The Northern Territory (1996-1997)

An examination of the Northern Territory's experience with legalised euthanasia was undertaken by the Senate Legal and Constitutional Affairs Committee in 2008. A majority (5-3) of the Committee recommended against the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*, which sought to give the Northern Territory, the Australian Capital Territory and Norfolk Island the power to make a law permitting euthanasia and to bring back into operation the Northern Territory's *Rights of the Terminally Ill Act.*

The experiment with legalised euthanasia carried out in the Northern Territory is of particular relevance because it is the only Australian jurisdiction to have any experience with legalised euthanasia.

Clinical depression or demoralisation

The *Rights of the Terminally Ill Act 1995* (the ROTI Act) was in operation in the Northern Territory from 1 July 1996 until it was suppressed by the Commonwealth's *Euthanasia Laws Act 1997* on 27 March 1997.

During the nine month period in which the ROTI Act was in effect and under its provisions, four people were assisted to terminate their lives by Dr Philip Nitschke.

Case studies on these four deaths have been published.[1] The principal author of this paper is Professor David Kissane, who is a consultant psychiatrist and professor of palliative medicine. Philip Nitschke is a co-author of the paper.

The case studies examine how the conditions required by the ROTI Act were met. Cases numbered 3, 4, 5 and 6 in this paper refer to those cases which ended with the person's life being terminated with the assistance of Dr Philip Nitschke.

Kissane noted that "*fatigue, frailty, depression and other symptoms*" – not pain – were the prominent concerns of those who received euthanasia. He observed that "*palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care… There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care*."

From the case histories, it is apparent that cases 3 and 4 each had depressive symptoms.

In case 3, the patient had received "*counselling and anti-depressant medication for several years*". He spoke of feeling sometimes so suicidal that "*if he had a gun he would have used it*". He had outbursts in which he would "*yell and scream, as intolerant as hell*" and he "*wept frequently*".

Neither the patient's adult sons nor the members of the community palliative care team who were caring for him were told he was being assessed for euthanasia. "*A psychiatrist from another state certified that no treatable clinical depression was present*."

In case 4, "*the psychiatrist noted that the patient showed reduced reactivity to her surroundings, lowered mood, hopelessness, resignation about her future, and a desire to die. He judged her depression consistent with her medical condition, adding that side-effects of her antidepressant*

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[1] Kissane, D W, Street, A, Nitchske, P, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia", *The Lancet*, Vol 352, 3 October 1998, p 1097-1102.

medication, dozepin, may limit further increase in dose."

Kissane comments that "*case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management*." While Dr Nitschke "*judged this patient as unlikely to respond to further treatment*", Kissane, comments that "*nonetheless, continued psychiatric care seemed warranted – a psychiatrist can have an active therapeutic role in ameliorating suffering rather than being used only as a gatekeeper to euthanasia*".

Further concerns are raised by the report on case 5. Dr Nitschke reported that "*on this occasion the psychiatrist phoned within 20 min, saying that this case was straightforward*". This assessment took place on the day on which euthanasia was planned. This case involved an elderly, unmarried man who had migrated from England and had no relatives in Australia. Dr Nitschke recalled "*his sadness over the man's loneliness and isolation as he administered euthanasia*". Dr Nitschke has since revealed in testimony to a Senate committee, that he personally paid for this psychiatric consultation and that it in fact took less than 20 minutes.[2]

Dr David Kissane, comments on the issue of demoralisation:

> *Review of these patients' stories highlighted for me the importance of demoralization as a significant mental state influencing the choices these patients made. They described the pointlessness of their lives, a loss of any worthwhile hope and meaning.*
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> *Their thoughts followed a typical pattern of thinking that appeared to be based on pessimism, sometimes exaggeration of their circumstances, all-or-nothing thinking in which only extremes could be thought about, negative self-labelling and they perceived themselves to be trapped in this predicament. Often socially isolated, their hopelessness led to a desire to die, sometimes as a harbinger of depression, but not always with development of a clinical depressive disorder. It is likely that the mental state of demoralization influenced their judgement, narrowing their perspective of available options and choices. Furthermore, demoralized patients may not make a truly informed decision in giving medical consent.*
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> *Demoralization syndrome … is an important diagnosis to be made and actively treated during advanced cancer. It is recognised by the core phenomenology of hopelessness or meaninglessness about life. The prognostic language within oncology that designates 'there is no cure' is one potential cause of demoralization in these patients, a cause that can be avoided by more sensitive medical communication with the seriously ill. While truth telling is needed, hope must also be sustained so that life may be lived out as fully as possible. Patients with advanced cancer can be guided to focus on 'being' rather than 'doing', savouring the experiential moment of the present, so that purpose and meaning are preserved through inherent regard for the dignity of the person. Active treatment of a demoralized state by hospice services would involve counselling and a range of complementary therapies, use of community volunteers and family supports, all designed to counter isolation and restore meaning.*[3]

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[2] Nitschke, P., *Hansard*, Senate Standing Committee on Legal and Constitutional Affairs, Reference: *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*, Monday, 14 April 2008, Darwin, p 42; https://www.aph.gov.au/~/media/wopapub/senate/senate/commttee/S10740_pdf.ashx

[3] Kissane DW., "Deadly days in Darwin" in *The Case Against Assisted Suicide*, K. Foley & H. Hendin (ed), Johns Hopkins University Press, 2002, p.192-209 Available at: https://www.aph.gov.au/~/media/wopapub/senate/committee/legcon_ctte/completed_inquiries/2008_10/terminally_ill/submissions/sub589_pdf.ashx

Terminal illness?

The ROTI Act provided (Section 4) that: "*A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life*."

The ROTI Act (Section 3) defined that: "*'terminal illness', in relation to a patient, means an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient*."

The ROTI Act further provided that a "*medical practitioner who receives a request*" may, if certain conditions are met, "*assist the patient to terminate the patient's life*".

The conditions to be met included that:

- "*the medical practitioner is satisfied, on reasonable grounds, that – (i) the patient is suffering from an illness that will, in the normal course and without the application of extraordinary measures, result in the death of the patient; (ii) in reasonable medical judgment, there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure; and (iii) 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*;" (Section 7(1)(b));

- a second "*medical practitioner who holds prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering*" has examined the patient and has confirmed *"(A) the first medical practitioner's opinion as to the existence and seriousness of the illness; (B) that the patient is likely to die as a result of the illness; and (C) the first medical practitioner's prognosis*" (Section 7(1)(c)(i) and (iii));

- "*a qualified psychiatrist*" has "*confirmed that the patient is not suffering from a treatable clinical depression in respect of the illness*" (Section 7(1)(c)(ii) and (iv)); and

- the illness is causing the patient severe pain or suffering (Section 7(1)(d))

In case 4, there was no consensus that the person was terminally ill. The person was diagnosed with mycosis fungoides. "*One oncologist gave the patient's prognosis as 9 months, but a dermatologist and a local oncologist judged that she was not terminally ill. Other practitioners declined to give an opinion. In the end an orthopaedic surgeon certified that the ROTI provisions for terminal illness had been complied with*."[4]

In case 3 the patient may have benefited from radiotherapy or strontium but neither of these was available in the Northern Territory.[5]

In case 5, the patient had an obstruction and was clinically jaundiced.[6] The ROTI Act required Dr Nitschke as a "*medical practitioner who receives a request*" to have "*informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive, that*

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[4] Kissane, D W, Street, A, Nitchske, P, op. cit., p 1101.

[5] Ibid., p 1099.

[6] Ibid., p 1100.

might be available to the patient."[7] However, Kissane reports that "*when questioned about options like stenting for obstructive jaundice or the management of bowel obstruction*" Dr Nitschke "*acknowledged limited experience, not having been involved in the care for the dying before becoming involved with the ROTI Act*."[8]

This raises doubts as to whether the patient in this case – who was reported by Dr Nitschke to exhibit "*indecisiveness*" over a two month period about whether or not to request euthanasia – would still have done so if he had been given better symptomatic relief for the jaundice and obstruction.[9]

Severe Pain Not the Issue

Section 4 of the ROTI Act provided that: "*A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life*."

Section 7(1)(d) provided that "*a medical practitioner may assist a patient to end his or her life*" only if, among other conditions, "*the illness is causing the patient severe pain or suffering*".

Section 8 of the ROTI Act provided that a "*medical practitioner shall not assist a patient under this Act if, in his or her opinion, and after considering the advice of the medical practitioner*" who has the "*prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering*" (cf Section 7(1)(c)(i)), "*there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient*."

Kissane reports that pain "*was not a prominent clinical issue in our study*"[10]. In case 3, "*the patient took morphine for generalised bone pain*."[11] For case 4, "*pain was well controlled*".[12] In case 5 the patient "*complained of mild background pain incompletely relieved by medication*".[13] In case 6, "*regular analgesia was needed for abdominal pain*".[14]

In none of these four cases is there any evidence of severe pain that was not being adequately controlled.

Other kinds of suffering or distress are reported. In case 3, these included "*intermittent nausea, constipation, and diarrhoea*" and "*catheterisation*"[15]. In case 4 the dominant problem was

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[7] *Rights of the Terminally Ill Act 1995*, Section 7(1)(e).

[8] Kissane, D W, Street, A, Nitchske, P, op. cit., p 1101

[9] Ibid., p 1100.

[10] Ibid., p 1102.

[11] Ibid., p 1099.

[12] Ibid., p 1099.

[13] Ibid., p 1100.

[14] Ibid.

[15] Ibid., p. 1099.

"*pruritus*".[16] In case 5 there were symptoms associated with the obstructive jaundice, which seems to have been inadequately treated. In case 6 a key factor seemed to be patient's distress at "*having witnessed*" the death of her sister who also had breast cancer, "*particularly the indignity of double incontinence*".[17] She "*feared she would die in a similar manner*". She "*was also concerned about being a burden to her children, although her daughters were trained nurses*".

Kissane noted that "*fatigue, frailty, depression and other symptoms*" – not pain – were the prominent concerns of those who received euthanasia. He observed that "*palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care… There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care*."

Conclusion

The failed experiment in the Northern Territory, thankfully brought to an end by the decisive action of the Commonwealth Parliament, shows that apparently strict safeguards fail to ensure careful practice.

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[16] Ibid.

[17] Ibid. p 1100.