

Physician Assisted Death: A Comparison of the Oregon and Northern Territory Statutes

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Introduction

Only two political entities in the Western world have explicitly authorised physicians to assist patients to die. One of these is Oregon¹ in the United States and the other is the Northern Territory in Australia.² This article compares these two legislative efforts. The purpose is to isolate the choices made, both those which are similar and those which are different, with a view towards evaluating the feasibility of legislation in this area and the probable future direction of such efforts.³ The conclusion will be that the two efforts under consideration represent different emphases, Oregon on autonomy and the Northern Territory on beneficence, but that careful attention to implementation makes either approach feasible and desirable.

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¹ As to Oregon's legislation, *The Death With Dignity Act* (1994), ors 127.800. The first death pursuant to this legislation was that of Bob Dent, 66, afflicted with prostate cancer, administered by Dr Philip Nitschke. See T Bushing, "Breathing Life Into the Right to Die", (1995) 11 *Issues in Law & Med* 269.

² As to the Northern Territory legislation, see D Mendelson, "Medico-Legal Aspects of Right to Die Legislation in Australia", (1993) 19 *Melb ULR* 112, S Trollope, "The Law and Active Euthanasia", (1995) 3 *J Law & Med* 20.

³ As to legislation generally, see N Macer, "Legal and Psychological Considerations in the Development of a Euthanasia Statute In the United States", (1995) 13 *Behav Sci & the Law* 3.

⁴ As to books generally concerning euthanasia and assisted death, see T Beauchamp & J Childress, *Principles of Biomedical Ethics*, 4th ed, New York: OUP, 1994; B Brody, *Suicide and Euthanasia: historical and contemporary themes*, Boston: Kluwer Acad. 1989; J Glover, *Causing Death and Saving Lives*, Harmondsworth: Penguin, 1990; D Humphry, *Final Exit: the practicalities of self-deliverance and assisted suicide for the dying*, Ringwood: Penguin, 1992; H Kuhse, *Willing to Listen, Wanting to Die*, Ringwood: Penguin, 1994; A Meisel, *The Right to Die*, New York: Wiley, 1995; J Mason & R McCall-Smith, *Law and Medical Ethics*, 4th ed, London: Butterworths, 1994.

The subject of euthanasia or physician assisted death is controversial and has generated extensive literature.⁴ This is perhaps surprising, since one of the few commonalities of life is death and that event in most advanced nations is usually accompanied by medical assistance. Moreover, for decades physicians have assisted people to die in hospital settings by active euthanasia or, more often, the simple withholding of life support or nutrition and hydration. Why then the controversy?

The present debate over legislation may be attributed to two factors. First, the legislation in Oregon and the Northern Territory attempts to take the pre-existing informal, yet widespread and well understood, death-practice of physicians into the public realm by defining, conditioning and legitimating that practice. This necessarily requires confronting issues and questions which previously could be evaded or resolved behind closed doors on a case by case basis. Secondly, and perhaps more importantly, the new legislation would move physician assisted death out of the hospital context and into the realm of private control, either in the home or another setting. Such a move has disquieting ramifications, raising the possibilities of abuse or imposition, with equally unsettling implications for religious and personal values.

The present article does not propose to repeat or evaluate the debate concerning physician assisted death.⁵ Some may see the terrible spectre of a technocratic brave new world; others may see the return to a kinder and gentler age, when people died with their families at home. Presumably, both visions are possible. The present article will simply evaluate the ways in which two legislative bodies have sorted their way through the tumult and the controversy to offer their citizens at least the limited possibility of controlling the time and circumstances of their own deaths, with the assistance of physicians of their choosing. Those physicians must be identified, trained, encouraged to participate and compensated fairly.⁶ If so, the legislation will work. With adequate funding, which seems likely, problems of implementation can be eased and effective, ethical services afforded. None of this is easy, and thoughtful legislation is needed at the

⁵ As to articles from various jurisdictions concerning euthanasia and assisted death, see D Bleich, "Life As An Intrinsic Good", (1994) 9 *Issues in Law & Med* 139; T Callahart and P White, "The Legalization of Physician Assisted Suicide", (1996) 30 *U Richmond LR* 1; A Jonsen, "Physician-Assisted Suicide", (1995) 18 *Seattle ULR* 459; P Key, "Euthanasia: Law and Morality", (1990) 6 *Auckland ULR* 224; H Kurtz, "The Case For Euthanasia", (1993) 8 *Issues in Law & Med* 309; K McLean, "Letting Die or Assisting Death", (1993) 11 *Law In Context* 3; D Mendelsohn, "Jurisprudential Aspects of Withdrawal of Life Support", (1994) 69 *ALJ* 259; A Modarski, "Medical Futility", (1993) 41 *Cleveland State LR* 751; M Takroukas, "The Case Against Assisted Suicide", (1990) 20 *Ohio NLR* 793; P Thompson, "The Law and Active Euthanasia", (1995) 2 *J of Law & Med* 233.

⁶ Medical groups and journals have commented extensively on euthanasia, usually in terms of professional standards, practices and attitudes. See T Preston, "Professional Norms and Physician Attitudes", (1994) 22 *J of L Med & Ethics* 36; J Ruark, T Raffin and the Stanford University Medical Center Committee on Ethics "Initiating and Withdrawing Life Support", (1988) 318 *NEJM* 25; R Weir, "Decisions to Abate Life Sustaining Treatment", (1990) 264 *JAMA* 1846.

outset to make it happen.

What will be seen is that the legislation of the Northern Territory and of Oregon is thoughtful, conservative, disciplined and balanced in its approach to the personal and societal interests in physician assisted death. To oversimplify, Oregon tends to assure protection by limiting those who qualify for physician assisted death and by limiting the means which may be employed and then leaving the patient to act independently. The Northern Territory chooses, in contrast, to assure protection by requiring more extensive physician participation in the actual bringing about of death. It might therefore be said that the Northern Territory emphasises professional beneficence while Oregon emphasizes patient autonomy, albeit for a smaller segment of the patient population.⁷ There are other differences, as the following discussion indicates, but these are the most important points of contrast.

This article will begin by discussing and contrasting the statutory elements of the two legislative efforts. It will then proceed to discuss three problems in implementation: physician-patient relations, access, and liability. It will close by reviewing recent litigation in the United States, which may be helpful in pointing the directions which future judicial or legislative efforts may take in any community seeking to assure physician assistance at the time of death.

Legislative and Statutory elements

Eligibility for Physician Assisted Death

Both jurisdictions, Oregon and the Northern Territory,⁸ require that a citizen seeking physician assisted death be competent to make such a choice. The Northern Territory requires that the person be of "sound mind", a phrase which has a long history and well established content in Commonwealth and American jurisprudence. As such, the phrase seems a good choice. The Oregon language is less felicitous. In Oregon, the person must be "capable", an odd choice of language. Moreover, the word "capable" is not defined; instead "incapable" is defined as meaning

⁷ The values of autonomy and beneficence are well established in the world of bioethics. See generally Beauchamp & Childress, fn 4, supra. In a simplistic way, they distil the spirit of American constitutional law, with its emphasis on rights and Australian constitutional law, with its emphasis on community.

⁸ Detailed footnoting — customary in the United States — to various sections of the two statutes, Oregon's *Death with Dignity Act* (1994) and the Northern Territory's *Rights of the Terminally Ill Act* (1995), is deliberately omitted in this paper. The two pieces of legislation are relatively short and may be accessed by conventional means on Westlaw and Lexis. In addition, the Northern Territory legislation is on the Internet, at <http://www.nt.gov.au./lant/rotti:amend.html>, where the latest amendment indicates three physicians — not two — are now needed to proceed with euthanasia in the Northern Territory.

"unable to make or communicate decisions". This awkwardness of drafting might seem unimportant in a less charged atmosphere. As it is, people seeking physician assistance in Oregon may be left needlessly at risk when, although competent, it is contended they are not "capable".

Still, both jurisdictions seem in agreement that seeking assistance to die requires a person or patient with normal, fully functioning decision making capacity. As will be seen in the next sections of this part of the article, that policy choice is buttressed by requirements that the decision be "voluntary" and that the procedure be well documented by second medical opinions. Moreover, the person must qualify as a "patient", language which requires a formal relationship with a physician. The end result under both statutes will doubtless be similar, if not identical, findings as to competence.

Beyond that threshold requirement of competence, common to both jurisdictions, there are significant differences in the choice of who qualifies for physician assisted death. Both the Northern Territory and Oregon require that a person face a terminal disease or illness. But Oregon defines that as being one which is incurable, irreversible and — in all medical probability — will lead to death within six months. The Northern Territory does not have a time limit. Perhaps this is because any time limit is necessarily arbitrary; perhaps it is because any prediction of death is necessarily approximate. Still, the consequence is that a much broader group of people in the Northern Territory qualify for assistance under the statute, with illnesses which may lead to death years or possibly decades later, making causation and complications potentially problematic. The differences might be dramatic in an AIDS, ALS, Alzheimer's, PVS or multiple sclerosis context.

The Northern Territory does narrow eligibility by providing that the illness must, in all probability, cause death "without the application of extraordinary measures, or treatment unacceptable to the patient", with available care being limited to the treatment of pain. The patient may seek assistance to die if anticipating or experiencing "unacceptable" pain. The physician shall not assist 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". This suggests that pain is the principal reason for assisting death, hardly a fair reflection of the full range of possibilities. Moreover, the concepts of treatment or pain "unacceptable" to the patient and the further concept that available care must be limited to that of pain management are subjective and permit second guessing the patient's decision making, emphasizing physician beneficence at the expense of patient autonomy.

The Northern Territory emphasis on physician participation jointly with the patient decision making is re-affirmed in the process and procedure in its legislation. At the same time, Oregon's choice against such involvement, while somewhat qualified in earlier provisions, provides a clear contrast in the policies and assumptions of the two jurisdictions. In

conventional bioethical terms as noted, it is a choice between beneficence and autonomy, with clear implications for procedural difficulties, as discussed in I C, below.

Process

In both the Northern Territory and Oregon, the process is relatively simple. Each jurisdiction contemplates a voluntary decision to die by a patient. The term "voluntary" obviously requires a certain refinement. Everybody *must* die at some time, and so there is ultimately no choice. Similarly, in the context contemplated by these statutes, the person is facing a terminal illness and so normal volition is curtailed. Still, the choice must be that of the patient and not that of other people. The Northern Territory legislation is quite elaborate in providing that over-reaching or duress or personal gain may not be pursued by others and that doing so will result in penalties and loss of benefit.

What is left open in both jurisdictions, however, is the ultimate issue of precisely *what* considerations are appropriate. Both jurisdictions provide that the attending physician and the consulting physician must confirm that the patient is capable or competent and that the person is not suffering from a disorder or depression which impairs judgment. Indeed, the Northern Territory requires that one of the physicians be an expert in the uses of palliative care and in the diagnosis and treatment of depression. Such a concern for depression seems legitimate, although problematic, since any person facing death is likely to be upset at the prospect. Moreover, finding an "expert" in depression may be difficult, particularly in a rural jurisdiction, and doubly so when diagnosis and treatment of depression take on new meaning in the death context.

Of the various considerations which might prompt a person to seek assistance in dying, the only one receiving attention in either statute is the avoidance of pain. The Northern Territory is quite clear in saying that a person qualifies with a terminal disease only if available treatment is limited to pain management and, moreover, only if the patient will be experiencing "unacceptable" pain. Isolating pain management for special consideration is problematic. First, it suggests that considerations other than pain may not be appropriate for decision making leading to death. Secondly, and more likely, as a source of difficulty, the Northern Territory's focus on pain management means that a physician might well override a patient's evaluation of whether pain is present, how much pain is being experienced and how much can be tolerated, and whether measures to alleviate pain are effective and acceptable. This particularly becomes a matter of concern with progressive degeneration in diseases such as cancer, where increasing amounts of pain relieving medication will cause progressive loss of mobility, dignity and consciousness. The patient

may choose against this; the physician may disagree.

Significantly, and wisely, both jurisdictions seem to leave open precisely which considerations a voluntary decision may involve. People may seek assistance to die so that they may avoid incurring costs in a hospital setting, thereby enabling them to pass along an estate to their loved ones. They may seek to arrange for their deaths to be in a setting and amongst people whom they prefer to a hospital. People may also choose to die at a time early in the development of a disease, to avoid the pain and trauma for loved ones which protracted and degenerative processes may inflict through the progressive decline inherent in many terminal illnesses. They may wish to accelerate death simply to avoid pain or the diminished consciousness and competence produced by increasing administration of pain killers, such as morphine.

In both jurisdictions, the most troubling reason a patient may express is financial. At the end of life, a month in an American hospital may cost \$60,000 or more, consuming a modest lifetime estate in 30 days. A patient, as with many AIDS victims, may be forced to cannibalize his life insurance by viatical arrangements. Valued possessions, intended for transmission between generations of a family, may be sold or seized to pay bills. A person of substance may lose his or her identity in a financial wasting of assets. A patient may be importuned to die sooner by family members or close associates in order to pass on his or her property. Such financial concerns are commonplace in estate planning, yet may easily suggest overreaching in a death context. Neither jurisdiction provides a statement of acceptable reasons for accelerating death, an omission which seems wise, yet each seems concerned about financial overreaching without acknowledging the legitimacy of financial providence.

Where there is a voluntary decision to die, both jurisdictions provide that the process involves a request by the patient. In Oregon, the request is for medication. The Oregon statute quite clearly contemplates that the physician's role is limited to prescribing a medication which will bring about death. Indeed, the Oregon legislation specifically excludes injection, "mercy killing", and "active euthanasia". The latter two terms are problematic, both as to their meaning and the reason for their exclusion. But the intent seems clear, that the death is to be volitional, by self administered means, at a time and in a place of the patient's choosing.

In the Northern Territory, the request is for "assistance", which includes prescribing, preparing, giving or administering a "substance". The legislators in the Northern Territory further provided that the physician must "assist" at the event itself. The Northern Territory legislation requires that the physician shall either provide the substance or administer the substance or, at a minimum, "be present" at the event. The Oregon legislation frees up the patient, but provides no assurance that the patient will take the medication, or will do so in an effective manner. It is entirely possible, then, that the attempt to bring about death in Oregon might fail and might leave the patient, facing a terminal illness, in far

worse condition than otherwise. In contrast in the Northern Territory even where the patient is engaged in self administration, by the mere fact of being there, the physician must unavoidably assume some responsibility and control. While this assures effectiveness and perhaps is desirable in a humane sense, it also means that making the arrangements and carrying through the process will be greatly complicated by limitations of time and resources concerning available medical personnel.

What is central in both jurisdictions, then, is the place of the physician. Thus, in addition to the elements of patient process already noted, for physicians, there is the question of medical ethics. Many physicians and medical groups oppose physician assisted death on the basis that physicians are trained by education and experience to save lives, not terminate them.⁹ The choices of physicians and their ethics are legitimate legislative concerns. The short answer is, of course, that physicians under both the Oregon and Northern Territory statutes may choose not to participate. But it remains true that, in rural areas especially, they may be subject to patient or peer pressure. And participation by willing physicians runs the risk of confusing public perception of the roles — and risks — in the physician-patient relationship.

Procedures

The process in both Oregon and the Northern Territory must proceed through, and be evidenced by, quite similar procedural steps.

In both jurisdictions, there must be a request for assistance. While it may initially be oral, the request must then be made in writing. It must then be repeated, in Oregon fifteen days later; in the Northern Territory, seven days later. In Oregon, the prescription may then be issued, with the death event occurring in the patient's own subsequent timing. In the Northern Territory, the death event must be delayed for at least two more days, and cannot occur without the physician's presence.

Both jurisdictions also require a second opinion. The consulting physician must concur as to the diagnosis and prognosis of the disease or illness and, as well, as to the competence of the patient. The concern for

⁹ The practice of assisting people to die by passive means has been well established in hospitals for decades by DNR and No Code notations. More active means have also been used, withdrawing life support or administering means of hastening death. Recent studies establish the continuing willingness of physicians to assist in such practices, both in and out of hospitals. See, eg, A Back, J Wallace, H Starks, and R Pearlman, "Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses", (1996) 275 *JAMA* 919; J Bachman, K Alcser, D Doukas, R Lichtenstein, A Corning and H Brody, "Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia", (1996) 334 *NEJM* 303; M Lee, H Nelson, V Tilden, L Ganzini, T Schmidt and S Tolle, "Legalizing Assisted Suicide - Views of Physicians in Oregon", (1996) 334 *NEJM* 310.

depression is procedurally accommodated in Oregon by requiring a referral for counselling if the patient suffers from a mental defect or has impaired decision making capacity by reason of depression. In the Northern Territory, the approach is significantly different; the consulting physician must be trained in treating depression. And assistance must be denied if the patient is clinically depressed.

The attending physician in both jurisdictions is required to assure an informed decision,¹⁰ an awkward concept in this context, but one which assures the patient will understand the prognosis, the procedures proposed, the alternatives and the risks. The consulting physician, although this is not clear, doubtless has some similar obligation. One of the alternatives to death is palliative care, including pain relief and surgery, and both jurisdictions are explicit in requiring advice as to this. The Northern Territory requires, as well, that one of the two physicians have appropriate expertise in palliative care.

In both jurisdictions, procedurally the final step is for the patient to arrange the death event. In Oregon, he or she simply leaves the physician's office with a prescription. It will be filled at a pharmacy and, at some future time, consumed. In the Northern Territory, the physician will be present, possibly administering the deadly substance, which may be an injection, gas or orally ingested material. Indeed, there may be other techniques. Neither statute prescribes the method or medium of death, requiring only that it be "humane and dignified", with the Northern Territory requiring the practitioner to "be guided by appropriate medical standards" and "appropriate pharmaceutical information".

There are presently no such standards or information. And the procedures in both jurisdictions gloss over a welter of other logistical problems. It may be difficult to find a second physician (or, now, in the Northern Territory, a *third* opinion) in many areas, particularly with expertise in depression or palliative care. The relationship with the attending physician may be difficult and the delay and expense of referrals and consultations may become intolerable. Conceivably, there may be conflict between the two physicians, raising then the question — left open by both statutes — of the possibility, indeed obligation, of further referrals, for a third or fourth opinion. There is also left open the obligation of the consulting physician who concludes assistance is not appropriate to take steps to prevent death.

¹⁰ Informed consent in Australia and the United States have come to have similar meanings. Compare *Canterbury v Spence* 464 F2d 772 (DCCis 1972) and *Rogers v Whittaker*, (1992) 175 CLR 479. Essentially, the physician must inform the patient of what he or she would deem material. Failure to do so is actionable if a reasonable patient, with such information, would have acted differently. Information must meet a subjective test: causation meets an objective test.

Safeguards

Much of the controversy concerning physician assisted death surrounds possible abuses. Critics claim there may be alternatives to death; there may be competent patients who are coerced into submission; there may be incompetent patients who are permitted or assisted to die.¹¹ Both Oregon and the Northern Territory, in their legislation, took impressive steps to guard against such abuses. As already noted, confirming medical opinions are required, both as to the diagnosis and the competence of the patient. A concern for depression is evinced in both statutes. Oregon provides that counselling may be required if the patient is suffering from a disorder or if judgment is impaired by depression. The Northern Territory similarly provides for diagnosis concerning depression and prohibits assisted death if the patient is suffering from a treatable clinical depression.

The Northern Territory further assures safety in requiring the physician to be present. Similar safeguards may be found in the Oregon exclusion of injection, "mercy killing" and "active euthanasia". The latter two terms are undefined and hardly self-defining, but would seem to mean that an incompetent patient could not be killed by active means, and consent would be required from a competent patient, although the longstanding practice of withdrawing life support or entering DNR and No Code orders in hospitals would presumably continue.

Oregon and the Northern Territory both require that the methodology of death be "humane and dignified". While these terms are not defined, they do significantly restrict methods of cruelty, abuse or exploitation.¹² The Northern Territory legislation may be deemed to incorporate similar safeguards in the requirement that the physician be present and it is also possible that the Northern Territory insistence on the presence of pain and the use of palliative alternatives is a significant safeguard. It assures some objective evidence of the existence and progress of the underlying disease. And it isolates the one reason — pain — which almost everyone agrees legitimates suicide. It also means any additional pain in

¹¹ There is a considerable body of commentary and confusion concerning the Netherlands experience, its legal foundation, and abuses thereunder. See D Schanker, "Of Suicide Machines, Euthanasia Legislation, and the Healthcare Crisis", (1992) 68 *Indiana LJ* 977; B Pollard, "Euthanasia in Holland", (1992) 36 (11) *Quadrant* 42; and the issue devoted to the topic in (1992) 22 (2) *Hastings Centre Report*. From these sources it appears the Netherlands tolerates, without explicitly authorizing, physicians to assist death, without clear criteria or safeguards, including involuntary euthanasia.

¹² The Oregon concern for method and appearances doubtless stems from a desire to avoid the controversy surrounding the work of Dr Jack Kevorkian, who as of May 15, 1996 had been acquitted in his third homicide prosecution in Michigan for assisting people to die by injection or other means. Many of the people, for example those suffering from Alzheimer's disease, ALS or multiple sclerosis, might not have been deemed to have a "terminal illness" in either Oregon or the Northern Territory. Dr Kevorkian has assisted in over 40 deaths as of November 1996.

the death event is likely to be less than the pain the patient was — or would be — suffering.

The risk of imposition by others is recognised in both jurisdictions. Improper motivation or imposition is forbidden. The possibility of personal profit or gain, by family or health care providers, is precluded. Both jurisdictions are concerned that witnesses to the various documents be reliable and make appropriate provision although — interestingly — taking opposite approaches. For example, the Oregon legislation provides that the witness to the request cannot be the attending physician. In contrast, the Northern Territory legislation provides that the witness must be the physician. The contradiction is less substantial than appears, since the underlying concern is identical: to assure that the documents are witnessed by people professionally involved yet personally disinterested.

Both jurisdictions provide that physician assisted death shall not affect wills, contracts or insurance. This is a significant safeguard for the statutory process, since it assures the patient may proceed in confidence that his or her estate will remain intact for those whom the patient has designated. It protects wills, contracts and insurance provisions from contentions to the effect that a physician assisted suicide evidences incompetence or overreaching or fraud sufficient to void the will, the contract or the insurance. It also relieves the patient from the pressures of threats by family members or others that, once the patient is dead, they will invalidate or seek to invalidate any documentary provisions which the patient has made. While not specifically so providing these legislative provisions probably would remove any doubts about viatical agreements, facilitating the funding of physician assisted death.

Finally, and perhaps most significantly, the chief safeguard for the process is the requirement that it be assisted by a "physician". In both jurisdictions, these are professionals who have obtained state licences and are subject to public regulation for the practice of medicine. Increasingly,¹³ they are subject to hospital peer review, board certification, continuing medical education and third party payment or scrutiny. Their involvement in their profession, and their commitment to saving lives, are the best assurance that care and consideration will be brought to the process of physician assisted death. It is in fact to their judgment that we have entrusted this process for decades; legitimising the process through legislation should not cause us to question the wisdom of that trust.

¹³ Physician controls in the United States involve the complexities of extensive "managed care" to a degree as yet not present in Australia, where a national health system exists.

Implementation

The Patient-Physician Relationship

When one steps back from the details of the Oregon and Northern Territory legislation, it becomes apparent that the success of physician assisted suicide requires a complex, intimate relationship between the patient and the physician. Presently, physician assisted death occurs chiefly in hospital settings.¹⁴ There, often it is simply the final stage of a slowly evolving, increasingly depersonalised, technology-dominated process. Often the patient is elderly or incompetent, and has been passed along to specialists who only know the patient as a disease or condition. At the very end the patient may be comatose and have no meaningful relationship with anybody. Then he or she is simply removed from life support in a decision making process that is distant and de-humanised.

The legislation in Oregon and the Northern Territory contemplates something quite different. A competent patient discusses death with his or her physician. In Oregon the patient's decision making is the dominant factor; in the Northern Territory that factor is at least counterbalanced by the judgment of the physician. In either instance, the physician is free to withdraw or impose conditions on his or her participation. The relationship is one of consultation and negotiation if they go forward and, in the Northern Territory, physician involvement in the death event, with a fully competent patient, will follow.

Such complex interrelationships may be present in the rendition of other medical services, but oftentimes are not. Many medical services are simply unavoidable and relatively little is negotiated. In other settings, where negotiation is extensive, the reason is that the service is optional and elective. Comparatively little may be at stake. In physician assisted death, much is at stake and yet much is optional, so the negotiated nature of the process, on balance, is distinctive and crucially important.

Public oversight and review seem imperative, particularly when guidelines and criteria are unclear, and practices are only evolving. Both statutes, however, contemplate that the process be essentially private, much as it is now in hospitals, subject only to the requirement of a second

¹⁴ Simply withdrawing life support from a dying patient or one in a persistent vegetative state is permissible in the United States, *Cruzan v Director, Missouri Health Dep't*, 497 US 261 (1990), England, *Airedale NH Trust v Bland*, (1993) 2 WLR 316 and New Zealand, *Auckland Area Health Board v AG*, (1993) 1 NZLR 235. Australian case law is unclear, although various states have adopted administrative regulations or statutes creating healthcare powers of attorney. In Canada, the most significant case of relevance is *Rodriguez v Canada*, (1993) 3 SCR 519, where a narrow majority refused assistance to a woman dying of ALS. The case remains controversial, as much for its implications as its holding. See P Freedman, "The Rodriguez Case: Sticky Questions and Slippery Answers", (1994) 39 McGill LJ 644.

opinion. Ultimately, reporting and disclosure may lead to official review of the general practice. The question posed is whether some official oversight might be better at the outset in each individual case. Certainly, many states and third party payors (by requiring prior authorizations) in the United States have so concluded with respect to a range of other optional or controversial procedures. In large measure those efforts have assured quality and necessity of care, as well as cost effectiveness and, for similar reasons, external review may equally facilitate physician assisted suicide. But it would seem best for officials to stay out of individual cases.

Involvement of agencies, insurers or third party payors, such as HMOs, poses the risk of compromising the role of the physician, particularly if cost containment measures are in place and not disclosed to the patient. This is true generally with managed care but seems especially problematic with assisted death. For one thing, the qualifications and selection of physicians for the death process will pose unusual difficulties. Similarly, selection of methodology and timing will be, at least at the outset, problematic. In this context, physician autonomy may be almost as important as patient autonomy.

Perhaps most difficult for the physician will be evaluating or deferring to the reasons given, or withheld, by the patient. In most medical situations the patient's reasoning is commonplace and commonly understood and, oftentimes, perfectly self evident. With physician assisted death, this may not be so. And, even when reasons are stated, the unstated issue remains of the extent to which a physician should review or reject the patient's desires, perhaps dismissing them as attributable to depression. The counselling role becomes of foremost importance in death.

To isolate one common consideration which may acquire uncommon significance in the death process, the physician must weigh carefully the obligation to those other than the patient.¹⁵ The Oregon and Northern Territory statutes contemplate that the patient need not advise the family. In Oregon, the physician must request the patient to do so; in the Northern Territory, the physician must be satisfied the patient has considered implications for his or her family. Since the physician need not participate at all, he or she presumably is free to condition participation upon the insistence that the family be informed. If the patient refuses, the physician may withdraw. The question posed is a complex one, of duties to those other than the patient or, somewhat differently, the duty of the physician to help the patient involve the family as a part of dying and healing before death.

When, for a family doctor, is the family equally the patient? The answer,

¹⁵ When there is a danger to a third party, the physician may have a duty to warn. See *Tarasoff v Regents of California*, 551 P2d 334 (Cal 1976). But the privacy of the patient requires confidentiality, barring communication with others. See *Head v Colloton*, 331 NW2d 870 (Iowa 1983).

if patient autonomy¹⁶ is to be respected, must be when the person facing death says so. Yet, especially in a death context, physician concerns warrant consideration, if they are to be induced to participate. While traditional roles cannot be compromised, without the physicians, there can be no assisted death. And while hospitals and many medical specialists, such as oncologists, frequently deal with death, for many practitioners death is an infrequent outcome. For them, the prime directive remains "first do no harm".

Access

Assuring the availability of physicians is a pragmatic consideration of profound importance. It cannot be said that patients in Oregon and the Northern Territory have a "right" to assisted suicide if that "right" cannot be implemented. It seems unlikely that most family or general practitioners will readily and publicly undertake death services. Professional or administrative guidelines will help. So would continuing education and certification. Yet the controversy and politics of suicide may generate pressures like those surrounding abortion, which have driven many physicians in the United States to decline to perform them.

Particularly, in many rural areas then, it may be difficult to find even one physician who will participate in arranging death. To find a second physician, to consult with the first, may be impossible, particularly in the Northern Territory, which requires that there be expertise in palliative care and treatment of depression. Coupled with this, is the difficulty posed where there is disagreement between the attending and consulting physicians. Then, quite possibly, a third physician is required. An ethics or conflicts panel may be necessary, possibly formed within a local medical society or hospital, to deal with disagreement. All of this may well be beyond the existing resources of the medical profession even in a sizeable community.

These problems may be eased by effective funding and adequate finance. Much health care, particularly at the end of life, is funded through public programmes such as Medicare or Medicaid. This is true both in the United States and in Australia. In the United States, in addition, a large volume of health care is funded through MCO's, employers and private insurance. Prompt, adequate funding of assisted death is financially cost-effective, and should be widely supported by third party payors. Some issues of liability, discussed below may arise. But the financial

¹⁶ As noted earlier, autonomy is a central concept not only of physician-patient relations, but of bioethics. It is as well a central principle of constitutional rights under the United States Constitution. See *Planned Parenthood v Casey*, 112 SCt 2791 (1992).

wisdom of assisting death is so clear as to be unmistakable. It is, simply, cost-effective. It will work.¹⁷

It seems inevitable that public and private programmes of health care finance must confront the issue of reimbursement. Denying reimbursement seems unacceptable, particularly since the legislation in both jurisdictions provides that existing contracts of insurance will not be affected by physician assisted suicide. Such contracts are heavily regulated and are subject to state mandated services, so it must be assumed that in time, if not at the outset, physician assisted death will be reimbursed. Third party payers may then be part of the system of safeguards in the death process screening for quality and necessity, especially in relation to palliative care, as part of their quality assurance efforts.

It may be that the cause of death, even if assisted, will simply be attributed to an underlying illness, such as cancer. However, customary record keeping and billing reflect individual services, such as x-rays, medications, surgery and — presumably — assisted death. It would seem inconsistent with customary practice — and disingenuous to say the least — to eliminate, as somehow unimportant, provision of service or a prescription intended to bring about death. Even more improbable would be failing to mention a fatal injection, under the Northern Territory legislation, or provision of a substance at an event brought about death. Amending DRG's or the CPT-5 appropriately seems relatively easy — and essential — to accommodate reimbursement.¹⁸

The truly difficult question concerning compensation will be at what level and upon what terms. Related to that is defining the accepted methodology to be used in bringing about death. There presently is no agreement on this. In varying ways, this range of issues in the past has been resolved by professional norms, with reimbursement being at the usual and customary rate. Since physician assisted death, at least outside hospital settings, will represent a new range of services, new standards and valuations must be developed. The Northern Territory legislation specifically recognizes this, requiring physicians to follow professional standards. Development of such standards is feasible and imperative, to encourage participation and define services, allaying anxieties of both physician and patient.

¹⁷ It may seem callous, or calculating, to speak of death and ethics in such a fashion. Yet cost consciousness and managed care in the United States have been essential to maintaining health care. Recent budget shortfalls in Australian healthcare point in the same direction which the United States Medicare program took in 1984, with prospective payment for diagnosis related groups. Without financial management and support, physician assisted death simply cannot be a reality, no matter how deserved or desirable.

¹⁸ This may be a needless level of detail for this article. Still, some attention to detail may avoid problems. DRG's are the hundreds of categories of reimbursement under the United States Medicare program; they are averaged for services by diagnosis, and would not include death. The CPT-5 is the standard office billing manual in physicians' offices in the United States. It has 7000 or more billing items. They do not include death. By amending these categories, nationwide funding will become routine in the United States. Similar arrangements are possible, probably easier, in Australia.

To follow this through, there should be concern for the prices and practices of the pharmacies and pharmaceutical companies. Delay or predatory pricing could defeat patients of limited means. Appropriate modifications of listings in the Physicians Desk Reference,¹⁹ to indicate pharmaceuticals appropriate for death usages, as well as changes in formalities, will be necessary. Research funding may need to be directed for new methods of thanatology.

For all of this, and more, there is a need for thoughtful regulations by agencies and the profession. It may well be that the greatest barrier to access to the services in a physician assisted suicide context will arise, ultimately, by the absence of clear, practical thinking. Funding will not be the problem. In a very cold, calculating way, assisted death is in the interests of those who pay for health care. Medicare and health insurance will save money by avoiding the crushing costs of end of life health care. A faith in finance, if not justice, assures that assisted death legislation will be made to work. Whether it will do so in the interests of those it was intended to help remains to be seen, however.

Liability

The involvement of physicians will doubtless be influenced by the extent to which they perceive risks of liability through medical malpractice litigation. That has long dictated the availability of services and the nature of medical practice in the United States. Similar concerns are coming to have an impact in Australia as well. With this in mind both the Northern Territory and Oregon have provided in their statutes that participants shall not be liable either civilly or criminally for discharging responsibilities under the statutes. However, immunity from liability is limited to "good faith" participation. And, in any event, immunity from liability does not prevent suits from being brought, it only promises the prospect of an ultimately successful defence.

One particular area of problematic concern is the precision of determining eligibility. In Oregon, the disease must be incurable and irreversible, leading to death within six months. In the Northern Territory, similar requirements, without the time frame, exist, along with a focus on palliative care and levels of pain. Estimates must also be made of depression and exclusion of family. Ordinarily, there are margins for error in medical judgment which are simply accepted as inevitable. In the death process, it may be that tolerance of error will be far less. This may be because the factors for evaluation are greater, as is the intense publicity

¹⁹ The PDR lists all prescription pharmaceuticals, providing information about content, efficacy, indications and counter indications. It would not list pharmaceuticals designed to produce death.

and political controversy surrounding assisted death. It may as well be because many innovative — often experimental — treatments become worth consideration once it is concluded patients are dying. Risks not otherwise acceptable become worth assuming or incurring.

Initially, there is a cluster of conventional liability concerns over misdiagnosis. A physician may engage in a misdiagnosis, either as to whether the disease exists or whether it is incurable and irreversible and, hence, "terminal". The misdiagnosis may either lead to improper delay or actionable acceleration in bringing about death. There may also be error in diagnosis as to the patient's competence, or the extent of any depression, or the efficacy of palliative care. If death would have resulted anyway, the measure of damages may be reduced. But if the malpractice was egregious, inflicting trauma on family members, punitive damages may be available.

None of this is particularly new. What is new, and problematic, is how to measure permissible error as being "reasonable" in a death context, one quite different from the conventional hospital setting. In a hospital setting, where physicians have been assisting patients to die for decades, there is a bureaucratic, largely standardised process, where death is usually inflicted in a window of a few days, not months. Death in the community is not so contained and controlled and may be affected negatively by a number of factors — time, funds, family, friends. They may administer death ineptly; they may themselves become victims. Over time, variables multiply beyond control. What is physician liability in Oregon, once the patient leaves the office to get the prescription filled?

The Northern Territory at least assures continuing physician involvement, but with an open ended time frame. This creates a significant area of potential liability, that concerning the actual bringing about of death. As noted earlier, the physician and patient must settle upon the methodology of death (eg, injection, ingestion, or inhalation) and the substance to be employed (eg, morphine, insulin, Valium). There are a number of ways this can all go badly. One risk is that the patient will die horribly. Another risk is that the patient will not die at all, but will continue to exist in a twilight zone, for example in a persistent vegetative state. A third risk is that a third party will kill the patient, or the patient will kill a third party. There simply are not existing norms, standards or case law for determining when such misadventures are so "unreasonable" as to be actionable.

A quite separate area of concern is the obligation arising upon a diagnosis that the patient is not competent to seek assistance or is so depressed that decision making capacity is impaired or missing. The question posed is whether the physician may simply decline assistance or must take affirmative steps to prevent the patient from bringing about death independently.²⁰ Should the physician seek commitment to an institution?

²⁰ One might ask, conversely, whether the physician might — or must — seek surrogate decision making, with the family and possibly through court process, for a now incompetent patient who earlier expressed the desire for assisted death. See *Cruzan*, *supra*.

For example, should the physician advise the family? And is there a duty to notify a third party who may be at risk of harm from the patient? There would seem then an obligation to warn, but once this is concluded, a host of questions arise as to when, how and who? In the Northern Territory, with its emphasis on beneficence, the physician might have a greater obligation to intervene than in Oregon, which places greater emphasis on autonomy. But, neither statute speaks to this obligation of the physician affirmatively to override the patient's wishes and prevent death.

The issues raised concerning the duty to override and the duty to warn are at the outer edge of developing case law and ethics concerning physician/patient relations. It has long been held that physicians have an obligation, even contrary to a patient's instructions, to act in the patient's best interests. There has long been a "therapeutic privilege" for physicians. Of more recent origin is the notion that a physician may have obligations to those other than a patient, even contrary to a patient's wishes. The uncertainty of the principles in these areas makes them particularly problematic in the death process. Both Oregon and the Northern Territory immunise physicians from liability for good faith participation in assisting death. But this does not help to define the scope of the physicians' obligation toward the patient or the scope or reasonableness of good faith.

Nor do the statutes help to define or limit the measure and elements of damage. The death of the patient is clearly a compensable event, if wrongfully effected or accelerated. More speculative is measuring reduced opportunity to survive, or pain and suffering, or trauma to others. Error in delaying death, or palliative care or in administering death may also be problematic in damages. This may all be compounded by punitive damages where the misconduct is deemed reckless or outrageous.

As suggested earlier, what is clearly needed are practice guidelines and official regulations, prescribing acceptable practices. Contractual provisions waiving or limiting liability may also be appropriate. And Oregon and the Northern Territory should at least consider, as well, a cap, in terms of dollars, on liability should malpractice be found or, in the alternative, a fund for compensating victims.

Constitutional Validity

The preceding portion of this article examined problematic areas within the legislation in Oregon and the Northern Territory. The presence of such areas raises the question of whether the legislation is sufficiently flawed so that it would ultimately be held invalid by a court upon Constitutional review. The standards for such review are quite different in the United States and Australia. But the principles to be invoked, and the modes of analysis, are quite similar. They therefore warrant examination.

Litigation is now pending in both Australia and the United States. There are three decisions of significance: *Lee v Oregon*,²¹ a decision by the United States District Court for Oregon invalidating the Oregon statute; *Compassion in Dying v Washington*,²² a decision by the United States Court of Appeals for the Ninth Circuit, invalidating a Washington statute prohibiting physician assisted death; and *Quill v Vacco*,²³ a decision by the Second Circuit Court of Appeals of the United States, invalidating a similar statute in the State of New York. Although the terminology in these cases is that of United States Constitutional analysis, much of the discussion would fit within the "natural justice" construct of Australian jurisprudence. The following discussion of the three cases, therefore, is offered as equally germane to the Oregon and Northern Territory legislation. It would also be of importance to any other jurisdictions, Commonwealth or continental, which may be considering such legislation.

Due Process and Autonomy

In *Lee v Oregon*, within days after the adoption of the Oregon legislation by referendum, opponents of the physician assisted death statute filed an injunction proceeding in the United States District Court for the District of Oregon. The federal courts of the United States have jurisdiction over a state statute which violates the United States Constitution. The Federal District Court Judge, Judge Hogan, granted an injunction. He found that the Oregon statute denied due process of law because the terms were too vague to protect citizens, leading to a high risk of error under the statute and placing vulnerable, depressed citizens at risk of death.

Related to this, but quite distinct, Judge Hogan also found that the Oregon legislation denied equal protection of the laws. In his view, a certain segment of the population — terminally ill and depressed patients — had been subjected to a risk not shared by the rest of the population. Specifically, that small segment faced the possibility of homicide by exclusion from laws prohibiting homicide. The risk was that of death at the hands of those seeking to benefit from accelerating the death of a terminally ill person.

Those familiar with current Constitutional jurisprudence in the United States would be struck by the strangely convoluted analysis reflected in Judge Hogan's opinion. A number of Supreme Court decisions over the past two decades make it clear that there is a right to refuse medical treatment, a right which Judge Hogan concluded Oregon could not extend,

²¹ 891 7 Supp 1429 (DOreg 1994).

²² 49 F3d 590, - F3d - (En Banc 9th Cir 1996).

²³ F3d - (2d Cir 1996), No 95-7028. The *Compassion* and *Quill* cases are now pending before the United States Supreme Court. A decision is expected in 1997.

even to competent, terminally ill patients. There is also a state's right to legislate for the health of its citizens, a well established principle ignored by Judge Hogan. Most importantly, autonomy of decision making, an important right under the Constitution, was found to be an impermissible burden by Judge Hogan.

Quite a different view is found in the opinion of the Ninth Circuit Court of Appeals in *Compassion in Dying v The State of Washington*. That decision, subsequent to the decision in *Lee v Oregon*, made a special finding that, although the issues were different, the reasoning in *Compassion in Dying* necessarily rejects the reasoning and holding in *Lee v Oregon*. The Ninth Circuit Court of Appeals in *Compassion in Dying* held that the State of Washington could not prohibit physicians from assisting patients to die. It did not uphold a particular statutory scheme, and therefore the decision does not provide detailed authority for endorsing either the Northern Territory or the Oregon approaches. Still the decision in *Compassion in Dying* means that *some* approach must be permitted and, *under some circumstances*, physicians may assist patients to die. The Oregon and the Northern Territory approaches would both seem to qualify.

The Ninth Circuit's reasoning turned upon due process analysis. This required a finding that there is a fundamental "liberty interest" in refusing health care and in choosing death. This the court found by extensive reference to the Supreme Court decisions in *Cruzan and Casey*.²⁴ From these, it drew the logical conclusion that if health care may be declined, thereby bringing about death, affirmative assistance in bringing about death must also be permitted.

Historically, active euthanasia has been viewed as quite different from simply withdrawing assistance; hence, the Oregon legislation explicitly rejects "mercy killing" and "active euthanasia". But such distinctions were rejected by the Ninth Circuit which undertook an extensive review of the history of suicide, noting that today states in the United States decline to criminalise suicide, and have authorized, by durable powers of attorney, precisely to facilitate reasoned decision making concerning death.

The Ninth Circuit specifically enumerated and rejected the reasons offered by the State of Washington for prohibiting physician assisted death. The Court found the State had no compelling State interest in preserving life in those facing terminal illness. There was no State policy to prevent suicide since the State not only did not make suicide criminal, it also had elaborate legislative provisions authorising people to decline health care, even when it would lead to death. The risk of imposition by third parties could be dealt with by criminalising such imposition, as indeed the Northern Territory legislation does. Concern for medical integrity could be protected simply by providing that no physician must participate, as both

²⁴ As to *Cruzan*, see fn 14 supra, as to *Casey*, see fn 16. See also A Meisel, "A Retrospective on *Cruzan*", (1992) 20 *Law, Med & Healthcare* 340.

Oregon and the Northern Territory provide. Finally, the Court simply concluded that a total ban on physicians assisting patients to die could not be justified.

There was no state interest sufficiently compelling to overcome a person's fundamental liberty²⁵ in declining medical attention and choosing, instead, to seek assistance in dying. A blanket prohibition on assistance denies due process of laws under the United States Constitution and, by parity of reasoning, principles of natural justice under Australia's national and state constitutions.

Equal Protection and Beneficence

The decision in *Quill v Vacco*, by the Second Circuit Court of Appeals, similarly rejected the reasons offered by the State of New York for preventing physicians from assisting suicide. However, the court was unpersuaded that there is a fundamental liberty interest, protected by due process, in bringing about one's own death. The history of the treatment of suicide, the Court concluded, would suggest the contrary. Also, the list of fundamental "rights" by the United States Constitution is relatively short, involving clearer textual bases than the "right to die" enjoys.

The Second Circuit instead was persuaded that the New York legislation denied equal protection of the laws. It found that there was a segment of the population facing terminal illnesses divided irrationally into two groups. The first group would be patients in a hospital, supported by tubes or machines providing life support; that group could choose to be disconnected and thereby to die. A second group, also facing a terminal illness, but not connected to life support equipment, could not make the choice to die because physicians were prohibited from assisting them. The Court found the distinction irrational. One group was permitted to die, the other was compelled to live; yet both were facing death.

Like Judge Hogan, the Second Circuit found irrational discrimination. But the higher court found the discrimination was adverse to those who wanted to die, denying that option. Where Judge Hogan found imposition, the Second Circuit found affirmation in removing barriers to death, at least for those competent to choose to end a terminal illness. The Second Circuit view is clearly the better one.

As a matter of Constitutional analysis, however, the Ninth Circuit's opinion seems preferable to the Second Circuit's. The Ninth Circuit

²⁵ Constitutional rights are only beginning to be discovered by courts in Australia, who do not have the benefit of provisions for individual rights akin to those in the United States Constitution. See G Kennett, "Individual Rights, The High Court and The Constitution", (1993) 19 *Melb ULR* 581 and P Lane, *A Manual of Australian Constitutional Law*, 6th ed, North Ryde: Law Book Co, 1995.

recognises a liberty interest supported by Supreme Court case law, such as the *Cruzan* and the *Casey* opinions. It also recognises medical, ethical and bioethical concerns, affirming the autonomy and dignity of patients. Most importantly, by finding that such interests are fundamental, the Court did not need to hold that the State interests were utterly irrational, only that they were not so *compelling* as to override individual interests.

In contrast, the Second Circuit's approach, under the Equal Protection Clause, would require that the State's interests be utterly without rationality. While the Second Circuit so found, such an argument is very difficult to maintain. Moreover, the line drawn by the State, which the Second Circuit found irrational, is between simply withdrawing support and affirmatively taking steps to bring about death, a line which both professionals and non-professionals would see as significant. Finally, the Second Circuit's approach is essentially negative; it does not affirm either the interests of the patient or the physician and so provides no focal point around which to build affirmative legislation.

It is that focal point, the autonomy and needs of the patient, which is recognised in the Ninth Circuit's Opinion and which is implemented by the legislation in the Northern Territory and Oregon. By recognising the importance of the patient and the physician, and by reposing the death decision within the conventional framework of the physician/patient relationship, the Oregon and Northern Territory legislation honours both the public debate opposing such legislation and the public choice to adopt it. Such an approach is not only legislatively sound, it is also Constitutionally preferable, and one may expect that the Ninth Circuit's approach in *Compassion in Dying* will ultimately be the approach adopted by the United States Supreme Court.²⁶ Although less clear, it should prevail as well in the litigation pending in Australia.

Conclusion

The legislation in the Northern Territory and in Oregon both provide excellent models for making physician assistance available to those facing terminal illness. While both jurisdictions face a number of problems in implementing their legislation, it seems clear that the approaches they have taken are far superior to pre-existing methods. For decades, physicians have assisted patients to die in hospital settings, without explicit authorisation and public oversight. The legislation in the Northern Territory and in Oregon, then, accomplishes two major benefits: it explicitly legitimates a practice whose existence and validity were essential, yet *sub*

²⁶ But see R Bopp and S Coleson, "The Constitutional Case Against Physician-Assisted Suicide", (1995) 11 *Issues in Law & Med* 239.

rosa, and it moves that practice out of the sterile setting of a hospital, back into the community, family and home of the terminally ill citizen.²⁷

In so doing, physician assisted suicide legislation returns death to the setting where it belonged for centuries and still belongs today. It is only over the past few decades that death has been largely entrusted to the bureaucracy and technocracy of hospitals. There, people have slowly wound their way through layers of staff, rooms and machines towards a death declining in quality and dignity to a level which oftentimes could be considered inhumane. Where once the normal life span of individuals was such that they shared death with family and friends, with many of their powers and personal qualities still intact, today most of us face a lonely death among strangers, in sterile conditions, at a time when much of our humanity will have drained away.

One might well choose to avoid such a fate, particularly when clearly faced — early on — with a terminal illness. Appropriate legislation to facilitate such a choice should be welcome and available. The danger is not that such legislation will be abused. The danger is not, as critics have argued, that the vulnerable or the poor will be victimised under such legislation. The danger is, instead, that such legislation will be so expensive or complex as effectively to be unavailable to the great mass of those who need it. The great challenge for society is not to protect against abuse of those facing terminal illness, it is — rather — to assure the funding and resources which will make physicians available to assist them to die.

This discussion in this Article on implementation is thus crucial to success of physician assisted death. The patient-physician relationship needs to be clarified by education, certification of specialty and adoption of practice guidelines. That, in turn, will ease access problems by assuring the availability of participating physicians, by reducing areas of conflict or ambiguity between attending and consulting physicians, and by providing for ready and adequate compensation. The liability problems, while significant, should be easily resolved by practice guidelines and careful counselling, with full documentation, of patients.²⁸

In the end — as at the outset — are the age-old problems of defining the roles of the physician and patient. The physician in the death context must expand his or her cognitive, counselling role. The “patient” may well have to expand — despite the legislative provisions — to include

²⁷ In a comparative law essay such as this, it is tempting to infer that differing approaches are explainable, even dictated by, cultural differences. To some extent this is true. Australia emphasizes a community, public health, beneficence-based approach. The United States emphasizes a “rights” or autonomy-based approach. But the two statutes reviewed here are better contrasted functionally than culturally. Oregon provides safeguards by narrowing eligibility; the Northern Territory does so by physician involvement. Either state could easily have adopted the other’s approach. Culture is not the determinant; safety is.

²⁸ Draft guidelines and regulations have been developed by the Departments of Health of the Northern Territory and Oregon, and may be obtained directly from those bodies.

family and loved ones. No man or woman is truly an island, and society, while respecting each individual's autonomy to choose death, may legitimately — in its beneficence — expect the process to be shared, in order to effect, if this is possible, a just and decent end of life.²⁹ As with Dylan Thomas, we may individually rage against the dying of the light, but, as with Emily Dickinson, death will pause for each of us, and the tidying up of a home, and putting cares away, the morning after death, is truly the solemnest of industries enacted upon Earth.

²⁹ The ending of this piece has been re-written several times over the past week, the week of 20 May 1995, during which the author learned of the death by suicide of, first, a former brilliant student/graduate in Oregon and, then, of a present, fine student here at Murdoch University. The former had become a member of distinction in the Oregon Bar. The second had just received a grade of distinction on a major paper written for the author's bioethics course. Both will be missed by the author and many others, and their spirits have breathed life into this present essay.