8th April, 2008

Committee Secretary
Senate Standing Committee on Legal and Constitutional Affairs
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Sir,

Regarding the Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008.

As a surgeon, I strongly oppose this Bill, and I would like to appear as a witness before the Committee when it visits Darwin, (Monday would be preferable, please.).

I wish to thank the Committee for the opportunity to contribute to its deliberations. However, I am concerned that the Committee has allowed so little time for the public to respond regarding such an important issue as the deliberate termination of a person's life.

I, for example, am writing this submission in the early hours of 9/4/08 as a result of operating well into the night on three occasions this week. I work at the Royal Darwin Hospital as the sole Vascular Surgeon in the Northern Territory. I also direct the Diabetic Foot Service.

Many Indigenous people have diabetes and also have other risk factors for vascular disease resulting in foot ulceration, infection, gangrene and at times amputation. I have been treating Indigenous people daily. Towards 80% of my patients are Aboriginal.

I am writing because euthanasia is totally inappropriate in the context of the Northern Territory. This is because:-

(1) Indigenous people are often presumed to have a greater understanding of English, when if fact they may actually understand very little medical and technical language, even with the aid of an interpreter. This poses huge problems in obtaining informed consent for operations, which may be life saving; and indicate to the person that they are valued members of the community.

Conversely, to inform a patient that euthanasia would be an option rather than life sustaining or palliative treatment.would be particularly confusing and frightening for patients for whom hospitalization is already a traumatic experience, and especially (in the case of remote patients) without the comfort and support of relatives. Many will simply not understand the concept of euthanasia, and may inadvertently agree to lose their lives prematurely.

(2) Indigenous people are frequently very insecure and anxious about accepting medical treatment and procedures. The reintroduction of a euthanasia option, would greatly increase the patient's level of anxiety regarding the fear of a negative impact from medical treatment. There would be resultant distrust of the medical profession through the negative message that euthanasia gives to patients, ie, that the doctor who heals, may also kill the patient. Aboriginal people are already concerned that many of their relatives die in hospital. Some have told me that they suspect that the doctors have not valued or appropriately treated their relatives who have died in hospital, and some believe that their relatives were actively "put down". All of this is in the present context where euthanasia is illegal. If doctors are allowed lawfully kill patients, as well as to treat, then no "safeguards" in the world will restore indigenous confidence in the medical profession. Euthanasia corrupts the doctor/patient relationship, by allowing patient killing. There is no doubt that many indigenous people would be very fearful of every encounter with a doctor in the Northern Territory.

(3) I have witnessed situations where I have had to intervene to ensure that appropriate treatment would be given to indigenous people and I have saved lives by so doing. There are times when Aboriginal lives appear not to have been given the same value as those of another race. Due to the history of dispossession, marginalization and past massacres of Aboriginal people in the Northern Territory, many indigenous people do not trust white people unless they really know them well. Legalized patient killing by white doctors will ring very loud warning bells and will again cause Indigenous people to be reluctant to seek medical care for themselves or for their family members.

(4) I am also opposed to euthanasia because:

(a) Mistakes in prognosis are possible. I have seen patients who had extensive and incurable malignancy in the abdomen, which was proven at operation and by histology, to spontaneously recover completely with no treatment.

Also, one of Dr. Nitschke's patients, who was thought to have terminal cancer, was found on autopsy to have no disease and presumable was simply depressed and should have had appropriate treatment. Even one life unnecessarily lost is enough grounds to emphatically reject assisted suicide (euthanasia).

(b) Once legalized, the rationale for euthanasia progressively extends, often beyond the law. This has been well documented in Holland and Belgium where euthanasia is legal. "Safe-guards" have not prevented unreported cases. Often patents in Holland are euthanized well and truly outside the law and doctors may falsify certificates. This is easily concealed. A chilling demonstration in the U.K. of this process is the activity of Dr. Shipman who "euthanized" over 100 patients before the law caught up with him, despite being in a country where active euthanasia is illegal. Dr. Shipman was only apprehended because of his greed; otherwise, he would still be quietly euthanizing patients whom he judged to have a poor quality of life. If euthanasia becomes legal in the Northern Territory, such activities will be more difficult to detect and doctors will be less timid about killing.

(c) Doctors in hospitals are often overworked and chronically tired due to staff shortages, and because of impossible patient loads. For example, if the N.T. Rights of the Terminally Ill Act was reinstated, and perhaps a patient who is close to death is admitted at 3am., then a tired doctor, who may have become quite accustomed to killing patients under that Law or be at least philosophically acclimatized to the idea, may face a choice between staying up all night actively trying to save a life or to decide to let the patient "slip away" by omitting treatment, or by actively facilitating the death process with medication, or 'turning off" the oxygen, or omitting nutrition and hydration. It is so much quicker, cheaper and "easier" to kill than to treat. Administrators and governments may be delighted by the cost savings, and the "freeing" up of hospital beds to alleviate the shortages. This callous scenario and a pervasive culture of death would be encouraged by the passing of pro-euthanasia laws.

"Rights of the Terminally Ill" legislation will inevitably and progressively degrade all patient/doctor relationships and will have a negative flow-on effect to the nursing profession and indeed on all societal attitudes to sick and "burdensome" (chronically ill) patients. Similar legislation overseas has had this effect.

(d) The perception that doctors are keeping people alive with burdensome and futile treatments by using enormously expensive technology against the wishes of the patient and family is false and is a figment of the imagination of those who wish to promote "assisted suicide". In fact, the opposite scenario exists at this time of inadequate funding for public hospitals with insufficient numbers of beds and staff, etc. There is considerable pressure on hospital doctors to clear hospital beds as quickly as possible. Virtually everyday administrators at Royal Darwin Hospital notify me via my pager "that there is a serious shortage of beds and request that patients be discharged ASAP".

(e) The real risk is that patients will not receive the treatment that they need, and in this economic climate it is highly improbable that patients would ever receive futile treatment. Rather, economic pressures may result in early cessation of valid treatments and the promotions of Advance Health Directives and Doctor Assisted Suicide which are "cost-effective" and "efficient". Economic rationalists may use euthanasia laws to assist hospital budget targets.

(f) Euthanasia is a door we must not open for the safety of society's most vulnerable people, for example, the disabled, the socially marginalized, the aged, the poor, the sick, the Indigenous people of the Northern Territory.

(g) Euthanasia became "normalized" in pre-WW2 Germany and by the time Hitler came to power, doctors were accustomed to killing the physically and mentally disable patients, etc. The progression to killing particular ethnic groups such as Jewish people and Gypsies followed. Few doctors objected, because patient killing had been 'normalized'.

(h) Euthanasia Laws place undue pressures on patients to choose 'not to be a burden' to their relatives who may have compassion fatigue, or be avaricious regarding early access to the patient's Will.

(i) There was an analysis of Dr. Nitschke's "patients" who were legally killed under the presently defunct Northern.Territory's 'Rights of the Terminally Il Act", which was published in the Medical Journal of Australia. The Analysis by Prof. David Kissane revealed that most of the patients who were killed were lonely, felt unloved and were depressed. It is not compassionate to kill such people instead of treating the real problems. The flagrant abrogation of a Doctor's Duty of Care in favour of Doctor assisted suicide is unethical.and contravenes the Hypocratic Oath.

(j) A fuller range of Oncology treatments, more palliative care beds, sufficient aged care and disabled accommodation as well as greatly improved health and education services for Indigenous people in the Northern Territory are what is needed.

(k) Finally I would say that doctors are uniquely qualified to appreciate how precious and extraordinarily complex life is. A doctor should therefore have a deep respect for the life of each person. He should do his utmost to treat disease, pain and suffering, and when life is irretrievably ebbing away, the doctor's role is to comfort and to relieve unpleasant or painful symptoms. The antithesis of Patient Care is to allow the legalization of Patient Killing by doctors; it indicates a return to the Age of Barbarism.

Yours faithfully,

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C/- Royal Darwin Hospital

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