Submission to the Senate Legal and Constitutional Committee's Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008

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Executive Summary

ACL vigorously opposes the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008. The bill is seriously flawed in its philosophical foundations and its foreseeable consequences.

The Australian Parliament is being asked to vote on a bill that enables another bill in another jurisdiction. Certain politicians have claimed that this bill is therefore not about euthanasia but simply about whether the Federal Parliament has the right to reinstate the Northern Territory's former laws on the subject. This is deeply disingenuous.

The effect of the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008 will be to reintroduce euthanasia into the Northern Territory by enabling legislation which the Australian Parliament cannot change no matter how flawed its provisions may be. Australian Parliamentarians must consider the matter of euthanasia itself and the safety or otherwise of the NT euthanasia laws before voting on this legislation. Failure to do so amounts to a grave breach of responsibility to the Australian public and particularly to the most vulnerable members of the community.

Euthanasia violates the right to life as outlined in the United Nations human rights documents. It forever changes the doctor-patient relationship by clothing doctors in the 'black hood of the executioner'. It places vulnerable patients at risk as the so-called 'right to die' solidifies into the 'duty to die' to spare families or the government the burden of care. Voluntary euthanasia is never a truly free decision and its availability leads to the inevitable practice of involuntary euthanasia as doctors and family members become used to determining which patients should live and which ones should die.

The matter is far too serious to be entrusted to small assemblies with no upper house such as those in the Territories. It is right that decisions on euthanasia in the Territories should rest with the Federal Parliament, which is better placed to make such profound decisions as it has the collected wisdom of a larger number of members and of a house of review.

Euthanasia is the 'quick fix' method of addressing the complex issues surrounding end of life care. It rejects the innate value of each person and perverts medical practice by accepting killing as a form of treatment. Australian politicians need to be much more thoughtful and creative in addressing end of life issues. An important first step in this process would be to

direct more resources into the widespread provision of high quality, comprehensive and accessible palliative care.

Should the Territories have the power to legislate on euthanasia?

According to the bill, its object is:

> …in recognising the rights of the people of the Australian Capital Territory, the Northern Territory and Norfolk Island to make laws for the peace, order and good government of their territories, including the right to legislate for the terminally ill, to repeal the *Euthanasia Laws Act 1997* which removed that right.

The bill therefore aims to allow the territories to make laws on euthanasia, a power that currently rests with the States and the Federal Parliament.

Laws for the peace, order and good government of the territories

The discussion below will demonstrate the grievous harm caused by legalised euthanasia, which forever changes the ethos of medicine from one of care to one of killing, which places real or perceived pressures on sick people to relieve others of the burden of their care by dying, and which inevitably leads to involuntary euthanasia where patients who have not asked to die are murdered by those charged with their care.

It can clearly be seen that legalised euthanasia is not remotely close to being a law for the 'peace, order and good governance of the territories.' Rather, euthanasia is an extremely serious matter with an extensive list of negative repercussions on matters as weighty as the right to life and the right to medical care without fear of murder.

The territory legislatures are small assemblies with no upper house of review and very few members (17 members in the ACT and 25 in the NT). In the ACT just nine politicians form a government on behalf of 300,000 people. In the Northern Territory's case, a small territory with the population of a suburban council district in Melbourne or Sydney passed the euthanasia law by one vote.

Such small legislatures with no upper house should not be given the power to make decisions on a life and death issue such as euthanasia which would radically change the social air we all breathe by severely undermining the protection of life.

Indeed, when more robust Parliaments considered the issue of euthanasia in five different parliamentary inquiries spanning three continents, every single inquiry concluded that no euthanasia law could ever be made safe from jeopardising the lives of others who had not expressed a wish to die[1,2,3,4,5].

Failure of previous territory attempts to regulate euthanasia

It should be noted that when the Northern Territory's euthanasia laws were briefly in force a decade ago, the promised safeguards were insufficient. Reviewing the issue, the University of Adelaide's Professor Robert Goldney commented:

> …even with ostensibly strict guidelines embodying most issues considered by proponents of euthanasia to be important, as a result of the clinical details provided there exist reservations about what occurred with two of the four persons who died under the Northern Territory legislation. This is hardly a reassuring record for examples of euthanasia…[6]

Perhaps it is not surprising that the current Northern Territory Government has strongly criticised Senator Brown's actions in attempting to force its old euthanasia laws back on a very different Territory. On the ABC's *World Today* program, NT Chief Minister Paul Henderson noted that:

> The public policy and the debate that we had in the parliaments here back in 1995 around how we as a Northern Territory care for our terminally ill patients is a totally different debate in 2008 than it was in 1995.
>
> I had an opinion back in 1995 that was supportive of the euthanasia bill as it stood. I would have to re-educate myself at this time, given the very sensitive nature of euthanasia.

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[1] Select Committee on Medical Ethics, House of Lords, January 1994

[2] *When death is sought – assisted suicide and euthanasia in the medical context,* New York State Taskforce on Life and the Law, May 1994

[3] *Of life and death: report of the Special Senate Committee on Euthanasia and Assisted Suicide,* Senate of Canada, June 1995

[4] *Report on the need for legislation on voluntary euthanasia,* Community Development Committee, Parliament of Tasmania, June 1998

[5] *Report of the inquiry into the voluntary euthanasia bill 1996,* Social Development Committee, Parliament of South Australia, October 1999

[6] Goldney R, 'Euthanasia: the Australian experience,' in De Leo, D (ed) *Suicide and Euthanasia in Older Adults: A Transcultural Journey,* 2001 Hogrefe & Huber, Seattle, pp172-179.

> And for Bob Brown to introduce legislation on such a sensitive subject in the Federal Parliament without any consultation with the people of the Northern Territory is arrogance of quite breathtaking proportions and the two issues shouldn't be linked.[7]

Indeed, despite his strong criticisms of Kevin Andrews' actions in repealing the NT euthanasia laws, Senator Brown seems guilty of the same offence: that of telling the residents of the Northern Territory that the Federal Parliament knows best.

The right to legislate for the terminally ill

The territory legislatures already enjoy the rights to legislate for the terminally ill, as evidence by the NT's Natural Death Act, which allows a terminally ill patient to express their "desire not to be subjected to extraordinary measures, namely medical or surgical measures that prolong life, or which are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation."

Again, the language used by this bill is misleading. The territories can already legislate on behalf of the terminally ill: they simply cannot legislate for euthanasia, which jeopardises the care and welfare of those vulnerable people.

The perils of legalised euthanasia

Contrary to claims by some politicians, this Inquiry is most definitely about euthanasia as one immediate and disastrous consequence of the bill if passed will be to reinstate the Northern Territory's repealed euthanasia laws. As such, it is now appropriate to consider the matter of euthanasia itself, to which ACL remains firmly opposed.

The human rights case against euthanasia

Despite its stated aim of protecting the 'rights of the terminally ill,' this bill is totally incompatible with basic human rights as outlined by the United Nations and assented to by Australia. The so-called 'right to die' has been invented by the euthanasia advocates.

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[7] 'NT Government rejects bid for euthanasia bill,' *The World Today,* ABC Radio, 6th February 2008

Like all human beings, people suffering terminal illness have the right to life[8] and to the protection of the law against violation of this right[9]. They also enjoy the right to medical care and social services[10]. People also have the right to effective remedy against violations of these rights, 'notwithstanding that the violation has been committed by persons acting in an official capacity[11].'

Finally, people are subject to limitations on their freedom by law but only for the purpose of 'securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and general welfare in a democratic society[12].'

Whilst a very tiny percentage of the population may persistently and determinedly request euthanasia, there is no right to it. In fact, the law rightly denies their so-called 'right to die' and upholds the right to life because this best protects the rights and freedoms of other vulnerable patients who would be placed at risk by legalising euthanasia.

Consequences of legalised euthanasia

Despite the talk of 'safeguards', 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.

Impact on the doctor-patient relationship

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. Doctors may decide that a treatment is futile but they should never be allowed to determine that a life is futile.

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[8] Article 3, *Universal Declaration of Human Rights 1948*, United Nations, Article 6, *International Covenant on Civil and Political Rights*, United Nations 1966

[9] Article 7, *Universal Declaration of Human Rights 1948*, United Nations

[10] Article 25, *Universal Declaration of Human Rights 1948*, United Nations

[11] Article 2, *International Covenant on Civil and Political Rights*, United Nations 1966

[12] Article 29, *Universal Declaration of Human Rights 1948*, United Nations

Since the earliest days of medicine, doctors have been trained in the art and science of healing. For two and a half thousand years, doctors who took the Hippocratic Oath swore that they would 'neither give a deadly drug to anybody who asked for it, nor make a suggestion to this effect.'

According to Professor John Wyatt, a specialist in neonatal paediatrics at University College, London, legalised euthanasia would 'toss away, almost in a casual way, two thousand years of a tradition that doctors would only be dedicated to healing[13].'

Trust between doctors and patients would be eroded. At what point has the doctor's approach shifted from trying to heal and comfort the patient to trying to bring about death? As the British Medical Association has noted, where legalised euthanasia is available, patients will never be sure whether their doctor is wearing the white coat of the healer or the black hood of the executioner[14].

Inevitability of involuntary euthanasia

Sadly, overseas experience shows that there would be good reason for patients to mistrust their doctors once euthanasia was legalised. Despite talk of 'safeguards' to protect patients, euthanasia changes the climate to one in which some doctors begin to feel that they have a right to end their patients' lives, whether or not the patient has asked for this.

Essentially, legalised euthanasia results in the murder of patients who have not requested to die – vulnerable individuals who have trusted their doctor to care for them, not kill them. This is aptly and disturbingly demonstrated by the example of Holland, which first permitted euthanasia in the mid-1980s then officially legalised it in 2002.

Three surveys over a ten-year period by Dutch researchers show that in Holland, around 1,000 patients are killed every year against their wishes, or without consent, by their doctors. The first report, published in 1991 showed that in 1,000 cases, physicians administered a drug with the explicit purpose of hastening death without an explicit request

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[13] 'Views of doctors on assisted dying,' *Care Not Killing Alliance* UK.

[14] 'Statement on End of Life Decisions,' *British Medical Association* 2000

from the patient. These findings were confirmed in 1996 and again in 2001, when 1,000 patients were still being killed against their will[15].

As noted above, doubt exists over the deaths of two of the four patients who died by the NT's laws when briefly in force in the late 1990s[16].

Put simply, legalised euthanasia quickly turns a blind eye to murder.

Failure of intended safeguards

The fact that voluntary euthanasia inevitably so quickly leads to involuntary euthanasia demonstrates the failure of intended safeguards. Under the Northern Territory legislation, the treating doctor has greater power in the process than the patient and may be the only surviving witness in possession of the full facts about what occurred.

The treating doctor chooses the consulting physicians whose second opinion is required to authorise euthanasia and can keep 'shopping' for the 'right' opinion until one is given). Furthermore, s/he does not have to reveal to medical experts important aspects of the illness or its treatment before euthanasia is carried out. Indeed, the Northern Territory's brief experiment with euthanasia showed that in at least two of the seven cases studied, important information about the patients' mental state was withheld from the psychiatrist undertaking the mandatory assessment to ensure that patients were not suffering from treatable clinical depression. Crucial withheld information included the death of a patient's child, alienation from another child, and the effectiveness of one patient's treatment for depression[17].

Given the existing power imbalance between a terminally ill patient and a treating physician, the control invested in the doctor is cause for serious concern, particularly since doctors,

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[15] Van der Maas PJ et al, 'Euthanasia and other medical decisions concerning the end of life,' *Lancet* 1991; 338: 669-74. Van der Maas PJ et al. 'Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands,' 1990-1995. *New England Journal of Medicine* 1996; 335: 1699-705. Onwuteaka-Philipsen BJ et al.: 'Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995, and 2001' *Lancet* online 17 June 2003. http://image.thelancet.com/extras/03art3297web.pdf

[16] Goldney, op cit.

[17] David W Kissane, Annette Street, Philip Nitschke, 'Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia,' *The Lancet,* 1998 Vol 352: 1097-1102

whilst experts in the practice of medicine, are prone to the same temptations and character flaws as anyone else.

One such temptation would be to take the easy medical way out by authorising euthanasia instead of working hard to ensure higher quality of life for the patient. In a recent House of Lords debate, Baroness Finlay of Llandaff, professor of Palliative Medicine at Cardiff University reminded British peers that:

> Another danger is the doctor, nurse or other carer who is tired, burnt out or simply a little lazy, and who perhaps dislikes the patient and finds caring for them taxing. It is all too easy to abandon efforts at diagnosing the true roots of distress and working hard to find resolution through meticulous attention to detail. Subtle secondary financial pressures are also felt by clinicians, and we know from the Dutch evidence how financial factors can subtly influence the thinking of some when it comes to end of life decision-making[18].

Doctors can also overestimate their own skill, concluding that a patient is in 'unrelievable' pain because they, the doctor, have not been able to ease the suffering. In 1992, Dr Nigel Cox, a consultant rheumatologist from Hampshire, England, was found guilty of attempted murder, after injecting a 70-year-old patient with a lethal drug. He was seriously admonished by the General Medical Council for failing to take advice from colleagues who had far greater skills in pain control and would have been able to offer clinical advice on how to relieve the patient's distress in an ethical manner.

Once the sentence of euthanasia has been carried out, it is too late to intervene on the patient's behalf and perhaps the only witness to the unsanctioned killing is now dead and the doctor-killer continues to control the trail of evidence.

Noting that the Dutch guidelines which require the reporting of euthanasia deaths are only ever loosely enforced, a healthcare lawyer, I J Keown notes that the "overwhelming majority of cases are falsely certified as death by natural causes and are never reported and investigated… a doctor who has acted in breach of the law is no more likely to admit having done so in his report than a tax evader is likely to reveal his dishonesty on his tax return."[19]

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[18] Baroness Finlay of Llandaff, House of Lords debate on reforming murder laws, House of Lords Hansard, 1st March 2007

19 I J Keown, 'The Law and Practice of Euthanasia in The Netherlands,' *The Law Quarterly Review* (January 1992), pp. 67-68.

The fact that the "vast majority of deaths from euthanasia are illegally and incorrectly reported as natural deaths itself casts doubt on the lawfulness of much of the euthanasia which is being carried out."[20]

An Australian palliative care specialist, Dr Brian Pollard made similar observations to Keown in a 1992 paper in the *Medical Journal of Australia* in which he referred to the Dutch Advocate General's comments that, "The medical profession is in all likelihood the only academically trained group of professionals, who by virtue of their profession, are guilty of making false statements in writing with great regularity when, after a euthanasia procedure, they make inaccurate death declarations which conceal the unnatural death case."[21]

Death: the new and most cost-effective treatment

Euthanasia makes death a form of treatment. This is a terrible perversion of medicine. Rather than kill the pain, doctors are given authority to kill the patient. This situation degenerates further as society quickly discovers that this is a very cost-effective approach to healthcare.

Dying from a terminal illness is expensive, both for the patient and their family and for the wider society. Doctors, nurses, hospital stays, state of the art treatments, costly pain-relief drugs, round the clock care and support all cost many thousands of dollars per patient. A society that values the patient's life and sees him or her as being of intrinsic worth will accept this cost. However, 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?

And why discriminate against other patients by limiting this new treatment to those with terminal conditions only? 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.

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[20] *Ibid.,* 67.

[21] Brian Pollard, "Medical aspects of euthanasia", *Medical Journal of Australia*, 154:9, 1991, 613-616

'Mercy killing' of those who are not terminally ill

Horrifyingly, vulnerable newborn babies are also at risk from euthanasia – always involuntary as they cannot give consent.

Belgium legalised euthanasia for competent adults in 2002. Though it remains illegal to kill babies, by 2005 seven per cent of deaths of newborn babies were due to lethal injection because the infants were premature or malformed at birth and a staggering 75 per cent of all neonatal physicians were prepared to engage in euthanasia of newborn babies[22]. In the Netherlands, nine per cent of deaths of newborn babies occurred following the administration of drugs designed to hasten death. Nearly three per cent of deaths of Dutch children between the ages of one and 17 are from euthanasia[23].

Better responses to the call for euthanasia

Rather than reimposing the Northern Territory's euthanasia laws and giving the Territories the power to legislate on euthanasia (which is likely to see it introduced given that the official platform of the ACT Labor Party supports euthanasia), the Federal Parliament should instead explore the drivers for euthanasia and identify better ways of addressing the fears many people hold about the end of their lives.

What lies behind demands for euthanasia?

The wish to die is rarely driven by a genuine, unrelenting desire for death. For many patients, it is more often an expression of untreated depression, pain, or poor symptom control. For others, it is driven by a fear of being a burden to others, or of being subjected to extended and unwanted treatment that makes their last days distressing.

Untreated depression, poor symptom control and pain

A study in the *American Journal of Psychiatry* found that occasional wishes that death will come soon were common in nearly half of all terminally ill patients but less that 9 per cent of

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[22] Provoost V et al, 'Medical end of life decisions in neonates and infants in Flanders,' *Lancet* 2005; 365: 1315-20

[23] Vrakking A et al. 'Medical end-of-life decisions made for neonates and infants in the Netherlands,' 1995–2001. *Lancet*, 2005; 365: 1329-1331 and Vrakking A et al. 'Medical end-of-life decisions for children in the Netherlands,' *Archives of Pediatrics & Adolescent Medicine* 2005; 159: 802-9.

these acknowledge a serious desire to die. This desire for death is strongest in those with severe pain and low family support and, significantly, in those with severe depression. Nearly 60 per cent of those who expressed a desire to die were depressed, whereas depression was only found in 8 per cent of those without a desire to die. The authors of that particular study conclude:

> The desire for death in terminally ill patients is closely associated with clinical depression – a potentially treatable condition – and can also decrease over time. Informed debate about euthanasia should recognise the importance of psychiatric considerations as well as the inherent transience of many patients' expressed desire to die[24].

In Oregon, where physician assisted suicide is legal, nearly half those patients who initially requested euthanasia changed their minds after initiation of treatment such as pain control, prescription of anti-depressant medication or referral to a hospice. However, among patients where no active symptom control was initiated, only 15 per cent of those who initially requested euthanasia changed their mind[25].

Baroness Finlay of Llandaff, professor of Palliative Medicine at Cardiff University comments that:

> Pressures, real of perceived, can coerce a person to feel that their life is of no value. Only too often that changes when good care is given in a way that enhances dignity. The vulnerable emotional state of the person who is frightened, in despair and possibly distorted by undiagnosed depression which occurs in almost a third of those with serious life-threatening illnesses should not be underestimated[26].

Fear of being a burden

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

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[24] Chochinov H M et al, 'Desire for death in the terminally ill,' *American Journal of Psychiatry* 1995; 152: 1185-91

[25] Ganzini L et al, 'Physicians' experiences with the Oregon Death with Dignity Act,' *New England Journal of Medicine,* 2000; 342; 557-563

[26] Baroness Finlay of Llandaff, House of Lords debate on reforming murder laws, House of Lords Hansard, 1st March 2007.

feel that they are simply too much of an economic and emotional drain on their families and that the best way out is to end their life.

The US state of Oregon legalised euthanasia in 1997. As physician assisted suicide was increasingly accepted, the percentage of patients whose reasons for requesting death included feeling like a burden to others began to climb from 12 per cent in 1998 to 63 per cent in 2000[27].

Euthanasia places increasing pressure on vulnerable people to agree to be killed. Whilst a tiny minority are lobbying for the right to die, if this law is passed, many more vulnerable people – those who are elderly, lonely, depressed, disabled or distressed – will feel pressure, whether real or imagined, to request an early death in order to avoid being a burden to others. The so-called 'right to die' inexorably becomes the duty to die as economic pressures and deference to other people's convenience begin to dominate decision-making.

The Australian Parliament should not pass a law such as this, which will lead to elderly, disabled or sick Australians feeling that society prefers them to die. Our law should continue to protect the right to life.

Fear of extended and unwanted treatment

Some of the fear that leads to advocacy of euthanasia could be addressed by making clear that, even whilst euthanasia remains illegal, a person will not be subjected to burdensome, futile, or unwanted treatment, and will be allowed to die at the natural time. The aim of treatment is to prolong life and, where this is not possible, to make the patient as comfortable as possible. The aim is never to prolong death, which is a natural process we all must face at some point.

Recognising the intrinsic and precious value of human life prohibits intentional killing but it does not require the preservation of life at all costs through invasive, burdensome or futile treatment against the wishes of a competent patient. A person's refusal of burdensome treatment is not equivalent to suicide. In such cases, both the doctor and the patient may decide that the treatment is futile; this is not the same as deciding that the patient's life is futile.

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[27] Sullivan A D et al, 'Legalised physician assisted suicide in Oregon, 1998-2000,' *New England Journal of Medicine* 2001; 344: 605-607

Effective and accessible palliative care

Palliative care is an essential specialist service for those with a life-limiting illness. Expert care and pain management can greatly improve the quality of life for patients.

Palliative Care Australia defines palliative care as:

> A concept of care which provides coordinated medical, nursing and allied services for people who are terminally ill, delivered where possible in the environment of the person's choice, and which provides physical, psychological, emotional and spiritual support for patients, and support for patients' families and friends.
>
> The provision of hospice and palliative care services includes grief and bereavement support for the family and other carers during the life of the patient and continuing after death.
>
> The primary objective of hospice palliative care is to enable people facing death: to be as free as possible from unnecessary suffering (physical, emotional or spiritual); to maintain their dignity and independence throughout the experience; to be cared for in the environment of choice; to have their grief needs recognised and responded to; and to be assured that their families needs are also being met.

Palliative care experts have criticised the aggressive promotion of euthanasia as the key issue in end of life care for giving ‘a narrow and misleading view of death and dying’ that neglects far more important issues for patients such as access to high quality end of life care.

Whilst noting the world-standard quality of Australian palliative care, Professor Margaret O’Connor, one of Australia’s leading authorities on palliative care research and practice at Monash University and President of Palliative Care Australia, believes that:

> …in Australia we have some way to go to make sure we have systems in place and adequate funding to support care of the dying in the manner that we all aspire to…Palliative care professionals, who are experts in end-of-life care, do engage in discussions with patients and their families about their care wishes and discussion on the desire to die can be part of this. Importantly, this doesn’t mean they actively want to take steps to end their lives. In many

cases the person may not have had access to the best care available. Our focus should be the broader picture of how we assure quality end-of-life care[28].

Conclusion

ACL sincerely hopes that the Senate Legal and Constitutional Committee will censure this bill as it violates human rights, places vulnerable people in grave danger, and turns doctors into agents of death. Neither should the immature Territory assemblies be given the right to legislate on such a serious matter, which has implications for the protection of human life throughout the country.

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 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.

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. Euthanasia emphasises a person's worthlessness and isolation. Instead we should emphasise community support and solidarity with those who are suffering.

Lyle Shelton
Chief of Staff, Australian Christian Lobby
April 2008

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[28] *Dying choices more than a one-issue debate*, Palliative Care Australia, media release of 1st February 2007, available at http://pallcare.org.au/Portals/46/Media/euthanasia%20media%20release.pdf