Submission

To
The Legal and Constitutional Affairs Committee
Of
The Australian Senate

Inquiry Into

The Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008

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1. Introduction

Thank you for the opportunity to comment on the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008 introduced into the Senate by Senator Bob Brown.

The Senate Committee's webpage providing information about this inquiry points out that, "Persons lodging submissions should note that this inquiry is into the bill only, and to be considered relevant to the inquiry, submissions must address the provisions of the bill."

This submission will attempt to address the bill, its provisions and some of the effects should it be passed into law. However, as was the case in the Legal and Constitutional Affairs Committee hearings into the original *Euthanasia Laws Bill* in 1996 and 1997 and the ensuing parliamentary debate, this submission (and the inquiry) cannot help but involve itself to some degree in a discussion about euthanasia itself.

The Catholic Church's opposition to euthanasia and assisted suicide is well known. It remains firmly based upon the premise that human life comes from God and the basis of all goods. The time of life's end is something that is determined by God alone.

However, in arguing the case against this bill and euthanasia in general we do so from a natural law perspective, attending to what we see as the dangers that such laws visit on all of society, not just those who hold to a particular religious view.

2. The Effect of the Bill

The object of this Act 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 *Euthanasia Laws Act 1997*, utilizing Commonwealth powers under Section 122 of the Constitution removed from the three territories mentioned the right to make laws that permit euthanasia, mercy killing or assisted suicide. The immediate effect of that Act (in amending the self government acts of the NT, the ACT and the *Norfolk Island Act*) was to render the NT *Rights of the Terminally Ill Act* (ROTI) *1995* to have no force or effect as a law of that territory.

The effect of the bill in question, however, is not simply about restoring a right – namely the right to pass laws in respect to euthanasia etc. Its stated intention is to restore the legitimacy of the ROTI Act 1995 in the Northern Territory which will also make available the grant of that law to all Australian citizens.[1]

The enactment of this bill would directly affect all residents of the Northern Territory and all Australians. We believe it is correct to say that, in debating this bill, members of the federal parliament will be voting primarily about the issue of euthanasia and whether

[1] As was the case when the ROTI Act was in force, Australians resident outside the NT can travel to the Territory to avail themselves of the provisions of the Act.

or not euthanasia is good public policy contributing to 'peace, order and good government'.

This point was made abundantly clear by the NT Chief Minister Paul Henderson when commenting on the introduction of this bill earlier this year:

> *"I find it very high-handed and arrogant of Bob Brown from Tasmania to be introducing legislation in the Federal Parliament that effects* (sic) *the Northern Territory, without any consultation at all with the Territory Government, or the people of the Northern Territory."*

He added:

> *"Back in 1995 I was a supporter of euthanasia, but I have to say I haven't been in to the detail of how we provide palliative care, and all of the legal and ethical issues that are inherent in our society in 2008 as opposed to 1995."*[2]

Mr. Henderson also commented that the make up of the NT Parliament has changed in the ensuing 23 years, complementing NT Opposition Leader Terry Mills' statement in the same article that the legislation (concerning euthanasia) should be voted on by (current) NT MLAs.

The primary and immediate effect of the passage of the bill in question would be to re-instate a law allowing euthanasia in the Northern Territory and making euthanasia available to all Australians. Members of the Federal Parliament will be casting their vote either for or against euthanasia.

The Commonwealth would be effectively imposing a law allowing euthanasia upon Territorians without reference to the existing elected members of the NT Legislative Assembly. Existing MLAs and all Territorians would be denied the ability to review whether or not this Act reflects current social mores, best practice and the intervening growth and developments in palliative care.

3. Public Opinion – what is the reality?

Public opinion polling can be a useful tool in gauging both the sentiment in Australian society and the level of understanding on a particular issue. However, the ethics and moral probity of an action cannot be determined by reference to the level of concern in the community. Ethical and moral concern, however, can be confirmed by polling; particularly when such polling comprises more than just a single question and includes clarification on the issue.

Euthanasia is a complex issue. End of life issues such as the double effect principle are not widely understood which, as we observe, can tend to skew survey results as it simply cannot be taken into account in the context of a simple one or two question poll. For example, the 2002 Roy Morgan Poll question mentioned by Senator Brown in his second reading speech read as follows:

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[2] ABC News online: *Brown's moves on NT euthanasia bill labelled arrogant* www.abc.net.au/news/stories/2008/02/05/2155259.htm

> *"Thinking now about voluntary euthanasia. If a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to give a lethal dose or not?"*

Terms such as *hopelessly ill* and *unrelievable suffering* not only lack precise meaning but also serve in the context of this question to paint the bleakest of situations, along with *absolutely no chance of recovering.* The application of a *lethal dose* could include a double effect situation where the intention was pain relief and the consequence was a hastened death – which is not euthanasia at all. Nor is there any attempt to consider within the terms of the question relief through palliative care or the fact that pain management can be extremely effective for all but a few conditions.

Professor Margaret Somerville made a similar observation in the following terms:

> *"I have been looking at these surveys for a very long time. That confusion is a technique for getting euthanasia approved. It was a technique that was consciously utilised. What happens is that there is a lack of definition of what euthanasia is and a lumping of all these things in together. In one case in Washington State, where they had a referendum on this—they went to the people—the question on the referendum said: do you agree with rights to refuse treatment, adequate pain relief treatment and physician assisted suicide? And you had to vote yes or no on the package. That is the sort of thing that is appalling. All of these things have extraordinarily important differences between them."* [3]

Senator Brown made a great deal of the results of various Australian polls on euthanasia since 1995 in his Second Reading speech. It is quite legitimate for him to do so but another matter entirely to simply accept the poll results as being either indicative of the fully informed sentiment within the community or as some mandate for legislative change (or both).

While opinion polling can be a useful tool, the complexities of the subject of euthanasia and the limitations inherent in polling itself render most, if not all, recent poll results on the subject meaningless.

4. Euthanasia's errors – ROTI as an example

What really matters is whether or not euthanasia and assisted suicide is both ethically sound and good public policy. We argue that it is neither.

The dignity of human life is such that it should never be diminished by reference to quality, life expectancy, disability, illness or suffering or by any other means. All human life is of equal and inestimable value. To create a law that allows euthanasia and assisted suicide, even if limited to the rarest of circumstance, diminishes all humanity precisely because it seeks to treat some people differently (and less favourably) than others.

Nor can laws drafted to allow euthanasia only within a strict framework for application in limited cases, ever be contained. International experience has shown that what was

[3] Legal & Constitutional Committee hearings into the Andrews' Bill 14 Feb 1997. http://www.aph.gov.au/hansard/senate/commttee/s7354528.pdf

initially limited in application to adults of sound mind can, over time, be extended to youth, children and depressives.

The NT ROTI Act 1995, in common with all euthanasia legislation we have opposed, includes clauses that lack precision as to their application and definitions that hold no precise meaning in any medical discipline.

NT Rights of the Terminally Ill Act 1995:

Section 3. Interpretation.

> *"terminal illness", in relation to a patient, means an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient.*

The definition of an illness (any illness) can never be made subject to whether or not a patient finds the treatment(s) for that illness acceptable. Except in cases where refusal (non acceptance) of treatment is recognised as suicidal in motive, every person has the right to refuse treatment; but such refusal cannot be the 'trigger' for qualifying for euthanasia. Further, measures to provide comfort and alleviate pain in terminal illnesses are ordinary, not extraordinary. The use of 'extraordinary' tends to suggest 'burdensome treatment' and is not only misleading but may tend to foster the opinion that all treatment be considered as burdensome.

Section 7. Conditions under which medical practitioner may assist

This section uses a number of subjective phrases (some repeatedly) to define and limit the involvement of a medical practitioner in an act of euthanasia. The improper use of 'extraordinary' (see above) is also repeated (7(1)(b)(i) & 7(1)(e)).

The medical practitioner is required to be satisfied on *reasonable* grounds; to use *reasonable* medical judgment; to consider medical treatment *reasonably* available and to determine the state of mind of the patient on *reasonable* grounds. It may well be that a determination by any exacting empirical standard other than reasonable judgment may not always be possible. This is, itself, an argument against euthanasia: in a matter so grave as to have irreversible consequences, subjectivity (particularly, compounding subjectivity) is an unacceptable standard of proof. However, the repeated use of such subjective terms in respect to the judgment of the certifying practitioners not only leaves the law open to abuse, it also makes prosecution for such abuses virtually impossible. A law that cannot prosecute abuses is bad law.

Further evidence of the use of subjective proofs can be found in subsection (1)(d) wherein the assistance of a qualified medical practitioner in euthanasia or assisted suicide is made subject to *'the illness causing the patient severe pain or suffering'*. The severity of the pain endured will be different in each and every case and is subject to both the pain tolerance of the patient and whether or not they have accepted ordinary means of pain management.

Other clauses require the confirmation that the patient is 'not suffering from a treatable clinical depression' (c(iv)), is of 'sound mind' and the 'decision to end his or her life has

been made freely, voluntarily and after due consideration'(h). Clinical depression is not easily diagnosed – particularly if the patient is previously unknown to the certifying psychiatrist and, as may well be the case, only receiving one consultation.

Coercion, likewise, may not be immediately evident. It would be almost impossible to assess the impact of subtle and implied messages from family members over perhaps many years. Likewise, the impact of the oft heard comment that in infirmity someone would desire 'not to be a burden' upon other family members. In a similar vein, well meaning comments from family and friends that 'it's awful to see you suffer' could be construed as a wish that they would simply die.

Section 8. Palliative care

This section constrains a medical practitioner in respect to the death of a patient under the provisions of the act in two ways both relating to palliative care. Once again we find the use of subjective and imprecise phrases that render the clauses problematic in their application.

Subsection 1 provides that a practitioner shall not assist a patient if, 'there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable by the patient." Could it be argued that if access to appropriate palliative care meant that the patient was transferred from a regional domicile to, say, Darwin, that this was unreasonable? Could a patient determined to hasten death claim that the mitigation of pain levels delivered by such palliative care was unacceptable *to them*?

Subsection 2 allows a practitioner to resume action towards euthanasia should palliative care pain relief no longer be acceptable to the patient where assistance had been formally requested prior to the use of palliative care. The patient would need to indicate to the practitioner their willingness to proceed. However, the section is silent on how this should be done. Should it be a simple nod of the head? Or a 'yes' not heard by anyone else? Could it be as a response to a leading question? This provision is wide open to abuse.

Legislation that is open to abuse is bad legislation. The NT ROTI Act 1995 is open to abuse through its use of subjective criteria and phrases lacking in precise meaning in both common usage and in medical terminology. ROTI should not be reinstated as a law of the Northern Territory.

5. Summary and Recommendations

The passage of the *Euthanasia Laws Act in 1997* utilized Commonwealth Constitutional provisions to remove the force and effect of the NT *Rights of the Terminally Ill Act 1995*. Arguments at that time, ten years ago, focused on the pros and cons of both euthanasia and the manner and use of constitutional powers.

It is appropriate, therefore, in revisiting this situation by way of this committee's inquiry into Senator Brown's repeal bill that euthanasia and the process and effect of Commonwealth intervention are reviewed.

We argue that the successful passage of the Brown bill would not simply restore the status quo circa 1995 (in respect to the self government acts of three Australian territories); it would also impose euthanasia upon the Northern Territory and all Australians. In effect, Federal Members of Parliament will be voting on the merits or otherwise of euthanasia.

We have pointed out some of the major flaws in the ROTI Act. ROTI is not only bad law, but it is bad law written and enacted some 13 years ago. Terms and phrases that lack precise meaning are easily misused. As such ROTI is open to abuse and it is inappropriate for the Federal Parliament to pass a bill with the direct effect of bringing the force of law to such a flawed Act that fails to protect the lives of Australian citizens.

Recommendation: That the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008 not be supported by this committee.