Christopher Harkness

Committee Secretary
Senate Legal and Constitutional Affairs Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Committee Secretary,

In the writing of this submission the views are my personal ones, and do not intend to represent any organisation with which I have an association. I begin this submission by referring back to a speech to the Euthanasia NO Secretariat by renowned author Colleen McCulloch in March 1996 titled “Why I Oppose Euthanasia”. McCulloch mentioned that she was not a religious person, and not arguing from a religious standpoint, but rather one of ethics and morals. McCulloch spoke of the social nature of human kind, which has given rise to the Magna Carta, Bill of Rights, and United Nations Covenants. McCulloch asserts that if human kind was not social, records of the exercise of mercy, compassion and care would not exist. McCulloch spoke of the mystery of life, which no one has the right to terminate. That we deplore war, famine and pestilence is testament to the right to life, whatever its quality, as being universal and sacred among human kind.

On the question of “Who Will Do the Killing?” McCulloch believes that those who ask others to kill them genuinely do not want to die. Anathema to McCulloch is asking medical personal to bear the guilt of such an act when, in accordance with the Hippocratic Oath, they profess to heal.

McCulloch spoke of the practical implications of euthanasia surrounding such questions as: “Who stands to benefit from premature death? In how many cases are inheritances involved? Emotional Rivalries?” Moreover, once legislation is in place it becomes “much easier to contemplate euthanasia in ways many of those who advocate it today insist is not their aim”.

The views of Colleen McCulloch have implications that transcend claims of those who advocate voluntary euthanasia that such an act is an individual human right. McCulloch told her audience that “hope is what keeps most of humanity going”. It is my belief that it is this hope that drives human kind to invest in research to find cures for conditions such as AIDS and cancer. It is this hope that dedicated professionals work in palliative care so as to ease the pain of those with terminal illnesses, and provide them comfort. It is this hope that governments and people contribute millions of dollars in overseas aid so that those who are poor and disabled can have better lives. I believe that voluntary euthanasia will in time undermine the hope among human kind that life has meaning and purpose, notwithstanding that it may be perceived by some sections of society to have less ‘quality’ at a particular stage of one’s life, or because of a terminal medical condition.

I too live in hope. In March of 2011 I was diagnosed with multiple myeloma, which is a blood-borne cancer. Not knowing much of this condition at the time I consulted an Internet source, in which I found that the average life span for this condition was five years. It is now over ten years since my diagnosis. I am currently completing a part-time PhD at UWA with a goal of completion by this year's end. I am active in a number of organisations within my parish and wider community. I would be disingenuous to deny that my journey since diagnosis hasn't been difficult at both a physical and emotional level. I have received my share of chemotherapy, and other medical treatments since my diagnosis. However, I have been encouraged by the dedicated medical and nursing staff, which has greatly helped me to remain positive about my condition. I am grateful to have received the support of family and friends. I have also seen over these years an improvement in the range of drug treatments, such that people now diagnosed with multiple myeloma are living longer. The range of drug treatments continues to improve. These responses and developments arise from a culture that has the capacity to instil hope and possibility, rather than one of hopelessness and helplessness.

I too share McCulloch's concern that once legislation is in place there will occur a 'slippery slope' in which voluntary euthanasia becomes an easy to negotiate 'treatment' to meet individual and societal pressures as they arise. This has been evidenced in the Netherlands, which introduced euthanasia legislation in 1973. The Remmelink Report released on 10 September 1991, and which documents the results of the first official government study of the Practice of Dutch euthanasia, points to a number of adverse consequences arising from this legislation. These include doctors to a large degree having taken over making decisions about end of life. Guidelines to protect patients did not prevent abuse, which became an accepted norm. For example, 11,840 people had their lives deliberately ended by Dutch physicians through lethal overdoses or injections - a figure that represented 9.1% of the annual death rate. Moreover, these figures did not include involuntary euthanasia performed on newborns who were disabled, children with life-threatening conditions, or patients with psychiatric conditions. The report found that the most frequently cited reasons given for involuntary euthanasia were: "low quality of life", "no prospect for improvement" and "the family couldn't face it anymore". To avoid paper work and scrutiny, patient death certificates were deliberately falsified by doctors in the majority of Dutch euthanasia cases to that of death from natural causes.

While efforts to regulate euthanasia in the Netherlands were made through the Request and Assisted Suicide (Review Procedures) Act in 2002, the number of deaths from euthanasia has risen. In this Act physician assisted suicide is not a crime if the attending physician meets the criteria of due care, and which include the patient experiencing unbearable and hopeless suffering. However, these criteria can be subjective, and do not give due weight to advancements in the treatment of pain and new drug therapies. In 2003 euthanasia accounted for 1.2 per cent of all deaths in the Netherlands. According to a Dutch news report in April 2017, this figure rose to 4.5% of all deaths in 2016. Moreover, a citizen's initiative in February 2010 called Out of Free Will demands that all Dutch people over 70 who feel tired of life have the right to access professionals to end it.

Apart from the important ethical and moral issues relating to doctor assisted suicide, a neglected area of the debate relates to those areas of our employment and economy we want to develop and expand at a time when employment in some sectors is contracting. It seems incongruous that much research and employment opportunities are being developed in public health, when the introduction of voluntary assistance dying could contract research and employment opportunities that seek to maintain the health and wellbeing of older people. In this regard I am mindful of Australia having been at the forefront of research into the prevention and treatment of Alzheimer's disease. It is alarming that advocates of euthanasia sometimes argue that doctor assisted suicide would enable people with dementia a release from their burden. As a former lecturer in Certificate 111 Aged Care, and in which I delivered a module on Dementia, I spoke about many employment areas that contained a focus on maintaining, and indeed promoting, the health and wellbeing of this group of predominantly elderly. These include, but were not limited to, nursing, personal care, physiotherapy, and occupational therapy. Will the introduction of voluntary assistance dying lead to a disincentive for graduating students in these fields to work in the area of the elderly, even at a time when the population of elderly in Australia is increasing exponentially?

Feelings of hopelessness, helplessness, and perhaps even suicidality, can be experience by anyone at some stage of their life. When these feelings arise, people can benefit from appropriate treatments, and the support of family and friends, rather than be seen as a justification for euthanasia.

I am most concerned that the debates in our culture about euthanasia take a populist and superficial stance that fails to consider the implications for both the individual and society at large. The debates sometimes fail to progress beyond the right of the individual to have a dignified death. In liberal democracies, responsibilities out of necessity provide a balance to rights, particularly as they apply to the common good. Restrictions on the rights of individual to congregate freely during the Covid pandemic are a case in point. Thus, there is a relative lack of consideration pertaining to euthanasia of the moral and ethical responsibilities of individuals in society, government, and professionals in medical and allied health.

Due to the above-mentioned considerations, I assert that the Commonwealth must show leadership in this important issue by exercising the right to intervene in Northern Territory legislation to ensure that the Territory does not follow the path of state government legislation that allows for voluntary assisted dying. The Voluntary Assisted Dying legislation passed by the state governments of Victoria, Western Australia, and proposed legislation in Queensland demonstrate a lack of consideration of the adverse implications of this legislation to society.

Sincerely,

Christopher Harkness

Candidate for PhD, University of Western Australia