

Lazy euthanasia law makes life difficult for doctors

WHILE PRECEDENTS can be "very cosy" in a medical situation where an extraordinary range of contexts makes statutory law difficult, they are "lazy law" and leave doctors adrift, according to Dr Rodney Syme in a recent talk at the University of Sydney's Centre for Health Governance, Law and Ethics.

In the case of euthanasia, the lack of specific law makes doctors particularly vulnerable, creating a black hole of ambiguity for them and their patients, said Dr Syme, who is also the author of *A Good Death: An Argument for Voluntary Euthanasia*, and who in 2005 famously provided to a cancer sufferer – media adviser and journalist Steve Guest – the drugs which Guest used to end his life.

Dr Syme said end-of-life medical practice was an area of human endeavour requiring particular regulation, but none existed.

"In theory, a doctor who hastened the death of an intolerably suffering patient by an hour, or even a minute, is subject to the same law that applies to an out-and-out gun for hire," he said.

As far as he knew, only two doctors in Australia had been charged with murder or manslaughter, or aiding and abetting suicide, in the last 45 years. Both were acquitted, which led to the argument that the medical profession need not feel at risk.

Doctors, he said, were "relatively safe" as long as they assisted patients with drugs which also had therapeutic value, such as analgesics and sedatives – based on a 1957 English decision of Justice Devlin, in *R v Adams*, which said a doctor could use narcotic analgesics to relieve pain and suffering, even though

The legal profession is practising avoidance when it comes to end-of-life decisions, Dr Rodney Syme tells ANNE SUSSKIND.

the foreseen but unintended consequence was to cause or hasten death.

This was essentially an application of "double effect", with the English precedent generally thought to apply in Australia, although never tested locally.

In the absence of appropriate law for end-of-life medical practice, the medical profession had "made the law", Dr Syme said.

With the advent of technologies to save and prolong life, such as artificial ventilation, doctors were faced with the problem of withdrawing treatment that had become futile, but where withdrawal would lead to death.

While fearing they could be charged with murder, they went ahead anyway, because it was the proper thing to do. Prosecutors had demurred from charges, and the practice of the law was changed.

Similarly, the introduction of deep continuous sedation, with the clear potential to cause death, did not have the sanction of statutory law, and relied on an extension of the *Devlin* principle of double effect.

Doctors had welcomed it, and potentially death-hastening

treatment was introduced with no-one being charged. Compassionate doctors had again remade the law and it seemed quite clear that, unless a relative complained, treatment palliative in nature would not be questioned.

Dr Syme said: "It is salutary to reflect on the fact that such treatment goes on without any guidelines, without the necessity for any second opinions, medical or psychiatric, sometimes without consent, without the necessity to report such action to the coroner, and without any official oversight.

"There is no knowledge as to how frequently deep continuous sedation is used in Australia. The law ties itself in knots over medically hastened deaths because it applies the same law and legal principles to them as those that relate to murder. It then tries to justify the obvious problems caused with dodgy precedents, dodgy arguments about causation, and turning a blind eye to much that goes on."

Reassessment needed

Instead, Dr Syme said, there should be a reassessment of two longstanding legal princi-

ples in the medical end-of-life context. The first was consent, which, while a fundamental principle of medicine which changed many acts from criminal to acceptable, was not a defence to a crime.

"I suggest that consent is of the greatest importance in establishing a new paradigm for medical acts that hasten death. It is a gold standard that should always be required to be demonstrated. After all, consent makes sexual intercourse a legal act of love – without consent, it is a crime."

The other was intention, the cornerstone of criminal prosecution in capital matters. When a known criminal shot someone he had never met for payment, it could be reasonably argued that it was his intention to kill. Medical intentions, however, were more complex, and included palliation and easing or hastening of death. "I believe that in every instance where a doctor hastens death, he or she does so with the primary intention of relieving suffering, but acknowledging that death may be an unavoidable consequence.

"This is so whether the intervention is by deep continuous sedation, lethal injection, or the provision of medication for the patient's ingestion. To attempt to distinguish some acts as having the primary intention to kill, but others not, or only a secondary intention, is foolish ..."

In 1992, Dr Syme said, a respected British rheumatologist, Dr Nigel Cox, had a patient with end-stage rheumatoid arthritis suffering appalling pain. She, and her family, pleaded for his help to die. At the time, Cox had not heard of terminal sedation and injected her, and recorded the fact, with potassium chloride – a drug with no effect other than to

stop the heart, and he was convicted of attempted murder.

"It is noteworthy that if he had injected her with the 'right drugs' – potentially lethal sedative pentobarbitol, he would almost certainly not have been charged. If he hastened her death with a barbiturate, it was palliation, but with potassium it was murder. One has to ask whether the time taken to die, either quickly or slowly, or the drug used to hasten death, are sufficient reasons to distinguish between a criminal act and good medical practice."

Dr Syme said he had himself prescribed oral morphine and sedatives – the same drugs used in terminal sedation – to a patient with terminal prostate cancer. He knew that the patient might use them to end his life, which he did. He had reported this to the police, and was not charged. He could not, in fact, have been charged, even though it could have been argued that he had aided and abetted the suicide.

He had also prescribed oral barbiturates to a young woman with an inoperable brain tumour, and explained how the drugs might be used to end life. While she had not used his medication, but had died 'naturally' by terminal sedation two-and-a-half years later, the medication he prescribed had provided her enormous palliation by giving her the sense of control over the end of her life.

In 2005, he had assisted Steve Guest to die. Guest, who had terminal oesophageal cancer, was wasting away in pain. He died of a lethal dose of pentobarbitol. Dr Syme said he had told the media and police that he had given Guest control over the end of his life, advice about barbiturates, and given him medication.

"The coroner, after detailed discussions with the police and DPP, had closed the case without an open inquest, despite it being requested by his brothers and myself. Was this the oral equivalent of double effect by injection? One has to ask, is aiding and abetting 'suicide' a crime in the medical context?"

"Good law depends on the

refined and defined use of language. There is no good law where the language does not exist. Steve's death provided the final impetus to my view that there is a 'benign' conspiracy between the prosecutorial

arbitrary. It depends on their doctor's experience, training, beliefs and courage.

"It depends on the nature of their disease, and where they are being cared for – hospital, hospice, nursing home or their own

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authorities to avoid prosecution of doctors who help their patients to die, with their consent and for the relief of their suffering, even if there is circumstantial evidence that the law has been broken."

Medical practice at the end of life was entirely arbitrary, depending to a great extent on a person's particular doctor.

"This means people with similar medical contexts will receive widely differing outcomes. Whether they get the treatment they want is entirely

home. And it depends on the sufferer's education, influence and awareness of the medical system. These are not the hallmarks of a just legal system."

Death law

Another speaker, Dr Roger Magnusson, is the author of *Angels of Death: Exploring the Euthanasia Underground*, an investigation focused on HIV/AIDS patients and the network of "underground" health care professionals in Australia and San Francisco who cooper-

ate informally in the organisation and delivery of euthanasia services.

Dr Magnusson, who is program coordinator for Sydney University's Master of Health Law degree, said the topic of euthanasia was covered in a unit on death law.

Taught by Dr Kristen Savell, the unit covers the legal and ethical issues at the intersection of criminal and medical law, end-of-life decisions, and making and withdrawal of treatment.

These were increasingly complicated and technical, Dr Magnusson said, concerned as they are with matters such as tissue transfer, withdrawal of treatment, criminal liability for euthanasia and issues around appropriate palliative care.

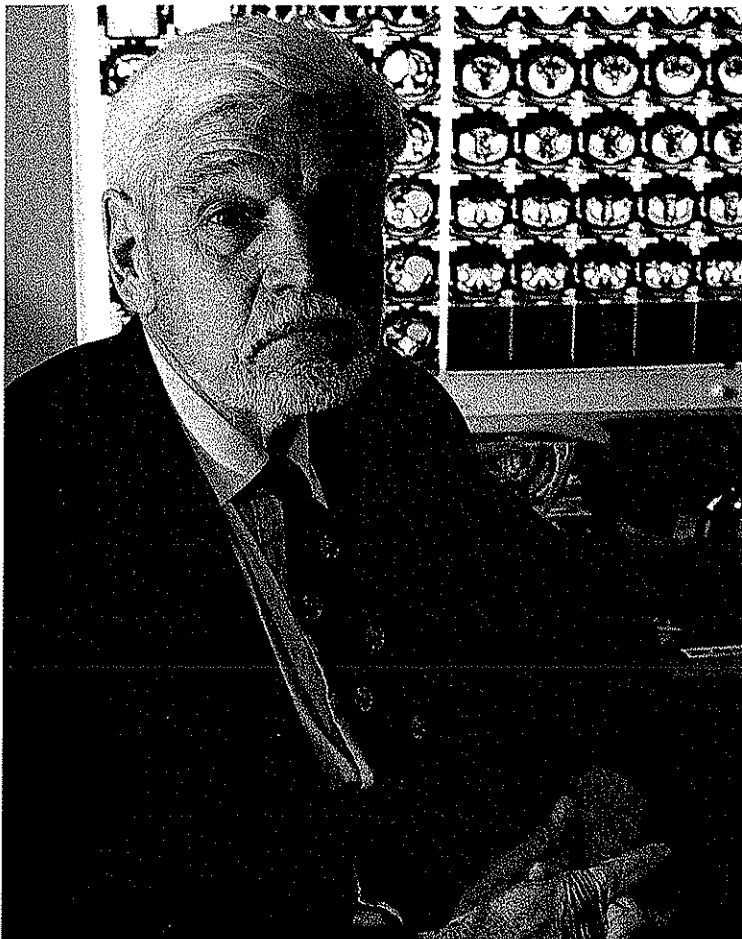
The course, which has been going for about 12 years, had about 50 students enrolled at any one time, mostly lawyers in the area of medical law. Health lawyers, he said, tend to come in two flavours – those who do risk management and litigation and advise on court proceedings for the recovery of damages and might advise health professionals, and those with more of a business focus, who might do health-related intellectual property matters, and buying and selling of hospitals and running chains of nursing homes.

Other participants were often health professionals – doctors and nurses wanting to understand more about the legal dimensions of clinical practice, and who might be expert witnesses in tribunals or court hearings.

The two streams created a rich course with multiple perspectives on medico-legal issues.

Among other units are public health law, law and genetics and class actions. The issues they dealt with had initially given rise to the discipline of bioethics, which had gradually hardened into health law.

"When first discussed 30 or 40 years ago, there was no body of law or specialised regulation, but now, as a result of legislation and the development of case law, medical law is an acknowledged specialist area." □



Dr Rodney Syme says the law tries to justify the obvious problems caused by end-of-life decisions with "dodgy precedents, dodgy arguments about causation, and turning a blind eye to much that goes on".

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