthanasia offers no data on the extent to which involuntary euthanasia was practised prior to the practice of voluntary euthanasia. Nor does it reveal whether there is a difference between Holland and other countries where voluntary euthanasia is not practised openly.⁵¹

However, the absence of such comparative evidence does not invalidate the conclusion that euthanasia gives doctors even more power over life and death of their patients,⁵² and that the alleged justification for euthanasia is not self-determination, but the doctor's judgment that certain lives are not worth living and that it is right to terminate them.⁵³

It is clear that non voluntary euthanasia has received the approval of the medical profession in Holland. The killing of incompetent patients, including babies and patients in persistent coma, has been approved in principle by a committee of the KNMG.⁵⁴ Whether patients with severe dementia should be killed has also engaged the attention of the committee.⁵⁵ The Alkmaar District Court has recently held that the killing of a disabled infant at the request of the

⁴⁷ MJ Muller et al, 'Voluntary Active Euthanasia and Physician-Assisted Suicide in Dutch Nursing Homes: Are the Requirements for Prudent Practice Properly Met?' (1994) 42 *Jo of the American Geriatrics Society* 624, 626, Table 2.

⁴⁸ Press Release by Ministry of Foreign Affairs of the Netherlands, May 1995.

⁴⁹ The Law and Practice of Euthanasia in Holland is fully discussed by Dr J Keown in 'Some Reflections on Euthanasia in the Netherlands' L Gormally (ed) *The Dependent Elderly: Autonomy, Justice and Quality of Care*, (1992) 70; KJ Mason and RA McCall Smith, *Law and Medical Ethics*, (4th ed 1994) Chap 15; J Keown, 'Slippery Slope' op cit (n 43) 281; D Lanham, *Taming Death by Law* (1993) 170.

⁵⁰ D Lanham, loc cit (n 49).

⁵¹ P Singer and H Kuhse, 'Active Voluntary Euthanasia, Morality and the Law' (1995) 3 *JLM* 129, 132.

⁵² AMJ Henk and VM Welie, 'Euthanasia: Normal Medical Practice?' (1992) 22(2) *Hastings Centre Report* 34, 38.

⁵³ Dr J Keown, 'Slippery Slope' op cit (n 43) 262.

⁵⁴ H Hellema, 'Life Prolonging And Life Terminating Treatment of Severely Handicapped New Born Babies' (1992) 8 *Issues in Law and Medicine* 167.

⁵⁵ H Jochemsen, 'Dutch Doctors Support Life Termination in Dementia' (1993) 306 *BMJ* 1364.

parents was justifiable in the circumstances of the case and attracted the defence of necessity.⁵⁶

The merger of non-voluntary euthanasia and voluntary euthanasia is facilitated by expanding the defence of necessity or force majeure which has been used to justify killings without an explicit request.⁵⁷ If the safeguards are observed and 'only the best interests of the patient are taken into account' such killings allegedly are 'certainly not murder'.⁵⁸

Voluntariness was the keynote of the introduction of euthanasia in Holland. At its inception there was repeated insistence on a request. Thus, the KNMG Report of 1984 confined three of its five guidelines to postulating a free, well considered and persistent request. In 1985 a State Commission on Euthanasia declared that agents and third parties were ineligible to request euthanasia on behalf of incompetent persons such as minors, the mentally handicapped and elderly persons.⁵⁹ The Vice-Chairman of the State Commission on euthanasia, Professor Leenen wrote that the protection of the right to life contained in Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms did not prohibit the killing of a patient who requested death, but 'it prohibits the State and others from taking another's life without his request'.⁶⁰

Reliance on the voluntariness of the patient was seen as making it 'impossible for people who do not want euthanasia to be manoeuvred or forced into it'.⁶¹

However, it has not taken long for the climate of opinion to change. Non-voluntary euthanasia has come to be regarded as inevitable by the authors of the van der Mass survey. They wrote '[Is] it not true that once one accepts euthanasia and assisted suicide, the principle of universalisability forces one to accept termination of life without explicit request, at least in some circumstances, as well? In our view the answer to this question must be affirmative'.⁶²

The acceptance of involuntary euthanasia is made easier by the flexibility of the guidelines set out by the courts and the KNMG. Fears are allayed by using a narrow definition of euthanasia 'as a strategy for winning acceptance of the general practice, which would then turn to . . . relief of suffering as its

⁵⁶ *The Independent*, 27 April 1995.

⁵⁷ JJM van Delden et al, 'The Rummelink Study: Two Years Later' (1993) 23(6) *Hastings Centre Report* 24, 25; HJJ Leenen and C Cieselski-Carlucci 'Force Majeure (Legal Necessity): Justification for Active Termination of Life in the Case of Severely Handicapped Newborns after Forgoing Treatment' (1993) 2(3) *Cambridge Quarterly of Healthcare Ethics* 271, 274.

⁵⁸ L Pijnenborg et al, 'Life-Terminating Acts without Explicit Request of Patient' (1993) 341 *Lancet* 1196, 1199.

⁵⁹ HJJ Leenen, 'Euthanasia, Assistance to Suicide and the Law: Developments in the Netherlands' (1987) 8 *Health Policy* 197, 204. Without a request 'the termination of life is murder'; HJJ Leenen, 'Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands' (1989) 8 *Medicine and Law* 517, 520 except in the case of one who became incompetent after making a living will in which they asked for the termination of life; *ibid*.

⁶⁰ *Id*, 519; H Rigter, *op cit* (n 45).

⁶¹ HH van der Kloot Meijburg (1989) 19(6) *Hastings Centre Report* 47, 48 (letter).

⁶² JJM van Delden et al, *op cit* (n 57) 26.

justification in cases in which patients are unable to request euthanasia'.⁶³ That is accompanied by a self-arrogated right to decide that the lack of quality in some lives justifies their termination.

Dr John Keown, whose research into euthanasia in the Netherlands is extensive, remarks that the hard evidence of the van der Mass survey is that the progression from voluntary to involuntary euthanasia has taken place in a remarkably short time.⁶⁴

The Dutch experience has led the House of Lords Select Committee on Medical Ethics to reject the legalisation of euthanasia. Apart from the impossibility of framing adequate safeguards against non-voluntary euthanasia⁶⁵ there was unease felt by the members of the Committee who had visited Holland. That discomfort came from the evidence that non-voluntary euthanasia was commonly performed.⁶⁶

Equally daunting was the fear that the gap between the theory and practice of voluntary euthanasia that existed in the Netherlands could happen in England. Pressures on sick and elderly people who saw themselves as a burden on others were anticipated. The pressure that could be exerted by relatives and those concerned with the allocation of resources on doctors and nurses was regarded as a further disincentive to decriminalisation.⁶⁷

The course of the slippery slope has been starkly demonstrated in the area of non-voluntary euthanasia. The House of Lords decision in *Airedale NHS Trust v Bland*⁶⁸ affords a pointed contrast to the later decision of the Irish Supreme Court in *Re A Ward of Court*⁶⁹ where the terms persistent and vegetative were not applied in a strict sense.

In *Bland* it was held that the withdrawal of treatment would not amount to a criminal offence where the patient's cognitive function and sensory capacity were obliterated. In *Ward* the cessation of treatment was held to be lawful despite limited cognition by the patient who could recognise some staff, show distress and track people with her eyes, leading Hamilton CJ to observe that she was 'nearly, but not quite within the definition of a permanent vegetative state (PVS)'.⁷⁰

Lord Mustill had declared in *Bland* that he may not have reached the same conclusion if the patient had shown glimmerings of life, but the Irish Supreme Court was willing to hold that cessation of treatment was lawful despite the minimal cognitive functions of the patient in *Ward*. The latter decision has

⁶³ Professor Capron's report on a euthanasia conference in Holland refers to the chilling candour of the hosts; A Capron 'Euthanasia in the Netherlands: American Observations' (1992) 22(3) *Hastings Centre Report* 30, 31.

⁶⁴ Dr J Keown, 'Slippery Slope' op cit (n 43) 286; see supra, n 42. The essence of the slippery slope argument is that once voluntary euthanasia is legalised, voluntariness will become dispensable; R Goff, 'A Matter of Life and Death' (1995) 3 *Medical Law Review* 1, 17; JA Burgess, 'The Great Slippery Slope Argument' (1993) 19 *Jo of Medical Ethics* 169.

⁶⁵ United Kingdom, *Report of the Select Committee on Medical Ethics* (Vol 11994), 49.

⁶⁶ (1993-94) 554 *Parliamentary Debates* HL col 1345, 1346.

⁶⁷ Id, col 1398.

⁶⁸ [1993] AC 789.

⁶⁹ [1995] 2 ILRM 401.

⁷⁰ Id 416.

led to the comment that it was surprising that in Ireland, where sanctity for human life was entrenched in the Constitution, permission was given to stop nutrition and hydration for a patient who was not truly in a PVS condition.⁷¹

An equally poignant depiction of the slippery slope is seen in *Chabot's* case⁷² where there was a natural progression from physical suffering to mental anguish as an acceptable ground for accelerated termination. The Dutch Supreme Court impliedly condoned voluntary active euthanasia on the ground of acute mental distress; the absence of a second medical opinion merely led to a formal conviction without punishment.

The drift to accommodate infants and the non-sentient is equally pressing. Although the Act stipulates the maturity and consciousness of the patient, the Dutch case of *Prins* showed that non-compliance with those requirements in the case of a brain damaged spina bifida baby ('a sleeping plant') did not lead to punishment by the Supreme Court despite a formal conviction of murder being entered.⁷³

In the US, the Supreme Court has yet to rule on the legality of physician assisted suicide, for which judicial and academic support is strong.⁷⁴ Although there has not been the same momentum for voluntary active euthanasia, it is virtually certain that if the US Supreme Court rules that physician assisted suicide is lawful, the decriminalisation of the former will follow.⁷⁵

The transformation from voluntary to involuntary euthanasia which has taken place in Holland bears a close parallel to the virtual installation of abortion on demand from the starting point of abortion for therapeutic purposes only. *The Abortion Act 1967* (UK) decriminalised abortion if certain conditions were satisfied. These had to be (a) the concurring opinions of two registered medical practitioners, (b) that the continuance of the pregnancy involved risk to the life or to the physical or mental health of the mother, (c) which risk was greater than if the pregnancy was terminated or (d) that there was a substantial risk that if the child was born it would be seriously handicapped. These conditions are now largely ignored and abortion is an option

⁷¹ AJ Carroll and KM Doyle, 'The Slippery Slope' (24 May 1996) NLJ 759, 761.

⁷² J Keown, 'Physician-Assisted Suicide and the Dutch Supreme Court' (1995) 111 LQR 394.

⁷³ 'Dutch Court Convicts Doctor of Murder' (1995) 310 *British Medical Journal* 1028; 'Dutch Doctor Convicted but not Punished for Euthanasia of Infant' (1995) 14(3) *Monash Bioethics Review* 5.

⁷⁴ *Quill v Vacco* US App Lexis 6215 (1996); 'Compassion in Dying' US App Lexis 3944 (1996); L Gostin, 'Drawing a Line between Killing and Letting Die . . .' (1993) 21 *Jo of Law, Medicine and Ethics* 94; T Quill et al, 'Care of the Hopelessly Ill: Proposed Clinical Criteria for Assisted-Suicide' (1992) 327 *New England Jo of Med.* 1380-83.

⁷⁵ Y Kamisar, 'Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia' in J. Keown (ed), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* op cit (n 39) 225; Y Kamisar 'Against Assisted Suicide — Even a Very Limited Form' (1995) 72 *U of Detroit Mercy LR* 737; cf RA Sedler, 'Are Absolute Bans on Assisted Suicide Constitutional — I Say No' (1995) 72 *U of Detroit Mercy LR* 535.

for all pregnant women. The climate of opinion in which pregnancy must be faced has changed radically.⁷⁶

A postal survey of Australian medical practitioners has recently been conducted by Helga Kuhse, Peter Singer, Peter Baume, Malcolm Clark and Maurice Rickard (hereinafter, the Kuhse-Singer survey) with the objective of comparing Australian and Dutch medical end of life decisions.⁷⁷

The authors observe that '... 30% of all Australian deaths were preceded by a medical decision explicitly intended to hasten the patient's death', either by the doctor prescribing, supplying or administering drugs (5.3%) or by withdrawing or withholding life prolonging treatment (24.7%). Further, in only 4% of the cases was the decision taken in response to an explicit request by the patient.⁷⁸ The survey also claims that Australia had a significantly higher rate of intentional ending of life without the patient's consent (22.5% in 1995) than the Netherlands (5.3% in 1991).⁷⁹

The phrasing of the questions in the Kuhse-Singer survey merges two distinct issues into a single category. The principle of double effect is not recognised. A medical decision which intends to relieve pain but does not intend to cause death is different from a decision which intends to accelerate death. The foresight of death, unaccompanied by an intention to kill is the essence of the former. This distinction is not reflected in the questions about the intent of the doctors and constitutes 'a serious obfuscation'.⁸⁰

It has been suggested that the findings of the Kuhse-Singer survey warrant guidelines and independent audits to secure compliance and that these are best secured through legislation.⁸¹ It is doubtful that legislation can secure compliance when the thrust of the survey is that the incidence of non-voluntary euthanasia is greater where it is illegal, as in Australia, than where it is practised openly, as in the Netherlands and that Australian law which prohibits the intentional termination of life by act or omission '... has not prevented the practice of euthanasia or the intentional ending of life without the patient's consent'.⁸²

A criticism of the surveys conducted by van der Maas and others in the Netherlands⁸³ and by Kuhse, Singer and others in Australia is that their focus was on the intention of the doctors but neither study 'validates the doctors'

⁷⁶ Rt Rev JS Habgood, 'Euthanasia — A Christian View' [1994] 3 *J of the Royal Soc. of Health* 124, 126. Dr Habgood, now Archbishop of York, is a member of the House of Lords Select Committee on Ethics. Professor Waller discusses the unsatisfactory nature of the law of abortion and the need for reform in L Waller, 'Any Reasonable Creature in Being' (1987) 13 *Mon LR* 37, 53–5.

⁷⁷ H Kuhse et al, 'End-of-life Decisions in Australian Medical Practice' (1997) 166 *MJA* 191–196.

⁷⁸ *Id* 195, 196.

⁷⁹ *Id* 195.

⁸⁰ Dr J Fleming cited by A McGarry in *The Australian*, 25 February 1997.

⁸¹ MB Van Der Weyden, 'Deaths, Dying and the Euthanasia Debate in Australia' (1997) 166 *MJA* 173, 174.

⁸² H Kuhse et al, 'End-of-life Decisions in Australian Medical Practice' *op cit* (n 77) 196.

⁸³ L Pijneneborg, PJ van der Maas, JJM van Delden and CWN Looman, 'Life Terminating Acts Without Explicit Request of Patient' (1993) 341 *Lancet* 1196–1199.

responses by examining clinical data and *prescription records*', for these responses are 'complex and variable'.⁸⁴

Kuhse, Singer et al ask 'why some Australian doctors choose intentionally to end the lives of some of their patients without the patients' consent, especially in situations where the patient is competent and could be consulted'. They suggest that one reason 'may be that, because existing laws prohibit the intentional termination of life, doctors are reluctant to discuss medical end-of-life decisions with their patients lest these decisions be construed as collaboration in euthanasia or in the intentional termination of life'.⁸⁵

This suggestion presents some of the respondent doctors in a curious and paradoxical light. They are shown as not reluctant to break the law or to run the risk of prosecution, conviction and sentence for murder or manslaughter, but they are reluctant to provide evidence of their legal accountability. They are afraid to have their decision seen as evidence of participation in euthanasia, but not afraid to commit euthanasia in violation of the law. Some of the respondents deem that the termination of life is in the best interests of the patient, regardless of the patient's wishes, but justify their decision on the basis of concern for the patient.

Clearly, their perceptions of necessity and their disapproval of the existing law motivated the conduct of some respondents to the Kuhse-Singer survey. Neither the perceptions nor the disapproval will be changed by legislative procedures which restrict a medical practitioner's power to bring about a permanent end to pain. The limited penal sanctions contained in the Act and its dilatory procedures for bringing about accelerated termination will not deter those doctors who had earlier risked a conviction for the more serious offences that preceded decriminalisation. The confidence gained by a doctor who disobeyed existing laws is likely to encourage non-compliance with any legislation that seeks to curtail the powers that had been exercised with impunity.

TERMINAL ILLNESS AND AUTONOMY

As defined in s 3 of the Act, 'illness' includes injury or degeneration of mental or physical faculties, 'terminal illness' refers to an illness which in reasonable medical judgment, will in the normal course, without the application of extraordinary means or treatment unacceptable to the patient, result in the death of the patient. A condition precedent is that the illness is causing the patient 'severe pain and suffering'.⁸⁶ These requirements are linked to the compassion which motivates the pro-euthanasia lobby to put the sufferer out of an agony which only the person experiencing it can know.

⁸⁴ M Ashby, 'The Fallacies of Death Causation in Palliative Care' (1997) 166 MJA 176, 177.

⁸⁵ H Kuhse et al, 'End-of-life Decisions in Australian Medical Practice' op cit (n 77) 196.

⁸⁶ *Rights of the Terminally Ill Act* 1995 (NT) s 7(1)(d).

There is a contrast between the 'severe pain and suffering' referred to in s 7(1)(d) and the 'pain, suffering and or distress unacceptable to the patient' referred to in s 4. The difference in wording may lead to the use of an objective test or one used by the psychiatrist because the patient's own assessment will not ordinarily be available to the court unless the Certificate of Request declared that the pain and suffering could not be endured.⁸⁷

The exclusion of any reference to emotional pain is a notable omission from the definitions of 'illness' and 'terminal illness'. A person may suffer inconsolable grief for a variety of reasons. That pain of mind may be no less difficult to bear than the 'illness' which entitles a person to seek assisted suicide under the Act. Indeed its impact on the sufferer may have no palliative counterpart that is available in the case of physical injury and illness.

When the Act excludes irreparable grief as a justification for voluntary euthanasia it does so on a basis which has but a tenuous justification.

Arguably the deepest grief may pass, it may be sublimated. There may be acceptable consolation for any loss or affliction. However, there are individuals who are inconsolable and for whom the termination of life is the only answer to their sorrow. Physically and emotionally they may be as incapable of committing suicide and equally in need of assisted termination as those with a terminal illness.

These exclusions may be seen as restrictions on autonomy, limits on 'the right to die with dignity' and an unwarranted interference by the State with individual self determination. Opposition to voluntary euthanasia is characterised as a denial of the right to self determination. Yet to refuse euthanasia on the supposition that anything other than a terminal illness can and must be borne with equanimity is no less a denial of personal autonomy. To ask for voluntary euthanasia in a case where emotional loss is regarded as irreparable is consistent with seeking it in the case of a terminal illness. To grant the latter and refuse the former is to elevate bodily needs over emotional pressures. If autonomy is 'that quality which describes the degree of mastery an individual exercises over his or her life, [and] has to do with the exercise of choices'⁸⁸ then the limitations placed by the Act on making a request and carrying it out severely curtail that autonomy. A case for limited paternalism, overriding the wishes of an impaired person who cannot act rationally and independently, has been argued.⁸⁹

The best known and most influential statement of what autonomy should entail comes from John Stuart Mill: 'That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others . Over himself, over his own body and

⁸⁷ M Eburn, 'Voluntary Euthanasia' (July 1995) *Law Soc J* (NSW) 40, 43.

⁸⁸ ES Cohen, 'Autonomy and Paternalism: Two Goals in Conflict' (1985) 13 *Law, Medicine and Health Care* 145, 146.

⁸⁹ JB Childress, *Who Should Decide? Paternalism in Health Care* (1982) 102-103; supported by ES Cohen, op cit (n 88) 146. For an incisive analysis of the dichotomy between paternalism and autonomy in medical jurisprudence see L Doyal, 'Medical Ethics and Moral Indeterminacy' (1990) 17 *Jo of Law & Soc* 1-15; I Freckelton, (Editorial) (1995) 3 *Jo of Law & Medicine* 99 who alludes to the arbitrariness of confining compassion to those in physical pain when persistent mental anguish deserves equal pity.

mind the individual is sovereign'.⁹⁰ The statement is a striking prescription rather than an accurate description, for power is often exercised by the modern State in areas of drugs, health, and safety and in some sexual activities.

Extremists are entitled to argue that there should be no restriction on the state of mind or body that seeks suicide or abetment of suicide. They are entitled to claim that a person should be free to seek assistance in terminating life for any reason, in the same way that suicide may be committed for any reason.

The recent case of *Chabot* shows that in Holland mental distress alone may justify a patient's request for accelerated termination provided a second doctor examines the patient. A doctor terminated the life of a woman who was suffering severe mental distress after the breakdown of her marriage and the death of her two sons and father. Her depression and grief had led to a persistent refusal of treatment and to a request for her life to be terminated. She had no somatic illness and her depression was not psychotic. The Dutch Supreme Court held that the doctor could not invoke the defence of necessity because a second medical opinion had not been obtained but no punishment was imposed.⁹¹

Each precondition in the Act limits the right of self determination. It is 'paternalist' to claim that there is a right to die and then set down fundamental restrictions on that right. For instance, the illness must be terminal,⁹² incurable,⁹³ and the only available treatment should be palliative care.⁹⁴ These conditions, like the presence of severe pain and suffering,⁹⁵ are restrictions on assisted suicide. If they were not in place and if the Act decriminalised abetment of suicide absolutely, in the same way that suicide has no preconditions, then only will true autonomy be in place.

Implicit in the definition of terminal illness is a right to refuse treatment as well as 'extraordinary measures'. The term is not commonly used in bioethics and the dichotomy between treatment which may or may not be stopped lends itself to subjective judgments being passed off as objective ones.⁹⁶ It is possible for a patient to convert a serious but curable illness into a terminal one by rejecting treatment or extraordinary measures.

Such an eventuality is not fanciful for those patients who seek the option of assisted suicide rather than prolonged treatment. The power to seek termination is enhanced by the definition of terminal illness. The illness need not be terminal from its inception for the patient to qualify under the Act. Before it becomes terminal, the patient who is predisposed to seeking assisted

⁹⁰ JS Mill, 'On Liberty' in Mary Warnock (ed.) *Utilitarianism, Essay on Bentham* (1962) 135.

⁹¹ J Keown, 'Physician Assisted Suicide and the Dutch Supreme Court' (1995) 111 LQR 394. J Griffiths, 'Assisted Suicide in the Netherlands: The Chabot Case' (1995) 58 MLR 232; M Spanjer, 'Assisted Suicide for Mental Distress' (1995) 345 *The Lancet* 246.

⁹² *Rights of the Terminally Ill Act* 1995 (NT) s 7(b)(i).

⁹³ *Rights of the Terminally Ill Act* 1995 (NT) s 7(b)(ii).

⁹⁴ *Rights of the Terminally Ill Act* 1995 (NT) s 7(b)(iii).

⁹⁵ *Rights of the Terminally Ill Act* 1995 (NT) s 7(1)(d).

⁹⁶ M Ashby, 'Hard Cases, Causation and the Care of the Dying' (1995) 3 JLM 152, 159; M Somerville, *op cit* (n 2) 602.

termination can invoke the provisions of the Act by a unilateral decision to refuse treatment. The blood transfusion, the life support system, dialysis or insulin may be declined at will, thereby reducing the patient to a stage where, by a voluntary omission, he or she may have recourse to euthanasia although the original state of the illness did not permit this. So euthanasia becomes available under the Act not only to one who is afflicted by a terminal illness but also to one who by refusing treatment even before it reaches that dreadful state chooses to convert the illness to a terminal one. The exercise of autonomy extends to refusing treatment in order to qualify for euthanasia, no less than the right to claim it for a pre-existing illness.

As euthanasia is predicated on patient autonomy it is instructive to note the multifaceted nature of the concept. Gerald Dworkin refers to nine definitions of autonomy by different authors and treats it as an equivalent of liberty, self rule, sovereignty or freedom of the will. The term is equated with dignity, integrity, individuality, independence, responsibility and self knowledge. He points out that autonomy has been identified with self assertion, critical reflection, freedom from obligation, absence of external causation and knowledge of one's own interests. The notion is related to actions, beliefs, reasons for acting, rules, the will of other persons, thoughts and to principles. The only constant features in this variety of views are that autonomy is desirable and relates to persons. The existence of an underlying core meaning is doubted in what is a term of art.⁹⁷

Dworkin argues that autonomy consists of a capacity to reflect critically on one's desires, wishes and preferences and a capacity to accept or attempt to change these in the light of higher order preferences and values, so enabling people to 'define their nature, give meaning and coherence to their lives and take responsibility for the kind of person they are'.⁹⁸

Having regard to their diminished mental and physical attributes, it is doubtful that the ratiocinative powers inherent in Dworkin's discussion can be exercised by terminally ill patients. Similarly it is difficult for such an impaired person to achieve the level of cerebral activity required by John Rawls, who maintains that 'acting autonomously is acting from principles that we would consent to as free and equal rational beings, and that we are to understand in this way'.⁹⁹

Autonomy has been identified with the ability to control one's destiny by exercising one's faculties¹⁰⁰ or with the ability to 'exercise individual liberty to do what one pleases'.¹⁰¹ It is doubtful that all terminally ill persons possess these elements of control and choice.

Autonomy may sometimes result in questionable decisions such as the deliberate choice of evil, or of enslavement of oneself to another person or to drugs, or the use of one's autonomy so as to deny it to others. Thus Stephen

⁹⁷ G Dworkin, *The Theory and Practice of Autonomy* (1988) 5 and 6.

⁹⁸ *Id* 20.

⁹⁹ J Rawls, *A Theory of Justice* (1972) 516.

¹⁰⁰ J Harris, *The Value of Life* (1985) 195.

¹⁰¹ J Finnis, 'Living Will Legislation' in L Gormally (ed.) *Euthanasia, Clinical Practice and the Law* op cit (n 42) 171.

Gardbaum argues that autonomy is not the 'only essential and constitutive value of liberalism' and that 'autonomy is not the only thing of value'.¹⁰²

The 'right to die', which is treated as integral to patient autonomy, involves two different rights, namely the right of someone to be killed on request in certain circumstances and the right of others to respond to that request by killing them.¹⁰³ Neither of these rights exists in society. The Preamble to the Act is tendentious in referring to the right to die, for its provisions seek to establish such a right rather than to implement a pre-existing one.

THE REQUEST FOR ASSISTANCE

Part 2 of the Act deals with the request for and the giving of assistance. It comprises sections 4 to 11 of the Act. Under s 4 the request for assistance in terminating life may be made by the patient to the practitioner if three conditions are satisfied. The request must be made in the course of a terminal illness, the patient must be experiencing pain, suffering and/or distress, and its extent should be unacceptable to the patient.

The precondition of a terminal illness excludes pain, suffering and distress brought about by grief and emotional trauma. A valid request cannot be made for motives other than the relief of pain. Sacrifice is not accommodated. A desire to donate a vital organ in order to keep a patient or child alive will fall outside the Act.

Altruism has no place in the legislation. The bequest of vital organs for the benefit of scientific research is not an acceptable ground for assisted termination under the Act, even where the patient wishes to die.

It is appropriate that the extent of pain is determined by the subjective test of unacceptability to the patient. Whether it is episodic or constant, the intensity of pain is so personal that the sole arbiter of the threshold of tolerance should be the patient rather than the reasonable person.

The combined effect of the definition of a terminal illness in s 3 and the conditions for requesting assistance under s 4 empowers a patient to refuse treatment as being 'unacceptable' or to assert that the available treatment makes the pain and suffering 'unacceptable'. This legitimises the refusal of treatment and the rejection of palliative care. Imminent death is not a precondition for a request. The patient's evaluation of the treatment and extent of pain enables her or him to choose accelerated death for a potentially life

¹⁰² S Gardbaum, 'Liberalism, Autonomy and Moral Conflict' (1996) 48 *Stanford LR* 385, 416-17; cf M Charlesworth who asserts that the right to control the duration of one's life is part of moral autonomy: Victoria, *Options for Dying with Dignity 1st Report Victorian Parliament Social Development Committee* (1986) 39, 44, while the ability to choose or be self determining and autonomous is seen as giving 'special value to the lives of persons': H Kuhse, *Active and Passive Voluntary Euthanasia*, *ibid*, 89, 94.

¹⁰³ B Pollard, *Euthanasia: Should We Kill The Dying?* (1989). The right to refuse treatment is not based upon, nor does it support 'a positive right of a patient to direct or demand a specific medical intervention'; J Murphy, 'Beyond Autonomy ...' (1993) 9 *J of Contemp. Health Law & Policy* 451, 478.

threatening illness and to request it once it has deteriorated from non-terminal to terminal.

Some persons may prefer the quicker release of accelerated termination to prolonged treatment of a non-terminal condition which verges on, or may lapse into, a terminal one despite the treatment. This preference may be given effect to by refusing treatment, including palliative care, on the ground that the level of pain or extraordinary measures are unacceptable. Once the illness becomes a terminal one, the Act comes into play. The Act does not disqualify a person either because there was a refusal of treatment or because the terminal illness began as a non-terminal one. The primary requirement of a terminal illness with pain may be satisfied from the inception or by deterioration as a result of the patient's conduct.

The scope of the Act is thereby altered to legalise assisted suicide where a patient decides that the pain or treatment is unacceptable. This result is one dimension removed from the professed aim of providing assistance to end an illness which does not require any initiative by the patient to be classified as terminal.

To allow assisted termination of life on the grounds mentioned in the Act will facilitate claims based on other reasons. In singling out pain and terminal illness as the sole justification for the request in s 4, the Act erodes the individual's right to choose assisted suicide. If personal autonomy is given its fullest expression, a person should be free to request assisted termination on demand without stating a reason. There should be parity between suicide and assisted suicide. The decriminalisation of suicide is not dependent on the validity or existence of reasons for committing it.

Abetment of suicide has remained a crime even after suicide was decriminalised in some jurisdictions.¹⁰⁴ The Act seeks to decriminalise abetment but its many restrictions are incompatible with the prime reason for introducing the legislation, namely the securing of self determination.

Part of the rationale of the Act is that a person who wishes to commit suicide but is too ill, too wracked by pain, too helpless to do so, should have the assistance of a doctor to end life.¹⁰⁵

The same reasoning may be used to justify recourse to external assistance when a person's desire to end life is not accompanied by the capacity to implement that desire, regardless of whether that incapacity arises from physical infirmity or from irresolution. Terminal illness, inconsolable grief, terminal altruism and sacrifice and sheer hopelessness have an equivalence which the law should reflect.

The request must be to the 'patient's medical practitioner'. This eliminates friends and relatives of the patient as persons from whom assistance may be sought. Although the patient's own doctor knows the facts and needs of the sufferer best, a patient who wants the ultimate act performed by a specific person is denied that comfort although a relative or a friend may in some cases

¹⁰⁴ *Crimes Act 1900 (NSW) s 31C; Crimes Act 1958 (Vic) s 6B(2).*

¹⁰⁵ An attempt to secure this was rejected by a majority of the Supreme Court of Canada in *Rodriguez v A-G for British Columbia* [1994] 85 CCC (3d) 15.

provide assistance with greater acceptability than a doctor. It is arguable on grounds of privacy and expense, that assistance should be available from a non-medical source, and not exclusively from the patient's medical practitioner.

The restriction further illustrates the curtailment of patient autonomy and is likely to provide grounds for later claims to expand the category of legal terminators of life.

The arguments for barring relatives from accelerating termination are that there may be a conflict of interest if they are beneficiaries under a will, and that doctors are less likely to perform the termination negligently.¹⁰⁶ However, physician assisted suicide may be too expensive for some and too time consuming for others. After decriminalisation under the Act a relative or friend may act upon a patient's request with as clear a conscience as the doctors who did so prior to decriminalisation. The surge of compassion which has led to non-prosecution of the doctors, despite their admissions, should help the caring relative to act with the same impunity.

PALLIATIVE CARE AND THE ACT

The Act places two limitations on a medical practitioner's power. First, no assistance to terminate life must be given if 'there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient'.¹⁰⁷

The subsection takes account of the patient's needs. A palliative care option may not be reasonably available to a particular patient on grounds of expense, delay or inaccessibility. Similarly, palliative care may not reduce suffering adequately for a patient who has greater susceptibility to pain than others. Resort to illegal euthanasia has been attributed to a need for symptom relief which current arrangements for palliative care fail to provide.¹⁰⁸

An empirical study has found that only 6% of terminal patients requested assistance to die.¹⁰⁹ Most patients are satisfied with the level of symptom control.¹¹⁰ It is clear however that all pain and suffering that is consistent with terminal illness cannot be relieved by palliative care.¹¹¹ Nerve pain, bone pain and psychological pain are reportedly the most difficult to treat.¹¹²

¹⁰⁶ J Pugliese, 'Don't Ask — Don't Tell, The Secret Practice of Physician Assisted Suicide' (1993) 44 *Hastings LJ* 1291, 1307.

¹⁰⁷ *Rights of the Terminally Ill Act* 1995 (NT) s 8(1).

¹⁰⁸ P Baume and E O'Malley, 'Euthanasia: Attitudes and Practices of Medical Practitioners' (1994) 161 *MJA* 137, 142.

¹⁰⁹ R Hunt et al, 'The Incidence of Requests for a Quicker Terminal Course' (1995) 9 *Palliative Medicine* 167 reporting a survey done at an in-patient hospice and palliative care unit in Adelaide.

¹¹⁰ Evidence of the Association for Palliative Medicine to the Select Committee on Medical Ethics of the House of Lords; United Kingdom, *House of Lords Report by the Select Committee on Medical Ethics* (Vol 2, 1994) 183 ff.

¹¹¹ M Ashby, 'Hard Cases, Causation and Care of the Dying' op cit (n 96) 155.

¹¹² Canada, *Of Life and Death — Report of the Special Canadian Senate Committee on Euthanasia and Assisted Suicide* (1995) 19.

Palliative care may hasten death while relieving pain in the short term. Such care includes the state of pharmacological oblivion which makes a patient unconscious through the administration of drugs. The principle of double effect is used to justify this procedure.¹¹³

At one point the distinction between palliative care and euthanasia corresponds to the distinction between foresight of death and the intention to kill. The administration of drugs may be foreseen as a likely or even a probable cause of death in the short or long term; but if they were given with the intention of relieving pain and not with the intention of killing the patient, the principle of double effect stands in the way of a conviction for murder.¹¹⁴

The second limitation is that no assistance must be given if palliative care causes a remission of the patient's pain and suffering after a request for assistance was made. Subsequently, if the palliative care ceases to alleviate pain to a level acceptable to the patient, then assistance may be given only 'if the patient indicates to the medical practitioner the patient's wish to proceed in pursuance of the request'.¹¹⁵

There is potential for a conflict between doctor and patient in the wording of s 8(1). The existence of options is a matter of medical opinion and reasonable availability, whereas the patient decides whether the palliative care is effective and the level of pain is acceptable. It is possible for a patient to indicate that the suffering is too great and the palliation too ineffective to be endured any further, although the doctor's considered and informed opinion is that 'there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient'.

For a patient to know that the relief provided by palliative care is 'acceptable' he or she must be given that care. However at the time of the parliamentary debates on the Bill, the Northern Territory had 'no medical oncologist, very limited radiotherapy services, not a single palliative care specialist, an inadequately resourced domiciliary palliative care program and not a single hospice'.¹¹⁶ During the parliamentary debates on the Bill, it emerged that there was just one designated palliative care bed in Alice Springs, there were no qualified experts in palliative care in the Northern Territory and no qualified interpreters in the Aboriginal laws, although the Act required these.¹¹⁷ An alternative to the legal and ethical problems posed by legalising voluntary euthanasia or homicide by consent is the 'urgent

¹¹³ M Ashby, 'Hard Cases, Causation and Care of the Dying' op cit (n 96) 156; cf R Hunt, 'Palliative Care — The Rhetoric-Reality Gap' in H Kuhse (ed) *Willing to Listen, Wanting to Die* (1994) 115–137.

¹¹⁴ *Airedale NHS Trust v Bland* [1993] AC 789, 867 per Lord Goff; *Auckland Area Health Board v A-G* [1993] 1 NZLR 235, 252, 253 per Thomas J; H Palmer, op cit (n 12) 375. The principle has been criticised; see R Syme, 'A Patient's Right to a Good Death' (1991) 154 MJA 203, 204; P Cotton, 'Medicine's Position is Both Pivotal and Precarious in Assisted-Suicide Debate' (1995) 273 JAMA 363.

¹¹⁵ *Rights of the Terminally Ill Act* 1995 (NT) s 8(2).

¹¹⁶ Dr J Zalberg Director of Medical Oncology and Palliative Care at Heidelberg Repatriation Hospital, Melbourne, *The Age*, 8 February 1995, 12 (letter).

¹¹⁷ M Eburn, 'Voluntary Euthanasia' (July 1995) NSW *L Soc J* 40, 44.

dissemination of palliative care principles and practice into general medicine'.¹¹⁸

The inadequacy of proper facilities for palliative care in the Northern Territory is duplicated in Holland. The Dutch Health Council reported in 1987 that the lack of expertise in the management of pain by health professionals caused unnecessary pain in a majority of cancer patients.¹¹⁹ A working party of the British Medical Association has reported that palliative care in Holland is inferior to that available in Britain.¹²⁰

The intensity and visibility of prolonged pain that results from such inadequate palliative care is undeniably a factor that accounts for the de facto or de jure legalisation of voluntary euthanasia in Holland and the Netherlands.¹²¹ Dr Zylic, Medical Director at one of Holland's newer hospices, urges that necessary resources for hospice care should be provided and that more hospices should be established. He notes that the treatment of cancer pain and control of symptoms receives inadequate attention and is practised at a very poor level.¹²² The legalisation of euthanasia is likely to result in fewer hospices and a reduced budget for palliative care.¹²³ The reduction or lack of palliative care will result in increased pain for those who are unwilling to request euthanasia.¹²⁴

The relief of pain experienced by those who seek euthanasia must be balanced against the pain endured by those who reject it but have little or no access to palliative care.¹²⁵ The promotion of palliative care is more productive than 'the stagnant, circular and divisive' debate on euthanasia as modest investments on palliative care 'have yielded excellent results for

¹¹⁸ J Buchanan, 'Euthanasia: the Medical and Psychological Issues' (1995) 3 JLM 161, 168; BJ Pollard (1994) 161 MJA 572 (letter); B Pollard and R Winton, 'Why Doctors and Nurses Must Not Kill Patients' (1993) 158 MJA 426.

¹¹⁹ Dr J Keown, 'Slippery Slope' op cit (n 43) 280, citing *Nederlandse Jurisprudentie* (1985) 451, 452.

¹²⁰ United Kingdom, *Euthanasia, Report of the Working Party to Review the BMA's Guidance on Euthanasia* (1988) 49.

¹²¹ L Karin Dorrepaal et al, report that pain management in the Netherlands Cancer Institute was inadequate in slightly more than 50% of evaluated cases: L Karin Dorrepaal et al, 'Pain Experience and Pain Management Among Hospitalised Cancer Patients' (1989) 63 *Cancer* 593, 598.

¹²² Dr Z Zylic, 'The Story Behind the Blank Spot' (1993) 10 *Jo of Hospice and Palliative Care* 30, 32-4.

¹²³ SG Potts, 'Looking for the Exit Door: Killing and Caring in Modern Medicine' (1988) 25 *Houston LR* 493, 507. Peter Singer refers to the burden on already strained health care resources and to the need for indefensible and substantial budgetary cuts if euthanasia is not legalised. Victoria, *Report of the Victorian Social Development Committee on Options for Dying with Dignity* (1986) 86; cf D Mendelson 'The Northern Territory's Legislation in Historical Perspective' (1995) 3 *J Law & Med* 136, 141; EJ Emmanuel and LL Emmanuel, 'The Economics of Dying: The Illusion of Cost Savings at the End of Life' (1996) *The New England Jo of Medicine* 540.

¹²⁴ EJ Cassel, 'The Nature of Suffering and the Goals of Medicine' (1982) 306(11) *The New England Journal of Medicine* 639.

¹²⁵ In Adelaide only 6% of terminal patients in a palliative care unit sought assistance to die when asked; R Hunt et al, op cit (n 109) 167; Cundiff points out that over the past 18 years of practice as an oncologist and a palliative care doctor, of several thousands of his patients, only 10 have requested euthanasia and another 15 to 20 have attempted suicide; D Cundiff, *Euthanasia is not the Answer* (1992) 7-8. See also M Bagaric, op cit (n 8) 26 and 27.

patients and families by improving care and decision making at the end of life'.¹²⁶

PENAL SANCTIONS

There is good reason for some scepticism about the restrictions placed on doctor, patient and illness before termination may take place legally. If doctors and patients in Victoria could have disregarded the substantive penal law and risked prosecution by confessing to performing illegal euthanasia, there is no guarantee that mere procedural and evidentiary provisions in the Act will ensure compliance. A four year sentence of imprisonment or a penalty of \$2000 imposed by s 11(1) of the Act will not deter non compliance with procedures for assisted termination, when many doctors have risked conviction for murder or manslaughter by terminating lives without the 'safeguards' introduced by the Act. Despite written admissions by seven doctors that they had assisted some of their patients to commit suicide, and a further admission by one of them, Dr Rodney Syme, that he had administered euthanasia for over 20 years, the Victoria Police has not prosecuted any of them.¹²⁷

The two penal provisions of the Act are concerned with preserving the integrity of the Certificate of Request and with maintaining a full chronicle of the circumstances of the death. The penalty referred to above is imposed on a person who by deception or improper influence procures the signing or witnessing of a Certificate of Request. Additionally the procurer forfeits any financial or other benefit from the death of the patient regardless of whether the benefit is direct or indirect, and whether or not the death results from assistance given under the Act.¹²⁸

The forfeiture provision in s 11(2) cannot be implemented where a benefit is indirect. The person who exerts improper influence may not derive a direct benefit under the patient's will. Nevertheless that person's spouse or child may receive one which brings financial security and tangible rewards to the procurer which are incapable of being forfeited.

Punishment and forfeiture for procuring an assisted death may deter the use of undue influence in some cases. However the difficulties of limiting the myriad ways in which a patient's will may be overborne and of eliminating the advantages derivable from an accelerated end to a wealthy relative's life are insuperable by legislation.

The proscription of improper conduct in s 11(1) raises some problems. The

¹²⁶ M Ashby, 'The Fallacies of Death Causation in Palliative Care' op cit (n 84) 177.

¹²⁷ N Davies, 'Helping Patients to Die' *The Age* 25 March 1995, 1 and 6; R Buchanan 'Police Probe on Euthanasia' *The Age* 22 June 1995, 3; R Buchanan, 'Police Drop Euthanasia Inquiry' *The Age* 10 August 1995, 3; and 'A Time to Die' *The Age* 25 March 1995, 23. For further examples of prosecutorial discretion or judicial clemency exercised in favour of euthanasia see M Otlowski, 'Mercy Killing in the Australian Criminal Justice System' (1993) 17 *Crim LJ* 10; T Grace, 'Mercy Killing and the Criminal Law' (unpublished Master of Laws thesis, Law Faculty, Monash University, 1994); RMagnusson, op cit (n 39) 1110.

¹²⁸ *Rights of the Terminally Ill Act* 1995 (NT) s 11(2).

description of the vitiating element as 'deceptive or improper influence' is part of many criminal offences. In the case of euthanasia it is more difficult than usual to decide whether a particular form of influence exerted over a terminally ill person is improper. There can hardly be any cases where proper influence may be exerted to procure a request for assisted death.

A related problem is whether the request was caused by the inducement, whether it was self induced or whether it was brought about by a combination of both. The words of the section require causation to be proved. Given the irreversible consequence of death there is likely to be a greater deterrent effect if any promise or threat entailed punishment where it preceded a request, regardless of whether it caused the request to be made. The statutory duty cast on the practitioner to ensure 'that the patient's decision has been made freely, voluntarily and after due consideration'¹²⁹ will be discharged more convincingly if, to his or her knowledge, there has been no antecedent influence, causative or otherwise.

The Act grants immunity from a civil or criminal suit and from professional disciplinary action where conduct has been '. . . in good faith and without negligence in compliance with this Act'.¹³⁰ It is difficult to satisfy these conditions where the practitioner is aware of any influence exerted on a patient and proceeds to carry out the request on the ground that the influence was not improper.

If a violation of s 11(1) procures not only the signing of a certificate of request but the death of the patient as well, it ought to be possible to charge the person with the crime of procuring another to kill himself under s168 of *the Criminal Code* (NT), for instigation of suicide may amount to murder.¹³¹

A duty to keep medical records is imposed under a penal sanction which carries two years imprisonment or a fine of \$10000. The records provide evidence of compliance and help the doctors to ensure that there is a step by step observance of procedures and conditions for assistance with termination. The duty is to 'file and keep' certain information as part of the patient's medical record.¹³² The information that must be recorded relates to the patient, the medical practitioners and the Act.

The keeping of medical records has desirable aims and the penalty seeks to enforce them. However, a practitioner whose instincts, conscience and reason had led her or him to terminate life on grounds of compassion for a terminally ill patient and to risk a far longer term of imprisonment if charged with murder or manslaughter is unlikely to be deterred by the level of punishment in s12. If the circumstances are compelling enough it is certain that procedural steps, including the witnessing and signing of a request, may be dispensed with on the grounds of necessity.

The ineffective nature of legislative restraints and penal sanctions on doctors who practise voluntary and non voluntary euthanasia is starkly

¹²⁹ *Rights of the Terminally Ill Act* 1995 (NT) s 7(1)(h).

¹³⁰ *Rights of the Terminally Ill Act* 1995 (NT) s 20(1).

¹³¹ D Lanham, 'Murder by Instigating Suicide' [1980] *Crim L R* 215, 220, discussing the position in UK and Victoria.

¹³² *Rights of the Terminally Ill Act* 1995 (NT) s 12.

documented in the Kuhse-Singer survey.¹³³ The *Rights of the Terminally Ill Act* 1966 (NT) and future legislation modelled on it may be equally unavailing. Whether the modified limits imposed by that Act on their power will be welcomed by doctors or whether they will be violated on the same scale depends on the practitioners' perceptions of individualised justice and power. Cases of extreme urgency where the pain or physical degradation is intense are more likely to influence health care providers to disregard even the liberalised limits of the Act.

If the argument is that euthanasia is practised despite legislative bans and criminal sanctions, the imposition of modified regulations and lesser punishments is likely to increase the practice. The practitioner who regards himself or herself as the best arbiter of the patient's needs and interests will not surrender that judgment to the generalised provisions of laws and procedures which he or she disapproves or which conflict with the immediacy of the patient's needs.

THE CORONER'S ROLE

An assisted death is not deemed to be unexpected, unnatural or violent for the purposes of the definition of 'reportable death' under the *Coroners Act* nor is it a reportable death by reason only of having occurred during an anaesthetic.¹³⁴

This provision needs to be amended. An assisted termination is 'unnatural' and ought to be a reportable death. The Coroner ought to be informed each time a practitioner assists a patient to terminate life. It is an abuse of language to regard an accelerated death as a natural one. The interests of the community require that a public official such as the Coroner should be satisfied that all safeguards have been complied with. The Attorney-General must be informed by the Coroner if there is reasonable cause to doubt that statutory procedures have been fully observed.

In fact the Coroner should be informed as soon as a patient indicates a wish to have life terminated. His or her presence and participation at each subsequent stage is essential. The Coroner should be a witness to the signing of the Certificate of Request by the patient or a delegate where the patient cannot sign. Consultation with, reference to and the presence of the Coroner are means of ensuring the supervision of an independent official in the apocalyptic act of causing another person's death. The involvement of the Coroner may make an inquest unnecessary. The inconvenience and expense that will result from securing the Coroner's presence are offset by gaining an independent quasi-judicial official to monitor the termination of a life.

Even in Holland where euthanasia is practised openly, a doctor who performs euthanasia should not certify death by natural causes, but should summon the local medical examiner. This official must examine the corpse,

¹³³ H Kuhse et al, op cit (n 77) 191.

¹³⁴ *Rights of the Terminally Ill Act* 1995 (NT) s 13(2).

interview the doctor and lodge a report with the local prosecutor who then decides whether to hand the body over to the next of kin or to investigate further.¹³⁵

The reliability of the safeguards is not guaranteed by a bare assertion made by interested parties such as the practitioners who assisted and witnessed the death that 'all requirements under this Act have been met'.¹³⁶ Under the present provision the Coroner does not investigate the assisted death or carry out an autopsy. The medical records are kept by the practitioner and are not checked by the Coroner at the time they are drawn up. The records are sent to the Coroner only after the death has occurred. The discretion given to the Coroner under s 15 is to report to the Attorney-General or not; it is not a discretion to investigate the death.

The Act seriously undermines the Coroner's role as one of the guardians of the community in identifying any suspicious factors surrounding a death. An autopsy reveals not only the cause of death but the stage and extent of the disease as well. Two or even three medical prognoses and a death certificate are not as reliable as an autopsy.¹³⁷

A Melbourne study which examined the autopsy rate and the accuracy of death certificates showed a clinical diagnostic error rate of 21% in death certificates.¹³⁸ A similar study in the Australian Capital Territory had an error rate of 23%.¹³⁹

Arguably autopsies have limitations and their number has declined,¹⁴⁰ showing the reluctance of doctors and patients to consent to hospital autopsies.¹⁴¹ However the unique nature of an assisted death cries out for the Coroner's supervision prior to the death and for a full coronial investigation after the death. Dr David Ranson argues that 'increasing interest in the medical audit and the issue of value for money in health care' also support a need to evaluate patient outcomes.¹⁴²

IMMUNITIES

The Act confers wide ranging protection for conduct performed in accord with its provisions. This extends to immunity from civil actions, criminal prosecutions and professional sanctions:

A person shall not be subjected to civil or criminal action or professional disciplinary action for anything done in good faith and without negligence

¹³⁵ Dr J Keown 'Slippery Slope' op cit (n 43) 264.

¹³⁶ *Rights of the Terminally Ill Act 1995* (NT) s 12(e)(ii).

¹³⁷ D Ranson, 'The Coroner and the *Rights of the Terminally Ill Act 1995* (NT)' (1995) 3 *JLM* 169, 174.

¹³⁸ P McKelvie and J Rode, 'Autopsy Rates and a Clinicopathological Audit in an Australian Hospital — Cause for Concern?' (1992) 156 *MJA* 456.

¹³⁹ G MacLaine, E MacArthur and CA Heathcote, 'Comparison of Death Certificates and Autopsies in the Australian Capital Territory' (1992) 156 *MJA* 462.

¹⁴⁰ S Corder, 'The Autopsy in Decline' (1992) 156 *MJA* 448.

¹⁴¹ R Start et al, 'Public Perceptions of Necropsy' (1995) 48 *J Clin Path* 497.

¹⁴² D Ranson, op cit (n 137) 175.

in compliance with this Act, including being present when a patient takes a substance prescribed for or supplied to the patient as the result of assistance under this Act to end the patient's life.¹⁴³

Apart from the patient, many persons perform functions under the Act. Medical practitioners, witnesses, health care providers and officials such as the Coroner and the Attorney General will be granted immunity, provided that they acted in good faith and without negligence in complying with the Act.

Under s 20(1) of the Act, omissions to comply are not specifically protected, the immunity being for 'anything done'; in contrast, s 20(2) confers a different immunity for 'anything that . . . was done or refused to be done'.

Immunity is extended by the provision that 'a professional organisation or association or health care provider shall not subject a person to censure, discipline, suspension, loss of licence, certificate or other authority to practice, loss of privilege, loss of membership or other penalty for anything that, in good faith and without negligence, was done or refused to be done by the person and which may under this Act lawfully be done or refused to be done'.¹⁴⁴

The protection given from 'professional disciplinary action' in s 20(1) is amplified with a wealth of detail in s 20(2) which may have well been subsumed by the general provision. Compliance with the Act, good faith and the absence of negligence are preconditions for the grant of immunity in both sections.

These immunities result in inadequate safeguards against a range of wrongs that may be committed deliberately or maliciously.

Negligence results in a loss of immunity under s 20(1) only if it is in conjunction with a lack of good faith and non-compliance with statutory procedures for giving assistance. This is unsatisfactory. Responsibility should lie for any one of these, where the actor's conduct causes death or prolongs pain by mismanagement of an attempt to perform euthanasia. If the three elements are treated disjunctively there will be greater accountability and more care in observing the procedural steps.

The Act is starkly deficient in not imposing criminal responsibility for intentional, reckless or negligent causing of death in contravention of the Act. It is clearly more important to hold a medical practitioner accountable for such conduct than to impose liability for faulty record keeping¹⁴⁵ or undue influence in drawing up a Certificate of Request.¹⁴⁶ These two provisions focus on acts which are peripheral to the central act of causing death. They merely penalise non-observance of procedural and evidentiary requirements.

It is naive to imagine that every request for assisted termination involves true and informed consent or that no reward will ever be offered by a beneficiary to a doctor or that every doctor will refuse such an offer. Apart from

¹⁴³ *Rights of the Terminally Ill Act 1995* (NT) s 20(1).

¹⁴⁴ *Rights of the Terminally Ill Act 1995* (NT) s 20(2).

¹⁴⁵ *Rights of the Terminally Ill Act 1995* (NT) s 12.

¹⁴⁶ *Rights of the Terminally Ill Act 1995* (NT) s 11.

providing an end to pain, the newly decriminalised act of assisted termination may lead to abuses by greedy beneficiaries, disgruntled relatives, impatient, incompetent or avaricious doctors.

In not criminalising the wrongful causing of death and by conferring immunity in the widest terms, the Act leaves the door open to many dangers, despite the concern voiced in the Preamble 'to provide procedural protection against the possibility of abuse of rights recognised by the Act.'

A specific immunity is conferred by the Act on guardians who may seek voluntary euthanasia and on doctors who may provide it.

A request by a patient for assistance under this Act, or giving of such assistance in good faith by a medical practitioner in compliance with this Act shall not constitute neglect for any purpose of law or alone constitute or indicate a disability for the purposes of an application under s8 of the Adult Guardianship Act.¹⁴⁷

A patient who is a guardian may have a conflict of interest in providing continuing care for a ward, as opposed to seeking a permanent end to a painful illness. A doctor who assists in terminating life may have a pending application to become a guardian, or may already be one. In these and other examples the relief of pain sought or provided by voluntary euthanasia is not to be regarded as neglect or as a disqualification from applying for, continuing or discharging the duties of guardianship.

A patient who has made a request for termination should not be considered to be suffering from an intellectual disability under s 8 of the *Adult Guardianship Act*, and therefore will not need a guardian to make medical decisions.

An acceptable form of immunity is found in the provision that 'a health care provider is not under any duty, whether by contract, statute or other legal requirement to participate in the provision to a patient of assistance under this Act, and if a health care provider is unable or unwilling to carry out a direction of a medical practitioner for the purpose of the medical practitioner assisting a patient under this Act and the patient transfers his or her care to another health care provider, the former health care provider shall, on request, transfer a copy of the patient's relevant medical records to the new health care provider'.¹⁴⁸

The autonomy of the health care provider as well as the patient is secured by this provision, for the former may refuse to implement a request for assisted termination and the latter may change to another provider. No reason has to be given for the unwillingness or inability to provide assistance nor for the decision to transfer to another provider. The obligation to transmit the medical records to the new provider ensures that there is continuing information on which to base a medical diagnosis in the changed environment.

¹⁴⁷ *Rights of the Terminally Ill Act 1995 (NT)* s 20(3).

¹⁴⁸ *Rights of the Terminally Ill Act 1995 (NT)* s 20(4).

MEDICAL PRACTITIONERS

A medical practitioner under s 3 of the Act is a person who has been entitled to practice as one in a State or Territory of the Commonwealth for a continuous period of not less than five years and who resides in, and is entitled under, the *Medical Act* to practise medicine in the Territory.

The definition does not require actual experience, merely a qualification. A doctor who has never practised after admission, but who goes to the Northern Territory five years after qualifying, will be entitled to assist a patient to terminate life. No period of continuous residence or practice as a doctor in the region is required.

In defining a 'medical practitioner' the Act gives no indication whether 'resident in' includes constructive residence. If it does, a doctor who owns land or a home in the Northern Territory and is registered there, but physically resides in another State, may perform euthanasia in the Northern Territory on flying visits for that purpose.

As there is no requirement that the patient must reside in the Territory, it is possible for doctors from other Australian States with dual registration and property rights in the Northern Territory to service patients who have travelled from other Australian States and Territories and overseas to seek termination.¹⁴⁹

A 'qualified psychiatrist', whose concurrence with two other medical practitioners is a condition precedent for assisted termination of life, has been defined to accommodate legal status, professional qualifications or employment. The qualifications are that the person is (a) entitled by law to practise as a specialist psychiatrist, (b) is a Fellow of the Royal Australian and New Zealand College of Psychiatrists or (c) is employed by the Commonwealth or a State or Territory as a specialist or consultant psychiatrist.¹⁵⁰

The 'qualified psychiatrist' should have examined the patient and confirmed that the patient is not suffering from a treatable clinical depression in respect of the illness.¹⁵¹ The definition of a 'qualified psychiatrist' had to be changed from the stipulation in the principal Act that the person should hold 'a diploma of psychological medicine or its equivalent'. This qualification had been unavailable since 1970 after examinations for membership of the Royal Australian and New Zealand College of Psychiatrists were conducted. The original enactment showed that no research had been done into whether the qualification was available and whether there were practising psychiatrists in the Northern Territory who possessed it.¹⁵²

¹⁴⁹ D Lanham, 'Where Angels Fear to Tread' in H Selby (ed) *Tomorrow's Law* (1995) 180, 181. Of the four persons who had used the Act by 5 March 1997 two had travelled to Darwin from South Australia and New South Wales, while the other two were residents of the Northern Territory.

¹⁵⁰ Section 3 of the Principal Act as amended by the *Rights of the Terminally Ill Amendment Act* 1996.

¹⁵¹ Sections 7(1)(c)(ii) and (iv) of the Principal Act as amended by the *Rights of the Terminally Ill Amendment Act* 1996.

¹⁵² D Mendelson, 'The Northern Territory's Euthanasia Legislation in Historical Perspective' (1995) 3 JLM 136, 143.

The Act seeks to ensure that the doctor's assistance or refusal to terminate life is not motivated by greed or fear. This is done in two ways. The first is by imposing a sanction. Anyone who gives or promises an advantage or reward other than a reasonable payment for medical services or who causes or threatens a disadvantage to a medical practitioner or other person for the purpose of compelling or persuading either to assist or refuse to assist in terminating a patient's life incurs a penalty of \$10,000.¹⁵³ The second is by divesting the recipient of a reward or advantage of any legal right or capacity to receive or retain the reward or to accept or exercise the advantage. It is irrelevant that the recipient was aware or not aware of the intention or promise to give the reward or advantage.¹⁵⁴

The concern of the Act to secure independence could have been reinforced by an additional provision which penalised the doctor or other person for soliciting or accepting a reward or advantage other than a scheduled fee. This ought to have been in conjunction with the provision in s 6(2) which effectively takes away a right of action to sue for the reward.

A discretion is given to a medical practitioner by s 5 to refuse assistance to a patient who wishes to have life ended even though the prerequisites of the Act have been met. No reasons have to be given for the refusal. When it was a criminal offence to abet suicide in the Northern Territory, a doctor's refusal to assist was explicable on the basis that the criminal law must not be contravened. Once abetment was decriminalised under the Act and if all the preconditions were met, a doctor who refuses assistance hurts a patient more than one who refuses to risk prosecution. Dr John Buchanan suggests that a power to end life on request will add to the stress experienced already by health professionals who treat a terminal illness.¹⁵⁵

However, the Act preserves the doctor's autonomy by not imposing a duty to assist termination. A doctor's refusal to risk prosecution by abetting suicide under the old law and a conscientious objection to assisting it under the new Act are different but equally valid exercises of self determination. The patient's discomfiture in having an intransigent doctor may be temporary, for an obliging one may fly in or drive over. It seems fair that the Act gives a patient an option of assisted suicide provided that a doctor is willing to assist, while every doctor is given the option of refusing to assist termination of life though agreeing to treat the patient otherwise.

The medical practitioner's statutory entitlement to turn down the patient's request may be misleading. A practitioner is not ordinarily entitled to refuse to administer a legally authorised procedure on conscientious grounds. If a doctor refuses accelerated termination one adverse consequence will be the loss of a practice in that special area. Another problem is the dilemma of having to choose between the patient's request, the doctors personal opposition to euthanasia and the loss of potential earnings. The statutory exemption does not necessarily free the doctor from a personal crisis of conscience.

¹⁵³ *Rights of the Terminally Ill Act* 1995 (NT) s 6(1).

¹⁵⁴ *Rights of the Terminally Ill Act* 1995 (NT) s 6(2).

¹⁵⁵ J Buchanan 'Euthanasia: the Medical and Psychological Issues' (1995) 3 JLM 161, 164-5.

It introduces a complexity into the doctor-patient relationship by giving the doctor power to override the patient's newly acquired right. There is no duty that correlates to that right.¹⁵⁶

Part of the slippery slope argument is that a doctor may be compelled to assist termination. Once voluntary euthanasia is in place and a climate of legality has replaced the clandestine and criminal atmosphere of the past, there will be greater pressure on doctors internally and externally to assist acceleration of death. It is conceivable that a court may be asked to award damages against a doctor who declines. Such a claim will have little chance of success as long as the discretion of the doctor is unfettered and while there remains an element of personal judgment as to the nature and course of the illness.

The conditions under which a medical practitioner may assist termination are contained in s 7(1)(b), (c) & (m) of the Act. The acts of witnessing and certifying the request are dealt with in s 7(1)(k).

The focus of s 7(1)(b) is the doctor's assessment of the illness and its treatment. The patient's doctor must be satisfied on reasonable grounds that the illness will result in the patient's death in the normal course and without using extraordinary measures.¹⁵⁷ The provision gives the doctor a power to classify a treatment as an 'extraordinary measure'. In the absence of a definition, what is 'extraordinary' will vary with the patient's condition. Ordinary surgery may be an extraordinary measure depending on age and vulnerability. The conversion of a serious illness into a terminal one does not depend solely on deterioration or a change in its course but on the judgment of the doctor as to the classification of a treatment. The need for 'reasonable grounds' and for two other opinions, one medical and one psychiatric, acts as a brake on arbitrary or idiosyncratic judgments. Incurability is another precondition which depends on a combined decision by the doctor and the patient. 'In reasonable medical judgment' there must be 'no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure'.¹⁵⁸

Incurability is stressed by the requirement that the available treatment is merely palliative. The doctor must be 'satisfied on reasonable grounds' that 'any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress with the object of allowing the patient to die a comfortable death'.¹⁵⁹

An attempt is made to obtain greater reliability and independence in forming the medical judgment by requiring confirmation of the practitioner's opinion. This must come from a second medical practitioner who is not a relative, employee or member of the same medical practice as the first practitioner and who has qualifications and experience in treating the terminal illness from which the patient is suffering. Further confirmation must come

¹⁵⁶ See the useful discussion on 'The Opt-Out Clause' by Bagaric; M Bagaric, op cit (n 8) 44-6.

¹⁵⁷ *Rights of the Terminally Ill Act 1995* (NT) s 7(1)(b)(i).

¹⁵⁸ *Rights of the Terminally Ill Act 1995* (NT) s 7(1)(b)(ii).

¹⁵⁹ *Rights of the Terminally Ill Act 1995* (NT) s 7(1)(b)(iii).

from a qualified psychiatrist.¹⁶⁰ The dichotomy between general practitioner and specialist probably accounts for the requirement that experience with terminally ill patients is not required of the first practitioner who treats the patient, but is required of the practitioner who provides a second opinion.

There are four matters on which confirmation must be obtained. These are (a) the first medical practitioner's opinion as to the existence and seriousness of the illness; (b) the likelihood of death as a result of the illness; (c) the first practitioner's prognosis; (d) the fact that the patient is not suffering from a treatable clinical depression in respect of the illness. The soundness of the opinions is questionable when the definition of medical practitioner in s3 does not require actual experience, as long as the person has been entitled to practise for not less than five years. Qualifications and a mere licence to practise provide little or no assurance of reliable judgment in a matter of life or death.

Section 7(1)(c)(iv) allows a patient who is terminally ill other than with 'treatable clinical depression in respect of the illness' to request assisted suicide. The exclusionary aspect of this provision maintains the emphasis on bodily pain as a motivating factor. Its terms do not provide a plausible rationale. Some depressions cannot be treated, some psychiatric disorders do not involve depression and some depressions may not be connected with the illness. Indeed, depression must be inevitable when the patient is aware that the illness is terminal, although some may control this better than others. This restriction on autonomy should eventually yield to the plausible argument that the terminal nature of the illness should suffice to justify the request, regardless of depression.

The Act seeks to remove inducements, pecuniary or otherwise, which may vitiate the medical judgments. Both practitioners should have no reason to believe that either of them or a close relative or associate will gain a financial or other advantage, other than a reasonable payment of medical services directly or indirectly as a result of the patient's death.¹⁶¹ The Act binds the practitioner to be guided by appropriate medical standards and guidelines in assisting the patient. There is a duty to consider the appropriate pharmaceutical information about any substance reasonably available for use in the circumstances.¹⁶² This provision may help resolve a dilemma faced by a doctor who considers that medical ethics or the Hippocratic Oath prohibit assistance in terminating life, but who is moved by the severe pain and suffering of the patient. Resort may be had to the guidelines and standards referred to by the Act provided that they do not contravene any law or violate medical ethics. It is doubtful that such guidelines exist when it has hitherto been a criminal offence to abet suicide and when the Australian Medical Association has so far opposed voluntary euthanasia. There cannot be

¹⁶⁰ Section 7(1)(c) of the Principal Act as amended by the *Rights of the Terminally Ill Amendment Act 1996*.

¹⁶¹ *Rights of the Terminally Ill Act 1995* (NT) s 7(1)(m). See also the penalties and forfeitures imposed by ss 6(1) and 6(2).

¹⁶² *Rights of the Terminally Ill Act 1995* (NT) s 7(2).

'appropriate medical standards and guidelines' for conduct that has been decriminalised so recently.

The requirements of s 7 as to the presence, certification and signatures of witnesses and the patient provide evidence of the voluntariness and sanity of the patient and the authenticity of the request. The concurrence of two experts on the nature and course of the illness, their discussion with and information to the patient clarify the options. The psychiatric qualifications of one of the practitioners will help to determine whether the patient's decision is truly voluntary and, even more significantly, whether sanity is established. The medical practitioner is required to provide the assistance and/or to remain while the assistance is given and until the death of the patient.¹⁶³

This provision gives rise to the danger that a medical practitioner may delegate to a health care provider the unique power of causing the patient's death. Section 5 confers power on a medical practitioner to assist in the termination of a patient's life. A health care provider, defined by s 3, is not under a duty to provide assistance to terminate life.¹⁶⁴ Although s 16 exempts from criminal liability a health care provider who acts on the instructions of a medical practitioner, it is undesirable that the crucial act of termination may be delegated merely by an implication that runs counter to the express nomination of a medical practitioner in s 5.

A doctor should not be empowered to instruct a health care provider to cause the death of a patient, even though the practitioner is present during the Act. The wide definition in s 3 includes institutions and individuals, nursing homes, hospitals and those responsible for the management of institutions where the patient is located as well as nurses or others whose duties relate to the care or medical treatment of the patient. The assimilation of individuals and institutions as health care providers is undesirable. Their legal and ethical responsibilities are not identical and may, in some cases, create a conflict of interests.¹⁶⁵

The provisions, especially s 16, increase the number of persons who may cause death and obtain immunity. A doctor who supports euthanasia, but who does not wish to commit the act which causes death, may instruct a health care provider to do it. The latter may comply on account of the immunity given by s 16 and because he or she may feel less independent than the doctor. Under s 5 a medical practitioner has an unfettered discretion to refuse assistance for any reason and at any time, in line with the law which existed prior to the Act. It will take an intrepid health care provider to disobey a doctor's order and risk the disapproval of the doctor or the institution which employs both.¹⁶⁶

Accordingly, we have a medical practitioner who may cause death and a delegate of the medical practitioner who may be instructed to do so; we also

¹⁶³ *Rights of the Terminally Ill Act 1995 (NT)* s 7(1)(p).

¹⁶⁴ *Rights of the Terminally Ill Act 1995 (NT)* s 20(4).

¹⁶⁵ M Ashby, *op cit* (n 96) 159.

¹⁶⁶ cf Trollope who suggests that s 16(1) allows the medical practitioner to delegate the power to terminate life by administering a substance; S Trollope, 'Legislating a Right to Die: the *Rights of the Terminally Ill Act 1995 (NT)*' (1995) 3 JLM 19, 21.

have an agent of the patient who may request death on behalf of the patient without any record on the certificate to indicate that an agent had signed it or that the agent confirmed and attested to the patient's signature.

DELEGATION BY THE PATIENT

Section 9 of the Act makes provision for a patient who is 'physically unable to sign the Certificate of Request'.¹⁶⁷ No mention is made whether the disability should be permanent, nor is the cause of the disability mentioned as being relevant to the power to delegate. Presumably the disability must be physical and not mental, because the agent's signature has to be requested by the patient. This is arguably restrictive and discriminatory against those who cannot request an agent to sign on their behalf. The capacity to request assistance as well as to request an agent to sign depends on voluntariness and understanding, attributes which are denied in fact or law to minors and the intellectually impaired.

It is consistent with both voluntariness and autonomy to allow a patient to ask another to sign for him or her. If a request for assisted termination of life is legitimate, a request for another to sign on the patient's behalf should cause no concern. What will cause concern later is the advantage given by law to those who can make a request for assistance or for a proxy over those who are incapacitated from doing that.

Section 9 has some pointed anomalies. First it refers to a preceding request to end life although there is no earlier mention of a request in any section except for an 'indication' that the patient has decided to end his or her life.¹⁶⁸ Secondly, the delegate or agent is not required to disclose on the face of the certificate that he or she is signing on behalf of the patient. Nowhere in the Certificate of Request is there an indication that it is an agent who is signing, nor is the agent required to disclose any knowledge of the patient's incapacity. Section 12, which specifies the keeping of medical records, does not refer to a delegated signature or a proxy which the medical practitioner must note.

The record that all requirements of the Act have been met¹⁶⁹ does not require express mention of the agent's status, knowledge or capacity. The presence of witnesses does not alter the need for a statutory designation of the agent's capacity. The hope that the practitioner may record the fact that an agent signed on behalf of the patient is no substitute for the omissions in the Schedule and in ss 7 & 9. The Schedule merely requires both practitioners to state that the person signing the request is known to them.

A delegated retraction of a request is given the same lax treatment. A person who has been told by a patient that a signed certificate is no longer valid because of the patient's wish to continue living, should be empowered to communicate that information to the practitioner who must regard that

¹⁶⁷ *Rights of the Terminally Ill Act 1995* (NT) s 9(1).

¹⁶⁸ *Rights of the Terminally Ill Act 1995* (NT) s 7(1)(f) & (i).

¹⁶⁹ *Rights of the Terminally Ill Act 1995* (NT) s 12(e)(ii).

information as sufficient to prevent assistance. Section 7(1)(o) does not provide for an authorised resiling from a signed Certificate of Request. Instead, it requires the patient to give an indication 'that it was no longer the patient's wish to end his or her life'. This is not possible if the patient has become unconscious after telling another person that the Certificate was no longer operative.

REVOCABILITY

A precondition to assistance is that the request to terminate life should not have been revoked. Constancy must be shown, for 'at no time before' assistance to end life was given should the patient have indicated to the doctor that it was no longer her or his wish to terminate life.¹⁷⁰ Revocability accords with the finding that failure of an attempted suicide is sometimes welcomed by the survivor.¹⁷¹ Even a request for termination may sometimes be 'a covert plea for considerate and committed care'.¹⁷²

A serious defect in the revocability of a request lies in the requirement that the 'indication' not to proceed must come from the patient. A signature on a Certificate of Request can belong to a delegate but there is no provision for another person to communicate the patient's withdrawal. A realistic scenario is where a patient signs a request for assisted termination which is followed by a later intimation to a friend that there should be no termination. If unconsciousness follows, the patient becomes unable to give the medical practitioner an indication that there is no longer a desire to terminate life. Section 7(1)(o) does not allow for a patient's change of mind to be notified by another person. If the patient remains unconscious the practitioner may legitimately proceed to terminate life because a contrary indication has not come from the patient. Even the specific sections on delegation (s 9) and rescission (s 10) make no provision for an agent to notify the practitioner that the patient has decided to revoke the request.

A hypothesis of fluctuating desires, one to end life and one to sustain it, must be resolved in favour of life. 'At no time before assistance' means that a desire to live, however feebly expressed or at whatever stage of the illness it was uttered, must not be overridden by a later decision to end life. Such an interpretation may be difficult to sustain, having regard to the purpose of the Act which is to make euthanasia more accessible to the terminally ill.

At the first intimation that the illness is incurable a patient may have a hope and a will to fight on, and may state categorically that treatment, extraordinary measures and prayer will triumph. At that point euthanasia may be firmly rejected. However, as the disease takes a greater hold, and faith and hope begin to dwindle, the desire for assisted suicide may replace the will to

¹⁷⁰ *Rights of the Terminally Ill Act 1995* (NT) s 7(1)(o).

¹⁷¹ United Kingdom, *Euthanasia: Report of the Working Party to Renew the BMA's Guidance on Euthanasia* (London 1988).

¹⁷² L Gormally, 'The BMA Report on Euthanasia and the Case Against Legislation' in L Gormally (ed), *Euthanasia, Clinical Practice and the Law* op cit (n 42) 180.

recover or to die a natural death. A literal interpretation of s 7(1)(o) makes euthanasia unavailable where the patient has indicated at any time that life must go on.

An alternative construction is that a decision to terminate life may be revoked just as a decision not to terminate is revocable, provided that the latter was not expressed after an initial decision to terminate was communicated. No decision to end life should be irreversible. If there has been any indication that life must not be terminated, and this was given after a decision to end life was once expressed, then life should be spared. Fluctuations of the will to live must result in non-termination. It is only an unrevoked, uncontradicted and constant wish for assisted termination that should be carried out.

However, some proponents of the Act may argue that the construction of s 7(1)(o) should be to facilitate rather than impede euthanasia, for that is the true purpose of the Act. Accordingly, their view will be that if a request for termination is not revoked it should be carried out, regardless of whether it was once preceded by a wish to continue living. The last uncontradicted wish should be decisive, one way or the other. Assistance should not be withheld if that was the last wish. Conversely, assistance should not be given if the wish to live was never changed.

The Act does provide some assistance on how to cope with fluctuations of the will. There are cooling off provisions to enable a patient to withdraw a request. After a patient or a patient's agent first indicates to a medical practitioner a desire to seek assisted termination, there has to be a lapse of at least 7 days before a Certificate of Request is signed by the patient.¹⁷³ A retraction during this period will supersede the earlier indication. After the patient signs the Request there must be a lapse of a further 48 hours before the actual assistance is given.¹⁷⁴ Until the very moment that assistance is provided the patient may withdraw the request.¹⁷⁵

In two crucial paragraphs, ss 7(1)(f) and (i), the Act uses the word 'indicates' or 'indication' to represent the communication required as a precondition for assistance. Clearly, the word is appropriate where the patient is speech impaired or too feeble to do more than make a mere indication. The dangers are that there is room for ambiguity in interpreting an 'indication' and that the practitioner's interpretation may be misconceived. The 'indication' may be in answer to a leading question and such a response has less weight than a spontaneous or volunteered request. When the practitioner has to decide whether the patient's decision 'has been made freely, voluntarily and after due consideration'¹⁷⁶ it is slender evidence indeed that there was an 'indication' by the patient to signify that decision. The unsuitability of the word is accentuated where a delegate signs for the patient under s 9.

The use of the same word in s 7(1)(o) is more appropriate because even a slight 'indication that it was no longer the patient's wish to end his or her life'

¹⁷³ *Rights of the Terminally Ill Act 1995* (NT) s 7(1)(i) read with s 7(1)(f).

¹⁷⁴ *Rights of the Terminally Ill Act 1995* (NT) s 7(1)(n).

¹⁷⁵ *Rights of the Terminally Ill Act 1995* (NT) s 7(1)(o).

¹⁷⁶ *Rights of the Terminally Ill Act 1995* (NT) s 7(1)(k).

should suffice to prevent the assisted termination. An indication to save life is reversible even if misinterpreted, unlike an indication to end it.

Autonomy is presented in absolute terms in the provision that 'the patient may rescind a request for assistance under the Act at any time and in any matter'.¹⁷⁷ This is a right to preserve life. No limitations are placed on rescission unlike the right to seek assistance in termination, which must satisfy several preconditions before it may be exercised.

Where palliative care has been administered after the request and brings about remission of the pain or suffering, the medical practitioner must not, in pursuance of the patient's original request for assistance, assist the patient under this Act. If the palliative care ceases to be effective there must be a separate and distinct indication by the patient of a wish to proceed in pursuance of the request.¹⁷⁸

On rescission there is a duty cast on the practitioner to destroy the Certificate of Request 'as soon as practicable' and the fact must be noted on the patient's record.¹⁷⁹ The duty should have been reinforced by a penalty for its breach.

Some supporters of the Act may argue that the legislation, while purporting to confirm the right to die, actually contains limitations which discriminate in favour of the right to life and that there ought to be no difference between the right to life and the right to death, the right to request assisted termination and the right to rescind the request. Reasons should not be sought nor given for the exercise of any of these rights. Personal autonomy demands that a person's control over his or her death should be as free as the control exercised over life.

The duty to destroy a certificate of request when the patient revokes the request is consistent with autonomy. The extent of the duty to 'note that fact on the patient's medical record' is less clear.¹⁸⁰ Is it the destruction of the certificate that must be noted or the rescission of the request?

In either case, the fact that a patient was suicidal at one time but overcame that inclination is important for future treatment and diagnosis. A record of the request for assistance as well as its rescission will be relevant to medical and psychiatric conditions that may arise.

The patient's right to rescind a request corresponds to the practitioner's duty not to assist termination where at any time the patient has indicated 'that it was no longer the patient's wish to end her or his life'.¹⁸¹

The right to rescind presupposes voluntariness, sanity, maturity and reasoned judgment. Once voluntary euthanasia is implemented the feelings of compassion and the motivation to help those who are in dire need are likely to shift naturally and spontaneously to children and mentally impaired persons who cannot or are deemed to be unable to act rationally.

¹⁷⁷ *Rights of the Terminally Ill Act 1995 (NT)* s 10(1).

¹⁷⁸ *Rights of the Terminally Ill Act 1995 (NT)* s 8(2).

¹⁷⁹ *Rights of the Terminally Ill Act 1995 (NT)* s 10(2).

¹⁸⁰ *Rights of the Terminally Ill Act 1995 (NT)* s 10(2).

¹⁸¹ *Rights of the Terminally Ill Act 1995 (NT)* s 7(1)(o).

Resistance to the idea that voluntary euthanasia will lead to non-voluntary euthanasia comes partly from the argument that the law is built on the competence of individuals and that many legal disabilities have been imposed on minors and the mentally impaired. They cannot vote or sit on juries or enter into contracts. There has been no pressure to give them these rights on the ground of equal opportunity. Some will argue that there has been no clamour for the removal of the legal disability to vote, perform jury service, or the contractual incapacity of minors and intellectually impaired persons. Likewise, they will suggest that the installation of voluntary euthanasia will not lead to a surge in calls for involuntary euthanasia.

Any such disclaimer is unconvincing. Voting, jury service and contracts affect the candidates, the accused and parties to a civil action or to a contract in a variety of ways. The law has a duty to such persons to prevent adverse consequences being visited on them on account of a person's lack of reason or judgment. In contrast, it is arguable that the denial of euthanasia to a disabled person affects only that person. The absence of reasoning power and the lack of a capacity to choose and to decide, it will be suggested, have no adverse influence on the lives and fortunes of others when a disabled patient's pain and suffering are permanently ended.

CONCLUSION

By limiting the availability of voluntary euthanasia to sane and conscious adults the Act is likely to provoke a strong claim for non-voluntary euthanasia for children, the non-sentient and mentally impaired adults on the grounds of equality and non-discrimination.

Apprehension about such expansion cannot be dismissed with the argument that it is mere surmise. It is no less a matter of conjecture to argue that a claim for expansion will not be made, or that the claim will be resisted. The appeals to unlimited compassion and unrestricted self-determination are reinforced by claims of equality and non-discrimination on behalf of those who are excluded from the Act.

Plausible arguments based on logic or on intuition may be invoked on both sides. To some, the Northern Territory Act is the ultimate expression of compassion and autonomy based on need. To others, the legislation is the first step in claims for euthanasia on demand with or without reasons, and the precursor to legitimising non-voluntary and involuntary euthanasia for those who cannot choose the option of accelerated death.

The Act is confined to one category of persons who draw on our compassion and who have a claim to self-determination. Its safeguards are inadequate to deal with the potential for abuse even within that group. The dangers of proliferation were not anticipated. Those very safeguards are likely to fuel other claims because they provide only a restrictive and arbitrary accommodation for the highly emotive and expansionist notions of compassion and autonomy.

The provisions of the Act must be reviewed with special care because several jurisdictions have declined to decriminalise voluntary active euthanasia and physician assisted suicide after comprehensive inquiries. An evaluation of the consequences of decriminalising voluntary euthanasia has been conducted by six highly credentialled bodies in five state or national jurisdictions. Over a period stretching beyond fifteen years they have all concluded that euthanasia should not be legalised. The inquiries conducted were the following:

1. Euthanasia, Assisted Suicide and the Cessation of Treatment (1982, Law Reform Commission of Canada)
2. Inquiry into the Options for Dying with Dignity (1987, Social Development Committee of the Parliament of Victoria)
3. Select Committee of the House of Lords on Medical Ethics (1994, England)
4. When Death is Sought; Assisted Suicide and Euthanasia in the Medical Context (1994, New York Task Force on Life and the Law)
5. Of Life and Death (1995, Special Committee of the Senate on Assisted Suicide and Euthanasia, Canada)
6. 'Euthanasia Laws Bill: Consideration of Legislation Referred to the Committee' (March 1997, Parliament of the Commonwealth of Australia, Senate Legal and Constitutional Legislation Committee).

There are many existing limits on the 'sanctity of life' which should dispel any notion of an absolute right.¹⁸² Instances abound of legal breaches and erosions of a 'right to life'. The right to kill in self defence, subject to limits, is one exception. The right to kill in armed conflict under the laws of war is another. A more dubious example is the infliction of capital punishment by some states. There are other instances. A refusal of treatment by the patient may absolve a doctor from criminal sanctions for not treating the patient even if the consequence is fatal. Force feeding of a prisoner on hunger strike is not a legal duty. A more recent example is the legal exemption given to doctors who withdraw futile treatment from a patient in a persistent vegetative state whose death then eventuates.

However, patient autonomy which is posed as antithetical to the sanctity of life in the euthanasia debate also has limits. It cannot be invoked as an absolute right. Autonomy often needs to be compromised in order to accommodate a competing interest or value in a patient's life. A temporary sacrifice of autonomy may be required in the short term in order to make a lasting or more durable gain in the long term. A person's autonomy may be non-existent or diminished in cases of incompetence, imprisonment and unconsciousness.

These and other limits have caused a leading commentator to observe, in a medical context, that '... nothing I have said commits me to the view that respect for autonomy is or ought to be absolute'.¹⁸³

¹⁸² Magnusson discusses the decline of the sanctity of life ethic in R Magnusson, *op cit* (n 39) 1112–1136; cf S Joseph, 'The Right to Life' in D Harris and S Joseph (eds) *Covenant on Civil and Political Rights and United Kingdom Law* (1995) 158, 181–2.

¹⁸³ G Dworkin, *The Theory and Practice of Autonomy* (1988) 114.

The Act furnishes a half-way house between the absolutist claims made by both sides of the euthanasia debate. The safeguards and compromises in the Act have many imperfections, many inconsistencies to which this article alludes. The potential for abuse by those who value neither life nor death has not been eliminated.

The repeal of the *Rights of the Terminally Ill Act* 1995 (NT) was based primarily on the opposition to intentional mercy killing and physician assisted suicide. Nonetheless, the arguments of opponents of the Act derived as much sustenance from conceptual and philosophical difficulties associated with voluntary euthanasia as from procedural, evidentiary and substantive shortcomings of the legislation.

The most sanguine supporter of euthanasia must concede the need for safeguards and limits on unrestrained autonomy. The Act represents an unsuccessful attempt to implement legislative controls of some forms of abuse and wrongful exploitation of voluntary euthanasia. However, repeal of the Act does not totally invalidate the experiment, it merely makes the experience more pointed for future initiatives.

The Northern Territory is not far from becoming a State of the Commonwealth of Australia. When it does, the repealed Act may be re-enacted in full or modified form. A constitutional challenge to the validity of the repeal may be another way of reinstating the Act. Its most immediate influence may be over the South Australian Private Members' Bill to legalise voluntary euthanasia which will be debated in June 1997.

While some provisions of the Act will be copied, some modified and some rejected, it is certain that all future enactments in Australia or overseas will be influenced to varying degrees by the pioneering efforts of the Northern Territory. This article seeks to analyse and evaluate the first attempt by a legislature to straddle the exacting claims of those to whom all innocent human life is inviolable and of those to whom a life riddled with ineradicable pain and a terminal illness may be ended by another on request.