CHAPTER 4

EUTHANASIA POLICY ISSUES

Introduction

4.1 This chapter examines some of the key moral, ethical and social arguments for and against the legalisation of voluntary euthanasia.

4.2 Some submissions expressed the view that the legal and constitutional policy issues were the only issues that should be considered by the committee during its inquiry. For example, the South Australian Voluntary Euthanasia Society submitted that 'the Bill is not about the issue of euthanasia and this should not be considered as its basis'.[1] In contrast, the ACL described claims that the bill is not about euthanasia as 'deeply disingenuous'.[2] Indeed, some suggested that the moral issues addressed in the Bill should override all other considerations.[3]

4.3 The legal and constitutional policy issues examined in Chapter 3 raised important threshold issues for the committee. That said, the committee also received a considerable amount of highly polarised evidence focussing on the policy arguments for and against voluntary euthanasia. Further, the committee considers that discussion about the legalisation of voluntary euthanasia cannot be avoided, given that the Bill proposes to revive the NT RTI Act.

4.4 The committee notes that many of the issues raised during this inquiry were similar to those raised, and discussed in detail, during the 1997 Euthanasia inquiry.[4] The committee therefore refers readers to the 1997 Euthanasia Inquiry report where relevant for a more detailed discussion of some issues. However, this chapter will endeavour to highlight relevant developments that have occurred since 1997.[5]

4.5 This chapter will first examine some of the key arguments in favour of legalising voluntary euthanasia, together with some contrasting perspectives on those arguments. Key arguments against the legislation of voluntary euthanasia will then be discussed, again incorporating some alternative perspectives on those issues.

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1 *Submission 74*, p. 1.

2 *Submission 422*, p. 3; see also Mr Marshall Perron, *Committee Hansard*, 14 April 2008, p. 17.

3 See, for example, the Federal Presbyterian Church of Australia, *Submission 366*, p. 1.

4 See 1997 Euthanasia Inquiry, especially Chapters 5-8.

5 The committee notes that some witnesses and submitters expressed the view that little has changed since 1997, or that, if anything, the anti-euthanasia case has slightly strengthened and therefore the current Euthanasia Act should not be changed: see for example, Father Frank Brennan, *Committee Hansard*, 16 April 2008, pp 9-10.

Key arguments in favour of voluntary euthanasia

4.6 In summary, some of the key arguments advanced in support of legislating for voluntary euthanasia included that:

- it is a matter of individual rights, autonomy and choice;
- it is the compassionate and merciful answer to insoluble pain, suffering and indignity in the case of terminal illness;
- it is merely regulating what in reality is already common practice, particularly now that Australians have resorted to travelling overseas to obtain euthanasia;
- opinion polls show that the overwhelming majority of Australians support voluntary euthanasia; and
- several overseas jurisdictions (such as Switzerland, Belgium, the Netherlands and Oregon) have legalised voluntary euthanasia.

These issues are considered in turn below.

Individual rights, autonomy and choice

4.7 Many submissions supporting voluntary euthanasia put forward arguments based on the principle of individual rights and autonomy. That is, a competent individual should have the right to determine how and when to die as long as this does not interfere with the rights of others.[6]

4.8 For example, the NSW Council for Civil Liberties told the committee that 'the principal argument for legalising voluntary euthanasia is that a terminally-ill adult should have the right to choose to end their own suffering.'[7] The NSW Council for Civil Liberties further submitted its belief that:

> …the Bill will restore respect for the rights of the terminally ill in the Northern Territory to choose the time of their own death. The Bill will ensure that the terminally ill, if they so choose, can die with dignity and in a humane manner. The Bill will respect the fundamental principle that the individual is sovereign over their own body and mind.[8]

4.9 The West Australian Voluntary Euthanasia Society submitted that:

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6 See, for example, Civil Liberties Australia, *Submission 365*, p. 1; NSW Council for Civil Liberties, *Submission 418*, p. 3; West Australian Voluntary Euthanasia Society, *Submission 370*, p. 2; Council of Australian Humanist Societies, *Submission 396*, p. 1; Voluntary Euthanasia Society of Queensland, *Submission 431*, p. 1; also 1997 Euthanasia Inquiry, pp 57-61.

7 *Submission 418*, p. 3.

8 *Submission 418*, p. 2.

> It is time we decided to give the people the right to decide about their life according to their conscience and judgement. It is sheer arrogance to think that anyone else can or should decide someone else's fate.[9]

4.10 Dr David Leaf, a medical practitioner, told the committee that:

> …the majority of patients who are facing this terminal stage of illness just want the option of whether to participate in voluntary euthanasia, where they have some control over what is going to happen to their lives, or, frequently, they would elect not to participate in that action as well. One of the options I would like to have as a doctor treating these people is the option to offer them voluntary euthanasia. In the same way that they can have an operation or elect to go down the palliative care route, they would like to have options.[10]

4.11 Mr Marshall Perron also argued that:

> …voluntary euthanasia legislation does not require anybody to do anything. If you disagree with it, you can go through life pretending that the law does not even exist and it will never affect you.[11]

4.12 However, concerns were expressed that if a legal right to euthanasia were granted, more vulnerable people would be at risk, particularly if they feel they may be a burden to family or society.[12] As a result, the Australian Catholic Bishops Conference argued that the demands of the common good must be measured against claims of liberties:

> A request for voluntary euthanasia is a request to be killed by another. It is not a private matter. Aspects of the common good affected by the legislation of euthanasia include equal protection under the law, the ethos of the practice of medicine, and factors affecting an individual's sense of security at times when they are particularly vulnerable.[13]

4.13 The Australian Family Association (WA) also suggested that euthanasia cannot be considered as autonomous:

> Firstly, since it involves at least one other person, it must be viewed as a public action, and so be assessed in relation to its social implications.
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> Second, as a public act, it should be assessed via the perspective of societal ethics. In other words, does sanctioning private killing benefit society to a greater extent than its prohibition?…[R]ecognition of euthanasia not only extends personal autonomy, but also redefines the concept of private killing

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9 *Submission 370*, p. 2.

10 *Committee Hansard*, 16 April 2008, p. 15.

11 *Committee Hansard*, 14 April 2008, p. 20.

12 See, for example, Dr Mark Boughey, *Committee Hansard*, 14 April 2008, p. 40; also Dr David van Gend, ACL, *Committee Hansard*, 14 April 2008, p. 14 and *Submission 413*, p. 6.

13 *Submission 410*, p. 3; see also p. 5.

> in society. The magnitude of this change needs to be evaluated, as well as its social impact.
>
> Thirdly, and perhaps ironically, the right to personal autonomy on which euthanasia supposedly depends is actually contradicted when one cedes to another, either directly or indirectly, the right to take one's life. Handing the power over one's life to another destroys one's freedom...[14]

Compassionate answer to pain, suffering and indignity

4.14 Proponents also argued that voluntary euthanasia is the compassionate and merciful answer to insoluble pain, suffering and indignity in the case of terminal illness.[15] For example, Emeritus Professor Philip Ley pointed to reasoning given by patients seeking euthanasia in the US state of Oregon and the Netherlands. Key concerns for these patients, included loss of autonomy and dignity and a decreasing ability to participate in activities that make life enjoyable.[16]

4.15 The committee also received many submissions detailing case studies of patients who had a difficult death and who may have benefited from the availability of voluntary euthanasia.[17] In this context, Dr David Leaf told the committee that 'death is not the worst outcome for them at times like this':

> …if you are…subject to daily incurable pain, loss of dignity, immobility and being a burden to your family, to many such patients that is a worse outcome than quietly passing away at a time of their own choosing in a painless manner.[18]

4.16 Dr Leaf further told the committee that a lot of patients:

> …do not want to be at a stage where they are immobile, they have a lack of dignity, someone else is cleaning them up several times a day. Even though they might be out of pain, they do not want to be at the stage where a palliative care team, doctors, nurses and GPs, are looking after them.[19]

4.17 In contrast, the ACL argued that:

> There is no dignity in euthanasia, which effectively means a person's life is viewed as so awful it should be brought to a premature end. Rather there is

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14 Australian Family Association (WA), *Submission 380*, p. 4; see also Christian Democratic Party, *Submission 1001*, p. 6.

15 See also 1997 Euthanasia Inquiry, pp 61-62.

16 *Submission 363*, p. 3; see also Oregon Department of Human Services, at http://oregon.gov/DHS/ph/pas/index.shtml and "Summary of Oregon's Death with Dignity Act - 2007" at: http://oregon.gov/DHS/ph/pas/docs/year10.pdf (accessed 19 May 2008).

17 See, for example, NSW Council for Civil Liberties, *Submission 418*, pp 4-5; Dr David Leaf, *Submission 57*, p. 2 and *Committee Hansard*, 16 April 2008, p. 15.

18 *Committee Hansard*, 16 April 2008, p. 16.

19 *Committee Hansard*, 16 April 2008, p. 17.

> dignity and comfort in knowing that Australian society recognises that all human beings, even in the agony of suffering or in a twilight mental state, deserve respect, empathy and protection from abuse, harm, manipulation or wilful neglect and which affirms that every patient, no matter how deformed the body, deranged the mind or diminished the personality, should receive equal protection and medical care.[20]

4.18 Similarly, Mr Christopher Meney, Director of the Life, Marriage and Family Centre of the Catholic Archdiocese of Sydney told the committee that:

> A key element of respecting human dignity is the need to respect and value human bodily life. Hence, the individual and social resolve to respect all human life and to never regard a life as lacking worth is essential for a society that wishes to protect and equally value all its citizens.[21]

4.19 Many submissions opposing euthanasia also pointed to the need for good palliative care (discussed later in this chapter). Others told the committee that 'hard cases make bad laws'.[22] However, the Australian Federation of AIDS Organisations argued to the contrary:

> …when individual cases are clinically evaluated and confirmed for their presentation and specific circumstances, and it is evident there are no other options to relieve a person's pain and distress, that it is entirely appropriate to have a process whereby that person can rationally request an end to their life…
>
> Surely when no other options are open to a person in the final stages of a terminal illness, a person suffering unrelievable pain and distress who consistently and rationally requests an end to their agony, there should be some process whereby their dying wish can be granted.[23]

Opinion polls indicate popular support

4.20 Most submissions supporting the Bill pointed to opinion polls indicating that the vast majority of Australians (80%) support voluntary euthanasia.[24] For example, the Voluntary Euthanasia Society of NSW submitted that:

> In the last two decades, surveys have consistently shown that a majority of Australians believe that terminally ill individuals should have a right to seek and obtain assistance to end their life with dignity. In 1962 it was close

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20 *Submission 422*, p. 16.

21 *Committee Hansard*, 16 April 2008, p. 28; see also p. 29.

22 See, for example, the National Alliance of Christian Leaders, *Submission 359;* Dr Ruth Powys, *Submission 388*, p. 3; Pro-Life Victoria, *Submission 408*, p. 2.

23 *Submission 400*, p. 3.

24 Mr Marshall Perron, *Submission 393*, p. 5; West Australian Voluntary Euthanasia Society, *Submission 370*, p. 2; Humanist Society of South Australia, *Submission 454*, p. 1; Council of Australian Humanist Societies, *Submission 396*, p. 2. See also Chapter 7 of the 1997 Euthanasia Inquiry, which canvasses the history of opinion polls on the issue of euthanasia.

> to a majority (47%) and by 1978 it was up to 67%, and in 2002 was 73%+. An independent poll [was] conducted by Newspoll in 2007 and found 80% of Australians in favour, and just 14% opposed.[25]

4.21 Others disputed the legitimacy of arguments based on opinion polls. For example, Dr Brian Pollard submitted that:

> …many people have erroneous ideas of what actually constitutes euthanasia…it is well-known that the wanted results can be manipulated by the structure of the questions, opinion polls can carry no certainty about euthanasia. Would it really become OK to rob old ladies when 80% thought so?[26]

4.22 Dr Mark Boughey, a palliative care physician, told the committee that, despite these opinion polls, in his experience the reality was quite different:

> Even though populist opinion states that euthanasia is popular and is something that the Australian population wants, I think the reality when you are actually working with and dealing with people in the dying phase of their palliative condition is very different. The reality, which we are exposed to every day, is that people are still trying to engage actively in life, even though their life may be fast approaching the end.[27]

4.23 Support for voluntary euthanasia within the medical profession was a matter for debate. For example, Dying with Dignity Victoria pointed to opinion polls indicating that 78% of Victorian nurses favoured law reform (in 1992), and 80% of nurses in NSW gave support in 1997.[28] However, in its submission, the Australian Medical Association (AMA) opposed the Bill and voluntary euthanasia.[29] At the same time, it recognised:

> …the divergence of views regarding voluntary euthanasia and physician-assisted suicide in Australia. Indeed, the range of views, from those who fully support voluntary euthanasia to those who totally oppose it, is reflected within the medical profession itself.[30]

Regulating a common practice

4.24 Another argument raised in favour of legalising voluntary euthanasia is that it is regulating what in reality is already common practice.[31] Submitters pointed to a

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25 *Submission 216*, p. 1; see also Humanist Society of Victoria, *Submission 382*, p. 2.

26 *Submission 47*, pp 8-9; see also the Committee on Bioethics of the Uniting Church in Australia (Victorian Synod), *Submission 384*, p 1.

27 *Committee Hansard*, 14 April 2008, p. 37.

28 *Submission 399*, p. 4.

29 *Submission 375*, pp 1-2.

30 *Submission 375*, p. 1.

31 For example, Dying with Dignity Victoria, *Submission 399*, p. 4; Mr Marshall Perron, *Submission 393*, p. 4; see also 1997 Euthanasia Inquiry, pp 62-63 and pp 87-89.

study, also examined during the 1997 Euthanasia Inquiry, indicating that, in practice, many Australian doctors already take steps that lead to an earlier death for patients.[32] It was therefore suggested that it was better to regulate the process to ensure that it was open to scrutiny. For example, the Humanist Society of Victoria argued that:

> The practice [of euthanasia] occurs frequently, in a clandestine mode, as testified by doctors and nurses. It is essential that the process be open to scrutiny and performed by experienced and accountable medical practitioners.[33]

4.25 The Australian Federation of AIDS Organisations similarly submitted that:

> …some seek assistance to end their own lives at a time they choose despite the fact that doing so is illegal. Numerous studies and polls suggest that acts of euthanasia and assisted euthanasia are not isolated occurrences…work on HIV positive people also reveals cases of 'botched' suicide attempts resulting from euthanasia's illegality, and the dreadful impact on all involved.[34]

4.26 In this context, Associate Professor Cameron Stewart, from the Division of Law at Macquarie University, submitted that:

> By providing a different process for dying the Rights of the Terminally Ill Act does not depart in a massive way from existing laws but rather it provides a safeguarded process for the management of death in the terminally ill.[35]

4.27 Dying with Dignity Victoria was also concerned that 'continuous deep terminal sedation' is 'now commonly used in palliative care', in the same circumstances where a person might otherwise request voluntary euthanasia:

> Its undoubted advantage is that it relieves intolerable suffering, but it has two major disadvantages. It is often provided without any explicit discussion with the patient, and it may take days before death occurs. In addition there is no reporting procedure and no prescribed safeguards.[36]

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32 See, for example, Emeritus Professor Philip Ley, *Submission 363*, p. 2 and Dr Alan Rothschild, *Submission 452*, pp 17-18, referencing Kuhse, H., Singer, P., Baume, P., Clark, M. and Rickard, M. (1997) "End of Life decisions in Australian Medical practice", *Medical Journal of Australia*, Vol. 166(4), 17 February 1997, pp 191-197. See also 1997 Euthanasia Inquiry, pp 87-89.

33 *Submission 382*, p. 3; see also Council of Australian Humanist Societies, *Submission 396*, p. 2.

34 *Submission 400*, p. 2.

35 *Submission 729*, p. 14.

36 *Submission 399*, p. 6.

4.28 Dying with Dignity Victoria therefore queried 'why it is acceptable to deliberately put a person with intolerable suffering to sleep for days before they die, but not to allow the same person the choice for a quick death.'[37]

4.29 There also appears to have been another significant development since the 1997 Euthanasia Inquiry: Australians are now travelling overseas to obtain euthanasia. In particular, Dr Philip Nitschke of Exit International gave examples of patients seeking euthanasia who had ended up travelling overseas.[38] Dr Nitschke explained that there were two key overseas options. Mexico was the 'predominant choice of nation', as people could lawfully acquire the drug Nembutal and bring it back to Australia (illegally) to die here. Australians are also opting to die in Switzerland under their system of legalised euthanasia, where certain preconditions must be met.[39] Indeed, the committee heard directly from submitters who had travelled overseas – for example, one whose husband had travelled to Switzerland to obtain euthanasia,[40] and another who had travelled to Mexico to obtain 'a product leading to a 'peaceful death".[41]

4.30 Dr Nitschke told the committee that he knew of at least 150 people who made a trip to Mexico last year to obtain the drug Nembutal – and effectively broke Australian law to import a class 1 prohibited drug.[42] Dr Philip Nitschke told the committee at its hearing in Darwin that:

> …what started off as a trickle but has now turned into a flood of people who are taking this so-called overseas option to try and establish for themselves viable end-of-life choices.[43]

4.31 Supporters of voluntary euthanasia expressed the view that this meant that those who could afford to travel overseas were 'lucky', but that those who could not afford to do so were 'penalised'.[44]

Overseas examples

4.32 In support of the Bill, the committee also heard that several overseas jurisdictions have now legalised voluntary euthanasia. For example, the Voluntary Euthanasia Society of NSW submitted that:

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37 *Submission 399*, p. 7; see also Dr Alan Rothschild, *Submission 452*, pp 12-16.

38 *Submission 390*, pp 2-3.

39 *Committee Hansard*, 14 April 2008, p. 26.

40 Mrs Angelika Elliott, *Submission 383*.

41 Mr Don Flounders, *Submission 110*, p. 1; see also *Submission 110A*.

42 *Committee Hansard*, 14 April 2008, p. 25.

43 *Committee Hansard*, 14 April 2008, p. 25.

44 See, for example, Mrs Angelika Elliott, *Submission 383*, p. 2.

> In the Netherlands, Belgium, Switzerland, and the American state of Oregon physicians are permitted to assist a patient in ending his or her life by means other than withdrawing life-sustaining medical treatment.[45]

4.33 The committee notes that the practice of euthanasia in the Netherlands, Switzerland and the US State of Oregon were considered during the 1997 Euthanasia Inquiry.[46] Since then, legislation relating to voluntary euthanasia and/or physician assisted suicide has now come into force in: the Netherlands (in April 2002 – prior to that, guidelines had been in place since 1990);[47] the US State of Oregon (in October 1997);[48] and Belgium (in September 2002).[49]

4.34 Some suggested that the experience in those places would reassure those opposed to legalising voluntary euthanasia. For example, Dying with Dignity Victoria submitted that:

> Practice in those places has been carefully studied. It is no longer a matter of conjecture as to the effects on the community and the medical profession of such laws. As a result, attitudes of many significant people and bodies have changed towards acceptance of VE [Voluntary Euthanasia].[50]

4.35 However, there was considerable debate in evidence about the practice and regulation of euthanasia overseas, particularly in the Netherlands. Many opposing euthanasia expressed concerns about the experience in the Netherlands.[51] This is discussed further later in this chapter in the section on the potential for a 'slippery slope' in the regulation of euthanasia.

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45 *Submission 216*, p. 1; see also Humanist Society of Victoria, *Submission 382*, p. 2; Dying with Dignity Victoria, *Submission 399*, p. 2; Mr Marshall Perron, *Submission 393*, p. 3.

46 1997 Euthanasia Inquiry, Chapter 8, pp 93-110.

47 See further: Ministry of Health, Welfare and Sport (Netherlands), http://english.justitie.nl/themes/euthanasia/index.aspx (accessed 20 May 2008): also Dr Alan Rothschild, *Submission 452*, p. 26. For the situation prior to 2002, see 1997 Euthanasia Inquiry, pp 96-106.

48 Note that this legislation was first approved in 1994 but subject to various court challenges: see further: Oregon Department of Human Services, "Death with Dignity Act", http://oregon.gov/DHS/ph/pas/index.shtml (accessed 15 May 2008).

49 See further: South Australian Voluntary Euthanasia Society, Fact Sheet 26, Voluntary Euthanasia in Belgium, available at: http://www.saves.asn.au/resources/facts/fs26.php (accessed 15 May 2008).

50 *Submission 399*, p. 2; see also Dr Alan Rothschild, *Submission 452*, pp 4-5.

51 See, for example, Dr Brian Pollard, *Committee Hansard*, 16 April 2008, p. 26; Darwin Christian Ministers' Association, *Submission 376*, p. 4; ACL, *Submission 422*¸ pp 8-9; Festival of Light Australia, *Submission 361*, p. 8.

4.36 Others opposing the Bill pointed to several international inquiries which have rejected proposals for euthanasia.[52] Many of these inquiries were canvassed by the 1997 inquiry into the Euthanasia Laws Bill 1996.[53] Some also noted the defeat of a Bill for voluntary euthanasia in the House of Lords in the United Kingdom in 2006.[54]

Key arguments against voluntary euthanasia

4.37 Some of the key arguments against legislating for voluntary euthanasia included:

- the availability of quality palliative care for people with terminal illnesses;
- the problem of adequate safeguards and the possibility that it would lead to a 'slippery slope' – for example, acceptance of voluntary euthanasia would lead to involuntary euthanasia and/or euthanasia for lesser diseases and conditions;
- the potential for erosion of the doctor-patient relationship;
- that it places pressure on people to end their lives even if they are not ready, for example, to reduce the burden on their family or the health system;
- the sanctity of human life; and
- in the case of the NT legislation, the particular impact on the Indigenous community.

These issues are considered in turn below.

Palliative care

4.38 Many suggested that, rather than legalising voluntary euthanasia, there should be an increased emphasis on, and funding for, palliative care.[55] For example, Palliative Care Australia submitted that:

> …informed community discussion about euthanasia cannot be had until quality palliative care is available for all who require it and there is enhanced community understanding of existing end of life decision making options, including advance care planning.[56]

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52 See, for example, Dr David van Gend, *Committee Hansard*, 14 April 2008, p. 9 and *Submission 413*, pp 3-5; Festival of Light Australia, *Submission 361*, pp 5-8; Dr Brian Pollard, *Documents tabled at public hearing of 16 April 2008*.

53 1997 Euthanasia Inquiry, Chapter 8, pp 93-110.

54 Father Frank Brennan, *Committee Hansard*, 16 April 2008, p. 13 and *Submission 428*, p. 2; Festival of Light Australia, *Submission 361*, p. 5.

55 That is, care that provides coordinated nursing, medical and other allied services for people with a terminal illness: see Palliative Care Australia, *Submission 424*, p. 12. See also, for example, Catholic Health Australia, *Submission 419*, p. 4; Little Company of Mary Health Care, *Submission 425*, p. 5; Family Council of Victoria, *Submission 263*, pp 5-6; and 1997 Euthanasia Inquiry, pp 74-79.

56 *Submission 424*, p. 1.

4.39 Similarly, the ACL submitted that:

> Whilst no-one wants to see someone they love endure pain, euthanasia is not the answer to this. Instead, we should put far greater resources into high quality, easily accessible palliative care so that people's last days can be made as comfortable as possible.[57]

4.40 Mrs Lois Fong, NT Director of the ACL told the committee that:

> …society's duty to terminally ill people is to improve the quality of their palliative care as well as support those who are isolated and who feel their lives are meaningless...The negative impact on hospice and palliative care if euthanasia is legalised cannot be underestimated.[58]

4.41 Indeed, many were concerned that, if euthanasia were legalised, there would be a negative impact on palliative care. For example, Mr Christopher Meney of the Life and Marriage Centre of the Catholic Archdiocese of Sydney told the committee:

> It is also easier and cheaper to kill a patient than to provide palliative care. Good palliative care can become a secondary concern and [is] less likely to be able to be accessed by those patients not wanting to be euthanised.[59]

4.42 Similarly, the ACL argued that:

> …once a society rejects the right to life and instead legalises killing as a form of treatment it will quickly begin to ask why it should foot the bill for expensive medical care that will, in any case, fail to save the life of a terminally ill patient. Why bother paying for expensive palliative care and support when euthanasia is so cheap?[60]

4.43 The NSW Council for Civil Liberties disputed these sorts of suggestions:

> It is argued that if we allow the 'easy' option of voluntary euthanasia, researchers will not make the effort they otherwise would to improve palliative care, both by relieving pain and by reducing or eliminating the side effects. This supposes that we should require patients to suffer intense pain, so that others will do what they ought to be doing anyway. This is obnoxious: a denial of the moral significance of the person, who is to be used, contrary to his or her own values, for others' benefit. This view also presupposes that everyone will choose voluntary euthanasia.[61]

4.44 Other evidence suggested that requests for voluntary euthanasia are often revised when palliative care alternatives are offered. For example, some pointed to

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57 *Submission 422*, p. 16.

58 *Committee Hansard*, 14 April 2008, p. 8.

59 *Committee Hansard*, 16 April 2008, p. 28; see also Medicine with Morality, *Submission 242*, pp 1-2.

60 *Submission 422*, p. 11.

61 *Submission 418*, p. 8.

evidence from the US State of Oregon indicating that where palliative care and/or counselling was offered:

> …nearly half of those initially requesting PAS [Physician Assisted Suicide] changed their minds after treatment for pain or depression commenced or referral to a hospice was undertaken. Where no active symptom control commenced, only 15% changed their minds.[62]

4.45 In this context, several submitters emphasised the importance of psychological considerations and counselling.[63] For example, Mr Christopher Meney, from the Life, Marriage and Family Centre of the Catholic Archdiocese of Sydney, told the committee that:

> A wish to die can often be an expression of depression, pain or poor symptom control rather than a sincere desire to be killed.[64]

4.46 However, the Australian Psychological Society recognised that:

> A patient's depression may be a response to a loss of control over the situation which could be alleviated by the perception of choice over terminating one's life. A diagnosis of clinical depression should therefore not automatically negate a person's right to request euthanasia. Rather, the presence of a depressive illness needs to be carefully assessed and treated, and form part of a detailed and thorough clinical assessment, administered on more than one occasion with a reasonable time interval between assessments.[65]

Advance care planning

4.47 In the context of palliative care, several submissions also pointed to the importance of 'advance care planning',[66] and the developments in advance care planning which have occurred in many state and territory jurisdictions since 1997.[67]

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62 Life, Marriage and Family Centre of the Catholic Archdiocese of Sydney, *Submission 360*, p. 4; see also Mr Christopher Meney, *Committee Hansard*, 16 April 2008, pp 31-32.

63 See, for example, Australian Psychological Society, *Submission 429*, pp 1-2; Dr Dianne Grocott, *Submission 387*; Suicide: NO, *Submission 395*, p. 2; ACL, *Submission 422*, pp 12-13.

64 *Committee Hansard*, 16 April 2008, p. 28 and see also *Submission 360*, p. 4.

65 *Submission 429*, pp 1-2. In this context, the Australian Psychological Society was concerned that certain safeguards need to be included in euthanasia legislation, and that the NT RTI Act did not make adequate provision 'to address the psychological needs of close relatives of the patient through counselling'.

66 See, for example, the Australian Nursing Federation, *Submission 591*, p. 1; Palliative Care Australia, *Submission 424*, p. 3.

67 See, for example, Mr Mark Boughey, *Committee Hansard*, 14 April 2008, p. 38; also Associate Professor Cameron Stewart, *Submission 729*, pp 4-5; Australian Federation of AIDS Organisations, *Submission 400*, p. 2.

4.48 Associate Professor Cameron Stewart advised that there are now legislative schemes in most state and territory jurisdictions which have enshrined the right to make an 'advance directive'.[68] Associate Professor Stewart explained further that:

> 'Advance directives' or 'living wills' are decisions made by patients about what medical treatments they would like in the future, if at some point, they cannot make decisions for themselves. Advance directives ordinarily record decisions about refusing life-sustaining treatments, but they can also contain the patient's preferences and desires about a whole range of treatment matters.[69]

4.49 In the context of the euthanasia debate, the AMA endorsed advanced care planning 'as a means for supporting patients' wishes in their end of life care'. The AMA submitted that:

> Some patients may fear that when they lose decision-making capacity, their goals and values in relation to their end of life care will be unknown or even disregarded by their families and/or the health care team since the patient can no longer actively participate in their own health care decisions. As such, this fear may lead some patients to consider undergoing euthanasia or physician-assisted suicide before they lose decision-making capacity.[70]

4.50 The AMA expressed its view that an advance care plan reassures patients that 'they can participate in future decisions regarding their health care by articulating their wishes and goals of care in their plan'.[71]

4.51 Palliative Care Australia further suggested that there should be an inquiry to identify and address the 'barriers to greater use of advance care plans and directives, to ensure patients' rights to determine their course of care are respected'.[72]

Palliative care in the Northern Territory

4.52 The committee received evidence that, at the time of the enactment of the NT RTI Act, the standard of palliative care in the NT was 'poor'.[73] Dr Mark Boughey told the committee that palliative care services have developed significantly in the NT in recent years, and are now probably above national standards.[74] Indeed, Mr Gerry Wood, MLA, a current member of the NT Legislative Assembly, submitted his belief

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68 *Submission 729*, pp 4-5. See especially the table in this submission summarising the regulation of advance directives in each state and territory under common law and legislation.

69 *Submission 729*, pp 4-5; see also AMA, *Submission 375*, p. 3.

70 *Submission 375*, p. 3.

71 *Submission 375*, p. 4.

72 *Submission 424*, p. 2.

73 See, for example, Professor David Kissane, *Submission 589*, p. 1; Mr Gerry Wood MLA, *Submission 453*, p. 1.

74 *Committee Hansard*, 14 April 2008, p. 38; see also *Submission 592*, p. 2.

that 'the NT and specifically Darwin now has a world class Palliative Care Unit'.[75] He suggested that:

> …with the increasing knowledge about palliative care there has been a lessening of support for the option of euthanasia. No doubt there is still support for euthanasia in our community but I feel that with more community education about palliative care more people are realising that you can have death with dignity without deliberately shortening life.[76]

4.53 At the same time, several submissions called for further improvements to palliative care and other medical services in the NT.[77] Indeed, for these reasons, Dr David Gawler of the Darwin Christian Ministers' Association, told the committee that:

> The Northern Territory is really the most unsuitable of all places in Australia to legislate to legalise patient killing. There are insufficient medical services—for example, radiotherapy is not available in Darwin for cancer sufferers. There are remote communities with inadequate health services. There is the tyranny of distance.[78]

Limits to palliative care

4.54 Some suggested that the option of good palliative care makes euthanasia altogether unnecessary – because, for example, it addresses the issue of pain, suffering and indignity in dying.[79] However, the committee also heard that palliative care does not always provide a solution.[80] For example, Dr David Leaf told the committee that, in his experience, 'palliative care is like any other medical specialty: it does not always have the answers...palliative care has its limits'.[81]

4.55 Similarly, Dying with Dignity Tasmania submitted that:

> Advances in palliative care have undoubtedly done much to make the final days of those suffering from terminal disease more comfortable and more bearable. However, there remain a small proportion of patients whose pain can not be relieved and there are others for whom freedom from pain is not the single factor that makes a life worth living. Debilitating factors that

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75 *Submission 453*, p. 1.

76 *Submission 452*, p. 1.

77 Darwin Christian Ministers' Association, *Submission 376*, p. 4; Dr David Gawler, *Submission 445*, p. 4.

78 *Committee Hansard*, 14 April 2008, pp 9-10.

79 See, for example, Medicine with Morality, *Submission 242*, p. 1; Australian Catholic Bishops Conference, *Submission 410*, p. 6; Catholic Health Australia, *Submission 419*, pp 3-4; Mr Gerry Wood MLA, *Submission 453*, p. 1.

80 See, for example, ACT Committee of the Voluntary Euthanasia Society of NSW, *Submission 238*, p. 1; Emeritus Professor Philip Ley, *Submission 363*, pp 5-6; Dying with Dignity Victoria, *Submission 399*, p. 6; NSW Council for Civil Liberties, *Submission 418*, p. 8.

81 *Committee Hansard*, 16 April 2008, p. 15.

> often accompany terminal disease may include extreme fatigue, paralysis, blindness, deafness, aphasia and incontinence and as a consequence, many of the most fruitful and rewarding activities of a previously full working and social life may no longer be possible. After a lifetime of being in control of one's destiny, a future of total dependence on others for all, even the most personal details can be a most horrific prospect.[82]

4.56 Dr David Leaf told the committee further that:

> …there are a minority of patients…in whom the pathway of palliative care is not what they choose, for whatever reason. If it is a misguided idea or lack of education about the specialty then that needs to be corrected. But if it is with informed consent; if they know what the idea of palliative care is about, and they do not wish to pursue it, or frequently they cannot pursue it for whatever reason then this [voluntary euthanasia] should be the next option.[83]

4.57 However, in this context, the AMA submitted that:

> The AMA absolutely recognises that for most patients in the terminal stage of illness, pain and suffering can be alleviated by therapeutic and comfort care; however, there are still currently instances where the satisfactory relief of suffering cannot be achieved.
>
> We must, therefore, ensure that all patients have access to appropriate palliative care and advocate that greater research must go into palliative care so that no patient endures such suffering. No one should feel that their only option for satisfactory relief of pain and suffering is to end their own life.[84]

4.58 Dr Leaf also recognised that the availability of palliative care in rural and regional Australia needs to be increased.[85] Similarly, Palliative Care Australia submitted that 'services are highly limited in some geographical areas and service demand outstrips supply in many others' and that:

> For many Australians access to appropriate care at the end of life is not a reality. For these people the fear of unnecessary pain and suffering, poor quality of life and loss of control over care — which drives much of the community discussion about euthanasia — is justified.[86]

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82 *Submission 412*, p. 1.

83 *Committee Hansard*, 16 April 2008, p. 17.

84 *Submission 375*, p. 2.

85 *Committee Hansard*, 16 April 2008, pp 17-18.

86 *Submission 424*, p. 3.

4.59 Palliative Care Australia concluded that further consideration of voluntary euthanasia must be preceded by, among other matters, a guarantee of access to quality care at the end of life for all terminally ill Australians.[87]

Committee view on palliative care

4.60 The committee welcomes evidence that palliative care has improved markedly in the NT since the 1997 Euthanasia Inquiry. Nevertheless, the committee is concerned about evidence, particularly from Palliative Care Australia, that palliative care is not widely available and that demand for palliative care in some areas is not being met. The committee suggests that Commonwealth, state and territory governments consider increasing funding and resources for palliative care as a high priority.

Safeguards and slippery slopes

4.61 Many arguments against voluntary euthanasia were based on the notion of a 'slippery slope' and/or the 'thin edge of the wedge' – that is, for example, that acceptance of voluntary euthanasia would lead to involuntary euthanasia and/or euthanasia for lesser diseases and conditions.[88] For example, the ACL submitted that:

> Once legalised, death becomes an acceptable treatment for an ever-increasing list of treatable, non-terminal conditions such as depression or for those whose quality of life is judged by others to be too poor to make caring for them worthwhile.[89]

4.62 Dr Brian Pollard told the committee:

> …voluntary euthanasia tends to morph into non-voluntary euthanasia—that is, taking life without a patient's request…The reason it happens is that when you regard euthanasia as providing those patients who request it with a benefit and you become accustomed to providing euthanasia as a benefit, when you come across other people who are perhaps comatose or for some reason are unable to make their request but who are suffering just as much, then it seems discriminatory to the doctor to withhold that benefit from that patient also.[90]

4.63 Mr Meney of the Life, Marriage and Family Centre of the Catholic Archdiocese of Sydney also suggested that:

> ….if a patient's suffering is deemed unacceptable by the patient or by others, why does it matter whether or not this suffering is due to a terminal

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87 *Submission 424*, p. 4.

88 See, for example, Dr David Gawler, *Submission 445*, p. 2; Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Submission 360*, pp 4-5.

89 *Submission 422*, p. 11; see also Mrs Lois Fong, ACL, *Committee Hansard*, 14 April 2008, p. 8; Medicine with Morality, *Submission 242*, p. 2.

90 *Committee Hansard*, 16 April 2008, p. 27.

> illness? If unacceptable suffering is sufficient, as euthanasia advocates appear to imply, there is a broad premise for an ever-widening range of individuals to be killed provided they satisfy this highly subjective criterion. Indeed, the argument which calls for the caring state to euthanise those unfortunate persons usually incapable of articulating a choice—such as the chronically ill, the elderly and the mentally handicapped—is given further momentum. [91]

4.64 Others disputed these arguments. For example, the NSW Council for Civil Liberties submitted that:

> If there is a real moral difference between two cases, accepting that one is permissible does not in any way commit us to the other. Each case should be accepted on its own merits.[92]

4.65 Many also argued that the notion of a 'slippery slope' has been disproved by the experience from overseas jurisdictions which have allowed voluntary euthanasia, such as the Netherlands, Oregon in the US and Belgium.[93] For example, Dr Alan Rothschild submitted that:

> ..the *Oregon Dying with Dignity Act*…actually has fewer safeguards than the *Rights of the Terminally Ill Act 1995* but its annual reports show that it has not been abused. The vulnerable such as the poor, uneducated and elderly have not been targeted. Research shows that it is largely the educated, employed, and medically insured who make use of the Oregon Act.[94]

4.66 At the same time, many alluded to the experience in the Netherlands to illustrate their concerns about the potential for a 'slippery slope' in the regulation of euthanasia.[95] Many pointed to studies indicating a high level of non-voluntary euthanasia in the Netherlands.[96] Others argued that more recent studies, conducted since the introduction of legislation in 2002, indicate that there is no slippery slope

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91 *Committee Hansard*, 16 April 2008, p. 29.

92 *Submission 418*, p. 8.

93 See, for example, the ACT Committee of the Voluntary Euthanasia Society of NSW, *Submission 238*, pp 1-2; Emeritus Professor Philip Ley, *Submission 363*, pp 6-7; Dying with Dignity Victoria, *Submission 399*, pp 2-5; Mr Marshall Perron, *Submission 393*, p. 3.

94 *Submission 452*, p. 4 and see also p. 5; cf Festival of Light Australia, *Submission 361*, pp 7-8; Right to Life Australia, *Submission 441*, p. 5.

95 See, for example, Darwin Christian Ministers' Association, *Submission 376*, p. 4; Committee on Bioethics of the Uniting Church in Australia (Victorian Synod), *Submission 384*, pp 3-4; Katrina George, University of Western Sydney, *Submission 398*; Festival of Light Australia, *Submission 361*, p. 8.

96 See, for example, ACL, *Submission 422*, pp 8-9.

and that both non-voluntary euthanasia and voluntary euthanasia have declined.[97] However, this was also disputed.[98]

4.67 As noted in Chapter 3, several submissions were concerned about the adequacy of the safeguards in the NT RTI Act, and the operation of the RTI Act while it was in force.[99] Some queried whether legislation governing euthanasia can ever be properly safeguarded against abuse.[100] For example, Dr Brian Pollard claimed that 'every major published inquiry in the world into the legalisation of euthanasia has independently concluded that such law could never be made safe'.[101] Similarly, the ACL expressed the view that:

> …euthanasia cannot be controlled once legalised and patients cannot be safeguarded against the fundamental philosophical shift from care to killing. The disturbing ramifications of legalised euthanasia include: the acceptance of killing as a very cost-effective form of treatment; the murder of terminally ill patients who have not asked to die; the 'mercy killing' of wider groups of people whose lives are deemed worthless such as handicapped newborn babies; and a forever changed doctor-patient relationship.[102]

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97 Dying with Dignity Victoria, *Submission 399*, p. 4; see also, for example, Dr Alan Rothschild, *Submission 452*, p. 22; and Dutch Ministry of Health, Welfare and Sport in May 2007 at http://www.minvws.nl/en/themes/euthanasia/default.asp (accessed 20 May 2008).

98 ACL, *Answers to Questions on Notice*, received 8 May 2008, pp 1-2 and Dr David van Gend, *Answers to Questions on Notice*, received 6 May 2008.

99 In this context, many submissions referred to the following study: D.W. Kissane, A. Street, P. Nitschke, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia", *The Lancet*, Vol. 352, October 3 1998, pp 1097-1102. See also Dr Nitschke, *Committee Hansard*, 14 April 2008, pp 28-30 and *Submission 390A*; Dr David van Gend, *Committee Hansard*, 14 April 2008, pp 14-15; Professor David Kissane, *Submission 589*; Dr Mark Boughey, *Committee Hansard*, 14 April 2008, p. 38; ACL, *Submission 422*, p. 9; Festival of Light Australia, *Submission 361*, pp 2-4.

100 See, for example, the Coalition of the Defence of Human Life, *Submission 367*, p. 3; Katrina George, University of Western Sydney, *Submission 398*, pp 1-24; Family Council of Victoria, *Submission 263*, p. 5. It was also noted that several other inquiries, such as House of Lords, *Report of the Select Committee on Medical Ethics*, 1994, and Parliament of Tasmania, Community Development Committee, *Report on the Need for Legalisation of Voluntary Euthanasia*, Report No. 6, 1998, had concluded that voluntary euthanasia legislation could not adequately provide the necessary safeguards against abuse.

101 *Submission 47*, p. 11.

102 *Submission 422*, p. 7.

Impact on doctor-patient relationship

4.68 Several submissions expressed concern about the impact of voluntary euthanasia legislation on the doctor-patient relationship.[103] The AMA, in opposing the Bill, believed that medical practitioners should not be involved in interventions that have the ending of a person's life as their primary intention:

> …medical practitioners participating in euthanasia or physician-assisted suicide undermines the trust that is the cornerstone of the doctor-patient partnership. The public trusts medical practitioners to care for patients (and their families and carers) throughout the course of their disease or condition and to advocate for their health and well-being.
>
> We cannot confuse the role of the medical practitioner as someone who supports life with someone who takes life.[104]

4.69 The ACL was similarly concerned that:

> Euthanasia is essentially about giving doctors the rights to kill their patients, as the decision over whether to terminate or preserve a patient's life will rest with the medical profession. Such a drastic move severely reduces patient autonomy and gives doctors the power of life or death over those in their care.[105]

4.70 However, Dr David Leaf told the committee that 'one of the options I would like to have as a doctor treating these people is the option to offer them voluntary euthanasia'. Dr Leaf emphasised that:

> …the term 'voluntary euthanasia' should also mean that it is voluntary for the doctor. I acknowledge that there are some doctors who would not feel comfortable in participating in that. That is their right, and I would seek to protect that. Equally, it is my right, I feel, to say that I would be comfortable to have that to offer my patients, should they so desire—after sufficient screening and sufficient counselling, and ruling out other conditions that would prejudice their ability to make a competent decision.[106]

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103 See, for example, Medicine with Morality, *Submission 242*, p. 2; Father Frank Brennan, *Committee Hansard*, 16 April 2008, p. 11; Dr David Gawler, *Submission 445*, p. 3 and *Committee Hansard*, 14 April 2008, p. 10; Dr John Murtagh, *Submission 450*, p. 2; Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Submission 360*, p. 3; Australian Catholic Bishops Conference, *Submission 410*, pp 6-7; Dr Christopher Meney, Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Committee Hansard*, 16 April 2008, p. 29; see also Dr Alan Rothschild, *Submission 452*, pp 19-20.

104 *Submission 375*, p. 2.

105 *Submission 422*, p. 7; see also Dr David van Gend, ACL, *Committee Hansard*, 14 April 2008, p. 9.

106 *Committee Hansard*, 16 April 2008, p. 21; see also *Submission 57*, p. 2; and NSW Council for Civil Liberties, *Submission 418*, pp 7-8.

4.71 Dr Leaf also took issue with the AMA's position:

> The AMA does not represent all doctors…[T]he AMA is not reflective, in my opinion, of current medical opinion. One of the AMA's chief problems with the voluntary euthanasia bill is that it changes the therapeutic relationship between a doctor and the patient. I do not believe this to be the case. I would say, based on what I have said already, that it would enhance some doctors' relationships with their patients. It would give them another option, and people are looking for options at this stage.[107]

4.72 As outlined earlier, others also submitted that, in practice, many Australian doctors already take steps that lead to an earlier death for patients,[108] and that many doctors and other medical professionals support voluntary euthanasia.[109]

4.73 The Australian Nursing Federation took a neutral position on the issue of euthanasia. It recognised that its 'members hold a range of ethical views on the subject of voluntary euthanasia'. The Federation further noted that if voluntary euthanasia becomes legalised, 'nurses and midwives have the right to conscientiously object to participating in the carrying out of voluntary euthanasia.'[110]

Pressure and fear of being a burden

4.74 The committee also received evidence suggesting that the legalisation of voluntary euthanasia would place pressure on people to end their lives even if they are not ready so as to reduce the burden on their family or the health system.[111] The ACL expressed the view that:

> Legalised euthanasia places immense pressure on those who are ill and especially those who feel that they have become a burden to society and especially to their loved ones. In an age of spiralling health costs and complex care needs it is all too easy for some patients to feel that they are

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107 *Committee Hansard*, 16 April 2008, p. 16; see also Dying with Dignity Victoria, *Submission 399*, p. 4; NSW Council for Civil Liberties, *Submission 418*, pp 7-8.

108 See, for example, Emeritus Professor Philip Ley, *Submission 363*, p. 2, quoting from Kuhse, H., Singer, P., Baume, P., Clark, M. and Rickard, M. (1997) "End of Life decisions in Australian Medical practice", *Medical Journal of Australia*, Vol. 166(4), 17 February 1997, pp 191-197; also Dying with Dignity Victoria, *Submission 399*, p. 4.

109 Humanist Society of Victoria, *Submission 382*, p. 3; Dying with Dignity Victoria, *Submission 399*, pp 4-5.

110 *Submission 591*, p. 3.

111 Medicine with Morality, *Submission 242*, p. 2; see also Dr David van Gend, *Submission* 413, p. 5; Rita Joseph, *Submission 371*, pp 12-13; Dr David Gawler, *Submission 445*, p. 3; Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Submission 360*, pp 3-4; Committee on Bioethics of the Uniting Church in Australia (Victorian Synod), *Submission 384*, p. 2; National Civic Council, *Submission 417*, p. 3.

> simply too much of an economic and emotional drain on their families and that the best way out is to end their life.[112]

4.75 The ACL was particularly concerned that vulnerable people, such as those who are elderly, lonely, depressed or disabled will feel such pressure.[113] Similarly, Mr Christopher Meney expressed the belief that:

> Legalisation over time affects hospital practice and societal expectations, ultimately resulting in undue pressure on patients to not overburden family, medical staff and/or resources. The subtle or not so subtle forms of persuasion ultimately diminish a person's freedom and personal choice.[114]

4.76 In this context, many submissions noted the 1994 House of Lords Select Committee inquiry into euthanasia, which found that:

> We are concerned that vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined to request early death…[T]he message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death but should assure them of our care and support in life.[115]

4.77 Dr Mark Boughey informed the committee that 'it is often not the person dying who is expressing the wish to be euthanased', and that the pressure for voluntary euthanasia often comes from families.[116] He acknowledged that this pressure occurs even without voluntary euthanasia legislation in place, but considered that it would be a greater problem if voluntary euthanasia were legalised.[117]

4.78 However, the ACT Committee of the Voluntary Euthanasia Society of NSW claimed that:

> Arguments that older people will be exploited by being pressured into decisions to die are disproved by anecdotal and any other evidence available. Younger family members are more likely to resist the rationally thought-out wishes of an older member to seek release.[118]

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112 *Submission 422*, pp 13-14.

113 *Submission 422*, p. 14; see also Australian Catholic Bishops Conference, *Submission 410*, p. 6; and Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Submission 360*, p. 6. See further the Women's Forum Australia, who opposed the Bill based on concerns about the particular impact of euthanasia on women: *Submission 397*.

114 *Committee Hansard*, 16 April 2008, p. 28; see also Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Submission 360*, pp 3-4.

115 See, for example, Dr David van Gend, ACL, *Committee Hansard*, 14 April 2008, p. 9; also 1997 Euthanasia Inquiry, pp 93-94.

116 *Committee Hansard*, 14 April 2008, p. 38; see also pp 39-40 and *Submission 592*, pp 2-3; and Dr Brian Pollard, *Committee Hansard*, 16 April 2008, p. 25.

117 *Committee Hansard*, 14 April 2008, p. 42.

118 *Submission 238*, p. 2.

Sanctity of human life

4.79 Many of those who opposed the Bill and the concept of voluntary euthanasia did so on the basis of the sanctity of human life.[119] These arguments were often based on religious beliefs – for example, the Australian Catholic Bishops Conference submitted that the concept of the sanctity of life in the western world 'owes much to the Judeao-Christian tradition which affirms that every individual is made in the image and likeness of God'.[120]

4.80 The Life, Marriage and Family Centre of the Catholic Archdiocese of Sydney submitted that:

> …all human life has value and…the life of every person possesses inherent and equal dignity. This is an important principle for the security and safety of us all. The accumulated wisdom of all successful cultures and societies tells us that the most advantageous way to nurture the understanding that all human life is precious and of equal worth is to maintain the prohibition on killing. Human bodily life has intrinsic value and respect for each human life is integral to respect for human dignity.[121]

4.81 Mr Christopher Meney, Director of the Life, Marriage and Family Centre of the Catholic Archdiocese of Sydney, told the committee that: 'respect for the inviolability of human life prohibits intentional killing':

> …the legalisation of voluntary euthanasia would have damaging private and public effects. It would say that some patients' lives have no value.[122]

4.82 Others also raised concerns that the Bill would send the wrong message about the sanctity of human life, and could thereby encourage suicide. For example, the organisation 'Suicide: NO' submitted that:

> …the underlying message that suicide is ok at least some of the time is highly likely to encourage other suicidal members of Australian society to consider their desire to commit suicide to be a reasonable desire. In other words, the Bill will strengthen the tendency for suicidal people to rationalise their desire to commit suicide.[123]

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119 See, for example, Federal Presbyterian Church of Australia, *Submission 366*, p. 1; Life, Family and Marriage Centre, Catholic Archdiocese of Sydney, *Submission 360*, p. 6; Right to Life Australia, *Submission 381*, p. 1; Australian Catholic Bishops Conference, *Submission 410*, pp 3-4.

120 *Submission 410*, p. 3.

121 *Submission 360*, p. 6.

122 *Committee Hansard*, 16 April 2008, pp 28 and 29.

123 *Submission 395*, p. 3; see also, for example, National Civic Council, *Submission 417*, p. 3; ACT Right to Life Association, *Submission 434*, p. 5; Dr David van Gend, ACL, *Committee Hansard*, 14 April 2008, p. 9; Family Council of Victoria, *Submission 263*, p. 4.

4.83 However, others countered the arguments based on the sanctity of human life with arguments relating to individual autonomy, as outlined earlier in this chapter. In particular, where this argument stemmed from religious beliefs, Emeritus Professor Philip Ley submitted that:

> …the issue is voluntary euthanasia. Those with religious beliefs forbidding euthanasia do not have to avail themselves of it. Nor does anybody, religious or not, have to take up the option.[124]

4.84 Similarly, the NSW Council for Civil Liberties pointed to evidence given to the 1997 Euthanasia Inquiry by its Vice President:

> It all comes down to choice. If a person disagrees with voluntary euthanasia for a religious reason, whatever reason it might be, that person does not have to exercise the right, but I don't think they should impose that moral or religious view - whatever their view might be - on those who do wish to die.[125]

4.85 Dr Alan Rothschild also argued that:

> …the sanctity of life is already compromised, it has exceptions, such as the right of a patient to ask for the withholding or withdrawal of life supporting medical treatment, knowing the result will be that he or she will die.[126]

4.86 Indeed, several submitters were at pains to make a distinction between voluntary euthanasia and the withdrawal of futile treatment.[127] The committee notes in this context that most submissions commenting on the sanctity of human life had no objection to the refusal or withdrawal of treatment.[128] This led some, such as the Australian Federation of AIDS Organisations, to argue that:

> Laws allowing patients to refuse medical interventions mean those requiring interventions or life support are 'lucky' – they can refuse. Others whose conditions are as painful or worse, are given only the right to refuse palliative care to reduce their pain, ironically the same care which may eventually expedite their deaths.[129]

Impact on the Indigenous community

4.87 Several submissions expressed concerns about the impact of the Bill, and any subsequent voluntary euthanasia legislation, on the Indigenous population in the NT,

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124 *Submission 363*, p. 4.

125 *Submission 418*, p. 3; see also 1997 Euthanasia Inquiry, pp 59-60, para 6.13.

126 *Submission 452*, p. 5.

127 See, for example, AMA, *Submission* 375, p. 2; Mr Christopher Meney, Director, Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Committee Hansard*, 16 April 2008, p. 28.

128 See, for example, Federal Presbyterian Church of Australia, *Submission 366*, p. 1; Life, Marriage and Family Centre, Catholic Archdiocese of Sydney, *Submission 360*, p. 2.

129 *Submission 400*, p. 2.

which comprises approximately 30% of the NT population.[130] As the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) submitted:

> The jurisdiction of the Northern Territory is comprised of some 30% Indigenous residents, many of who[m] are from remote and isolate communities. This fact marks the NT as being a highly unique jurisdiction in the Australian context with significant cross-cultural issues, challenges and opportunities being a regular part of business and life in the NT.[131]

4.88 AMSANT continued:

> As such, we believe the NT is a special case when considering such issues as the *Rights of the Terminally Ill Bill* of 2008 in that significant ground-work and consultation needs to occur with Aboriginal residents to ensure understanding of such a Bill and also whether communities are in support of the Bill, or otherwise.[132]

4.89 It was put to the committee that the Indigenous population of the NT was opposed to euthanasia, or that euthanasia was contrary to Indigenous law.[133] For example, the Aboriginal Resource and Development Services (ARDS) submitted that it was opposed to euthanasia on the basis that it conflicts with traditional law. ARDS quoted its Chairperson, Rev Dr Djiniyini Gondarra:

> Euthanasia is murder according to our traditional law. If our people want to die because they are in pain the patient tells the whole family that they will close their mouths to water and food and then spend the time left to get ready to transit to the other side. For someone to administer any form of substance to end the life of a person is murder in the eyes of our traditional law.[134]

4.90 The committee also received a standard letter signed by several hundred Indigenous residents of the NT opposing the Bill and raising concerns about the revival of the NT RTI Act.[135]

4.91 However, AMSANT was more circumspect, suggesting that there needs to be full consultation with Indigenous people to ascertain their support or otherwise.[136]

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130 See also 1997 Euthanasia Inquiry, Chapter 5; and Father Frank Brennan, *document tabled at hearing on 16 April 2008*: John Collins, Frank Brennan, "Euthanasia and the potential adverse effects for Northern Territory Aborigines", *The Lancet*, Vol. 349, June 28 1997, pp 1907-1908.

131 *Submission 660*, p. 2; see also Dr David Gawler, *Committee Hansard*, 14 April 2008, p. 11.

132 *Submission 660*, p. 2; see also Dr Teem-Wing Yip, *Submission 394*, p. 2.

133 Dr David Gawler, *Committee Hansard*, 14 April 2008, p. 11 and pp 9-10; Ms Isobel Gawler, *Submission 432*, p. 1.

134 *Submission 414*, p. 2.

135 *Submission 447*; see also *Submission 449*.

136 Mr Desmond McKenzie, AMSANT, *Committee Hansard*, 14 April 2008, p. 32; see also *Submission 660*, pp 2-3.

4.92 In response to concerns about opposition from the Indigenous community, Mr Marshall Perron stated:

> …prostitution, abortion, organ donation, autopsies and cremation are probably all grossly offensive to Aboriginal culture. A group in our society finding them offensive does not stop us from having laws regulating those areas and indeed permitting them. In regard to the Aboriginal situation, there is clearly a huge amount to be done educating remote Aborigines about the health system, much of which is a complete mystery to truly remote and tribal Aborigines. It is hardly a reason to deny the terminally ill the relief they seek because we have a big job ahead in educating the Aboriginal community…To presume that we should never have voluntary euthanasia legislation because an Aboriginal group somewhere will oppose it is not a sensible way to go.[137]

4.93 However, AMSANT recommended that 'the views of Aboriginal residents of the NT be given pre-eminence in any ultimate decision-making on [the Bill] and the ultimate practice of euthanasia in the NT'.[138]

Fears and impact on Indigenous health

4.94 Many expressed concern that euthanasia legislation in the NT would impact on the willingness of the Indigenous population to seek medical treatment. It was suggested that euthanasia legislation would contradict efforts to close the gap in health and life expectancy between Indigenous and non-Indigenous Australians.[139] For example, Father Frank Brennan stated that, in his opinion, legislation for voluntary euthanasia would have a negative impact on Aboriginal health.[140]

4.95 ARDS submitted that 'the prospect of legalised euthanasia has added to the confusion and fear that Yolngu [of north-east Arnhem Land] have of western medical practices and procedures'.[141] ARDS explained that this fear was exacerbated by historical experiences and by the language divide.[142] ARDS was therefore concerned that the Bill could exacerbate the Indigenous health crisis: 'Indigenous health in the Top End of Australia can be expected to worsen even further, as Yolngu stay away from medical professionals and institutions'.[143]

4.96 Similarly, Dr David Gawler told the committee that:

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137 *Committee Hansard*, 14 April 2008, p. 20.

138 *Submission 660*, p. 3.

139 Father Frank Brennan, *Submission 418*, p. 3; Dr Teem-Wing Yip, *Submission 394*, p. 2; Standard letter, *Submission 447*, p. 1; Ms Lorraine Erlandson, *Submission 448*, p. 1.

140 *Committee Hansard*, 16 April 2008, p. 13.

141 *Submission 414*, p. 3.

142 *Submission 414*, p. 2; see also Dr David Gawler, *Submission 445*, pp 1-2.

143 *Submission 414*, p. 6 and see also p. 4.

> Euthanasia legislation has the potential to prevent Aboriginal people from seeking health care because of the fear that they could be misunderstood, that their lives would not be valued or that they could be put down with a needle.[144]

4.97 Dr Gawler continued:

> Aboriginal people, with their history of displacement, marginalisation and even massacres at the hands of white people, find it difficult to form trusting relationships with white doctors. In Arnhem Land, the debate continues as to whether doctors are healers or witchdoctors. Consequently, many patients fear visits to white doctors and especially visits to hospitals, where they must often travel long distances to another part of the country. To add to this uncomfortable equation, the knowledge that the doctor may also kill people or have the power to do so will generally increase anxiety and may mean some patients refuse treatment.[145]

4.98 The committee also heard anecdotal evidence that Indigenous patients had left hospital when the NT RTI Act was enacted,[146] or had refused immunisations 'because of the perception that doctors could intentionally kill people with those injections'.[147] Similarly, AMSANT also submitted that at the time of the NT RTI Act:

> …there was considerable confusion and angst amongst elements of the Aboriginal community, particularly amongst remote area residents, about what the Act actually meant and how it would be applied in practice for Aboriginal people…[148]

4.99 Mr McKenzie of AMSANT was concerned that, if euthanasia legislation were re-enacted, Indigenous people would avoid coming to the health services altogether.[149]

4.100 However, The Hon Daryl Manzie told the committee that there was some misinformation at the time of the NT RTI Act:

> Anecdotally, I was told by some Indigenous people that they were informed that the government was going to be able to give them or their children a needle when they came to Darwin and get rid of them because it does not want too many Aborigines…[M]isinformation can cause a lot of grief.

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144 *Committee Hansard*, 14 April 2008, p. 10.

145 *Committee Hansard*, 14 April 2008, p. 10; see also Dr Mark Boughey, *Committee Hansard*, 14 April 2008, p. 37 and p. 39; also *Submission 592*, p. 1.

146 Dr David Gawler, *Committee Hansard*, 14 April 2008, p. 15; see also ARDS, *Submission 414*, p. 4.

147 Dr Teem-Wing Yip, *Submission 394*, pp 2-3.

148 *Submission 660*, p. 2; see also Mr Desmond McKenzie, AMSANT, *Committee Hansard*, 14 April 2008, pp 32-33.

149 *Committee Hansard*, 14 April 2008, p. 33.

> These are very sensitive issues but they are also very emotive and they do generate a lot of comment from people. Sometimes it is very ill informed.[150]

4.101 In response to questioning from the committee about the impact of euthanasia legislation on Aboriginal communities in the NT, Mr Perron expressed the view that:

> If the situation is handled sensibly, there will in my view not be an impact on Aborigines failing to come forward and seeking medical attention.[151]

4.102 Mr Perron then pointed to evidence given to the 1997 Euthanasia Inquiry which disproved rumours that Indigenous Territorians had avoided attending health services as a result of the RTI Act.[152]

4.103 Indeed, the issue of the impact of the NT RTI Act on the Aboriginal community was also of significant concern during the 1997 Euthanasia inquiry.[153] The inquiry considered whether misinformation was being provided to Aboriginal communities about the legislation,[154] and whether or not there had been a decrease in the numbers of Indigenous Territorians seeking health care.[155] Appendix 3 of that report outlined statistics, provided by the NT Government, on hospital services supplied to Aboriginal people in the NT, which concluded that:

> There is no evidence from hospital separations or patient travel data that the introduction of the Euthanasia Act affected the willingness of Aboriginal people to present to hospital for medical treatment.[156]

4.104 AMSANT nevertheless suggested that this Bill be delayed, until an education and awareness campaign on euthanasia is developed and implemented in the NT, with a particular focus on engaging Aboriginal people and communities.[157] Father Frank Brennan agreed that an education campaign would be needed prior to any re-introduction of voluntary euthanasia, and that 'the sort of education which would be required in remote Aboriginal communities is very great'.[158] However, Dr Teem-Wing Yip, a doctor working in the NT, argued that:

> …a large amount of resources would be required to adequately educate the NT's indigenous population about the right to ask for a doctor to kill them. Such a use of resources is completely inappropriate in light of the fact that

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150 *Committee Hansard*, 14 April 2008, p. 21.

151 *Committee Hansard*, 14 April 2008, p. 21.

152 *Committee Hansard*, 14 April 2008, p. 21.

153 1997 Euthanasia Inquiry, Chapter 5.

154 1997 Euthanasia Inquiry, Chapter 5, pp 40-46.

155 1997 Euthanasia Inquiry, Chapter 5, pp 52-52 and Appendix 3.

156 1997 Euthanasia Inquiry, Appendix 3, p. 198.

157 *Submission 660*, p. 3; see also Mr Desmond McKenzie, AMSANT, *Committee Hansard*, 14 April 2008, pp 34-35.

158 *Committee Hansard*, 16 April 2008, p. 10.

> these people are already dying prematurely of preventable diseases at an embarrassingly high rate – diseases that are badly in need of resources to prevent.[159]

Conclusion

4.105 This chapter and previous chapters are a summary of the views and evidence presented to the committee during the inquiry. However, there is no majority or minority view attached to this report. The next chapter sets out the views of the Senators who participated in this inquiry.

159 *Submission 394,* p. 3.