LAW REFORM

Euthanasia

On 22 February 1995, legislation was introduced into the Northern Territory Parliament by the Chief Minister, the Honourable Mr Marshall Perron, for the legalisation of active voluntary euthanasia and doctor-assisted suicide. The Bill, entitled the *Rights of the Terminally Ill Bill 1995* has been introduced as a Private Member's Bill with the aim of allowing Members of Parliament a conscience vote. Mr Perron has stated that there will be no compulsion on members of the government (predominantly Catholic) to vote for the Bill

(*Australian* 1.2.95). In the face of mounting debate following the introduction of the legislation, and strident opposition to it from some quarters, the Bill has been referred to a Select Committee (Northern Territory Legislative Assembly Select Committee on Euthanasia) which is to report back to the legislative assembly by mid May of this year. Only then will there be a clearer indication of whether this legislation will be enacted. The situation in the Northern Territory has been described at the most promising yet for reform in this area: a Bill sponsored by the leader of the government, a parliament of only 25 (of whom 13 indicated their initial support for the Bill) and no upper house to block the Bill.[1]

Outline of the Rights of the Terminally Ill Bill 1995

In essence, the *Rights of the Terminally Ill Bill 1995* seeks to make it lawful, in certain circumstances, for a doctor to assist a patient to die either by assisting the suicide of the patient or by administering active voluntary euthanasia. One of the key provisions of the Bill in this regard is cl.4. That clause states that a medical practitioner who receives a request from a terminally ill patient to assist that patient to terminate his or her life, may, if satisfied that the conditions specified in the legislation have been met, assist the patient to terminate the patient's life in accordance with the legislation.[2] The term 'assist' is defined in the interpretation section (cl.2) as including the prescribing of a substance, the preparation and the giving of a substance to the patient for self administration, and the administration of a substance to the patient. The legislation, therefore, clearly encompasses cases of doctor-assisted suicide in which the medical practitioner assists his or her patient to die by providing the means by which the patient takes his or her own life, as well as cases of active voluntary euthanasia where the medical practitioner is more directly involved, through the administration of a substance which brings about the death of the patient. Even though cl.4 is expressed in discretionary terms ('may assist'), thereby giving doctors a choice as to whether or not to provide assistance, it goes on to expressly state that the medical practitioner may, for any reason, refuse to give assistance. This additional wording has clearly been included to counter any concern that doctors who are opposed to assisting the suicide of a patient or administering active voluntary euthanasia would be compelled to participate in these practices if they were made legal.[3] Further, the Bill makes it an offence for a person to give or promise any reward or advantage (other than a reasonable payment for medical services) or by any means cause or threaten to cause any disadvantage to a medical practitioner or other person for refusing to assist, or for the purpose of compelling or persuading the medical practitioner or other person to assist or refuse to assist in the termination of a patient's life under the legislation (cl.5).

Critical to any proposal for the legalisation of doctor-assisted suicide or active voluntary euthanasia is the question of safeguards and the circumstances under which these forms of assistance will be available. The Bill contains an extensive list of conditions which must be satisfied before a medical practitioner may assist a patient to commit suicide or administer active voluntary euthanasia at a patient's request. Clause 6 of the Bill provides that a medical practitioner may assist a patient to end his or her life only if all of the following conditions are met:

- the patient has attained the age of 18;
- the medical practitioner is satisfied, on reasonable grounds, that the patient is suffering from a terminal illness and is likely to die within 12 months as a result of the illness, and this opinion has been confirmed by a second medical practitioner who has examined the patient;
- the illness is causing the patient severe pain or suffering or distress;
- the medical practitioner has informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, that might be available to the patient;
- there is no medical treatment reasonably available and acceptable to the patient that will relieve the patient's severe pain or suffering or distress;
- after being informed as to his or her condition, prognosis and treatment options, the patient indicates to the medical practitioner that the patient has decided to end his or her life;
- the medical practitioner is satisfied, on reasonable grounds, that the patient is competent and that the patient's decision to end his or her life has been made freely, voluntarily and after due consideration;
- the patient (or, in cases where a patient has orally requested assistance but is physically unable to sign, a person acting on the patient's behalf: see cl.7) has signed a completed certificate of request asking the medical practitioner to assist the patient to end his or her life;
- the medical practitioner has witnessed the patient's signature of request (or that of the person who signed on behalf of the patient);
- the certificate of request has been signed in the presence of the patient

and the first medical practitioner by another medical practitioner after that medical practitioner has discussed the case with the first medical practitioner and the patient and is satisfied, on reasonable grounds, that the certificate is in order, that the patient is competent and the patient's decision to end his or her life has been made freely, voluntarily and after due consideration and that the other conditions have been complied with;

- the medical practitioner has no reason to believe that he or she, the countersigning medical practitioner or a close relative or associate of either of them will gain a financial advantage (other than reasonable payment for medical services) directly or indirectly as a result of the death of the patient;
- at the time of assisting the patient to end his or her life the medical practitioner has no reasonable grounds for doubting that it continues to be the patient's wish to end his or her life; and
- that the medical practitioner himself or herself provides the assistance and/or remains present while the assistance is given until the death of the patient.

The Bill also seeks to ensure that a patient who has signed a certificate of request may, at any time and in any manner, rescind that request. In that case, the patient's medical practitioner must, as soon as practicable, destroy the certificate of request and note that fact on the patient's medical record (cl.8). In order to protect against improper conduct, the Bill makes it an offence to deceive or coerce another to sign or witness a certificate of request (cl.9).

Provision is made in the Bill for the keeping of records documenting the necessary steps under the legislation (cl.10). Further, the Bill requires that as soon as practicable after the death of a patient, following assistance given under the legislation, the medical practitioner who gave the assistance must send to the Coroner a copy of the death certificate and of the certificate of request (cl.12(1)). There is also provision for the Coroner to annually provide information to the Attorney-General of the number of patients who have died as a result of assistance under the legislation, and for the Attorney-General, in turn to report that number to the Northern Territory Legislative Assembly (cl.12(2)).

Another important feature of the Bill is the immunities it creates in respect of civil or criminal or professional disciplinary action for people acting in good faith in compliance with the legislation (cl.17).

Evaluation of the proposed reforms

There has, in recent years, been growing pressure and support for reform of the law to permit doctor-assisted suicide and active voluntary euthanasia. Notwithstanding significant developments in the practice and availability of palliative care, there will always be a small proportion of patients who wish to have assistance from a doctor to end their lives when faced with the distress and suffering of a terminal illness. There is incontrovertible evidence that a significant proportion of doctors in Australia are already involved in the practices of doctor-assisted suicide and active voluntary euthanasia and a majority of them support change to the law so that assistance can be given in appropriate cases without fear of prosecution.[4] Officially, however, the Australian Medical Association and other medical associations are opposed to the legalisation of these practices. So far as the general community is concerned, opinion poll evidence demonstrates that the great majority of Australians are in favour of reform of the law (78% according to the 1994 Morgan Poll).

Given that doctor-assisted suicide and active voluntary euthanasia do unquestionably already occur in Australia, but presently in a secretive and totally unregulated manner, there is much to be said for bringing these practices into the open by defining circumstances in which they can lawfully be performed. In this way, a regulatory framework can be established providing essential safeguards for the protection of patients, and at the same time, protecting doctors from the risk of prosecution if they have complied with the requirements of the legislation.

The conditions contained in the *Rights of the Terminally Ill Bill 1995* are quite strict and comprehensive and, if enacted, will ensure that doctor-assisted suicide or active voluntary euthanasia will only lawfully be available in very limited circumstances. These conditions have, to a large extent, been based on the guidelines which have been developed in the Netherlands for the practice of active voluntary euthanasia and which have been approved by the Dutch courts. To date, the Netherlands has come closest to the legalisation of active voluntary euthanasia, with legislation (in the form of regulations) having recently been enacted giving statutory force to the protocol for the notification and investigation of cases of euthanasia which has been in place since 1990. Although killing on request remains an offence under the Dutch Penal Code 1886, doctors who comply with the guidelines which have been developed and the procedural requirements under the legislation will be protected from prosecution. The legislative proposal in the Northern Territory seeks to go further with the outright legalisation of active voluntary euthanasia and doctor-assisted suicide.

This is by no means the first time that legislation for the legalisation of these practices has been introduced in the common law world. Indeed, over the years, quite a number of Bills in various forms have been introduced in the United Kingdom and the United States. Similar legislative activity is now occurring also in Australia, and much of it can be attributed to the voluntary euthanasia societies in various Australian jurisdictions. In 1993 Independent MLA, Michael Moore introduced a Bill for the legalisation of doctor-assisted suicide and active euthanasia in the ACT Legislative Assembly *(Voluntary and Natural Death Bill 1993)*. However, following the Report of the Select Committee on Euthanasia which was established to consider the proposal, the Bill was not proceeded with and instead, legislation was passed with respect to withholding and withdrawing of treatment based on the Victorian *Medical Treatment Act 1988 (Medical Treatment Act 1994* (ACT)). Legislation of a different kind providing for the recognition of 'living wills' in certain very limited circumstances already exists in South Australia and the Northern Territory. This legislation enables doctors to give effect to the advance declaration of a person that, in the event of terminal illness, their lives not be unnecessarily prolonged through the use of 'extraordinary measures'. At the time of writing, a Bill had also just been introduced into the South Australian Parliament by Mr John Quirke, MP for the legalisation of

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not just point out 'where they went wrong'. Administrative law teaching can explore the differences between executive and judicial decision making, the conflicts that will arise between the modes (as each privileges differing considerations), and criteria for criticising both the judicial and executive approaches. Administrative law teaching can explore, for example, the courts' concern with individualised rights-based justice, as against public officials' concern with delivery of an overall program to the entire population.

What such a course might look like

I offer three general themes around which developments in administrative law could be organised. I am not suggesting that no administrative law course currently does any of the things I discuss above. Among the better courses, material is offered that introduces students to the executive decision-making process, and its problematic relation to the body of administrative law principles. What follows here are brief suggestions on how such insights and problematics might be contextualised.

The first is work on the nature of the liberal and post-liberal state under conditions of capitalism. Theorists such as Jurgen Habermas and Claus Offe (and those who have adopted their concepts, such as Michael Pusey in his well-known book *Economic Rationalism in Canberra)*[1] offer one set of descriptions of the structural logic of the modern state. Offe and Habermas developed a 'systems' model to describe the state in capitalist societies; their model helps us understand the pressures and limitations on the state's capacity to act on and respond to the social and economic factors lying outside of itself. (See, especially, Habermas' discussion of their systems model in *Legitimation Crisis*[2] at pp 2-8, and problems of the shift from liberal to advanced capitalism at pp. 30-36.) In this way the functional role of various administrative law doctrines in system maintenance can be explored, together with the significance of doctrinal shifts that are continuing to occur as the state continues to move from a liberal to more welfarist/corporatist form.

Second, the continued utility of the concept 'state' itself can be put under scrutiny. Are we conceiving of the state too positivistically? Michel Foucault has remarked: 'We need to cut off the King's head: in political theory that has still to be done'.[3] This work of Foucault and the school known as 'governmentality' can be used to help examine the difficulty judges and administrators have in conceptualising what is going on in *public* administration, and what distinguishes it from other exercises of political or private power.[4]

Third, Offe's work can help us examine why courts and executive decision makers so often seem to be at cross-purposes, and how administrators themselves can be so readily bound up in competing considerations. In his essay 'The Divergent Rationalities of Administrative Action',[5] Offe describes how there is not just one rationality by which the system of executive government operates; there are several competing rationalities, representing different conceptions of the role to be performed by bureaucratic agencies. He describes how departments proceed either on the basis of faithfully carrying out policy directions (a Weberian model), or on the basis of the program results they are supposed to achieve, or on the basis of a corporatist model, whereby a number of differing (perhaps irreconcilable) interests are accommodated. Conversely, judicial review remains overwhelmingly tied to a Weberian conception of administrative rationality.

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References

1. Cambridge University Press, Melbourne, 1991.
2. Beacon, Boston, 1975.
3. In Morris, M. and Patten P. (eds), *Michel Foucault: Power, Truth, Strategy*, Feral Publications, Sydney, 1979, p.38.
4. See Burchell, G., Gordon, C. and Miller, P. (eds), *The Foucault Effect: Studies in Governmentality*, Harvester/Wheatsheaf, London, 1991.
5. Chapter 10 of *Disorganised Capitalism*, Polity, London, 1984.

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active voluntary euthanasia *(Voluntary Euthanasia Bill 1995)*.

This recent flurry of legislative activity reflects a general perception that the time has come for legislative reform in this area. In the light of the recent success of a citizen-initiated referendum in the State of Oregon in the United States for the legalisation of doctor-assisted suicide in certain circumstances,[5] it is not inconceivable that these legislative initiatives in Australia may also be successful. If that were to be the case, Australia would be the first country in the world to enact legislation for the legalisation of active voluntary euthanasia.

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References

1. 'We Can Achieve VE This Year!', Voluntary Euthanasia Society of New South Wales *Newsletter* No. 72, 1995, p.1.
2. Note also cl.13 which is to the effect that, notwithstanding s.26(3) of the Northern Territory *Criminal Code*, an action taken in accordance with the legislation by a medical practitioner does not constitute an offence under Part VI of the Code.
3. See also the immunity provisions in cl.17(2) and (4) of the Bill which reinforce the right of a doctor to refuse to participate in assisting a patient to die.
4. According to recent surveys conducted in a number of Australian jurisdictions, over a quarter of doctors who had been asked bya patient to hasten his or her death had complied with the patient's request. See Kuhse Helga and Singer, Peter,'Doctors' Practices and Attitudes Regarding Voluntary Euthanasia', (1988) 148 *Med J Aust* 263 dealing with Victoria (29%); and Baume, P. And O'Malley, E., 'Euthanasia: Attitudes and Practices of Medical practitioners'. (1994) 161 *Med J Aust* 137, commenting on a virtually identical survey conducted in New South Wales and the ACT (28%).
5. The introduction of this legislation *(Death with Dignity Act)* has, however, been delayed due to a constitutional challenge which has been brought against it by opponents of the legislation. See Kuhse, Helga, 'Oregon — Medically Assisted Suicide Becomes Law', (1995) 14 *Monash Bioethics Review* 1.