Following Caucus permission for Labor MLC Paul O'Grady to introduce right-to-die legislation as a private member's bill, New South Wales will soon be grappling with the substance of proposed laws to allow for voluntary euthanasia. The Northern Territory's *Rights of the Terminally Ill Act* provides the obvious model. It also provides important lessons, says Michael Eburn, a New South Wales lawyer who travelled to Darwin to witness the marathon 15-hour debate on the bill.

**The structure of the Act**

The Act contains 21 sections, most of which are concerned to ensure that before a person is subject to voluntary euthanasia, all possible alternative forms of treatment have been considered and rejected. The concern of the Legislative Assembly was to ensure that euthanasia is considered, in all cases, only as a last resort.

A person may only formally request euthanasia where, in the course of a terminal illness, they are suffering "pain, suffering and/or distress to an extent unacceptable to the patient". It is not clear what is meant when it says that a patient may only request euthanasia under certain circumstances, for a patient can, of course, request euthanasia at any time and irrespective of their condition. What is relevant is when may a medical practitioner lawfully comply with that request.

Sections 7 and 8 set out the requirements that must be met before euthanasia may be administered. In summary they are as follows:

1. The person must be over 18 years old.
2. The treating medical practitioner must be satisfied that the person is suffering from an illness that will, in the absence of extraordinary measures, lead to the person's death; that there is no cure; and that the only treatment that is
available is designed to allow the patient to die a comfortable death, that is, palliative care.

3. The person must be examined by a second medical practitioner who must hold a prescribed qualification in psychology. That medical practitioner must confirm the opinion of the first practitioner and also be satisfied that the person "is not suffering from a treatable clinical depression in respect of the illness".

4. The illness must be causing severe pain or suffering.

5. The person must have been advised of all the possible treatment options including palliative care and life support that may be available and must have rejected that treatment and indicated a choice to end their own life. Advice on palliative care options must be given by an expert in palliative care (that is a medical practitioner who holds the prescribed qualifications in palliative care).

6. The treating medical practitioner must be satisfied that there are no "palliative care options reasonably available

"pain, suffering and/or distress to an extent unacceptable to the patient."
to the patient to alleviate the patient’s pain and suffering to levels acceptable to the patient”.

7. The treating medical practitioner must be satisfied that the person has considered what effect such a decision may have on their family; that the person is of sound mind; and that the person’s decision to end their life has been made “freely, voluntarily and after due consideration”.

8. After having received the information on treatment options, and having decided to reject that treatment and to end their own life, the person must wait 7 days and then sign a formal certificate of request. If the person is unable to sign, then another person, acting on the patient’s request, and in the presence of the patient and the two doctors (and interpreter if required), may sign the certificate.

9. There must then be a waiting period of 48 hours after which, the medical practitioner may assist the patient to die provided that the patient has not, in the meantime, indicated that they have changed their mind and provided that the treating medical practitioner is present to provide or supervise the provision of the assistance under the Act.

10. At all times, if the person and the medical practitioners do not share the same first language, there must be an interpreter “who holds level 3 accreditation from the National Accreditation Authority for Translators and Interpreters” or other prescribed qualifications, who must interpret the information and also sign any certificate of request.

The Act provides that any doctor who is involved in the euthanasia process, and any person who signs the certificate on behalf of the dying person, automatically forfeits any benefit that they would have received (including any testamentary benefit) on the death of the person. The Act creates offences for improper conduct and makes miscellaneous provisions to ensure that wills, contracts, insurance and annuity policies are not affected by, or conditional upon, a person making, rescinding or not making a request for assistance under the Act.

The Act sets out what records of euthanasia must be kept and requires that the entire patient record is sent to the Coroner. The Coroner may investigate and report on any matter relating to the operation of the Act. This power is broad enough to allow the Coroner to investigate and report on any particular case under the Act, if the Coroner feels such investigation is warranted.

Any doctor who acts in accordance with the terms of the Act, in good faith and without negligence “shall not be subject” to civil or criminal action, or disciplinary proceedings arising from their involvement in the death of the patient. By the same token, a health care provider is under no duty to provide assistance and is immune from suit under contract, tort or any other action arising from their refusal to provide such assistance.

Commentary

The philosophy behind the Act was set out by the then Chief Minister, Marshall Perron in his second reading speech. He said:

“This Bill is based on a relatively simple principle, and that is:

“If there are terminally ill patients who wish to end their suffering by accelerating inevitable death, and there are sympathetic doctors who are willing to help them die with dignity, then the law should not forbid it.”

As such the aim of the Act was to remove the possibility of criminal and disciplinary action (and to a lesser extent, civil action) should a patient wish to die and a medical practitioner wish to help them. It has been generally agreed that even without the Act medical practitioners had assisted patients to die in circumstances that could constitute murder. During the debate a number of medical personnel admitted to assisting patients to die.”

Dr Brendan Nelson, the immediate past president of the Australian Medical Association was quoted in the Sunday Territorian (May 21, 1995) as saying:

“Technically it would be illegal but somebody would have to report it and register a complaint.”

“Now if you do your job properly there’s no way the family’s going to complain.”

Dr Nelson advocated that the law should remain as it is (namely that intentional killing is murder, irrespective of the ‘good’ motives of the killer) even though the option of medically assisted suicide should be available “in the two per cent of cases where there was no hope of recovery”.

It is bad law, however, where the law is ignored and where the law does not in fact represent the desire of the people living under the law. If we accept that the assistance is given, and that it is right and proper that such assistance is given, then it is not good enough for the law to prohibit such behaviour and ‘turn a blind eye’ to illegal activity. It was with this situation in mind, that the Chief Minister introduced his Private Members Bill.

Problems with the Act

There are a number of problems with the Act. Many of these are simple drafting problems that stem from the fact that the Bill was debated over 15 hours and
the matter was referred to Committee at 11 pm where discussion of 50 amendments to the original Bill lasted to 3:30 am.

Accordingly some of the amendments were inexpertly drafted on the floor of the Parliament and this has created problems of consistency and clarity.

One problem is that the criteria that must be met before a patient may request assistance to die (s.4) is different from the criteria that must be met before the medical practitioner may give such assistance (s.7). To request euthanasia, the person must be suffering from "pain, suffering and/or distress to an extent unacceptable to the patient", whereas to give euthanasia, the medical practitioner must have satisfied that the illness is causing "severe pain and suffering". The omission of "distress" as a ground for the administration of euthanasia was deliberate and designed to limit the cases which are considered acceptable for euthanasia, however, for the sake of consistency the reference should also have been deleted from the s.4.

Further, the reference to "pain, suffering and/or distress to an extent unacceptable to the patient" is clearly a subjective test. The failure to use the same words in the requirements that must be met before euthanasia may be administered may lead the Courts to find an objective test, or a test that requires the medical practitioner rather than the patient, to decide whether pain is "severe".

There are other sections where it is not clear whether the requirement is to be determined by the person seeking assistance to die, or by the medical practitioner involved. For example in s.8 the medical practitioner may not administer euthanasia 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..."

It is not clear in whose view the care is to be considered "reasonably available". Is a blood transfusion reasonably available because the medical practitioner thinks it is a reasonable procedure, or is it not reasonably available because the person rejects such treatment on religious grounds? Given the 'patient-driven' focus of the Act, it could be assumed that the question of what is reasonable is a matter for the patient, however that conclusion is not so clear where some sections of the Act refer to available treatment being "acceptable to the patient" and others (such as s.8) do not. If a Court is to give effect to the words in the Act, it will have to consider the effect of the words in the various sections and may conclude that where the reference "acceptable to the patient" is omitted, then it is intended that it is another person's view (most likely the medical practitioner's) that is relevant.

There is a major internal inconsistency with the Act and the power of a person to rescind their request for euthanasia. Under s.10, where a patient does rescind their request, the certificate must be destroyed and the fact that the patient rescinded the request noted on the record. Under s.8 however, a patient may elect to receive palliative care after they have signed the certificate. That care may cause a remission of the pain and suffering but should the treatment cease to be effective, the person may indicate that they wish to proceed with the decision to end their lives. In effect this means the request may be stayed during effective palliative care.

It was the intention of the Parliament to ensure that once the paperwork was completed, the person was not stuck with a fixed appointment with death, but could be flexible about the exact time re-assessment by a psychologist of palliative care. As circumstances could drastically change in that time, it would seem necessary to require that the decision is again confirmed to ensure that it is voluntary and that the person is not now suffering from a treatable depression. If there is to be a process when the request can be 'stayed' it should be limited to a relatively short time period after which re-assessment would be required.

The Act is narrow in its focus being limited to mentally competent adults, who are suffering from a terminal illness. It does not apply to children or people suffering from debilitating or degenerative diseases that may cause pain and suffering but are not in themselves terminal. Further the Act requires that "the illness is causing the patient severe pain and/or suffering". As such a patient may have a number of conditions that in totum, mean that they have severe pain and suffering but if the terminal condition is painless and it is another, non-terminal condition that is causing the pain, then strictly speaking they may be beyond the scope of the Act.

This Act to a certain extent compliments the Natural Death Act (NT) 1988 which reinforced the rights of the terminally ill to refuse medical treatment even if such refusal will lead to their death. Under that Act however, there is no requirement for cooling-off periods, for a second medical opinion or for a psychiatric or palliative care consultation.

If the community is concerned to ensure that persons do not make terminal decisions while affected by a treatable depression or due to pressure from families or the like, it seems that similar protections should be included in the Natural Death Act. The fact that they are not reflects a perceived moral difference between removing a life support machine and the administration of a fatal injection. Such difference is hard to maintain, though discussion of those difficulties is beyond the scope of this article.

**People who opposed the Bill did so on the grounds that this was the start of the slippery slope, and it seems inevitable that it is.**

...that they would receive the assistance and die. Unfortunately the Parliament does not appear to have achieved its intention. As it stands, if the patient has received palliative care and says that the pain and suffering is now acceptable so that today, they no longer wish to die, but later the palliative care ceases to be effective, a doctor could not then administer assistance as he or she would find that the patient had in fact indicated, between the time of completion of the certificate and the time that assistance was to be given, that they no longer wished to die (s.7(o)) or that they had in fact rescinded their request (s.10).

Alternatively, if these sections are not inconsistent, there is a problem in that there is no time limit in s.8. This means that a patient may receive palliative care that causes a remission of the patient's pain and suffering and it may be effective for 12 months. They may then restore their request for euthanasia without the need for commencement of the Act.

The Act will commence on a date to be fixed by the Governor of the Territory. It was decided during the Dorothy debate to insert a commencement clause so that the Government of the Territory could commence a publicity campaign to inform the Territory's citizens of the nature and effect of the Act and to reassure them that euthanasia under the Act is strictly limited to voluntary euthanasia. The select committee on the Bill reported that there was widespread concern, particularly among the Aboriginal community, that people attending a medical centre may be subject to euthanasia. In order to ensure that people continue to seek medical care, there will be a campaign to allay such fears.
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The Government also gave an undertaking to address the lack of palliative care services in the Territory. Currently there is only one designated palliative care bed, located in Alice Springs.

The Act requires that any person seeking euthanasia receive expert palliative care advice and that a suitable qualified interpreter is available. It was acknowledged during the debate that there were no suitably qualified experts in the Territory, and, at least with respect to the Aboriginal languages, there were no suitably qualified interpreters.

Conclusion

This Act is generally good law as far as it goes. Its defects arise from drafting errors caused by the large number of amendments that were proposed and inserted during the very early hours of the morning when it was clear that the members of Parliament were tired. It is impossible to ensure that all the inconsistencies are removed in those circumstances.

The Act does however have limited scope, being restricted to mentally competent, terminally ill adults. People who opposed the Bill did so on the grounds that this was the start of the slippery slope, and it seems inevitable that it is. However, just because the path is narrow and slippery, it does not mean that we should not take careful steps down that path to ensure that people may die with the same dignity that they enjoyed in life.

The members of the legislative assembly of the Northern Territory should be commended for their brave step in this direction, and those that voted against the measure should also be commended for their contribution to the public debate and their genuine concern with the issues. The debate was, generally, conducted in a restrained manner that in no way hid the serious matters that were under consideration or the level of genuine concern and thought that the members had given to the matter. The test now will be to see whether, in the absence of Marshall Perron (who announced his resignation at the commencement of the debate), the political will remains to carry the Act into effect, and whether this Act will provide lessons on how to carry the debate for death with dignity forward.

ENDNOTES
1. Voluntary Euthanasia legislation has been proposed or considered in South Australia, the ACT and Victoria.
2. See, for example, Sunday Territorian, April 9, 1995 p. 7; May 21, 1995 p. 3.
3. For example s. 7(6).

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