

LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

EXTRACTS FROM THE PARLIAMENTARY RECORD OF THE DEBATES OF THE
LEGISLATIVE ASSEMBLY ON THE RIGHTS OF THE TERMINALLY ILL BILL ON 24 AND 25
MAY 1995 A.M.

RIGHTS OF THE TERMINALLY ILL BILL

(Serial 67)

Continued from 22 February 1995.

Mr HATTON (Nightcliff): Mr Speaker, one could say I drew the short straw to be first on the list to discuss this legislation. Nonetheless, like many people throughout the Northern Territory, I have pondered on and given considerable thought to this matter. I have read a multitude of competing views and interests and have been lobbied and subjected to emotional blackmail by both sides of the debate. In the last 3 months, it has been not unusual to receive, on a daily basis, correspondence from proponents of euthanasia referring to horrifying cases of people dying in agony and distress, and correspondence about the destruction of society from those who are opposed to the concept of euthanasia under any circumstances. It is incumbent on each of us to work our way through the mass of information put before us and to attempt to sort the wheat from the chaff. We need to analyse that material and determine what issues need to be addressed.

Firstly, we need to develop our view, as a matter of some principle, as to whether or not such a proposal is ethically or morally correct. Secondly, we need to determine whether something positive can be developed in accordance with that ethical or moral viewpoint that accurately reflects the interests of society in the long term. I will outline a series of these issues and address the opinion that is evolving within Australia and elsewhere in the world and also some of the key issues involved in the medical and legal ethics associated with the proposed legislative reform. Thirdly, we need to address some of the broader factors. Finally, we need to address the extensive amendments that have been proposed to the legislation to determine whether any combination of provisions within those amendments and the bill itself has the capacity to provide safe and good law in this regard for the Northern Territory.

My initial comment is that there is clearly a view emerging in society that something needs to be done in respect of people at the terminal stage of their lives. The report from the committee informs us that opinion polls, not only in Australia but also in the United Kingdom, the United States of America and Canada, indicate that, over the last 30 years, support has been increasing steadily for the concept of voluntary euthanasia.

Mr Stirling: Not in the Netherlands.

Mr HATTON: Similarly, there is very strong support for it in the Netherlands. The Rummelink investigations were reported on in 1993. Following the Rummelink study, support for voluntary euthanasia declined in the Netherlands between 1993 and 1994 although only from 78% to 71%. The

committee's report notes, at page 53: 'There is little supporting evidence currently available to confirm whether or not this is an established trend'. Nonetheless, there is a preliminary indication of a decline in public support for voluntary euthanasia in the Netherlands. In the United States, the United Kingdom and Australia, there is increasing support for voluntary euthanasia yet, in the one place where voluntary euthanasia can occur, support for it may well be declining, perhaps as a consequence of the practical experience in that country. That is a matter that honourable members should bear in mind when considering this issue. Where euthanasia is not permitted, support for it is increasing but, where it is permitted, there is indication, following a major review, that support for it may be declining.

It is worth noting also that every inquiry that has been conducted in the world in relation to voluntary euthanasia - and numbers are listed - has found against a statutory provision for voluntary euthanasia. We are unaware of any report anywhere in the world that has come out in favour of voluntary euthanasia. Interestingly, in the Netherlands, voluntary euthanasia is permitted under certain circumstances as a result of a judicial interpretation of the legal principle of force majeure. There have been 3 separate attempts to introduce statutory legalisation on voluntary euthanasia in the Netherlands, but all have been unsuccessful. Thus, voluntary euthanasia remains statutorily illegal in that country, but is judicially permitted under the principles of force majeure and doctors' responsibilities to their patients.

These are not matters that we should ignore or take lightly. As legislators, we must ask ourselves whether we know better than everybody else in the world, whether everybody else has it wrong, or whether legislators have run scared and there is a case for some legislative solution to the issue. It is equally true that the common law in the western world, including in Australia, is evolving to provide a mechanism whereby doctors are performing what some describe as euthanasia. It is a matter of public information that many doctors have indicated that, in the latter stages of a terminal illness, they have taken actions that have resulted in a person's life being shortened or terminated, usually through the administration of a very large legal dose of an analgesic, often morphine or other heroin derivatives, which has the effect, in somebody with a low body weight and low respiratory rate, of their sinking into death. That is a fact. The so-called 'double effect' argument is used whereby the doctors state that their intention was not to kill the patient, but to relieve their pain even though the consequence was that the patient's life was shortened or they died. In those circumstances, that is emerging as a defence that is acceptable under common law.

Supporters of voluntary euthanasia, in particular the member for Fannie Bay, argue forcefully that there should be transparency in our law to clarify this situation. They ask why we should allow the situation to continue whereby doctors are acting possibly illegally but in the patient's interest, but everybody turns a blind eye. It is argued that there are no legislative safeguards as distinct from an interpretation of the facts of a particular case that may be brought before the courts if a complaint is lodged. Interestingly, such a matter would be dealt with only where a complaint was lodged. It is argued also that, in many ways, it is a case of involuntary euthanasia albeit with the aim of avoiding death.

I do not care whether people are desperately in favour of euthanasia or desperately against it. It is inevitable that we must deal with this issue, if not today then at some time in the future. The issue cannot be ignored. The parliament and the government cannot allow a situation to continue whereby they knowingly allow acts that are statutorily illegal to be carried out on the grounds that they are probably right anyway. To do so creates a legal inconsistency, a legislative inconsistency and probably a moral inconsistency. Nonetheless, in seeking a legislative solution, we must be sure that we know what we are doing, that we have thought through all the arguments and that the solution is appropriate.

At the outset, I state quite clearly that I believe this legislation is being rushed through with obscene haste. I admit that I am one member of this House who, when the legislation was introduced in February, had not sat down and thought about the issue of euthanasia. I did not have a fixed view on it. Frankly, it had not entered my thoughts. Thus, I have had to do a great deal of thinking over the last 3 months, as I am sure many other members have. I have had to undertake a crash reading course on the issue at the same time as attempting to prepare a budget and get on with my job.

Mr Ede: I told you that you had dropped one of them.

Mr HATTON: I did not drop the ball on the budget either because the budget came before this issue.

This has been done with undue haste. I note that 3 or 4 years were required to amend the Planning Act and the Local Government Act. It took 3 years to put the Work Health Act in place. The reason was that those pieces of legislation related to sensitive social issues. How can we become omniscient after 3 short months of debate? In a period of less than 3 months, how could a parliamentary committee obtain more than 1000 submissions, analyse them, determine the questions and arguments raised in them, check their veracity and report back to parliament? It could not and it did not. All it could do was inform the Assembly of what it was told.

Mr Stirling: It is still a good report.

Mr HATTON: It is a good report given the time constraints. However, all it indicates is what was told to it. It did not make a decision. It was too short a time in my view.

Mr Manzie: It was not supposed to make a decision.

Members interjecting.

Mr HATTON: Maybe it would have been better if it had.

I would like to deal with the issue of public opinion. Earlier, I raised the matter of international public opinion. It is worth noting also the views within the Northern Territory. In relation to a proposed law, we need to consider the validity of that law, whether the people of the Northern Territory support it, whether they understand it and whether they are comfortable with the process. I will table a report from one of the activist groups, the Coalition Against Euthanasia, which has Dr Chris Wake as its head. We have heard a great deal of comment from him. Nonetheless, I believe the report by Market Research Services is a balanced one. Some would argue that some of the questions, which are included at the back of the report, could be regarded euphemistically as having an element of push-polling. However, some of the earlier parts of the report provide some useful examples.

Interestingly, the report indicates strong support for the principle of voluntary euthanasia. The principal arguments in favour relate to the individual's freedom of choice, quality-of-life considerations and dying with dignity. Among the arguments against voluntary euthanasia, the one that stands out most clearly is that of inadequate safeguards against abuse. I noted the demographics relating to the survey. Not surprisingly, 85% of the participants in the survey were born either in Australia or the United Kingdom. An analysis of the educational groupings is only partly relevant, but it shows that 70% of the people had had secondary or tertiary education. Principally, the report is based on a survey of people who are Australian-born. They are people from a relatively secular community of whom about half hold religious beliefs. In the main, they are white Anglo-Saxon ...

Mr Perron: Females.

Mr HATTON: There were both males and females. It was well-balanced.

Mr Perron: I believe there were more females than males.

Mr HATTON: There were more females than males, but only marginally so.

What is most frightening is the enormous lack of knowledge among even the group that one would expect to be the most articulate and knowledgeable in our society. As high as 86.6% of the people surveyed either thought that the Territory did not have a Natural Death Act or were unsure. They were not even aware of the current legal framework. In relation to euthanasia, in particular the current legislation, about 50% of all those surveyed answered 'unsure' to almost every question. Half of the people in this survey did not know the legislation they were supporting or opposing. Yet this is probably the most articulate and informed group in the community.

Mr Perron: But they all supported the principle.

Mr HATTON: That is correct. I do not deny that. Indeed, I made that point very clearly.

Mr Speaker, I table that report. It is worth analysing because it indicates that there is a great deal of ignorance in the community about euthanasia.

Mrs Padgham-Purich: You are implying that everybody is dumb, but that is not so.

Mr HATTON: I am not. I am saying that most people do not know what the blazes we, in this parliament, are doing. That is what I am saying.

Let me say something further. The report from the select committee is the only evidence available, but it is overwhelming. It may be concluded reasonably that traditional Aboriginal people are fearful, at the very least, of this legislation and, at the most, reject outright any form of voluntary euthanasia legislation. Indeed, their rejection of the legislation is almost universal and the evidence for that is overwhelming. We are talking about 26% of our total population. From my informal research, I am aware also that there is considerable concern and fear among the non-English-speaking, non-Aboriginal communities in the Northern Territory, particularly in the Greek and Portuguese/Timorese communities which constitute a significant proportion of our population. Much of the fear stems from lack of knowledge and much of the opposition is religiously-based. Nevertheless, there is no doubt that there is opposition and/or fear among those people. There is concern and fear also among the elderly.

This means that, if this is the correct legislative step, there is a significant proportion of the population, perhaps as much as 40%, which has not been consulted properly and is fearful of or opposed to the proposal. These people would not be part of the opinion surveys because of their language and/or locational circumstances. However, their views must be considered. I do not believe it is possible to draw the conclusion that, across the whole spectrum of the Northern Territory population, there is 70% or 80% support for the proposed legislation. It might be argued that there may be 50% support for the principle, but not much more. I hope the member for Fannie Bay can dissuade me from that viewpoint.

Mr Perron: I will be trying to.

Mr HATTON: Nevertheless, that is the weight of the evidence before us at the moment.

Mr Perron: In the non-Aboriginal community, that is not true. It is across the Territory.

Mr HATTON: We are legislating for all Territorians, wherever they are.

Mr Perron: Absolutely.

Mr HATTON: This law will apply to all Territorians.

Mrs Padgham-Purich: Whether they are terminally ill or not.

Mr HATTON: Whether they are terminally ill or not.

I make that point because I do not believe there has been sufficient consultation. That is reflected in the obscene haste with this legislation. If the member for Fannie Bay really wants to do something in this regard, he should take the time to travel around the communities and ensure that everyone understands and is comfortable with what he is proposing. If he believes this to be the morally correct course, that is what he should do. If we are to pass a law, I do not believe that we should do it today. I do not believe the community has a proper understanding of the proposed legislation. Too large a proportion of our population is scared of it or opposed to it. This legislation represents a fundamental shift in a moral position and it would be unwise to proceed with it given this level of fear and opposition.

I would like to deal briefly with some of the more complex ethical issues. Basically, this debate is about whether one supports the principle of the sanctity of life or the right of an individual to make a choice in respect of their own destiny. The latter is the autonomous individual argument. Each of us has a view and, in an increasingly secular and pluralistic society, there is no doubt that individual rights are becoming increasingly important. I cannot answer the question. I ask the member for Fannie Bay whether he can. What are the legal and ethical implications of passing this law?

Mr Perron: I do not have a problem with it.

Mr HATTON: You may not have a problem with it, but I am asking you a legal question.

The House of Lords stated that it would be unsafe to pass such a law. The Canadians thought that it would be unsafe to pass such a law. It is interesting to note the comment from the House of Lords. I am not a legal ethicist nor a medical ethicist. I am merely a politician in the Northern Territory who is trying to work his way through a very complex issue. I believe this question deserves to be answered. This is the view from the House of Lords as outlined in the report:

... we do not believe that these arguments are sufficient reason to weaken society's prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy that would have such serious and widespread repercussions. Moreover dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.

That comment came after a year of research by 21 members of the House of Lords.

Mr Perron: But they are not governing the Northern Territory.

Mr HATTON: That is true, but much of our law is based on the principles embodied in the British common law. It is not unreasonable, therefore, for us to draw on their perceptions of the law or at least to ask the question about that point.

It becomes extraordinarily complicated. I have a submission against euthanasia from Dr Brian Pollard, FANZCA, Graduate Certificate of Bioethics from New South Wales. I will table this document. I do not intend to quote extensively from it. However, Dr Pollard does make one point relating to the principle of taking innocent life:

Taking innocent life is not seen to be wrong because it is illegal - it is illegal because it is seen to be wrong. Since current criminal law is ethically based, any law which would exempt from sanction its necessary provisions to protect life would be unethical. The bill would, therefore, allow unethical practices.

That is the question that we need to confront - the legal ethics argument.

We need to come to some determination. I believe strongly that, when no other options are open to a person in the final stages of terminal illness, who is suffering unrelievable pain and distress and who consistently and rationally requests that they should no longer continue in that agony, there should be some process whereby they can have their lives shortened or can shorten their lives. I do not believe this bill provides that. This bill goes much further than that. I would like to be satisfied ...

Mr Ede: Have you checked all the amendments?

Mr HATTON: I have. I am dizzy from reading amendments.

Mr Ede: Obviously, you have not read them.

Mr HATTON: If you can convince me that you can do it, maybe you can change my mind. At the moment, I cannot see it.

Mr Ede: The first step is to get the bill into committee. You can do that.

Mr HATTON: Put your arguments as to why you believe this bill should be changed. I do not believe that we should be debating the bill at this time. Too many people in the community are unsure and frightened about this bill. I do not believe all members know all the facts and arguments that we should be considering in a reasoned way. We are being driven to this debate by the personal desire of an individual member of this Assembly who wishes to resign. That is the only reason we are debating it today. We should be clear that we would not be debating this bill in this way and in this time frame if it were not for that reason.

Mr Bailey: Are you sure of that?

Mr HATTON: I am certain of that.

Mr Speaker, I would like to turn now to some of the specific issues. I attempted to circularise my electorate and I can say quite clearly that there is strong support in my electorate for the principle of voluntary euthanasia. Support is particularly strong for the concept of final palliative care. There is certainly strong feeling against any concept of supported suicide. There is reasonably good support for a

person who had given prior consent or who requests, under certain circumstances, to be euthanased. There was majority support - but not as strong - for that view within my electorate.

Mr Coulter: How many replies did you receive?

Mr HATTON: Not enough.

Mr Perron: It would not have been many. They are probably still filling out the questionnaire.

Mr HATTON: They probably are. However, I received over 100 responses and they are still coming in. I do not believe the overall statistics will differ much. At least, I did not issue a circular in the first week before I had thought about the issues. I tried to provide some information to my constituents before asking them to answer some questions.

Mr Manzie: You preferred to leave it until they could not reply before the debate.

Mr HATTON: Mr Speaker, unlike some members, I like to think about what I send out to my constituents. I like to be able to consider some of the questions.

In relation to some other points, strong views are held by people in my electorate. There is very strong support for psychiatric assessment and counselling to be undertaken in advance of any decision for euthanasia. There is strong support for the development of palliative care facilities at the earliest opportunity. The psychiatric effects of terminal illness ought to be considered seriously. I am aware that the Leader of the Opposition's submission addresses the matter to some extent in that he is proposing an amendment to the effect that the second medical opinion shall be that of a psychiatrically-trained person.

Mr Ede: A person who holds a diploma of psychological medicine.

Mr HATTON: That person will make an assessment as to whether the patient is suffering from clinically treatable depression at the time of making a decision.

My view is that a terminally ill person should have the right to the full range of palliative care. That should be their first and principal right. The first element of palliative care should be availability of psychiatric and other counselling services for the terminally ill person, their family and associates to assist them to adjust to the process at the earliest time.

Mr Bailey: Counselling, or psychiatric counselling?

Mr HATTON: Psychological counselling.

Much of the research indicates that this is of vital importance. I note 2 papers. The first, from a Mr Christopher Ryan, is entitled *Velcro and the Slippery Slope: the Role of Psychiatry in Active Voluntary Euthanasia*. I table that document because it provides a very convincing argument for the role of psychiatry in palliative care services. Secondly, similar arguments and views are expressed by a Dr Carole Gill in evidence to the Oregon inquiry into its death with dignity legislation. Dr Gill, who is a clinical psychologist specialising in issues affecting persons with disabilities, pain and/or chronic illnesses, expresses some very useful views and refers to research that indicates quite clearly that the most vulnerable in our society will be most at risk in terms of euthanasia issues. They are those in the lower socioeconomic groups, the disabled and dispossessed in our society. I table that research for the benefit of honourable members. I believe the committee received copies of it.

There is sufficient psychiatric and psychological information before us to say without doubt that the issue should be addressed formally with palliative care and that any legislation dealing with voluntary euthanasia must include the assessment of a person in respect of any clinically treatable mental circumstance. In particular, I note that the evidence indicates that between 90% and 98% of persons who suicide or seek death are suffering from a clinically treatable mental condition. It is usually a clinically treatable depression which the evidence indicates is highly unlikely to be identified by a treating physician. There is also evidence that the initial period after diagnosis of a terminal illness is the time when people are most vulnerable and most likely to enter a clinically treatable depression. It is the period when they are most likely to have suicidal tendencies.

Mr Perron: They have a pretty good reason to be depressed.

Mr HATTON: They certainly have, but it is treatable.

If we are to frame a safe law, it must provide that opportunity first and foremost as a right to all terminally ill people at the earliest opportunity. It is almost a public obligation. Secondly, if the option of voluntary euthanasia is to be provided to people, it is necessary to ensure that all the other options are available, including the option of the best available palliative care. It would be a tragedy if euthanasia were the only acceptable solution available to a person because palliative care was not available.

Mr Bailey: Are you suggesting that, if euthanasia is not an option, it is all right not to provide the other options. That is what you have been doing until now.

Mr HATTON: I am not saying that. I am saying exactly the opposite. There is an absolute compulsion on us, as a government, to upgrade urgently and provide high-quality palliative care ...

Mr Bailey: You have been in government for 20 years. As an ex-Minister for Health ...

Mr HATTON: You will have a chance to speak later.

It will cost government a great deal of money. One thing this debate has achieved is that, without doubt, palliative care services will be available for terminally ill people. That cannot be denied. It is incumbent on the government to provide that.

Equally, I do not believe we should be rushing to pass legislation on euthanasia in advance of dealing with the matter of palliative care. We ought to be developing our palliative care services and examining the issues relating to medical and legal ethics. It would have been good to have had advice from the Department of Law on the legal implications and from our medical and health professionals on the questions relating to medical ethics. Because of the peculiar means by which this bill was introduced, that information has not been available to us. The normal processes of developing legislation, of discussion within government and government departments, has not occurred.

Mr Bailey: It is a private member's bill.

Mr HATTON: It is a private member's bill. The matter has not been debated in Cabinet or in government. It is unusual to have a private member's bill coming from the head of the government.

Mr Bailey: It has happened before.

Mr HATTON: Not very often. It is an interesting experience.

There has been no comment from Treasury on the matter. What will be the budget implications of this, and of the development of palliative care facilities? The bill is being processed while the Department of Health and Community Services is still considering its appropriate response in relation to palliative care. We do not have those answers from the departments. We ought to have those answers before us. We ought to have advice, not only from the activists for and against euthanasia, but also from the Department of Law on the legal, ethical and medico-legal questions with which we are dealing. It is not unreasonable to ask for that advice, but it is not available to us as yet. We have had 3 months from go to whoa and, in respect of the ...

Mr Bailey: We get very little from you blokes in relation to any legislation.

Mr HATTON: ... determination to debate it to finality today, I will say clearly that I am not prepared ...

Mr Bailey: At least we had committee notes from this bloke when he wanted to pass some legislation.

Mr SPEAKER: Order!

Mr HATTON: The bill has no definition of 'extraordinary medical care'. It contains references to the situation in which you cannot help somebody if the only available services are 'extraordinary measures'. The definition of 'extraordinary measures' is in the Natural Death Act. It is not in this bill. It would be sensible to have that definition in this bill. That is a mechanical issue. If it is appropriate to have it in the *Natural Death Act*, why not have it in this legislation?

Mr Perron: I am happy to insert it. We will make an amendment. Let us think about the poor patient instead of everything else. What about the patient?

Mr HATTON: That is interesting because, in 20 years, you do not seem to have thought about it until now.

Mr Perron interjecting.

Mr Bailey: What have you done in the past? You used to be the Minister for Health and Community Services, yet you did not even think about it until today.

Mr HATTON: No. I must admit that it was not until late 1990 that I started investigating hospice services and developing my thoughts about them. Certainly my attention to that question was diverted subsequently by other ministerial responsibilities. That is true. However, it is before me now.

That is one definitional issue. Many of the provisions in the bill relating to the circumstances are unclear. Frankly, I believe the wording is too loose. Given the emotional nature of the circumstances, major concern is for the person who is suffering unrelievable pain in the final stages of their life. You are asked how you can possibly allow that person to endure such agony and your response is that you want to do something about it. This proposed legislation provides that something can be done provided the person is over 18. However, if it were my 9-year-old stepdaughter who happened to be in that circumstance, it would be okay for me to watch her continue to suffer. The legislation has no provision for children. Is it easier to watch a child dying in agony than an adult?

A member: Probably harder.

Mr HATTON: It is a damn sight harder.

When I have asked the proponents of this bill about this, they have urged me not to worry about it. They say that we should deal with this now and leave the rest until later. They pooh-pooh the argument about the so-called 'slippery slope'. Yesterday afternoon, I was speaking to a person who is terminally ill. He said: 'I am one of the people that this bill may help if it gives me the choice'. I understand his thoughts, but I thought also about the children in the Sunshine Association. What about those children? The response of the proponents of the bill is that the legislation should be brought in now. The *Natural Death Act* relates to people over 18 years who have the right to have the life support systems turned off. It makes no reference to young people. It happens. Will we deal with that?

Mr Perron: You are a politician. You can introduce a bill.

Mr HATTON: Will we deal with children? What happens when a Down's syndrome person is dying in agony. Do we ignore them too? Why is it right for a mentally-competent adult, but not right for anybody else?

Mr Bailey: Because a mentally-competent adult can make a decision for themselves. If you want to ...

Mr SPEAKER: Order! The member for Wanguri will have an opportunity to speak, and I ask him to hold his tongue until that time.

Mr HATTON: Interestingly, a 17-year-old cannot make a choice, but an 18-year-old can. We are making value judgments about these matters. We are not dealing with the emotional trauma of death nor with the medico-ethical questions. We are circumscribing it as tightly as possible to get it over the line and it will then be a matter of judgment as to how much further we should go. That is what this game is about. If we intend to debate the issue at all, we must debate the whole issue. We need to have a total picture around which we can place a frame so that it cannot be extended. It is no good coming in here and saying that this legislation locks everything up safely, that it will be the law and doctors will not go beyond the law. I am told by doctors that, in relation to the kids and mentally-incompetent people, they will continue doing what they are doing now. They will keep giving them the needle. They will turn a blind eye to everybody else but, for these people, they will go through this process. If this is passed into law and this Assembly maintains that it is right for mentally-competent adults, but not right for everybody else, it is incumbent on the government to prosecute for murder any person who breaches that law.

Mr Bailey: It is at the moment for everybody.

Mr HATTON: Is it better to let the common law evolve before you pass a statute or is it better to pass a statute in advance of the common law? That is what is occurring. That is the question that has faced every country in the world. They have allowed the common law to evolve on a case-by-case basis rather than attempt to pass an all-encompassing law. That is a fact.

Mr Bailey: Those are the same arguments for half of the legislation you attempt to pass in here, Steve.

Mr HATTON: How can anyone stand here and say that we will pass the law because of transparency in this case while knowing that we will make the decision to turn a blind eye in many circumstances because everyone believes that the existing practice is fair and reasonable emotionally for those other people?

Mr SPEAKER: Order! The honourable member's time has expired.

Mr STIRLING (Nhulunbuy): Mr Speaker, whatever else the member for Fannie Bay may have achieved in debate on his bill to date - and, in terms of palliative care at least, the achievement will be significant whatever the outcome - he has brought people into the gallery today and that is appropriate given the significance of the bill before us.

When I very first heard of the member for Fannie Bay's intention to introduce this private member's bill, I was in 2 minds. I must admit that I had never given the matter serious consideration. On the one hand, I had great sympathy for those people who were trapped in pain-wracked bodies and nearing the end of their lives. On the other hand, even at that very early stage of my considerations, I had instinctive doubts as to whether such a move could be legislated for adequately and safely. When it became clear exactly what the member for Fannie Bay was proposing, and how he had confined this bill artificially, to terminally ill persons over 18 years of age with a life expectancy of less than 12 months who are in pain and distress and competent to make a decision to have their life taken from them, it was easy to see his strategy. He wanted a bill that was as tight as possible to ensure that it would overcome as much of the expected opposition as possible. He was praised at the time by media commentators for his honesty and forthrightness in bringing on this debate in the Northern Territory.

At that point, I still had an open mind on the bill. However, what I saw in the bill was not honesty, but deception. The member for Fannie Bay well knows that, once such an act is on the statute books, it can be amended over time to broaden its provisions to cover any other people in pain, suffering and distress, but not terminally ill. To take an example, there is a case quoted - I think it is in one of Helga Kuhse's books - of a very active young person who had lost all movement below the neck as the result of an accident and who, in their own view, lived a life full of great pain, suffering and distress. The person could not adjust to the new lifestyle of great dependence on others. That person was not terminally ill and could not be covered by the provisions of the bill before us. Other people who suffer a debilitating illness, such as a motor neuron disease, may well be suffering increasing pain each day as the disease progresses, but they would not qualify necessarily under the strict requirement in the bill of being terminally ill or being expected to die within 12 months.

As part of my research into the background information, I learnt of the Rodriguez case. Sue Rodriguez was a young Canadian mother who was suffering from a motor neuron disease. Her life expectancy was unknown. She wished to continue living whilst her quality of life remained acceptable to her. However, at some future time, when her quality of life was no longer acceptable to her, she wanted the right to be assisted to die. After unsuccessful appeals through the legal system, she took her case to the Canadian Supreme Court where it was defeated 5:4. It is debatable whether that person would have qualified for assistance under the provisions of this bill. It is very easy for proponents of euthanasia to push extremely compelling and emotional cases such as the Rodriguez story. They run them on television because they are difficult to refute at an emotional level. They are difficult to refute because the opponents of euthanasia cannot put the whole of society on television, in contrast to the individual case, and demonstrate the risks and unknown dangers to society as a whole of legalising euthanasia.

Take the example of a 17-year-old who would qualify apart from their age. I would not like to be in that person's situation if this law were on the books. Parents of deformed infants, who believe it better for their infants to die shortly after birth rather than battle the medical odds confronting them, could also push for such a law to provide them with the right to ask a doctor to assist their infants to die. These are examples of groups of people who could and would put pressure on legislators to broaden the law once a law relating to the right to request medically-assisted death was on the statute books. If the member for

Fannie Bay had been truly forthright and honest in the first place, he would have allowed all such groups to be covered by his bill. However, he did not do so because he believed the narrower the scope of his bill, the more confined its provisions, the greater would be its chances of passage into law.

The argument of consequence, which is unavoidable once the subject is canvassed at any depth, is something that the member for Fannie Bay wanted to be avoided at all costs. I believe that is his reason for not wanting a parliamentary committee to inquire into the issue in the first place. A committee had the potential at least to arouse public consciousness beyond the high level of support for the simplistic notion that, if you are opposed to the principle of euthanasia as expressed in the Rights of the Terminally Ill Bill, you must be in favour of forcing people to die ugly, agonising deaths. That is nonsense. It is the type of claptrap perpetuated by the member for Nelson in the boondocks of her electorate. She circulated a petition there. People walk into the corner store on a Saturday morning and see a petition containing 2200 signatures for the yes case and 3 for the no case. Who in their right mind would put their name and address on a petition when faced with those odds on a simple yes/no proposition as pushed by the honourable member? The line was peddled also to some extent by the member for Leanyer in a disgraceful episode in this Assembly. He may have added some slight measure of sophistication to his polling, but it still amounted to a ring-a-round among those in the Northern Territory who had a telephone.

For the member for Fannie Bay, the risk in having a select committee was that people might actually come to a clear understanding of what was being proposed and proper and constructive debate in the community might begin to raise doubts and misgivings. Whilst I believe the committee achieved a somewhat higher level of debate in the community than might otherwise have been the case, it was short-lived and restricted in terms of what it could achieve. Nonetheless, the committee did produce an excellent and well-balanced account of the views and opinions received from people on the streets to acknowledged experts in the field on both sides of the debate.

One of the first witnesses to appear before the committee was a palliative care expert from South Australia who was opposed to euthanasia. He was a credible witness who delivered a very effective presentation in a measured and objective manner. At the time, I found myself in agreement with virtually everything that he had to say. However, by that very evening, after weighing up the evidence that he had presented to the committee and my feelings in relation to it, I found myself swinging into opposition to his views. A very similar thing occurred after one of the main advocates in Australia for euthanasia appeared before the committee a week or so later. I had no difficulty with the presentation and the substance of the evidence put before the committee. Nevertheless, by that evening, I found myself seriously challenging the position for euthanasia that had been put that day. No doubt, this is a natural process of weighing and considering the evidence before deciding what to hold on to and what to discard. This process continued, to greater or lesser degree, with each witness, at least with the early submissions made to the committee.

As the committee pursued its work, it became clear that the public's understanding of the bill was less thorough than it should have been for a bill of this importance. The committee's role was to receive the views of the people. It was not supposed to have, nor did it, an educative role other than to correct any blatant misinterpretations as they arose. The complexity of the terms used in the debate, and their ambiguity in many instances, served to cloud many of the central and serious issues involved. The committee heard views from a number of witnesses that euthanasia was a common enough practice in our hospitals and therefore why not legalise it. Whilst, for obvious reasons, the committee had to be very

careful in pursuing those claims too far, it was apparent to me that, on more than one occasion, what was being referred to as euthanasia was actually the end stage of palliative care where the intention of the doctor to relieve the pain and suffering of the patient resulted sometimes in the death of that patient, perhaps shortening life by a few days or a week. Those in favour of euthanasia used those examples to claim that euthanasia is occurring now. They argued that there was no difference between the treatment under palliative care and euthanasia where both result in the death of the patient.

The simplicity of that argument has an initial appeal but, after I had considered it for a while, I began to see a huge gulf between the 2 treatments and the 2 positions. The matter of intention is paramount. On the one hand, the intention is to counter pain and, on the other hand, the intention is to bring about the death of the patient. I have no difficulty with treatment that is designed to counter pain, even though it may shorten life, but I cannot countenance the alternative - that is, death by lethal injection. A point raised constantly by proponents of the bill is the right of a person to die with dignity. That is a very subjective term, but I for one can see nothing dignified about slipping a lethal injection into someone with the intention of killing them.

In many letters to the editor, the writers pointed out that we do not allow animals and pets to suffer a painful death. If our horse or our dog is in pain and suffering, we put them down. This leads to the question as to why we should not act in the same way with people. I believe the answer is obvious. We do not do it precisely because we are not the same as horses and dogs. We are human beings. We are not solitary, individual, living things. We are interconnected and interrelated with others in any number of ways. We have an ethical view of life and living as being important and precious to the point that no one can take it away, not even ourselves. When we breach those givens, we undermine the social fabric of humanity and we step off into the unknown. This is the reason why what may seem on the surface to be a good idea is not in practice anywhere in the world, apart from the Netherlands, despite the number of inquiries and the number of committees that have examined the issue.

Much has been made in this debate of the rights of the individual and the right of a person to say that they have had enough and want out. I want to make a couple of points about this matter of individual rights. Two witnesses before the committee suggested that pressure for this ultimate right of self-expression at the end of life was increasing as the first of the baby boomer generation moved into middle life and began to consider death from a much closer perspective. It is often said that ours has been and continues to be a selfish generation. We were given a great deal by parents who had suffered the deprivations of the Great Depression and who had experienced World War II. We are numerically strong in the population. Our tastes dominate in society. Even our music continues to be played at the expense of that of today's young people. We have been and are the 'me first, me second and me third' generation. What we want, inevitably we obtain.

This selfish drive for individual rights is pushing the 'right to die when we want to die' debate. The selfishness of this view is apparent when we consider that those who want this right have utterly no thought at all for the third party who simply has to be involved. Their demand is: 'I want to die. I want you to kill me. If you cannot or will not, I will find somebody else who will'. The proponents do not give a damn for the person who has to carry out the act of euthanasia. Of the videos I watched from both sides of the debate, I recall with particular clarity the haunted and exhausted look on the face - indeed, the general appearance - of a Dutch doctor whom we followed through the process of legally euthanasing a terminally ill patient. The doctor explained that he was not a particularly happy person and wondered whether his role in assisting patients to die was the cause of the lack of joy and happiness in his own life.

I did not wonder. It seemed almost self-evident to me, as it would, I believe, to anyone else who views that video. Although that was from a video supporting the case for euthanasia, the overwhelming impression I had after watching it was the enormous load that it placed on the shoulders of the doctor.

Mr Perron: Maybe he should have been a painter.

Mr STIRLING: It was one of your examples.

I do not believe the proponents consider for a moment the emotional load that is conveniently offloaded on to the doctor as a result of the person's fervent desire to have their own death wish met. There is another point about individual rights and, once again, it relates to the selfishness of the proponents of the legislation. No thought is given to how the right to an individual choice will cause harm to others. They do not care about the doctor nor about the possibility of harm to others, provided they are able to meet their individual need by claiming a right which they do not have legitimately.

The harm to others will result inevitably once the door is opened to legalised euthanasia because, once it is opened, that door can never be closed again. It can only ever be opened wider and wider. That will occur in 2 ways. There will be pressure to amend whatever legislation has been passed to include those who believe they have been excluded in the first instance - the groups to which I referred earlier. As the provisions are broadened, invariably others will be picked up - for example, those who feel guilty at being a burden to others and a great cost to their family. Perhaps the person is occupying a hospital bed at a time when the health budget dollar is being stretched ever more tightly. Who is to say that, in time, a hospital administrator, who is pushed for bed space, will not talk to the doctors about some of the old people who are filling hospital beds. It will happen.

Mr Perron: If you want a comfortable job with no pressure, don't be a politician.

Mr STIRLING: The old, the weak, the susceptible and the vulnerable in our society are the ones at risk in this regard. They are also the people who are most susceptible to persuasion.

The second means by which the provisions of the legislation will be broadened is through the natural functioning of the legal system. The law is often rounded off in practice and short cuts may be taken to make things work better and more efficiently. Safeguards are lowered in practice and the process of desensitisation to the practice of euthanasia will mean that the net will grow ever wider.

There is something quite special about life and being alive. My father died of leukemia when I was 11 years of age. He was in and out of hospital for 3 years and was bedridden for the last 12 months of his life. Virtually the only memories I have of my father are of lying in bed with him over those last 12 months, with his arm around me. I do not recall that we talked very much. However, those memories are precious to me. They are as precious as life itself. If he had been able to choose the option of euthanasia and had exercised it one or 2 years earlier, I simply would not have those memories to rely on.

At various times, the member for Fannie Bay has talked about the horrors of the deathbed and the unnecessary pain and suffering that occurs. Clearly, his own experience has been considerably different from my own, but no less valid or legitimate. They are simply personal experiences. I put it to him that, for the overwhelming majority of people who are dying, it is a time of sharing with those whom they love and an opportunity perhaps to redress old wrongs. Certainly, it is a time of grief and sorrow but, for many, it is also a time of learning and self-discovery ...

Mr Perron: Not if you are in a coma!

Mr STIRLING: It is a time perhaps of relief and even joy for a life well lived for a person whose time has come. It is a very special time for those involved, and not only for those people who are deeply spiritual and religious.

I want to address the matter of this being a free vote or a conscience vote. The advocates of the bill have made much of the need for each member to ascertain the views of their constituents, but I have a question for them: whose conscience is on the line at the end of this debate when the vote is taken? Is it the collective conscience of the 3000-plus constituents of each electorate or is it the conscience of the individual member? It is the consciences of the 25 individual members of this Assembly.

Some 40% to 50% of my constituents are Aboriginals whom I know to be opposed 100% to the provisions of this bill. Clearly, therefore, the Nhulunbuy electorate would be opposed to the legislation in any case. However, over the past few weeks, I recall seeing a nonsensical letter from the Rights of the Terminally Ill Approval Petition Group. The letter suggested that the Labor Party members of this Assembly needed to be careful how they voted on this issue otherwise their electorates might wreak vengeance on them at the next poll. The very next paragraph issued a similar warning to CLP members. Presumably, if the ALP members and the CLP members were not to be supported at a future election because of their opposition to this bill, we would have an Assembly of 25 independents. That is a nonsensical proposition. However, nonsense is one thing - and I can handle that - but misleading information is another thing entirely. The letter went on to say that the Aboriginal people to whom Ms Cracknell had spoken had voiced fears to her that, if the bill were defeated, it would be worse for Aboriginals. Not only is that misleading, but it comes very close to being a lie.

I visited and spoke about this bill with Aboriginal people at Elcho Island, Yirrkala and Gunyangara in my electorate. As a member of the committee, I visited Hermannsburg, Yirrkala, Milingimbi and Nguuiu. The view of these people was unanimous. They stated very clearly that it was wrong. They said that, when old people knew they were going to die and the land knew they were going to die, they had to come home to die on their own land and to be with their own family. I will quote Wally Wunungmurra from Yirrkala who gave evidence before the committee. He said:

Ethically, culturally and morally, traditionally, it's wrong as far as Aboriginal people are concerned. It's wrong. I mean, the only way to go past it is to assist them. If the doctors can't do anything about the sick person, then they've got to return that person to the community.

That view was expressed in one form or another in every Aboriginal community we visited and by every Aboriginal individual to whom I spoke throughout my electorate.

Mr Perron: The bill does not prevent that from happening.

Mr STIRLING: They spoke with one voice on that matter.

There was great concern at Bathurst Island, the community that expressed the greatest concern, that people may even stop going to the local health clinic, let alone to Royal Darwin Hospital, with all the talk about doctors having the right to kill. This lack of understanding of the bill meant that the fear and the consternation among the people was heightened. There was a lack of information and there was misinformation in the Aboriginal communities, despite the fact that the bill had not even been debated in this Assembly, let alone passed. I believe that confusion and misunderstanding was a direct result of the

indecent haste with which the member for Fannie Bay acted in his attempts to have this legislation enacted. A proper process of debate ought to have occurred, over perhaps a period of a year, after an exhaustive educative program had been run to enable everyone to know exactly what was proposed.

That current lack of accurate information, not only in Aboriginal communities but in our own urban centres, was highlighted to me in a survey carried out by Market Research Services only 12 days ago. Some of the misinformation and lack of information can be seen in the following findings. A mere 7% of Territorians surveyed were aware of the existence of the *Natural Death Act* and what it contained, 82% of respondents wrongly believed that terminal illness is defined in the bill, 89% wrongly believed that counselling or psychiatric assessment is required for the patient, 71% wrongly believed it applies only to Territorians, 88% wrongly believed there is a requirement for the family to be notified of the patient's request to end their life, and 99% wrongly believed there is a cooling-off period between the request and the act of terminating life. They were wrong on all counts, to the tune of 99% in that last example. There were further instances of people being totally wrong in their belief as to what is in the bill. The views expressed in that survey were what those people believed should be in the bill ...

Mr Bailey: No. They were questions that were asked.

Mr STIRLING: Read the survey.

Subsequently, many amendments have been proposed to pick up each of those concerns. However, the point is that the survey was carried out not on the amendments to the proposal but on the original bill. That survey highlights the abysmal ignorance that exists of the details of this most important bill, and the fact that no attempt has been made to educate the people as to what exactly is planned. Those findings underline both the haste with which the member for Fannie Bay has acted and the reluctance of the bill's proponents to have full, open and honest debate, based on a proper understanding of the bill's contents. The member for Fannie Bay feared that course from the outset and opposed the establishing of a committee. In the end, he has done both himself and Territorians a disservice. If he had allowed for a proper educative process and an informed debate, who knows? The support may well have still been out there.

Without doubt, the one overwhelming positive to emerge from this entire debate is the spotlight that has fallen on palliative care. A great deal of evidence on palliative care was put to the committee. One specialist saw euthanasia as a logical end-step in palliative care on those rare occasions when all else had failed. As a palliative care specialist, his was a lone view in this regard. All other palliative care specialists who appeared before the committee were opposed to euthanasia. If palliative care measures are not working, they believe it is because they are not being applied properly. Conflicting evidence was provided to the committee as to whether palliative care could meet all pain and suffering. There were differences also as to the actual percentage of patients who, at the end of the day, could not be assisted by top-quality palliative care.

Evidence was given that there is a paucity of trained palliative care doctors and nurses in Australia. It does not constitute a large proportion of a doctor's training. Evidence was given of a lack of expertise and knowledge about palliative care. When they can do no more for them, doctors often turn their backs on their patients and leave them to nursing care. I do not know how common that is in our hospitals. What has come out of the debate and the committee's findings is that a great deal of work needs to be done in the Northern Territory in relation to palliative care. It is not a hugely expensive exercise, as the member for Nightcliff seemed to indicate in his contribution to this debate. If the government approaches the

question in that manner, it will miss the mark. Rather than the building of numerous hospices, the committee was told that it is much more important to dedicate a small number of beds - perhaps 9 in all, in hospitals at Darwin, Palmerston, Katherine and Alice Springs. The overwhelming need beyond that is for a small team of trained palliative care specialists who can train, in turn, the medical profession in the Northern Territory and provide advice to medical staff in the regions beyond.

The member for Fannie Bay suggested that, in the Northern Territory, we are talking about 14 or 15 people in any one year. Quality palliative care ought to be able to address the needs of those 14 or 15 people each year. To introduce euthanasia prior to upgrading palliative care would mean, in all probability, that palliative care deficiencies would never be addressed. That is another example of the member for Fannie Bay's lack of understanding of the whole issue and his eager desire to push this bill through before addressing palliative care needs. Certainly, in the Netherlands, palliative care scarcely exists in the face of semi-legalised euthanasia. I am comforted by the fact that the Chief Minister has made a number of public statements that the matter of palliative care will be addressed irrespective of the fate of the bill. I commend him for that. Unfortunately, after tomorrow, he will no longer be Chief Minister. We will have to ensure that that commitment stands.

I do not know what the fate of this bill will be. The vote may be very close. I started with the positive view that we ought to be able to do something for those suffering great pain but, at the same time, having doubts that that could be safely and adequately legislated for. Throughout the life of the committee, as a result of my reading, my viewing of videos and my speaking to people from both sides of the debate, my doubts about the difficulties of legislating in this regard have hardened to outright opposition to the bill. The fact that so many amendments have been proposed by so many different members suggests that the bill was not thought through sufficiently in the first place. I recall suggesting in a letter to the Chief Minister early in the piece a number of amendments which had been picked up even at that stage by quite a number of people.

Mr SPEAKER: Order! The honourable member's time has expired.

Mr BURKE (Brennan): Mr Speaker, I enter this debate attempting earnestly to address in a rational and dispassionate way the issues in this bill. I do this in the way that the member for Fannie Bay has asked us to consider the bill. I hope that he puts aside also his emotion - and, certainly, it is completely understandable emotion - when debating this issue.

When we examine this bill, it seems to me that the first thing that we need to get clear is the terminology, particularly that used in the second-reading speech of the member for Fannie Bay. When I look at the documents, I cannot help thinking of the words of a tutor of mine a few years ago when I studied political language at university. On the subject of euphemisms, he said to us: 'Whenever you see euphemisms in political language, ask yourself why they are used. Euphemisms are wonderful tools for clouding real meaning. They soften the blow; they soothe'. Ever since it discovered public relations, the military has been particularly good at using euphemisms to talk about issues of life and death. The widespread destruction of civilian areas becomes 'collateral damage'. Bombs become 'packages' or 'ordnance'. People become 'targets'. Probably the best euphemism that was ever invented was in Operation Phoenix in Vietnam where the selective assassination of Vietcong officials became 'terminate with extreme prejudice'.

These are euphemisms at work and they work very well when one is trying to cloud meaning. So it is with the language of this debate. This subject has been made more palatable by the liberal use of

euphemisms. When we see something described as 'confirm the right', we should insert 'make it legal'. For 'death with dignity', we should insert 'kill by lethal injection', an injection that will drop a healthy person as quickly as it will kill a very ill person. For the word 'help', we should insert 'kill'. For the words 'assist to die', we should insert 'kill'. For the word 'substance', we should insert the words 'sodium pentothal', which I understand from my colleague puts you to sleep, and 'curare' which paralyses you. My tutor told us that the trouble with euphemisms is that 'we try to make the words do too much' and 'instead of our using language, language uses us'. That is the problem with the whole debate surrounding this bill.

This debate is not about death with dignity, nor is it about confirming a right or about helping people. Take away the euphemisms and this bill asks us to legalise a new category of killing - the intentional killing of certain persons in our society provided they meet some prescribed guidelines laid down in clause 6 of the bill and continually amended.

Mr Bailey: Isn't that what happens when you go to war? If the opposition fulfils certain guidelines ...

Mr BURKE: Do we have to go through this again?

Mr SPEAKER: Order!

Mr BURKE: Perhaps I could practise some refresher training and call it self-defence.

It is to add in fact the worst category of killing - private and self-determined killing. Its purpose is not to protect the nation, as in war, not for justice, as in capital punishment, nor for the saving of a life, as in self-defence. Rather, it is to satisfy the private wants and desires of certain people. This bill asks our community to turn its back on the rest of humanity's view of human life. It is about Territorians going against the cornerstone of law and social relationships - that is, the prohibition of intentional killing - in order to legalise this view of humane killing. That is the plain unvarnished fact.

When a person is ill, one thing is clear: they are vulnerable physically and they are vulnerable emotionally. When a person is terminally ill, that vulnerability is at its extreme. It causes extreme pain. That pain is mainly psychological, but it is also physical, depending on the level of palliative care that is provided. Patients bring these vulnerabilities to their doctors. They rely on a doctor's knowledge to ease their vulnerability. Such is the nature of the unwritten contract and relationship between a doctor and a patient. On the one hand, we have the profound dependence of the patient on the doctor to ease their vulnerability and, on the other hand, a duty of care on the part of the doctor. The proponents of this legislation would have us view this relationship in a certain paradigm. The paradigm we are shown is one of an emotionally-balanced, rational, dispassionate and well-informed patient - a patient who is the contractual equal of the doctor. The patient in this paradigm would obtain the opinion of medical and palliative care specialists. The patient would weigh those opinions rationally and dispassionately, and would consult family and friends. After weighing up all the options, the patient would decide to suicide and discuss how this would occur. This is the paradigm presented by the movie, *Death by Request*, that was shown on Channel 8. It is the paradigm painted most often in letters to the editor.

Mr Perron: It was not a movie. It was a documentary.

Mr BURKE: This is an unrealistic paradigm for legislators to deal with. We legislators must do a paradigm shift when we consider this in a societal context. As the member for Nhulunbuy says, you simply cannot put society on a video. Thus, we must turn to empirical evidence. We must dig deeper to find out whom this bill will affect. It will be the elderly, the disadvantaged, the physically handicapped,

the lonely, the demented, the depressed and, particularly in the Northern Territory, Aboriginals.

Mr Perron: Why the lonely?

Mr BURKE: They are the vulnerable ones.

Mr Perron: Because you are lonely.

Mr BURKE: I defer to your experience, member for Fannie Bay, but I ask you to let me have my say. You have had a pretty good run for a few months now. I would like simply to have my say in this Chamber.

Mr Perron: I just want to keep you accurate, that is all.

Mr BURKE: Mr Speaker, these are the vulnerable ones and we should fix an image of them in our minds when we see our paradigm of the people in our society who would be affected by this legislation. When we fix that image in our minds, the logic of euthanasia becomes clear and the logical and practical reasons why this new category of killing should not become law are also clear.

If euthanasia is of benefit for the competent patient, is it not logical to ask why it should be denied to the incompetent patient? Are the incompetent less entitled to relief than the competent? Do the incompetent suffer less because of their incompetence? Why should only certain groups qualify? Considered from these perspectives, there are no good reasons to limit euthanasia once the principle of taking life for that purpose has been legitimised. If we really believe in freedom of choice, any competent person should have a right to be killed for reasons that suit them. If we really believe in relief of suffering, is it not cruel and inconsistent to deny it to the incompetent?

There is no reasonable or logical stopping point once we have crossed this Rubicon and moved to legalise euthanasia. That is demonstrated in a practical sense by the experience in the Netherlands. It was demonstrated recently in what is known as the Chabot case. A physically healthy woman, who had lost her 2 sons and was divorced, was so mentally distressed that she qualified for euthanasia and was killed. The Dutch government has now announced moves - and it is logical - to remove terminal illness as a criterion for euthanasia. That is perfectly logical once you accept the logic of the concept of a life being not worth living. If that concept is accepted in law, how can it ever be confined? The authors of the Rummelink study in the Netherlands said:

'Is it not true that, once one accepts voluntary euthanasia and assisted suicide, this principle of universability forces one to accept termination of life without explicit request?' - at least in some circumstances as well - in our view, the answer to this question must be affirmative.

Let me praise the member for Fannie Bay for making us face issues in this debate, examine the evidence and listen to what the experts have to say. To my mind, 3 facts are clear and indisputable. The first is that palliative care has made enormous strides over the last 10 years or so and continues to make enormous strides. In 1990, a World Health Organisation report stated:

Now that a practical alternative to death in pain exists, there should be concentrated efforts to implement programs of palliative care rather than yielding to pressure for legal euthanasia.

In the Territory, palliative care is still in its infancy and we should ensure that its progress is not stifled in any way.

The second fact that no one disputes is that many patients, in particular the terminally ill, experience non-physical suffering for psychological reasons, such as the perception of being a financial burden on family and friends, unresolved family difficulties etc. The experts tell us that severe disease is often accompanied by clinical depression, and the member for Nightcliff outlined some of the studies. In one study of persons who expressed the wish to die, 95% suffered from depression or other emotional disorders. In other studies, 95% to 100% of suicides died whilst they had a diagnosable psychiatric disease. It is no wonder that Edwin Sheidman, a world authority on suicide, said: 'Suicide is not the thing to contemplate whilst one is feeling suicidal'. I am not being flippant in that regard. I am saying simply that this whole concept of rational suicide is illogical on the evidence.

The third fact is that many doctors are not trained in psychiatry or in the principles of palliative care. They simply do not have the skills to recognise clinical depression, much less to treat it. In one study, 75% of those who suicided saw a doctor in the month before they suicided. Not one of the doctors diagnosed depression. Take the 7 doctors who are now notorious in Victoria. Not one of them is a specialist. Not one of them was aware of their own limitations, but all of them took it upon themselves to kill or help to kill their patients.

The member for Fannie Bay is right: this is not a political issue, but a human rights issue. It is a human rights issue for those persons whom I described - the most vulnerable in our society. He is right that this issue must not be determined on religious grounds and he is right that we should put aside all irrationality and be honestly critical in our debate on this bill. As legislators, that is our solemn responsibility, and that is essentially my case against the bill. It is not religious. I have not been harangued. As I have been asked to do, I have been clear, logical and dispassionate.

I have been a politician for less than 12 months, but a soldier for 25 years, and it is a soldier's experience that I bring to this debate, not religious experience. Why is it that a doctor who is trained to care and a soldier who is trained to kill feel so strongly that this legislation would make bad law? The reason is that 2 of those who can exercise lethal power feel the danger in this legislation. The member for Nelson says that we kill horses if they are ill and therefore why not humans. I will tell her why. It is because we are so capable of it. That is why. Nothing is simpler for a soldier than to kill a person screaming in agony and asking to be put out of their misery - that is, the delivery of the coup de guerre - especially if that person is your enemy. In the officer training school, I can recall one exercise vividly. You walk in about 5 km, lay an ambush and spring the ambush at midnight. You have about 12 soldiers, and 3 badly-wounded enemy who are in agony. What do you do with them? If you carry them out with you, there is a great possibility of your being threatened by forces moving in and your own security compromised. What do you do with those 3 wounded enemy? You carry them out because that is the military ethos. It is a duty of care to the vulnerable, and it is the same duty of care that underpins our whole society.

It takes a great deal of training to be confident that a person can be relied upon to pull a trigger to kill another person. It takes more training to ease off the trigger when all your emotions are telling you to squeeze. The difference is to be human, and come out of those situations and live with oneself in a society that embraces the common values of care for the weak and the vulnerable - a society that a soldier is prepared to die to protect. The duty of a soldier is no different from the pledge of doctors, such as the member for Greatorex, when he joins me to reject this bill. There is a duty of care in the military ethos and it is enshrined also in the Hippocratic oath of doctors.

The member for Fannie Bay says that, if he helps one Territorian to die with dignity, he will have

accomplished something. I say that if, by the passage of this bill, this Assembly causes the death of one person that could have been avoided, I am guilty. I am diminished. We are the lesser for it. It has been the member for Fannie Bay's duty to provide proof to this Assembly that we should allow this new category of killing. He has yet to demonstrate that proof for me to support him on behalf of my electorate. The member for Fannie Bay quotes John Stuart Mill's *On Liberty* as the foundation of his argument. He quotes Mill as follows:

'The sole end for which mankind are warranted individually or collectively in interfering with the liberty of action of any of their number is self-protection. The only purpose for which power can rightfully be exercised over any member of a civilised community against his will is to prevent harm to others'.

But, Mill went on to say:

'His own good, either physical or moral, is not a sufficient warrant'.

The member for Fannie Bay despairs of our present situation in caring for the dying, and calls for compassion. This is a despair born of ignorance - a despair that asks this Assembly to kill the pain by killing the patient, a despair that asks us to take the last step first and to issue a warrant to kill to a new class of doctors. I say that any doctor whose morality is defined by law is a worry to himself, and might also be a worry to society. Territorians are being led to believe that we are on the crest of a wave of some ground-breaking legislation and that we are at the forefront of change. But, on the evidence, the time for euthanasia has come and gone throughout the world. Opinion polls in the Netherlands - the poll to which the member for Nightcliff referred was organised by the same company that did the *Death by Request* video - showed a fall in support for euthanasia from 81% to 71% on my information. The Oregon legislation is still held up in the United States' Ninth District Court of Appeal and the flood of legislation that was supposed to follow the Oregon decision has not eventuated in the United States. Rather than riding the crest of a wave, Territorians will be left stranded on the beach. The rest of the world has concluded that legalising euthanasia is too dangerous. The member for Fannie Bay has provided neither the proof that this law is necessary nor proof that it would be good law. In this context, whether individually we agree or disagree with the concept of euthanasia, this legislation should not pass.

Mrs PADGHAM-PURICH (Nelson): Mr Speaker, it gives me considerable pleasure to rise and speak in support of this legislation that was introduced by the member for Fannie Bay. I like to think that I speak for many ordinary people. I do not have much rhetoric myself. Like many others in this Chamber, I am not a facile speaker. My views are as they are expressed to me and as I express them myself. I believe also, together with many others who support this legislation, that I speak for many sick people and many dying people who know that they will die in pain. Unless they can do something about the pain, they know that they will suffer a very bad death. They would like to do something about it but, at the moment, their calls for help go unheeded.

I will not give any quotations and I will not indulge in euphemistic speech. I will not quote any overseas figures, as did the 3 members who have spoken. No doubt, other members who speak after me will use the same figures. I am not too worried by those honourable members here and elsewhere who say that I do not know what I am talking about and that the survey I circulated among my constituents and others was not true and correct because its results did not reflect their views. My shoulders are pretty broad. They have had to grow broad over the years. Others have tried to denigrate me, to belittle me and to laugh at my ideas over the years, but I will say this now: when they are my age, if those same people are doing what I am doing, with my level of experience, they will be doing pretty well.

Having said that, I want to raise briefly some points that have been put to me by my constituents and others who are vitally concerned that this legislation should be successful. I do not believe the member for Nhulunbuy intended what he said to be a deep insult, but he did intend to cast aspersions on my electorate by what he said. I do not mind people insulting me. I can give as good as I get. However, I believe it ill behoves the standing of an MLA to cast aspersions on people in other members' electorates. Several years ago, a certain member of the Country Liberal Party tried to do the same thing in relation to the houses that my constituents lived in. It did him no credit and it certainly enhanced my position in my electorate. I can take insults, but I do not believe it is the done thing for an MLA to try to insult other members' constituents. It does not sit well with them.

The fact that insults have been directed at me and my views and the views of those people who indicated, in the survey that I circulated, their support for the member for Fannie Bay's legislation, does not alter the fact that those views are honestly held and were expressed with sincerity by the people concerned. Insulting somebody does not change the nature of the truth. It simply belittles the person who is directing insults at others. You do not have to be learned or clever or anything out of the ordinary to hold particular views about how you want to end your life, how you want to live your life and what you want to do with your life. It is your own business entirely.

The member for Nhulunbuy said that humans are different from animals. Of course they are, and we all know that. However, he said that humans are 'interconnected', implying that we have a strong connection between each other. It is clear that he does not know much about animals because they are 'interconnected' in their own species as well, but never mind. When he said that humans are interconnected, to my mind he was implying that we cannot make a decision on our own, about our own life, without considering others. That may be true up to a point but, if you want to make a final decision about whether you will continue living in pain or whether you will take advantage of voluntary euthanasia if this legislation is passed, I believe, as do 89% of my constituents, that this should be a decision that is up to you and you alone.

I circulated my survey in my electorate immediately this legislation was proposed by the member for Fannie Bay. Unlike the member for Nightcliff, at appropriate times, I can make up my mind quickly and I can describe my views succinctly. To continue waffling about something implies a certain form of weakness. Either you cannot make up your mind or you do not want to tell anyone in case they will say something nasty about you. I can make up my mind. I may not be right all the time, but at least people know where they stand with me. Most of the views that I express are black or white. There are very few grey areas in my life because I can make my own decisions.

I would like to think that my constituents can make up their minds also. They are ordinary people and I am an ordinary MLA representing their views. If 89% of those people have a particular stance on a particular subject, I believe that view must be respected. We have heard a great deal about the conscience vote. The member for Fannie Bay said that this would be a conscience vote. It is a funny thing, but a conscience vote means standing on your own 2 feet and thinking on your own 2 feet.

Mr Perron: Some do not have a conscience, Noel.

Mr Bell: Every vote is a conscience vote for you, isn't it, Noel?

Mrs PADGHAM-PURICH: Hang on, don't take the words out of my mouth!

It is very funny from where I stand to see these party people running around literally like chooks with their heads cut off. Mr Speaker, if you have ever had to do a little anatomical dismemberment in the chook yard, you will know exactly what I mean. The party members have to make up their own minds about something and they do not know what to do. The toing-and-froing has been amusing to watch, and only I have seen it. The people from both parties have been aligning themselves with one, then with the another and then with somebody else. They have to stand on their own 2 feet and think for themselves. That is the problem with parties. Their members vote en bloc, whether it is the Country Liberal Party or the Australian Labor Party. Their constituents always come second; the party always comes first.

However, as the honourable member for MacDonnell says, every vote is a conscience vote for me. If I do not have any strong views one way or another ...

Mr Bell: We should give you a job as a speechwriter, Noel.

Mrs PADGHAM-PURICH: Do you reckon I would earn my keep that way?

If I do not have any strong views one way or another in relation to a certain legislative matter that comes before the House, and if it is a matter about which constituents have not expressed views one way or another, there are occasions - and there was one yesterday - when I abstain from voting. Some MLAs have very strong personal views, usually personal religious views, which I respect because they are entitled to their views as I am to mine. However, I do not believe that the conscience vote of a particular person should be put before the conscience vote of the people in the electorate. Basically, when we are elected as MLAs, we are elected to do a job and we are paid very well to do that job. We are paid from the public purse to which the taxpayers contribute, and those taxpayers are my constituents. My constituents pay my salary. Consequently, I have a duty to represent their views.

I have it easy in this debate because it happens that my views coincide with those of 89% of my constituents. I have said this before, and I will use the word again. Mr Speaker, because you represent a rural area, you know what I mean, and my constituents certainly know what I mean. I do not bullshit about. If the numbers had been reversed, and 89% of the people in my electorate were against the legislation, then I would have been compelled to vote against the legislation. It would not have reflected my personal view, but it would have been the view of the vast majority of the people in the electorate.

Somebody used what I believe is a false argument when the committee's report on voluntary euthanasia was presented to the Assembly. They said that, if you surveyed the community as to whether they are in favour of pornographic videos becoming available, you would obtain the same result and that, simply because the majority of people in the electorate want pornographic videos, that does not mean that legislation should be passed to make pornographic videos legal. I find that a pretty specious argument because I place a great deal more reliance on the truth, honesty and the good living of people in the community. Of course the majority would not vote to make pornographic videos legal. That is not to say that I have strong views one way or another in relation to pornographic videos. I have used that example only because it was used in a previous debate.

I circulated my survey not only in my own electorate, but also in the electorates of other members. In fact, when I had made my own views known publicly, different people in those electorates rang me and I was asked repeatedly whether they could have copies of this survey. The figures there were very similar - 89% of the people were for it and 11% were against it. There was no compulsion on people to write one way or another. I like to think that people have enough strength of character to express their own views.

Nobody knows who they are, and the shop people were not looking over their shoulders. People did register 'no' votes. If they registered a 'no' vote nobody castigated them or pointed a finger at them. To say that people would not vote 'no' when they saw all the 'yes' votes, because they would feel that they were being singled out and people would look at them, is a load of nonsense.

Although I did circulate the survey in my electorate, I would like to think that my constituents were pro-active rather than reactive. They came and wrote down their views; I did not knock on their doors and ask for their views. They were pro-active, and they expressed their views. It was very interesting because the views expressed in support of this legislation came from people across all spectrums of interest. They included old people, young people, middle-aged people, blue collar workers and white collar workers, if I can use that distinction, educated people and people with limited education. However, they all knew how to express themselves and all of them said that nobody had the right to tell them what to do with their lives.

I remember a similar debate in the Legislative Assembly a number of years ago. We were discussing abortion legislation, and clerics and some doctors were saying that women could not do what they wished with their own bodies. In that case, I believe it is a woman's right to do what she wants with her own body and to decide whether or not she will have an abortion. Neither of these matters should be taken lightly. They must be given a great deal of consideration. I am not saying whether, if circumstances had arisen, I would have had an abortion when I was carrying one of my 6 children. I am not saying that I will necessarily avail myself of voluntary euthanasia if I am in extreme pain near the end of my life. However, I am saying that I would like to think that that option would be available to me. I would like to think that we are not so hard-hearted and unthinking that we do not give other people that choice if they want it. We are not saying all people over a certain age will be knocked off the twig, that they will be put down, which some of the letters I received from southern states implied.

Mr Speaker, you should have read some of those letters. They were pretty scary, I can tell you. From the tenor of the letters, they were written by very frightened old people who obviously had been told - I do not know by whom - that, if they were to cross the border into the Northern Territory, they would need to look out because the authorities would put them down. In all of these letters, the word 'voluntary' was absent. All these poor old people were thinking they would be knocked off as soon as they came over the border. It was scare tactics in its worst form and the people who initiated that have nothing to be proud of.

I engaged recently in a debate with 5 other people on this subject. I was on the side that supported the legislation, as I continue to be. I had intended to repeat some of the remarks that I made at the time because I believe they are relevant. I am aware that some people consider that I am a hard-hearted old bitch when I express my conservative right-wing views on certain welfare issues. However, when compared with the people who want to keep alive unfortunate people who are dying in great pain, I have more kindness in my little finger than they will ever know about. If those people wish to end their lives because they are in great pain, how can anyone stand by and tell them to live with it, to put up with it, because that is their fate? How could anyone say that? You simply cannot.

It is all very well for the opponents of this bill to talk about palliative care. That is offered as the be-all and end-all, the answer to everything. Palliative care has a different client group. There are some people for whom palliative care will be a great help. However, I believe that, for people who are in unrelenting pain, it will not mean anything other than more morphine. The pillows will be plumped up, the bed tidied

a little more, nice things will be said to them as more people talk to them and try to keep them in a happy state of mind ...

Mr Bell: Oh, come on!

Mrs PADGHAM-PURICH: These are my views and similar views have been put to me by people who know more about the subject than you do.

Palliative care is okay up to a point, but it does not appeal to everybody and it does not appeal to many people who want to end their lives. It may not be my wish to end my life if I am in great pain, but who am I and who is anybody else to refuse the request of people who want to end their lives that way?

The previous president of the AMA admitted that, in 2 instances, he had assisted people. He said it only once and he did not say too much about it after he became a Liberal Party nominee. There are doctors in the Territory who have said publicly that they have given people overdoses of morphine or other pain killers, knowing full well that their bodies could not take it and that the drug would kill them. They excuse such an action by saying that the drug was administered with the aim of relieving pain rather than of ending life. Who are they kidding? They undertook 6 years study and graduated with an MB/BS - they are only bachelors, not doctors - and they do not know that, when they give a certain injection over a period of time and increase the dose, it will kill that person? They say that they do it only to relieve pain and, if the patient dies, that is by the way. They do not kid me, nor do they kid any of the people who can think more clearly than they do.

Mr Perron: It helps them to sleep at night, Noel.

Mrs PADGHAM-PURICH: That is true. I know all the stories about that. With apologies to the member for Greatorex, luckily I do not have much to do with doctors.

A great deal of the antagonism to this legislation has been mounted by clerics and doctors. Not many members will speak about the clerics and their antagonism for this legislation, but I will.

Mr Bell: A good solid atheist like you - that's the way!

Mrs PADGHAM-PURICH: I am not an atheist. I believe in God. She and I often talk to each other.

I know a little about clerics. I know more about them than I know about doctors. Both the clerics and the doctors can see their power base being eroded if this legislation is passed. Until now, they have had the power of life and death. There are people who will say that I am talking through my hat, but I know more about it than many of those people, as you know, Mr Speaker, because you know a little of my background even though we may not think the same way about some matters. They can see their power over life and death eroding. Most of these clerics are men, and that gets my back up. There are not too many women clerics. If there were, perhaps the situation would be very different.

There are some anomalies that I cannot work out. My views are those that have been put to me by constituents and others. The clerics say that voluntary euthanasia is killing, and it is a sin on the consciences of all those who participate - the doctors, the nurses, the pharmacists and others. That is okay but, in times of war, the same clerics quite happily bless and attend to soldiers who are engaged in killing people. I am not against killing, and I am not a pacifist. Don't get me wrong in that regard, I believe that war is necessary. However, the clerics do not say anything about the killing that occurs in time of war. In fact, they endorse it by their presence and their blessing. I am not against capital punishment. I only wish

that it could be brought back in a few cases. However, we do not hear too many clerics speaking out against capital punishment. That also is killing people, but it is accepted by the clerics. The fifth commandment is 'thou shalt not kill' and, to my way of thinking, the clerics speak with forked tongues when they apply that commandment very selectively.

Another anomaly relating to clerics, which I cannot understand, is their view that God will punish people who assist in voluntary euthanasia because, in actual fact, it is killing. Their God is thus portrayed as being full of revenge, retribution and retaliation and completely deaf to the pleas of those who are in extreme pain. It is a funny thing about that God. The God with whom I talk is kind and friendly and, as I said earlier, she and I often have long conversations as I go about my work on my farm. This makes me think that your God is in your mind and how you think your God wants you to behave depends basically on how you are.

These days, we hear a great deal about freedom of choice. Freedom of choice is the catchcry of activists. It is all the go. Ethnic people, feminists, monarchists and republicans have freedom of choice. We hear freedom of choice mentioned everywhere. Why can't we have the freedom to choose to do what we wish to do with our lives, provided it falls within community parameters? If you decide to make the final decision to end your life, you are not hurting anybody but yourself - if it is considered hurting. Many clerics say that we obtain the gift of free will from higher up. We can make our own decisions whichever way we like. It is not logical to state, on the one hand, that we have free will and then, when a person makes a free-will decision to end their life, to state that they cannot do that. That is a contradiction.

Since this legislation was introduced, I have received kilograms of letters at my office. It really hurts me to think of all the trees that have been cut down to produce the paper for these letters. I was saddened by the distress of many people who said they did not believe in euthanasia. They are probably impressionable people and facts had been left out probably when they were told originally about this legislation. In any case, while it is interesting to have these letters, booklets, pamphlets and all the other material from interstate, this decision has to be made by people in the Northern Territory, not by people in Victoria, New South Wales, Western Australia, Holland, Oregon or anywhere else. This legislation concerns people in the Northern Territory.

We have not had a definition of 'voluntary euthanasia'. According to the Macquarie Dictionary, voluntary is 'done, made, brought about, undertaken of one's own accord or by free choice'. Euthanasia is defined as 'painless death'. What is wrong with a person electing to make a free choice to end their life? We go through life making free choices about our lifestyle, according to how we view life. Provided these choices are accepted by the community as doing no harm to others, we go ahead and make them. Why shouldn't we have a choice about whether we live or die?

To say that a sick and dying person who is in great pain should put up with it for the sake of their family is callousness in the extreme. If we go into hospital for a serious medical procedure, we have to sign a consent form giving the doctor our permission to operate on us. This may be for a procedure that offers little hope of recovery or that may be risky. Doctors ask for, and we give, permission for them to proceed with the particular procedure. What is the difference between this type of process and people signing forms giving doctors permission to carry out the final procedure for them by giving an injection to end their lives?

I reiterate that doctors will not do this in a run-of-the-mill fashion. The patient has to be terminally ill with the probability of dying within 12 months. If the patient is in unbearable pain towards the end of

their life, they will have the choice to end their life. The choice is theirs and no one else's. I do not think the people who support this legislation can say that strongly enough - the choice is the person's and no one else's. All we will be doing, when we pass this legislation, is giving people a choice. We will not be killing anybody off. We will be giving people a choice to do what they want with their own lives.

I believe this bears repeating. As a politician, having won the privilege to represent my constituents and at the same time receiving a pretty good salary for doing it, I regard it as my duty to represent the views of those constituents, whether or not they coincide with my own views. Politicians are said to put forward the views of their constituents. This means that they should vote for those views or toss in the job. How many other people, who are paid to do things under a job description, do not do them? Not very many!

I do not know if any member has thought about abstaining from voting on this legislation when it comes to the vote. If, because of their personal views, they cannot vote for this legislation, despite the fact that their constituents support the legislation, I believe that they may have to think again about whether they should continue as politicians. This is not an easy life and, if you can't stand the heat, you stay out of the kitchen. If you are unable to make the hard decisions on occasion, you do not become a politician.

Many ordinary people have expressed their views to me. The majority of them - as I said earlier, 89% of them - are in favour of this legislation. A minority, the 11%, spoke to me with equally fervent opposing views. I respect those views. They are not my views and they are not the views of the majority. The vast majority of people want this legislation. I hope that it is successful for those unfortunate, sick people who are dying in great pain and for whom palliative care is no longer effective. I believe we owe it to those people to give them consideration. We do not have the luxury of considering only our own personal views.

Mr BAILEY (Wanguri): Mr Speaker, I must say that it is not very often that I agree with the member for Nelson. In this case, I agree with her outcomes, although I do not agree with all of her logic.

It is important to put on the record some of the issues involved in the decision-making process, as well as the final outcome. An important point - and it is one that the member for Nelson and others have raised - relates to the nature of a conscience vote and what we should do as politicians. It is my belief that, when you are a politician who belongs to a political party and supports the philosophies of that party, you have made a contract with the political party which supported your election to uphold the basic views of that party. Consequently, you stand by the decisions that are determined within caucus. However, a conscience vote, where the party has no particular view, requires an analysis of the rights and wrongs of an issue in terms of your own conscience. It is the role of the member to listen to the views of their constituents and to take them on board, together with views obtained from elsewhere. However, at the end of the day, a conscience vote has to mirror what your own conscience dictates in respect of the issue. As a politician, I must accept that, if my conscience differs from that of the majority of people in my electorate, I lose my job. That is the way politics works. However, in voting on a matter of conscience, I believe it is more important that that is the basis for one's decision rather than political expediency in terms of one's desire to be re-elected.

The member for Nelson also supports capital punishment. She would like to see it reintroduced. I must say that I cannot accept that. I disagree totally with the concept of capital punishment. I regard it as state-sanctioned murder. Even if 99% of my electorate stated that they wanted capital punishment reintroduced, I could not support it. On a lighter note, I am sure that, if I polled my electorate asking who

would like to pay less in taxes, everyone would say yes. If I asked who wanted more services, everyone would say yes. My understanding is that politicians have a role not only in representing the needs, aspirations and concerns of their electorate, but also to show some leadership. Leadership means at times that you have to move ahead of the debate. You have to provide some direction and, if the circumstances warrant it, stand up for what are not necessarily seen as popular decisions.

In relation to euthanasia, we have been told continually that a large proportion of the electorate supports the concept in principle, and I believe that to be the case. I believe that some very powerful vested interest groups have maintained an opposition to issues such as euthanasia for many years. In a way, by leading on this issue, politicians are not trying to bring a change in values in the community but are trying, in fact, to implement the values that are there already. In deciding what is appropriate for the community, the role of a politician is not only to take into account the wishes of the majority - and some may argue that that is what is happening here - but also to protect the rights of minorities. In history, there have been numerous occasions when governments have used the subjugation of minorities as a means of gaining majority support. In a democracy, it is very important that the rights of minorities are protected at times from the wish of majority to impose restrictive controls on them simply because the majority does not agree with what those minorities do in their own private lives. We have anti-discrimination laws which provide that people have a right to practise any religion even if that religion is accepted by very few in the community. If you are member of a minority racial group, which may not always be popular in the community, you cannot be persecuted for that.

It is important not only to ask what the majority wants, but also to ensure that we, as politicians, are not imposing the will of the majority on minorities. If we oppose euthanasia, we have to be careful that we are not imposing our will on the minority of people to whom euthanasia would apply. It is my belief that very few people would discuss euthanasia even with their doctor or with their family and fewer still would pursue the outcome of euthanasia.

Mr Perron: And fewer still would pursue it to finality.

Mr BAILEY: And fewer still would pursue it to finality. However, it is my belief that people have the right to pursue it.

Let us just look at an issue. The member for Brennan, a man trained in military theory ...

Mr Perron: I think he needs debriefing.

Mr BAILEY: Let us consider a scenario. We are being overrun by foreign invaders. The member for Brennan is at an outpost with his family. He has a gun and is trained to defend himself. He fights for as long as he can to keep the enemy away. From all of the reports that have come in, he knows that the enemy will torture him mercilessly until death. They will also torture his wife and family. He knows that, in the end, the enemy will kill him. Will the member for Brennan, who has been taught defensive rather than offensive techniques, fight to prevent the enemy from reaching him and his family, to torture them? I believe that many people trained in military techniques would fight to the death if they knew that, if they laid down their gun, the enemy would take them prisoner and torture them for days, weeks or months until they finally died.

That is a scenario that I am sure the member for Brennan can understand. As a military man, he would probably say that he would fight until the very end rather than endure the alternative. The invading enemy we are talking about is terminal illness. We know that that terminal illness will reach a stage of

torture and pain. We know that the person will fight as hard as they can when they first know that they have a terminal illness. Some people would rather fight to the end and die fighting than be taken off and tortured for weeks or months, deprived of their dignity and their ability to do anything.

Yesterday, opponents of the bill came to us with a public opinion poll. There have been many polls, but I believe it is important that this particular poll be given no credence whatsoever. The introduction itself stated that the questionnaire was drafted in collaboration with the client. The document was formatted for field use. Several changes were made to the wording and structure of questions and a final questionnaire was approved by the client. In other words, it was a questionnaire designed for those people who object to euthanasia. The sole purpose was to obtain a desired result. As a person who has done some research on questionnaire design, I am sure that anyone who examined it would realise that it was designed to obtain a specific outcome. Nowhere in the questionnaire is there a basic question as to whether or not the respondent supports the principle of euthanasia. The way the questionnaire is framed ...

Dr Lim interjecting

Mr BAILEY: I pick up the interjection from the member for Greatorex who suggests that this questionnaire would stand scientific scrutiny as a valid questionnaire on the issues surrounding euthanasia. It is quite clear that the questionnaire was set out purely to confuse people on the phone by giving them a series of options so that members could state in this Assembly that people really do not know what it is all about. The classic approach was to ask people questions about a highly-publicised proposed amendment providing for a cooling-off period. The question was asked: 'Is it your understanding that there is a clause in the bill relating to a cooling-off period?' Many people answered yes because the media has given such prominence to the proposed amendment. The people who prepared this knew that such a provision is not included in the original bill. In other words, they created a smokescreen about the lack of knowledge of the bill. If they were serious, they would also have asked: 'In principle, do you agree with the concept of euthanasia?' No such question appears. The aim was to achieve a result that indicated confusion in the community.

Questions were asked about a definition relating to the *Natural Death Act*. The people implementing the telephone poll had to decide whether the response indicated the person's understanding of the *Natural Death Act*. To obtain a tick, they had to demonstrate their understanding that the act gives legal effect to directions against the artificial prolongation of the dying process. I am sure most people who were asked about their understanding of the *Natural Death Act* would have fulfilled that criterion easily. Of course, if you undertook a survey in relation to half-a-dozen other pieces of legislation, there is no guarantee that people would know the general intention of those acts. There would probably be more knowledge in the community about the proposed euthanasia legislation at the moment than about any other piece of legislation in the Northern Territory. In any event, any concern about people not understanding what this legislation will provide for can be dealt with easily by delaying the commencement of the act. A commencement date has to be decided on. It is ludicrous to believe that, if the bill is passed tonight, people will be scared to death tomorrow about what will happen. The act need not be commenced until people throughout the Territory have been informed about it. Its commencement could be delayed for 12 months to ensure that people are completely aware of its provisions.

I will pick up on a number of the issues raised by honourable members who are opposed to the legislation. One of the arguments is that we should not be doing this because it has not happened anywhere else. Basically, that means that we should leave everything the way it is.

Mrs Padgham-Purich: Tied to mummy's apron.

Mr Perron: Only copy other people.

Mr BAILEY: Yes. We should wait until someone else has done it. The same type of argument was used when people first suggested that the world was round. People would say that such a suggestion could not be countenanced because all teachings held that, if you went to the edge of the world, you would fall off. People were burned at the stake for suggesting anything different. At one time, the earth was regarded as the centre of the universe. When the scientists suggested that that was not the case, they were accused of heresy. Many of the major changes in society were objected to by those in possession of the religious power at the time because change would mean a diminution of their authority.

In more recent times, there have been struggles related to slavery and the rights of women. Recently, we celebrated 100 years of women's suffrage. I read some of the debates held in the South Australian parliament on the granting of the vote to women. Some members argued that women should have the right to vote, but others rejected it as a ludicrous proposition - because nowhere else in the world were women permitted to vote. It was regarded as against the natural order that women should be treated as equal. Of course, there are still areas where women are not treated as being equal. Those areas are mostly where the opponents of this legislation are to be found. While there are many enlightened people in the churches, who say that women have the same rights as men and should be treated as equal, the dogma demands that the practices of the past be maintained. I have real concerns about that. When it was suggested that people of different races were equal and that slavery was not right, the same type of argument was put forward. The argument was that people were created differently and that some people were superior to others. It was a long struggle before change occurred.

In more recent times, there has been debate on the rights of children, and on domestic violence whereby women are bashed by their husbands. When legislation against domestic violence was first proposed, there was an argument that the wife belonged to the husband as his property and he could do as he liked with her and that courts or parliaments should not make decisions in relation to that. Some people still hold that children have no rights and are the property of their parents and, if a parent abuses their child, that is their decision. Why are the legal system and the parliaments becoming involved in decisions concerning the rights of children? It is only in the last 10 to 20 years that those types of issues have emerged. Generally speaking, there is now a consensus in relation to such issues, but it is relatively recent.

Let us examine other issues that are even closer to the euthanasia debate. I refer to contraception and abortion. Abortion is objected to strongly by many groups in society. It is a debate about the rights of a woman to decide what happens with her body. I must say that I would prefer that abortions never occurred. An ideal society, where there is never an unwanted pregnancy, would be fantastic. The reality is that contraception does not always work and there are unwanted pregnancies. I believe that women have a right to make a choice in that regard. We are all aware of the arguments that have raged both in recent times and 20 to 30 years ago. I believe that most reasonable people believe that it is appropriate that the woman should choose. Very few people disagree with contraception. Nonetheless, there was a very concentrated objection to people's right to choose whether or not they would become pregnant. In the United States, laws against birth control were taken off the books in 1965 and, in Canada, in 1969. Prior to that, it was illegal to use contraceptive devices. That prohibition was largely ignored, nonetheless it was illegal.

Such issues relating to individual rights have been argued over a long period. Certain vested interest groups have argued against the right of individuals to choose. There have been struggles about the rights of individuals, the rights of women, the rights of children, the rights of the disabled, the rights of racial groups etc. The time has come now for consideration to be given to the rights of people who are dying. Such people should have the right to decide whether or not they will die and when. That decision should not be vested within the state. I would be the last person to support any bill that gave such powers to the state. People often confuse the state being given powers and power being given to the individual. I support the principle of individuals deciding in relation to contraception. I do not support the Chinese philosophy of one child per family which is state-imposed contraceptive control. People have said that, if we support euthanasia, we will be like the Nazis because they decided that minority groups such as Jews, gypsies and mentally-retarded people should be euthanased. People argue that, if we do this, we are heading down that same road. Once again, it is a difference between state-imposed decision-making and an individual's right to choose. Anyone who suggests that what is being proposed today is state-imposed euthanasia should read the bill again. The legislation states clearly that it gives power to an individual to do what they want to do. At every step of the way, if they do not want it, they are not required to have it. There is an argument about the effect on Aboriginal people. If they do not want to use it, that is fine. However, if there are individuals who do wish to use it, they should not be denied the ability.

Members who oppose this bill have said, on the one hand, that they oppose the concept of euthanasia totally. Yet, on the other hand, they have said that, if the bill is passed, it should be made as wide as possible to ensure that it covers everybody. I find that a very difficult rationalisation process to follow. They seem to be saying that, if you support euthanasia for people who are competent and terminally ill, you should extend it to people who are incompetent, under 18 etc. However, we are supporting euthanasia for adult people who are competent to make their own decisions. If they reach a point where either the pain or the lack of quality of life is such that, despite medical intervention, they no longer wish to live, they should be able to decide that their life should be ended. If we widen the legislation to provide that other people can make those decisions, it is no longer an individual choice. That is a significant difference. If the person is under 18, is mentally-retarded or is unable to assess the situation, that person is not in a position to make that choice.

There is a suggestion that the legislation is moving into a dangerous area. We have already the *Natural Death Act* which allows a person or their family to make a choice for euthanasia if the person is being kept alive by machine. We have heard that, if a person is in considerable pain and a pain killer is used to kill them, that is all right. If that has been discussed with the patient or with the family, knowing that that is the outcome of proceeding down that road, in many ways that is a euthanasia choice.

The member for Brennan suggested that the time is past when euthanasia has relevance.. He said that we had reached the stage now where palliative care was so good that we really did not need euthanasia. It is an interesting argument because everyone to whom I have spoken who says we have reached the stage where the pain-killing drugs are so good that there is no longer any requirement for euthanasia, when asked whether they would have supported euthanasia 20 years ago, answer in the negative. There appears to be some hypocrisy there. Medical skills will progress as we move past the year 2000. There will be drugs that can remove the pain without killing the patient. There will be drugs that will have the ability to arrest some of the cancers. The patient may not be able to move and be able barely to communicate - the cancer may be in the spine - but their heart and lungs may be okay and the drugs will keep them alive for years. They will not be in pain, but simply lie there in a state of suspended animation.

I recall the story where a man made a deal with the devil that he would live forever. The catch was that the devil forgot to tell him that he would grow older and older but would never actually die. That was portrayed as one of the worst curses imaginable. In fact, that is what we are discussing. We want people to grow older and older and, as the medicines improve, we will be able to keep them alive for much longer. However, we will not allow them the choice as to whether that is a life that they wish to continue living.

From the Dutch situation, it is my understanding that most people who have chosen voluntary euthanasia have not been the very elderly, people in nursing homes etc, but younger people who were diagnosed with a terminal illness while they were still healthy. In other words, they had not started to go down the long road into debilitation and decay. Although some people seem to suggest that it is the old and infirm who will be affected most by this, in reality it has been those who had been leading active lives. They recognised that they had a disease that was rapidly debilitating. When their suffering or quality of life reached a stage at which they did not believe it appropriate any longer to continue, they believed they should have the right to take control of their life at the end. They wanted to be able to say to their friends and family that that was the decision that they had taken.

On those grounds, I believe it is important that we support this bill. We should amend it to make it the best legislation possible. We should monitor it in the future to ensure that there are no problems or loopholes. We should delay the implementation of the legislation, firstly, until we are convinced that the community is fully aware of its implications and the fears in the community, which have been aroused by the many opponents of the legislation, have been dealt with adequately and, secondly, until adequate palliative care is put in place in order that euthanasia is one option among many options. Nevertheless, it must be there as an option.

Mr REED (Katherine): Mr Speaker, I wish to divide my contribution to the debate today into 2 sections. I wish to make some remarks in relation to palliative care in the Northern Territory in response to some comments that have been made in the media and by some members of this Assembly. I wish also to make some remarks as the member for Katherine.

First, I will comment on the state of palliative care services in the Territory and the scope for expansion of those services. I have chosen to deliver this statement at this time, following some criticism about the level of this government's palliative care services. It should be recognised that the issues of euthanasia and palliative care are not interchangeable. Palliative care is an important issue that needs to be considered in its own right. Palliative care is the active total care of people - and their families - who are living with a terminal illness and whose disease is not responsive to curative treatment. This style of care is achieved by coordinated medical, nursing and allied services. Palliative care strives for the best quality of life by affirming life and regarding death as a natural process, neither hastening nor postponing death, providing relief from distressing symptoms, integrating physical, psychological, spiritual, cultural and social aspects of care, providing a support system that allows the terminally ill to live as actively as possible until death, and supporting the family and carers to cope before, during and after death.

Palliative care is a medical speciality developed from the hospice movement which commenced late in the 1960s in the United Kingdom. Hospices were established as a result of the inability of the British National Health Service to care adequately for dying people in acute care settings. Historically, the establishment of a hospice has required a large population base to ensure appropriate use of beds. As a result of this imperative, 2 other types of palliative care services have been developed. These approaches

include hospital support teams to advise medical and nursing staff on terminal care and the development of home care teams to ensure that general practitioners and community nurses have the skills to enable people to die at home where most people prefer to die if support is available. With the Northern Territory's relatively small population base, this latter palliative care option has been the approach taken by this government to date. Palliative care clients and their families have a range of needs which tend to involve many people in providing support and care. These include expert medical care for the relief of symptoms such as pain, 24-hour nursing care by the family or service provider in the final stages of life, appropriate spiritual, social and psychological support in the context of a person's culture, some specialist equipment such as syringe pumps, and respite care, be it home or residential.

In the Northern Territory, most of the services available to meet the needs of palliative care clients and their families are provided by existing mainstream services. Outside the family, hospital and community-based health staff in partnership with general practitioners are the principal providers of care to those who are terminally ill. These services are supplemented by home support services provided by non-government organisations, such as the Red Cross, which are funded through service agreements with my Department of Health and Community Services. Services provided by non-government agencies include home help such as assistance with cleaning and shopping, personal care such as assistance with bathing and dressing, counselling and chaplaincy services, and respite care. These service arrangements are different from those provided in the states in that the majority of home nursing services are provided by the Northern Territory government through the Department of Health and Community Services rather than by private and non-government organisations. I would like, however, to place on record my gratitude for the fine work done by a range of community groups such as the Anti-Cancer Foundation, Red Cross, the Sunshine Foundation, the AIDS Council, church groups, the Carers Association and the Ministers Fraternal.

It is estimated that, in 1994, approximately 180 terminally-ill persons were provided with assistance through the department. In addition to mainstream services, some specialist advice on palliative care has been available for general practitioners and community nurses since 1990 when a registered nurse commenced the service in Darwin. This position was supplemented by the appointment of a second nurse in 1994 and, in March this year, a part-time specialist palliative medical officer was appointed to oversight services provided by my department. These staff form the nucleus of a specialist palliative care resource team which is supplemented by the services of a psychologist, a social worker and a pastoral care worker. While other members of the team provide care for Darwin-based patients, the recently-appointed, part-time medical officer has a Territory-wide support and education role.

While we can be proud of the dedication and quality of service provided by existing nursing and home care staff to palliative care clients and their families, more needs to be done before we can claim that we provide a quality service that is accessible to all Territorians. In this context, there are a number of issues and gaps that need to be addressed. My department is currently identifying these issues to enable them to be reviewed by Cabinet. The lack of a coordinated approach to palliative care in the Northern Territory, with the exception of Darwin, is a key issue that has resulted in varying standards of care being provided to clients in other centres. There is a need also to ensure that specialist support for mainstream service providers is available throughout the Territory. This expert medical advice is needed in both the community care and hospital settings. This expertise includes good pain control and management of other symptoms. General practitioners and health workers who do not specialise in palliative care may deal with only 1 or 2 of these clients in the course of the year, and would benefit greatly from specialised advice and support in handling such situations. The options which will be investigated include: protocols

to ensure that palliative care clients are fast-tracked through the mainstream service access points such as the accident and emergency unit at Royal Darwin Hospital; the limited number of palliative care beds for symptom control, respite, or for patients who choose to die away from home; hospice facilities; limited home-based respite; limited after-hours support; improved staff training; and limitations in the provision of equipment. These issues will be considered by Cabinet in the near future. I emphasise, however, that the proposals are intended to enhance and complement the existing good services. It is not a situation, as some would have it, where there is an absence or total lack of palliative care services.

In this context, members would be aware also that the parliamentary committee that reported on this bill made some recommendations in relation to the number of general practitioners who may be having difficulty in obtaining adequate supplies of appropriate drugs for palliative care. This is a matter that I have asked officers in my department to investigate.

Meeting the challenge of improved services for the terminally ill and their families requires a strategic approach to the development of services that acknowledges the unique features of the Northern Territory. In our environment, the existing community-based service infrastructure of general practitioners, community health centres and non-government organisations will continue to be the cornerstone of palliative care service provision in the future. The government's role is to ensure that the best possible care is provided to enable terminally ill people to stay at home for as long as they wish or are able. Our experience indicates that, with appropriate care and support services, most terminally ill people wish to die at home. Any future strategy for the development of palliative care services in the Territory could be based on 3 principles: firstly, the right of clients to choose whether they die at home or in an appropriate place of their choice; secondly, that services should support existing caring networks; and, thirdly, that services should be innovative and flexible to meet the unique needs of the small, dispersed client numbers occurring in the Northern Territory. The Chief Minister has made a commitment to address the issue of palliative care services offered by this government as a matter of priority. Accordingly, my department is preparing a paper detailing palliative care needs in the Territory. The Assembly will be informed of the government's intention to improve palliative care services once these matters have been considered by Cabinet.

I wish now to make my contribution to debate on the bill as the member for Katherine. Unlike many other members, I have not declared my position in relation to this matter. As a result, I have been branded a Catholic, not that there is anything wrong with being a Catholic. I have been branded as being supportive of the legislation. Several other matters have been alleged, either in relation to my support for or opposition to the legislation, and most of them have been incorrect. That underscores the reason why I have not said anything. It has been my experience in this debate that anyone who has said anything publicly has been misconstrued in one way or another. Thus, I have kept my own counsel, if you like, until today.

I have approached this issue as being a Territory issue. It is a bill introduced by the member for Fannie Bay which will affect Territorians. In that regard, I have not taken great account of those people from interstate who have been lobbying me directly or trying to influence me to influence Territorians. I must confess also that I have not taken into account documents prepared for the House of Lords, the government in the Netherlands or any other overseas body. I guess it could be said that I have taken a fairly simple approach to this matter. Principally, I have confined my considerations to Territorians and, in particular, to people in my electorate.

I believe the debate has been very useful. I recall that, some 12 to 18 months ago, the then federal Minister for Community Services and Health, Senator Graham Richardson, commented on euthanasia. He implied that the matter should receive some public debate across the nation. Nationally, it has not attracted debate to the extent that has occurred in the Northern Territory. However, that situation may well change now, given that legislation on the subject is before a couple of the state parliaments. The member for Fannie Bay's introduction of this legislation has generated an incredible level of interest, as we can all attest. Indeed, it has played a very useful role in having what was virtually an unmentionable matter considered and discussed by the broader public although, in many circumstances, with a great deal of discomfort. It is said that some 80% of Territorians support the legislation. Personally, I support it, or at least its intention, because I believe simply that it is a matter which the individual should decide. In saying that I have not considered the papers written for the House of Lords and other august bodies, I do not wish to imply that I have ignored information that has been available to me. However, it would be fair to say that I have applied a fairly simple test to this legislation. It could be fairly said that I have applied a reverse onus.

The estimated percentage of people opposed to the bill ranges from 50% to 10%. Even if only 1% of the people were opposed to it, I do not believe they should be ignored. The reason that I am of that view is that I have spoken with many people. Most of them would be in the older age bracket. They are probably the most senior citizens in the Northern Territory and they are gravely concerned about this legislation and the implications that would follow if it were enacted. They are gravely concerned for all kinds of reasons. Some of those reasons are religious, some are personal and some could fairly be said to be perceptions. Whatever the reasons people have for their personal opposition to the legislation, I think their views are quite legitimate. I do not believe those views can be ignored. I am afraid that I have spoken with too many people who believe that they would feel alienated and certainly apprehensive if this legislation were to be enacted to believe that. They would be concerned about the confidence that they could have in our medical system when accessing our hospital services. Irrespective of whether their views have a religious or personal basis, they are held legitimately and I do not believe that we can impose on any percentage of the population, be it 1%, 10%, 20% or 50%, the feeling that they have been disenfranchised.

While I have great sympathy for the people who would seek to use the powers in this legislation if they found themselves in the unfortunate circumstances that would cause them to seek to avail themselves of such an option, I do not believe we can disregard the concerns of those people who would feel alienated. Individuals have a right to choose. Personally, I would like the right to choose if I found myself in circumstances where I might consider euthanasia as an option. However, I am not prepared to foist that view on those people who would be offended by it, who would feel disenfranchised by it or who would lose confidence in accessing the medical system. It is not possible to assess the level of division in the community that could be created by this legislation if it were enacted. That would become apparent only if the legislation were approved. I do not think we appreciate fully the division in the community on the issue at the moment because we are simply discussing what might happen. If it were to happen, I think we would find that, each time another piece of the mechanism came into play to implement the legislation, there would be more apprehension, more division and greater concern in the minds of too many Territorians in relation to their confidence in the services provided by our health system and our hospitals.

Accordingly, the Assembly will understand that I do not support the legislation. It would be easy to argue that the majority of constituents in my electorate of Katherine support the legislation and ask what I

should do as a politician. Obviously, one would consider at one level that the truth is the numbers and that one's future might well lie in the numbers. However, from a personal point of view, I have to look a little deeper than that, and I do not have the faith in the legislation that others may have. I believe that, in future years, we may achieve that faith and we may be able to find a way to satisfy those people whom I believe currently would feel disenfranchised by the enactment of this legislation.

In closing, I commend the enormous amount of work that has been done by the member for Fannie Bay on this legislation. I commend him also for the fact that he has brought the subject to the attention of the public and generated the current level of debate. His bill has certainly created a much higher level of awareness in the broader community about the subject of euthanasia. However, I do not believe that level of awareness is such that people are necessarily fully familiar with the scope of the legislation and what its impact might be on the community if it were introduced. Thus, whilst I believe that it has played an important role, nevertheless, for the reasons I have outlined in relation to the minority view and what I referred to previously as a reverse onus of proof, I am unable to support the legislation.

Mrs BRAHAM (Braitling): Mr Speaker, may I comment first of all on the way this debate is being conducted at the moment. It could be described as being conducted in a most sedate manner, given that this is such an emotive issue. I do not know whether that situation will change as the night proceeds, but I compliment members on their being able to put forward their cases in such an objective and calm manner.

I rise to speak in support of the bill. I realise fully that it is a very controversial bill and perhaps my stand will also be seen as controversial. However, I advised my electorate fairly early in the debate of my personal view in favour of the bill and I asked for feedback from my constituents. The majority of the feedback that I received was in support of the bill. Nevertheless, the response was fairly small and I am not saying that the views of these few provide a clear and concrete indication of the views of the total electorate. Therefore, I will take the stand that I will vote as my conscience tells me, and that is not to change my original stance but to vote in support of the bill. If I disappoint any section of my electorate, and some members have raised the matter of whether they should vote as their electorate tells them or otherwise, that cannot be helped. Let me assure my constituents, however, that I have not reached this point without extensive thought and discussion.

Let me explain from the outset exactly where I stand in relation to this bill. Although I have stated that I support the principle of euthanasia, I cannot support the bill in its present form. As many members have said, it needs to be amended to include further safeguards and to clarify the terminology and procedures. Therefore, I will vote for the bill to proceed to the committee stage for amendment which hopefully will reassure myself and the electorate that it does not simply address the wishes of the majority but also the concerns that other people may have. If the necessary amendments are not passed and we are left with a mish-mash, I will need to rethink my position. That may give the impression that I am sitting on the fence, but it is simply a matter of commonsense. This is an extremely important bill and it is important that it becomes good legislation without loopholes or grey areas. It is unfortunate perhaps that that was not the case with the original bill.

There are many different reasons for the decisions that members have made in relation to this bill. Some decisions have been taken on personal, moral or religious grounds and others have simply been politically motivated. I guess that, in each decision, there is a little of each motivation. Part of the reason for my decision is personal. Both my mother and father died of cancer. Without going into the details, let

me say that I want my own death to be swift and without loss of me - that is, I do not want to become the diminished remains of someone who used to be me. Most of all, for my family, I do not want to prolong the emotional anguish that accompanies bad deaths. To base one's decision on a personal experience may seem selfish, but that is obviously not the only reason for my decision. People have presented various scenarios to me, ranging from the absurdly hypothetical to real life experiences. Obviously, these have coloured their thinking, but what it reinforced in my mind was that each case is quite individual and unique, and that is the crux of this debate. This bill is about people having the right to decide for themselves as individuals because each person is an individual and is unique. The rights of the individual recognised in the society of 1995 encourage all people to make choices about their lives and there is an expectation that we can have this final choice. In his recent book, *Bioethics in a Liberal Democratic Society*, published in 1993, Max Charlesworth stated that, in a liberal democratic society, he could think of no good argument against individuals who consistently requested active help in ending their lives. He could find no good argument not to allow them that right. As an individual, I have no good argument against that position.

I was fortunate to be a member of the Select Committee on Euthanasia. I say 'fortunate' because the experience broadened my understanding of the bill and of people's points of view from both sides of the argument. Perhaps it is a little unfortunate that the member for Nightcliff did not take a little more interest in what the committee provided. He expressed his belief that the committee should have made a recommendation to the parliament. That was not in our terms of reference. If it had been, the committee would not have delivered the balanced report that was tabled in this Assembly. If it had been, the report would have included dissenting reports. I believe all members recognise that the final draft is a very good report. That indicates that the members of the committee were able to analyse the arguments for and against and collate them. The committee did more than simply listen to people. We spent hours reading submissions, academic papers and analyses of reports from other jurisdictions. We spent a great deal of time debating and arguing. A great deal of work was done. In that way, I believe the committee did its job.

During my time on the committee, I heard nothing that made me change my stance. I am very aware that this bill requires amendment to provide safeguards and to reassure the electorate that the intention of the legislation is to benefit the few who wish to access its provisions, and to ensure that abuse cannot occur. I will support the proposed amendment to strengthen the bill to allow the initial request to stand even though the patient may have become incompetent at the time of death. There have been a number of cases where the patient has become incompetent and would be unable to make the request at the point of death. The provision should be inserted, even though it will extend the scope of the bill and certainly people will regard it as a 'slippery slope'. However, advice from the Northern Territory Department of Law to the committee is that the amendment is necessary in order to protect doctors and not place on them the onus of taking the ultimate decision as to whether a patient's intention is still valid at the point of death. As it stands, the bill is not clear in this regard. Guy Riley, a lawyer from Philip and Mitaros, who was nominated by the Law Society as a specialist adviser to the select committee, stated:

Clause 6(m) in its present form will create problems for medical practitioners. Some will interpret this as meaning that, so long as patients do not give any indication that they have changed their minds, then it is okay to continue to assist them to die. The more cautious, though, of the medical practitioners may find that this clause prevents them from assisting patients who are no longer competent to know what they want to do.

This opinion is supported by Stephen Herne, Director of the Policy Division in the Department of Law.

When asked if clause 6(m) requires a patient to be competent, his answer was: 'No. The clause focuses on whether there is a positive indication that the patient has changed his or her mind'. This amendment will open the legislation to many who voiced their concern that the bill did not cater for those who suffer from a debilitating disease which will result eventually in their becoming incompetent.

In my speech in the debate on the tabling of the report, I mentioned that the majority of submissions in favour of the bill were from women. I equated this with the role of women as carers in our society. My support for the bill should come then as no surprise. That I am a Catholic and still support the bill may be difficult for some people to accept. However, I believe I have a personal right of choice on certain matters and see that right as an indication of modern, free thought as opposed to the past practice of imposition of traditional beliefs by the church. May I add that I am not alone in disagreeing with church doctrine, not only on this matter but on many others. Many Catholics exercise freedom of choice on issues such as contraception. Despite the fact that the Pope tells us not to use contraception, I cannot really believe that all Catholic women are actually practising the rhythm method. I believe we have the right, even as good Christians or good Catholics, to freedom of choice on certain matters.

To any member who may have a strong objection to the bill on religious grounds, let me say that I trust you will respect my point of view in exactly the same way that I am willing to accept and respect your point of view. The passage of this legislation will give me a choice but, if you do not want to exercise such choice, then that is your decision and in no way would I try to change your mind. We all have different belief systems and different sets of moral values. It is not appropriate to impose our own set of beliefs on every member of our society. This legislation is not an imposition; it is about rights.

We all are all aware of the dilemma in debating this topic. It is fraught with euphemisms that are emotive and extremely sensitive. Phrases such as 'the right to die', 'dying with dignity' and 'mercy killing' conjure up images that make us feel uneasy. The member for Brennan mentioned the way we use euphemisms. I was surprised to hear him go on to say something to the effect that supporters of the legislation wish to legalise a new method of killing. He said that this bill would apply to people who were lonely. I have never heard that said in the context of this bill. He is right about the way we use language. Our use of language sometimes clouds the issue. Perhaps we attempt to do too much with language. I believe that is what he did when he used the word 'lonely'. He went too far. Such usage of language clouds the debate and makes it very emotive.

Many of us base our decisions on personal knowledge. In hindsight, most of our decisions would have been different perhaps if we had been given a wider choice and better information. Although people are not generally aware of it, the *Natural Death Act* provides a degree of choice and some input by the person into the treatment of their illness. However, quite often, it is not the best choice or even a good choice because withholding or withdrawing measures will not assist with relieving pain. In his book, *The Challenge of Euthanasia*, Dr Brian Pollard, an opponent of euthanasia, stated:

There can be no doubt that this illness [AIDS] produces suffering, and physical and emotional degradation which is equal to that caused by the other worst kinds of diseases, and that there are frequently also other burdensome personal and social factors, possibly unique to some illnesses. Thus, the emotional components of the desire for euthanasia are obvious and weighty. How should the community respond? While the medical care currently available can relieve personal distress to a large extent, it cannot reverse the advance of the illness nor abolish many of the physical distresses even when it can mitigate them.

Dr Pollard went on: 'Legally, justice cannot be arbitrarily designed or dispensed. The law must apply to all equally, without exception ...' He left that fine argument by saying: '... so there could be no entity of euthanasia legalised only for AIDS patients'. I find it a little strange that someone can see the case for euthanasia so clearly, but is not prepared to support a bill that simply will provide people with a choice. That is why I am surprised when members stand in this Assembly and I hear them say that they support the principle of euthanasia, but are not prepared to support this bill. I wonder where they are coming from. Why do people constantly lose sight of the needs of the individual in order to promote their own point of view?

There is ample evidence that palliative care or pain control is insufficient in some cases. The member for Katherine spoke about palliative care in the Territory and how it is hoped that that matter will be addressed in the future. Nevertheless, there are some cases where palliative care is of little use. These cases may be few, but the suffering is very real for those involved. At present, they are denied the right to end their suffering in a peaceful way. None of us wishes a bad death for our loved ones. Death to me should be serene and not feared but, if it can occur only after a great deal of pain, it can only be called a bad death. Much has been made of palliative care, almost as if it is the solution in all cases of pain and suffering. No matter what quality of palliative care is available, it is unreasonable and unfair to expect to control all factors in all illnesses. There will always be cases that are beyond the sphere of palliative care and for which there are no solutions. We would be foolish if we were to believe that the introduction of further services in the Northern Territory will eliminate the desire to end pain and suffering. Although I strongly support and advocate the need for more assistance in terms of palliative care, it will not be the answer for all. We would be deluding ourselves if we felt we had solved this problem simply by increasing palliative care services. Dr Rodney Syme, a specialist in urology, states:

Palliative care, it is acknowledged, does not relieve all the pain and suffering of the terminally ill. While pain and suffering can be addressed, complete relief is not always possible in all cases even with optimal palliative care. The figure has been put somewhere between 5% and 10% of patients.

I admire the doctors who have had the guts to speak out in favour of this legislation. In fact, this legislation will place the burden directly on the shoulders of those in the medical profession. It may be that many doctors believe, in the care of their patients, that active euthanasia is an option that their patients would like. No evidence was given to the committee to suggest that all other care should not be given nor that all other options should not be explored. There was almost a sense of inevitability that this option would be desirable for some. Dr Syme also stated:

We have a hypocrisy at the moment. Euthanasia is being practised - described in a whole lot of other terms other than that - and it is being carried out under conditions that the medical profession seems to think are appropriate - that is, in accordance with their wishes and their deliberations. It is not being carried out in accordance with what the patient would want.

We saw an instance of this hypocrisy at the weekend when the immediate past president of the AMA, Dr Brendan Nelson, stated in an article in the Sunday Territorian: 'It is my attitude that in those cases' - he was referring to the 2% where there is no hope of recovery - 'if assisted death is not an unreasonable course, let those individual patients, their families and their doctors make those decisions and let it occur. Technically, it would be illegal, but someone would have to report it and register a complaint. Now if you do your job properly, there is no way the family is going to complain'. Is that what we really want? Is that what the medical profession wants? To do it covertly? We are playing ostrich if we continue to ignore what is being practised covertly at the moment. Do we wish to continue with this unregulated

system?

If there are unscrupulous doctors, as has been insinuated, I believe they are few and far between. In a place as small as the Territory, it does not take long for reputations to become well-known. As in all aspects of life, no matter whom we are dealing with, be they our accountants, bankers or lawyers, there must always be an element of trust. It seems to me that Brendan Nelson is saying that we should not legislate because that would bring it all out into the open, but that the doctors should continue to do it illegally.

We have heard strong arguments that palliative care will address the problems faced by those in the terminal stage of illness. However, there is enough evidence to indicate that palliative care is not a solution in all cases. Dr Hunt, the Director of Palliative Care from the Daw Park Hospice in South Australia, stated:

The palliative care community has traditionally said that all suffering can be controlled with good palliative care. I think that is a myth. It has been said that people who have good hospice and palliative care do not ask for euthanasia. That is another myth. It has also been said that good palliative care would negate any need for euthanasia. I think that is rubbish.

That is from a doctor who works in a hospice. A palliative care doctor is in a good position to judge whether euthanasia is appropriate. I believe that euthanasia will become eventually part of the repertoire of palliative care treatments. To denigrate the evidence given in good faith by a large number of medical people to the committee would be an insult to their professionalism. There are just as many different views in the medical profession as there are in the community and in this Assembly. These must be accepted as part of the individual's right to decide for himself or herself.

It worries me a little that the arguments against this bill have been tainted with a great deal of scaremongering and twisting of the facts and reality. The intention of the bill is to provide to individuals, who wish it, the right to hasten their death at the very terminal stage of an illness for which there is no cure. It will clear the way for those doctors who covertly practise euthanasia at present, giving legal status to their actions thus allowing them to act openly and in consultation with all concerned. We must recall that the bill does not have a requirement that doctors shall, as opposed to may, practise euthanasia. Like everyone else, they have the ability to say no.

There have been insinuations that, once the legislation is passed, it will apply to all people with a terminal illness. That is not the case. There is a fine if it is done without consent. There have also been suggestions that we should extend the legislation to include not only consenting adults, but also non-consenting children. When such arguments are introduced, the whole thing becomes an absurdity. We are talking about a simple bill that should be there for those people who want to exercise their right at a very late stage of their life, when they know there is nothing else for them. This bill is not about palliative care providing the panacea, but about palliative care being an option. It is not about giving doctors a licence to kill, but about protecting doctors from unlawful practice. It is not about denigrating the sanctity of human life, but about retaining dignity even in the face of suffering and death. It is not about playing God, but about humanity and compassion. It is about responding to the wishes of the community, demonstrated by public opinion polls, including even the results that were tabled today. I am prepared to support the bill for the sake of those people in our community who want that choice. I support the principle of voluntary euthanasia. I believe that, with the appropriate amendments, the bill can become good law. I believe it should go ahead. As a parliament, we should try to resolve this issue as well as we are able.

Mr COULTER (Palmerston): Mr Speaker, I declare my intention to support the bill so courageously put forward by the member for Fannie Bay. I do so without compunction because, although the terms and conditions of the bill are necessarily complex, the principle is all too simple and all too clear. I am asked today to vote according to my conscience, and my conscience tells me that this bill seeks to enshrine the right of the individual to make his or her own choice in a matter that could not be more personal. There is no more basic personal human experience than the moment of death. Every person who lives on this earth is entitled, in absolute terms, to make his or her choice as to the manner in which his or her life will end. I entered politics with the basic principle that I would always support the rights of the individual. I have tried to employ that principle in the job I have undertaken for the last 12 years. I can hardly turn my back on it now, and I will not.

Other contributors to this debate have agonised about a word here, a sentence there and a clause somewhere else. My view is that, if you support the basic principle, a way can be found to produce legislation which will work. I have no stomach for the view that it is all too hard. Anybody who says that simply does not support the basic principle and is looking for an expedient and convenient excuse. This bill is all about having the courage of your convictions. Weasel words belong to weasels. There has been much dishonesty in this debate. I have heard many who intend to oppose the bill on religious grounds say that they are opposing it on political grounds, when quite clearly that is not the case. I have heard many who intend to oppose it on religious grounds say that they have difficulties with certain clauses when, quite clearly, they have no intention of trying to resolve those difficulties. I have some respect for those who state their opposition on religious grounds. I have none for those who will not admit it.

I also treat with some scorn the claims that polls conducted in Australia and the Territory do not reflect accurately the majority opinion. Some people here today will make fools of themselves on that particular aspect of the debate. It is beyond question that the great majority of people in Australia and the Territory support the principles established in this bill. Any attempt to put any other interpretation on the polls is simply bigoted and ludicrous. Let me quote, by way of example, a poll of 550 residents of Palmerston that I conducted personally over the past month. To the simply phrased question, 'Do you support the principle of voluntary euthanasia?', 419 said yes, 78 said no and 53 said they did not know - that is, 76% supported voluntary euthanasia, 14% did not and 10% did not know. A sample of 550 in the town of Palmerston is a very good sample. Any professional polling organisation would be more than happy with such a sample. It is, without doubt, entirely representative of the people who elected me to office. The result of that Palmerston poll cannot be interpreted as anything other than overwhelming support for this bill. In the past, I have conducted other polls in Palmerston on other issues. The results have always been remarkably accurate. I do not doubt that people mean what they say. Why would I think otherwise?

One thing is clear: those who vote against this bill today do so against the wishes of the majority of Territorians, and they do so at their peril. Fortunately, I am not in the position of having to decide whether or not I am to behave today as an elected member of the Legislative Assembly or as a citizen with my own particular views regardless of what anybody else says or thinks. Fortunately, my beliefs coincide with my duty as an elected member. I do not know how others here today will come to terms with their own personal conflicts. They may well be able to fool themselves, but they will not fool the people of the Northern Territory. I say this as a born and raised member of the Roman Catholic faith. I am not here as an outstanding member of the flock, but I am a member nonetheless. On this occasion, I simply do not subscribe to the views of the Roman Catholic Church. I do subscribe to many of its views, but I do not do so blindly and automatically. I reserve my own individual right to disagree, issue by issue. On this particular issue, the Roman Catholic Church is a minority lobby group. It has joined forces with

other minority lobby groups in a coalition which still falls far short of a majority. Throughout my political career, I have tried to listen to the views of minority lobby groups, but I cannot recall ever having been swayed by such views against the majority view - against what I believe to be the common will and the common good.

Let me deal with the so-called spectre of palliative care. It can be argued, quite rightly, that palliative care should exist in better and broader quality in the Northern Territory. I suggest that it would always be the case that, however good it is, it can always be better. But better palliative care is not the answer for those seeking to end their lives with dignity and without undue suffering. In most senses, the quality of palliative care is a red herring in this debate. The argument before us is not whether sick and dying people should receive better care. Of course they should! The argument is all about whether terminally ill people have the right to choose when they want to die. Many people who are terminally ill will endure. They will stick it out regardless, and that is their right. Others, however, will find their circumstances intolerable. They will want to end their suffering, and I cannot understand why some members want to deny them such a basic human right.

I repeat my contention that any difficulties with the bill can be worked out if the will of the Assembly is that they should be worked out. We can come up with workable legislation if we want to do so. I fear, however, that too many members decided to oppose the bill at first blush and have never conceded a millimetre towards an effective compromise. Those members who said in their maiden speeches that they were here to represent the views of the people of their electorates will be sorely tested today. Are they representing the views of their electorate, or not?

I have heard many stories of the polling done by some people. Do they know what euthanasia really means? The poll that has been conducted by Dr Chris Wake and others never asked the questions, 'Do you believe in euthanasia or not?' and 'Do you believe euthanasia is an acceptable practice or not?' Those 2 basic questions were never asked, yet they say it is a bombshell. When you analyse what this poll was really saying, it is obvious that the people of the Northern Territory should not be treated as idiots. They know what they are talking about. They know what they want. They want this bill to go through this House today. That is obvious.

If this bill fails, the democratically-elected members of this Legislative Assembly will have tragically passed up the opportunity to enact legislation that genuinely would meet the criteria of need, that genuinely would bring about a substantial social change for the better, and that would accord us, the humble representatives of the Northern Territory, worldwide attention and respect. If we fail to pass the bill, we will have passed up the opportunity to show leadership to the rest of Australia. Nationally, we are in the vanguard of this debate. If we succeed, it is close to certain that the rest of the country will follow. Win or lose today, this issue will not be over. If this parliament does not enact this legislation, then the next one or the one after that will. One way or another, the Northern Territory will have voluntary euthanasia legislation. The only question before this Chamber is when. Like General Douglas MacArthur, it will return. Like Mike Tyson, it will climb back in the ring. Medieval opposition will decline over time, not grow stronger. I may not be here at that time to cast my vote, but the votes will be cast again and the cause will eventually be won. It is what the people want.

Mr RIOLI (Arafura): Mr Speaker, I rise to speak to the Rights of the Terminally Ill Bill and to outline my opposition to it. Since the member for Fannie Bay gave notice of his intention to introduce voluntary euthanasia legislation into the Northern Territory Legislative Assembly, people have been polarised in

relation to the issue. We have also found a failing in our health system - the failure to look after our terminally ill people adequately. The community has become aware of a palliative care unit that has been underfunded and under-resourced.

I have received nothing but indications of overwhelming opposition to this bill from constituents in my electorate of Arafura which contains 8 major Aboriginal communities and many outstations. Most of these communities have written and spoken to me about their concerns in relation to the bill. Community councils have discussed this issue in their meetings, talked with other community members at public meetings and presented their views as a whole. Nearly all Aboriginal people have had difficulty in understanding the details of the bill, as have many other people we have heard from in the course of the committee's travels. As the committee travelled through the Territory, its members became aware of the difficulty many people have in understanding the bill. We have talked with many people in Darwin and listened to their views. We travelled to Alice Springs, Tennant Creek, Katherine and Nhulunbuy. In addition, we visited 4 selected Aboriginal communities - namely, Hermannsburg, Yirrkala, Milingimbi and Nguiu. At the public hearings, the committee spent quite some time trying to explain the bill to the communities.

The Select Committee on Euthanasia had a life of just 3 months. This time frame did nothing but create confusion and fear among Aboriginal people. I believe the fear resulted from the fact that some people could not understand the issue, nor was there enough time for them to develop an understanding of it, and that applies not only to the Aboriginal people but also to other people in the Territory. However, even if Aboriginal people fully understood the bill, through all the appropriate cultural means of communication, I believe they would still oppose the principle of euthanasia.

The Aboriginal people say that this could cause problems and conflict within the family group, within their own community and their own structures. As I explained last week, when the committee's report was tabled, an example might be where one section of the family of a terminally ill person might be seen to be supporting that euthanasia be exercised whereas another section of the family opposed that option even if it was the will or the final decision of the terminally ill person involved. This is where conflict may arise among the sections of the family in that one may blame the other for encouraging and supporting the terminally ill person to kill himself or herself. Such a situation might result in the possibility of payback or some other form of family feuding.

We heard from Aboriginal people of the Territory that they want no part of this legislation. At Yirrkala, they were saying that, for some of their people, they know when they are going to die and they wish to be at home with their family in their own country, on their own land, listening to and hearing the songs that give meaning, purpose and the strength to endure and to help the life spirit return to its place of origin so that everything will be right with the world. At Nguiu on Bathurst Island, we heard from representatives that they were brought up by the missionaries. They said that they have strong Christian beliefs as well as their own cultural and traditional beliefs, and that they do not support the bill.

Much has been said by Territorians and others who have contributed to the debate about the lack of palliative care and what palliative care offers or does not offer. As a member of the committee, I had the opportunity to listen to witnesses and medical experts speak about palliative care and other issues relating to the bill. The medical professionals and experts put strong arguments for and against the bill. The introduction of the bill has highlighted the lack of palliative care available in the Territory. We all agreed that there was a real need to upgrade the training of our medical profession in palliative care and

pain relief.

It has concerned me that the time allowed for the Northern Territory community to come to terms with all the issues surrounding the euthanasia debate has been far too short. This is not my opinion alone. Other people, including some members of this Assembly, have voiced a similar concern. For example, the member for Nightcliff mentioned it earlier. This morning, he mentioned legislation that remained on the Notice Paper for a long time to allow for extensive community input and debate. Why are we rushing this sensitive social issue?

During my speech when the report was tabled, I gave a breakdown of submissions I received as the member for Arafura, and I wish to quote some of the figures received by my office over that time. We received 38 Territory submissions and, of those, only 4 supported the passage of the euthanasia legislation. I have heard other members speak about the results of polls in their electorates. My electorate opposes the introduction of voluntary euthanasia. I also place on record my own opposition to the bill. Even though I was a member of the Select Committee on Euthanasia, I still do not fully understand the complexities surrounding legislating to permit voluntary euthanasia. I find it unfair to ask the average person to accept in such a short time, what this parliament is doing in relation to this issue.

As a Tiwi person, I am all too familiar with death and dying, and so are many others. Not once have I heard of relatives seeking an earlier death through medical assistance. I believe in the sanctity of life. My religious and cultural beliefs and our country's laws protect this concept. Death is inevitable. What our society must provide is the best palliative care treatment available. I understand my stance here today will be seen to be against the rights of individuals, but I cannot walk away from my beliefs or those of my electorate. I do not support the member for Fannie Bay's bill.

Mr BALDWIN (Victoria River): Mr Speaker, much has been said already today about the moral, religious and technical as well as the ethical issues surrounding the member for Fannie Bay's private member's bill. Arguments have been put on both sides that I guess seem reasonable and indicative of the attitude of Territorians towards the passage or otherwise of this bill, but that is the problem. I believe the attitude of Territorians and the will of the people to support this bill is not as clear as some would like to make out.

On the one hand, varying polls supposedly tell us that the vast majority support a change of this nature, as the Deputy Chief Minister stated in his speech. On the other hand, the Select Committee on Euthanasia reported that the Territory submissions were almost equally divided on the issue, with 122 in favour and 123 against. At the end of the day, this parliament must make laws for the common good of all Territorians, laws that reflect the wishes and aspirations of all Territorians. I have attempted to reflect those views by canvassing the constituents whom I represent and making an informed judgment of support or otherwise on this very delicate issue of assisted death. I say I have made a judgment, as one must in the end, but if, as a parliamentarian, I am to cast my vote on this issue, I would like to be able to do so on the assumption that I am in line at least with the wishes of my constituency.

I have arrived at a position on assisted death or euthanasia for Territorians by canvassing the views of my electorate and by making a personal judgment on the responses and representations made to me by my constituents. When the member for Fannie Bay first gave notice that he intended to introduce legislation to allow euthanasia, I was asked to comment on my position. I put on the public record at that time - and I maintain the same view very strongly today - that, on an issue of this magnitude, I have some real concerns that the decision is to be made by 25 parliamentarians. That is not to say that I shirk for one

minute my responsibility as the elected representative of my electorate or that I would not do my utmost to sincerely canvass and represent the views of my electorate. I feel, however, that many people have remained silent on this very sensitive issue, both for and against, and I feel that they have done so because of family loyalties, business reasons, ethical reasons or simply because of a lack of understanding of the issue.

For many, the subject of euthanasia is a very personal one. For some at least, it is a subject about which they prefer not to disclose their position. For these people, the ability to have their say in a confidential manner is very important to avoid upsetting family, business or client/patient relationships. Whilst I have attempted to gain a broad majority view within my electorate, unfortunately I would never be able to ascertain the views of those who remain silent, for whatever reason. The only way that these people could have their say without fear of any sort is via a referendum, and that would probably be the only truly democratic way of judging a consensus on the subject of euthanasia. I know that would be an expensive and time-consuming exercise which would require a huge amount of information to be disseminated to all Territorians who are eligible to vote, but it would also be a good test, and the only real test, by which to decide the real extent of support for this bill.

Territorians should determine for themselves if the time is right to introduce a legal mechanism that would allow assisted death. If people in southern states agree that it is important for them to have their say via a referendum on the retention or otherwise of daylight saving, then I say that mercy killing surely must be of more importance. However, as I say, it is an issue for the people. Members have spoken about changing social attitudes for the sake of the people rather than those changes being determined by the people. I feel that is a very dangerous game and that, without the documented support of the people, it should not go ahead.

As I mentioned, I have canvassed my constituents and have come to the conclusion, albeit with a little of my own judgment, that I cannot support this bill. It will come as no surprise to members, particularly those who sat on the euthanasia committee, that Aboriginal people do not indicate general support for assisted death by doctors. This concept is fraught with many problems for Aboriginals, including those relating to family and cultural matters and a lack of detailed understanding of the subject. The select committee's report stated: 'It quickly became apparent that there was confusion and misunderstanding of the bill among Aborigines'. It was also stated that euthanasia and suicide were not concepts that were well known and understood within their culture. Indeed, there is a great deal of mistrust already in communities about travelling to hospitals for treatment, and this is exacerbated by the fact that, for many older Aboriginals, the English language does not come particularly easily.

The time allowed for reflection on the bill has been very short in terms of what may be an acceptable consultation period in remote communities, and this was emphasised by the preceding speaker, the member for Arafura. It is interesting to note too that, in regard to views solicited by the committee from Aboriginal people, it was felt, apparently very strongly, that the committee should recommend to overcome the confusion the bill has caused. In its recommendation 5.17, the committee stated:

Appropriate communication in Aboriginal languages should be prepared and distributed to Aboriginal communities as a matter of urgency to communicate with those communities the provisions of the bill.

From the response that I have received from my communities in the Victoria River electorate, I would agree with that. I would be very surprised if other members who have an electorate with a majority of Aboriginal constituents, as I do, have found that their constituents have a different view. I would very

much doubt that they do.

When the member for Fannie Bay's bill was introduced in the House, I produced an information sheet that was distributed by mail to the communities and to residents in other parts of the electorate. I believe the mail-out was an opinion-neutral release asking for community input, either by phoning or writing to my office or by way of submission to the select committee. The diversity and make-up of my electorate is such that I represent people living in rural areas of Katherine on pastoral properties, in communities and on outstations. As I have mentioned, the electorate has a majority Aboriginal population. The non-Aboriginal component of the population returned a fairly evenly divided view, either for or against the bill, as one would expect.

However, the feedback from the Aboriginal residents was almost totally against the bill, for reasons that I have outlined. From some communities came responses of an individual nature and from others came letters responding to my request with up to 40 signatures attached. Some communities held full community meetings to discuss and arrive at a position on euthanasia after receiving my letters. A representative of at least one of those communities rang me personally to ensure that what he had to say on behalf of his people would not be misinterpreted in a letter. The community as a whole had met and had voted not to support in any way the Rights of the Terminally Ill Bill. Other residents in the electorate opted to place their names on carefully prepared petitions to voice their concerns and I paid particular attention to those when weighing up what I believe is the general mood and attitude of the people whom I represent. It is my judgment therefore and, on the basis of the opinion of the majority of my constituents, that the Rights of the Terminally Ill Bill should be defeated, and I certainly will reflect that view by voting against the bill.

Mr LANHUPUY (Arnhem): Mr Speaker, in rising to speak to the private member's bill introduced by the member for Fannie Bay, I would like not only to address some of the issues that have confronted myself as an individual in the debate, but also to provide information which I have received from the Territory as a whole. There is no doubt that it is a very controversial issue. It has involved many people through the churches, through organisations and through those individuals who have known or been related to terminally ill people. The offices of all honourable members have received mountains of paperwork supporting or opposing this private member's bill on voluntary euthanasia.

Like other members, I have taken the issue up with many people in my electorate, not only with Aboriginal people but also with communities such as Angurugu on Groote Eylandt whose residents indicated their views to me. If we are to mature and accept responsibilities, such as statehood, it is time that we took on social issues such as the one we are debating today. Like the Chief Minister, I have had close personal experience of terminal illness and I can express a personal view as to its effects and what is involved in that traumatic period when seeing someone undergoing a very hard time in their life and facing a tragic end.

When the member for Fannie Bay introduced the bill, someone commented that it would not be in the interests of Aboriginal people because they are too busy trying to live a little longer. That is true. The statistics indicate that my people are dying at an early age. The infant mortality rate is high. The World Health Organisation has commented on the poor health standards and housing. In the end, that places a burden on government services. In this budget, the Minister for Health and Community Services has provided the funding which he promised. That would not have happened were it not for visits by the former federal Minister for Community Services and Health, Senator Graham Richardson, to places such

as Bulman.

In its short life, the Select Committee on Euthanasia visited communities, such as Hermannsburg, Yirrkala, Milingimbi and Nguiu, and travelled up and down the track to obtain the views of the people on this issue. It was crucial to obtain that information. Initially, the proposal was that members should obtain the views of their constituents and debate the bill. However, enough members decided that a committee should be established to travel extensively throughout the Northern Territory to ensure that the views of all the people in the community were taken into account. I believe the life of the committee should have been longer. There are many people for whom English is a second language. Some of them could not understand what euthanasia means. I was asked questions and I had to interpret it. I did not want to misrepresent anything when I was attempting to tell some of my constituents about the bill. It was important that they obtained the information and were aware of the implications involved. I would have expected the committee to continue for that purpose alone. For some 25% of the Territory's population, English is a second language. This debate relates to the matter of life and death. If the legislation is passed, it will affect forever our lives in the Northern Territory. The people will judge us. Historians will be able to discuss our judgment today for years to come and decide whether we acted wisely.

Many people have spoken to me personally about their concerns. They sought advice and wanted to ensure that there was solidarity in respect of Aboriginal representation on the floor of this House. I have my personal views. At the outset, when the bill was introduced by the member for Fannie Bay, I expressed my support. However, I question the safeguards in this bill. Many people have lived their lives from the time of their birth having to struggle for their right to freedom of speech, their right to freedom of religion, their right to political representation and their right to equality and justice. Those rights are crucial, and so too, to an extent, is the issue in this bill.

I have sat at ceremonies where Aboriginal people have been involved with death from natural causes. There are no deaths in Aboriginal communities that are non-suspicious. Aboriginal people are very aware of certain deaths in communities at certain times. If this legislation is passed, I wonder whether that suspicion will be held forever by the family because of the powers given to a doctor by this bill.

Mr Perron: You had better hope they do not learn what is going on now.

Mr LANHUPUY Mr Speaker, regardless of the comment by the Chief Minister, it is a matter of concern. I expressed that view because that has always been a matter which has existed in so far as Aboriginal people are concerned. It is crucial that those areas of concern are expressed and those views are made known.

As I said, my office received mountains of letters from people within the Northern Territory and throughout Australia. About 85% to 90% of those letters opposed this legislation. Those people were within their rights to express their views by way of letter or by telephone to give their opinions as citizens of Australia. Generally, the submissions that I received were based on religious grounds. Some of them were concerned about the lack of safeguards in the bill itself and, importantly, the lack of palliative care. We have heard the Minister for Health and Community Services speak earlier about palliative care, saying that the government is willing to inject funds into this specific area. Others expressed their concern about the dangers of undue influence from families if and when a dying person is making their request, whether it be for or against euthanasia. They spoke of the undue pressure that may come from people surrounding the family. That is something that I am very worried about because, in

Aboriginal situations, a decision which may be made by the terminally-ill person himself is not necessarily the final decision. Although it affects that person's life, the responsibility for the decision has ramifications down the line in respect of the families which that person may be married into, whether it be from the mother's side or from the father's side. On that basis, I said that I thought the consultation in communities should have been longer to ensure that the people knew at least what was happening. Other people in the community expressed their concern at the speed at which the bill was being dealt with. Others spoke about experiences of euthanasia elsewhere in the world.

I appreciate the comments and the representations which people have made, not only to me but also to other members of this Assembly on such an important bill. Unfortunately, in the time available, the committee was unable to visit many of the Aboriginal communities which it should have visited. A classic example is Yuendumu, which has a total population of about 2500, and Maningrida which has a population of about 1500. No visit was made to either community. One would have thought that it would have been crucial to visit some of those communities, including Angurugu, Umbakumba and Alyangula. Some people might think that, because Groote Eylandt is in the Gulf country, the people there belong with Cairns and Brisbane. However, they are Territorians and they want the right to be represented here. Therefore, I am disappointed that the committee did not visit those communities.

I turn to some of the issues which I mentioned earlier. Having gone to a Christian school, I have practised Christian beliefs. Certainly, my name indicates the Christian influence in my early days. I am very proud of the fact that that teaching has given me the ability to be able to express my opinion on matters of religion and culture, and on behalf of my people. In relation to this issue, the church has been a major voice. Whether that is right or not is a matter on which members will make a value judgment before voting on this bill. I heard in the community that some of the churches were telling people that they should not support the bill basically because of their religious beliefs. No information whatsoever was given as a reason for that. No information was given whereby people could determine their own beliefs. That was disappointing. Organisations and the churches have been influential in the Territory since its pioneering days. It was a matter for the churches themselves to determine their position in relation to this bill. Given the congregations to which they have access, the churches had a tool with which to express their views, whether for or against the legislation, and they utilised that. Whether that best suited themselves or not is something that I cannot fathom.

I expressed my personal views about that to many Aboriginal people in my electorate but, in the end, it was a decision which they had to make by themselves. After all the debate and controversy, I said to people that I hoped that they would be able to give me the right to exercise my right as an individual. It is not hard to ask for a person's rights as an individual. A man lives his life, whether for or against the law, and irrespective of whether he has received the rights that he has demanded or has had a cheerful life or otherwise. When he is about to make his last request, should we be in a position to deny him that last right which he wants? That is the question which I believe honourable members of this House will have to come to grips with by themselves, regardless of whether they have decided to support or oppose the bill and be that on religious or any other grounds.

Mr Speaker, I can assure you that, in the 11 years that I have been in this parliament, this is the most difficult bill that I have ever had to examine and ponder on. I have had sleepless nights over it for a whole range of reasons, not the least being my personal feelings towards it because of the personal tragedy that I mentioned earlier. At the time, I expressed my thanks to you, Mr Speaker, the Chief Minister and many others who helped me through that period. It was a very difficult time. I have never

had the opportunity to raise this issue except on the last occasion that I spoke in relation to this legislation. Based on such considerations, I believe a person should have the right to be able to determine what they want if they are of sane mind.

Many people in the Northern Territory are against this bill, from Groote Eylandt to Alice Springs, Finke and Hermannsburg. The people at every Aboriginal outstation that I visited told me to 'give it away'. They had no interest in it and they asked why would they support this bill. From what they have heard, their understanding is basically that the law will give authority to the doctors to give them an injection that will cause them to die. That is the basic information that they had about this bill. It was difficult to explain to them some of the concerns expressed during the debate. Comments which I heard from people such as the members for Arafura and Nhulunbuy, who were members of this committee, caused me concern and worry.

I for one would like to see this bill supported because I believe that I have been given the right to express my view in this case. I would like to see safeguards included in the bill during the committee stage but, at this stage, it is my intention to support the bill.

Mr SETTER (Jingili): Mr Speaker, I would like to take the opportunity to compliment the member for Arnhem on his remarks. I think he summed it up very well when he asked whether we have the right to deny a person the right to make a choice in a situation where that person is in their last few days or hours and, doubtless, suffering. Do we have the right to deny them the right to choose their future? What will happen in their last few remaining hours, days, or week or two?

I expressed my support for the concept of this bill when it was first introduced. I did that without hesitation because life provides for us many very sobering experiences. Over the years, most of us have had to come face to face with the death of a loved one. I am no exception to that. When you see people having to suffer the indignities and the agonies of what, in some cases, can be a very dreadful death, it is very difficult, not only for the person who is lying on their deathbed, but also for their family and friends. I suppose such experiences harden you, develop you and change your views.

Most of the members of this Assembly started from a similar background - that of a good Christian upbringing. I am very appreciative of having had that. However, I believe that, along the way, as a result of life's experiences, one perhaps changes one's views about certain matters. I still consider myself to be a Christian, albeit perhaps not a practising one. Nevertheless, I try to base my life on Christian principles. I always have, and I will continue to do so. However, I believe that for us, for doctors and for people of religion to compel people to suffer in the way that some people have to do is quite inhuman. I have great difficulty in accepting that they should be forced to suffer in that way. Like the member for Arnhem, I believe that a person, who has a terminal illness, who is suffering and who has only a short time to live, should have the right to make that last decision. I do not think that anybody has the right to make that decision for them.

When the member for Fannie Bay introduced this bill, I was particularly pleased because this is an issue that needs to be aired and debated in the community. For too long, this matter has been swept under the carpet because it is too hard. With a couple of exceptions elsewhere, nobody has been game to raise it because of the thought that a massive lobbying process would descend on them and make their lives a total misery for however long they persisted. I give full marks to the member for Fannie Bay for introducing this bill. He took it head on and I admire him for the gumption that he has demonstrated and the professional manner in which he has pursued the matter over the last few months. He has run the

gauntlet, as the rest of us have had to, of the lobbies from both sides, and it is not easy.

We have all been subjected to a deluge of letters, facsimiles and phone calls, if not in their thousands, certainly in their many hundreds. I have a pile in my office. Many of them say the same kinds of things. Although individually written, nonetheless, given their almost identical wording, many seem to be like photocopies. They have come from all around Australia, but the wording in many of them is almost identical. There is no doubt in my mind that, particularly in the southern states, there has been a very strong, organised lobby which asked all its supporters to write to Northern Territory MLAs expressing their point of view. That is their right. I have no problem with that at all but, when those letters appear to be almost identical to the line, one has to question their credibility. I was concerned about some of the letters that I received because I believe some of the accusations that were levelled in them were inaccurate and quite misleading. I do not appreciate that. I respect a person's right to put their point of view, but I believe they should be honest in what they have to say.

There are 3 main groups of opponents to the legislation. Firstly, there is the collective lobby group of the churches, although there are some churches which are not involved in that group. Secondly, there is the Australian Medical Association. Thirdly, there is a lobby group that has been formed in Darwin of which Dr Chris Wake appears to be the spokesperson. The reality is that, in this day and age, the church lobby, even collectively, does not represent the majority of people - far from it. One has only to attend services in any of the churches on Sundays to be aware of that. The AMA is split right down the middle. I am not saying 50% are in favour and 50% are against, but there is a considerable split among doctors in the community. I assume that the majority of doctors are members of the AMA.

Mr Perron: It is a minority in the Territory, a majority nationally.

Mr SETTER: That says a great deal for the AMA.

I received a number of letters from doctors who are not members of the AMA and who expressed their support for the concept underlying the bill. I will quote from a couple of those letters in a few moments, because the comments express how many of these people feel. The opponents of this bill - or perhaps of the concept of voluntary euthanasia - use 'murder' or some other emotive term to describe it. That is absolute nonsense. Those of us who intend to support this bill do not do so lightly. We have thought very long and carefully about this issue and about the details of the bill. The last thing that we want to do is to put anybody, least of all a dying patient, into a position where an accusation of murder could be levelled.

The opponents of the bill promote palliative care as some kind of panacea which will be the saviour, at least from pain and suffering, for terminally ill patients. I do not believe that is the case. I do not know a great deal about palliative care, although the Minister for Health and Community Services presented a statement earlier this evening giving some information and I have received written information. However, palliative care is very limited indeed, not only in the Northern Territory, but also elsewhere in Australia apart from perhaps the major cities. Outside the major capitals, it scarcely exists. A close relative of mine passed away last year of cancer in a country hospital in Queensland. Heavy doses of morphine were administered for many weeks, but no palliative care was available. I genuinely hope that the government funds the upgrading of palliative care facilities and the implementation of palliative care practices in the Northern Territory because I believe that, whatever we can do to lessen the suffering of terminally ill patients, we should do as quickly as possible. If this debate has done one thing, it has raised recognition of the need for palliative care services in the Northern Territory to be upgraded. So let us

pursue that.

The real issue in this debate is how people will die. People who are terminally ill will die in the short term. Whether that is 6 months from diagnosis, or 12 months or 3 years, is not the point. As the member for Greatorex would be well aware, that cannot be determined accurately. In many cases, the diagnosis is not made until a few months before the person passes on and, in other cases, it is much earlier. What is important is the quality of life that the person is able to enjoy during the countdown period, and their ability to be able to die with dignity, not to die racked with pain, writhing and suffering, doped up to the eyeballs with an ever-increasing quantity of morphine. I do not know whether it is true or false, but it has been said that some doctors have admitted to assisting people to die more quickly by increasing the doses of morphine to the point of an overdose. I believe that doctors are very responsible people,. When doctors are dealing with terminally ill patients, they will not give them the wrong advice. They will not treat them in an inhumane manner. They will treat them with as much care and understanding as possible. They will do anything they can to assist people to pass through that last, difficult phase of their life. Many doctors deal with dying and with death on a daily basis. It is not easy for them. It must be very difficult to have to interact with people in that situation day after day.

As I indicated, I believe doctors are divided on voluntary euthanasia and the Rights of the Terminally Ill Bill. To confirm that, I will quote from a couple of letters that I received recently from doctors. I will not mention any names, but 9 doctors signed the following:

As a group of medical practitioners, we wish to indicate to you our support for this proposed legislation. We feel that it is one of the most important pieces of social legislation to be introduced in a long time. Competent adults who find themselves in an intolerable and hopeless situation should have the right to exert some control over their circumstances and request assistance to die.

Another doctor wrote:

I have seen enough death and dying to know that it does not always happen very well. It is often not the peaceful and dignified end to life that a well-managed death is. There comes a time when the role of the doctor changes from one of aiming to cure or prolong life to one of aiming to help the patient to die well ...

A recent article in the newspaper was headlined, 'Euthanasia can be kinder than death'. It quoted a Mr Andy Chapman, whose wife passed away in Darwin Private Hospital not so long ago. He has written a book, There Has to be a Better Way to Die, which the article describes as 'a story of mental and physical anguish, of pain and suffering, and of difficult questions about life and death, dignity and despair'. That is the reality - let us not kid ourselves. I say repeat that I firmly believe that the final decision in this matter must rest with the patient.

Like other members, I canvassed the views of my constituents. I circulated a newsletter and I tried to explain the issues as best I could. I quoted in the newsletter considerable information that was provided by the member for Fannie Bay. I enclosed a questionnaire which contained 2 questions which basically asked the people whether or not they were in favour of voluntary euthanasia. 78% of respondents were in favour of the concept. They do not understand the details of course. We do not know what the final bill will contain because it has yet to pass through the committee stage in which 50 proposed amendments have to be debated. What we will end up with at the other end is a matter of conjecture at this stage. We owe it to people, who may well avail themselves of the provisions of the legislation, even though they may be very few in number, to go through this exercise. Polls undertaken by various members, national

polls and the poll that Dr Chris Wake's group undertook in the last few days indicate repeatedly that public opinion is strongly in favour of the concept of voluntary euthanasia.

Lobbyists make all kinds of assertions - for example, that voluntary euthanasia will be murder or assisted suicide. They complain that there has been a lack of consultation, that it has been done with obscene haste, that people do not understand the details, that there are inadequate safeguards and so on. That is nonsense because it is now 3 months since the bill was introduced. A committee has considered the issues. I wish to compliment the committee members on their work. The committee produced a raft of recommendations which are eminently sensible. There has been more debate on this matter than on any other that I can recall in the 11 years that I have been in this parliament.

I accept comments from members who have a majority of Aboriginal constituents that some of those people in remote areas have not had the opportunity to express their views and that they do not understand the bill. Whether or not they understand it and whether or not the community understands it, if this bill is passed, nobody will be obliged to avail themselves of its provisions. Nobody has to accept voluntary euthanasia - it will be their choice. Nobody will compel a terminally ill person to accept that fatal needle or whatever process eventually is decided on. The rights of those Aboriginal people and of any other person in this community are totally protected under the provisions of this bill. There is no compulsion whatsoever. The bill already contains tight safeguards. By the time we are finished with it in the committee stage, the safeguards will be tighter still. The other point is that doctors are not compelled to comply with an euthanasia request. Doctors can make their own choice about that. If a doctor, for whatever reason, feels that they cannot administer a lethal dose to terminate a life, that is their choice. However, they should not deny other doctors the right to do so if that is their choice.

We have been told that terminally ill patients lack knowledge and understanding of the process involved. I believe that any person who has been diagnosed as terminally ill and is contemplating taking advantage of the provisions of this legislation would find out in a hurry. They would ensure, as they approached the dying process, that they informed themselves fully of the provisions of the legislation to enable them to make a decision. If they decide that it is what they want, that is their choice. If it is not, that is fine. Nobody is saying that anyone must avail themselves of voluntary euthanasia. They can die in any way they choose. However, they must be able to make their own decision.

With perhaps a couple of exceptions, the members who support this bill are representing the views of their constituents. Those who intend to vote against it will do so for several reasons. First, there are those who are genuinely representing the views of their electorates - for example, where the majority of the constituents are Aboriginal people who apparently do not support it. That is fine. There are those whose conscience genuinely dictates that they must oppose it, and that is fine too. This is a conscience vote. I am exercising my conscience and I am lucky because my conscience happens to fall in line with the majority view in my electorate. There are those who support the concept of voluntary euthanasia, but have allowed themselves to be influenced by the lobby groups. They will not vote according to their conscience. They will vote according to the way in which they have allowed themselves to be pressured. I urge those colleagues to think again and to vote according to their conscience. If they are not prepared to do that, if they are not prepared to stand up and be counted, they should abstain.

In conclusion, I would like to compliment the member for Fannie Bay, albeit in some of his last hours in this place, for having the gumption to put this on the agenda. He has done a great service to the Northern Territory, even though it has been a very difficult time for him and indeed for the rest of us. Because he

has been prepared to do that, in my opinion, he will depart from this Chamber in a couple of days with a great achievement, irrespective of whether the bill is passed or defeated. He can be very proud that he introduced the bill, raised the profile of this issue and fought it right through to the end, whatever that might be. I support the bill.

Mr STONE (Port Darwin): Mr Speaker, this bill seeks to enshrine in legislation the principle of euthanasia. What is euthanasia? Euthanasia is a direct measure, such as lethal injection, applied by one person to end another person's life. It is not to be confused with taking away life support systems nor is it to be confused with assisted suicide where one person contributes to the death of another, but the person who dies takes his or her own life. Euthanasia legislation can contain all the safeguards imaginable but, at the end of the day, the principle remains - one person kills another person. If that sounds dramatic, the simple fact is that that is exactly what is involved. In that sense, the numerous amendments that have been foreshadowed are irrelevant. You either support euthanasia or you do not.

There are 2 prongs to the argument favouring euthanasia: the rights of the individual and compassion for the suffering. I support both sentiments yet I do not support euthanasia. I understand the motives of those who do and I make no criticism of them. I am, however, critical of the way in which this legislation has been introduced, amendments foreshadowed and the community generally bamboozled about what is now intended. We now have 50 amendments foreshadowed to a bill with 17 clauses. In any other circumstances, a bill subject to such extensive amendment would be withdrawn and reintroduced at a later date. In any event, that to one side, it is important that the public understand the processes involved here. The mover of this legislation, the member for Fannie Bay, has to demonstrate why the law should be changed. Any minister or private member who introduces legislation has an onus of proof placed clearly on their shoulders. The onus is on the member to demonstrate not only that the present law should be changed, but that what he now proposes will be good law, safe law and in the public interest.

Three general positions have emerged from the public discussion that has followed the introduction of this legislation. First, some believe that both practices, of assisted suicide and euthanasia, are morally wrong and should not be allowed. Others hold that assisted suicide or euthanasia is legitimate in rare and exceptional cases, but that professional standards and the law should not be changed to authorise either practice. Finally, some argue that assisted suicide or euthanasia should be recognised as legally and morally acceptable options in the care of dying or severely ill patients.

I am firmly in the first category and that should not come as any surprise to any Territorian as I have been upfront about my position from the outset. However, there are others who believe in the principle, but who have also come to the same conclusion that I have - that what is being proposed is unsafe law. There are those who support euthanasia, but believe this bill is now such a shambles that it cannot be enacted safely into legislation. There are 50 amendments so far. It would be irresponsible to press on. I am mindful of those reported early warnings by the Women's Advisory Council that there was a need for wide public consultation and education. There has been neither. If this bill had been approached in a different way, it might have succeeded. However, to add to the complications of what we find before us today, the bill that is now being proposed with all its amendments, bears little relationship to the bill that was originally circulated for public comment. What I say to those members who support euthanasia is that they still cannot support this legislation because it is unsafe law in the way that it is currently framed and presented to the Legislative Assembly.

It was suggested by the proponents that there were those of us who would wish the issue would simply

go away. I reject that observation. Parliament should debate such controversial issues. As parliamentarians, we should never shirk our responsibility to discuss openly matters like euthanasia. In the short time available to me, I propose to make some general comments followed by some remarks on the clinical background to euthanasia, the issue of the autonomy of the individual, the risks of legalisation and, finally, on what I believe we need to do for severely ill and terminal patients.

First, I will make some general remarks. It is an inescapable fact that the right to decide about medical treatment, including the right to refuse life-sustaining measures, has become a matter of considerable public debate in our community. In approaching this legislation, we should reflect a deep respect for individual autonomy as well as concern for the welfare of individuals nearing the end of life. What this legislation seeks to do is to transform the right to decide about medical treatment into a far broader right to control the timing and the manner of death. The issues are clearly not understood by the Northern Territory public and this is most clearly evidenced by the AMA poll which demonstrates that most Territorians do not realise that they already have the right to refuse life support measures. Territorians already have the right to make a directive that will ensure that they are not subjected to extraordinary measures to prolong life. Those rights are enshrined in the *Natural Death Act* which has been in place in the Territory since 1988. What a shame it is that we did not embark on a process of public education on this very important issue before it was precipitously announced and then introduced into the Legislative Assembly. What the member of Fannie Bay's private bill proposes is to transform the right to decide about medical treatment into a far broader right to control the timing and manner of death. I am firmly of the persuasion that the dangers of such a dramatic change in public policy would far outweigh any possible benefits.

In the light of the pervasive failure of our health care system to treat pain and diagnose and treat depression, legalising assisted suicide or euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable. Those at greatest risk would be the elderly, the poor, the socially disadvantaged and those who do not have access to good medical care. It is an indisputable fact that requests for suicide assistance by terminally ill patients are correlated with clinical depression or unmanaged pain, both of which ordinarily can be treated effectively with current medical techniques. As a community, I believe we can do far more to benefit these patients by improving pain relief and palliative care than by changing the law to make it easier to commit suicide or to obtain a lethal injection. In a word, we have started at the wrong end of the equation. As a community and as a government, we have a responsibility to address first the issues of palliative care and hospice services before we start down the track of euthanasia and assisted suicide. I am firmly on the record as a supporter of palliative care and hospice services. I do not support euthanasia or assisted suicide.

Much has been made of the fact that I am a Catholic. I make no apologies for my faith. In fact, I am probably a fairly poor example. Let me assure people listening to this debate that religion alone has not shaped my thinking on this issue. Those who oppose euthanasia do so usually within the context of diverse religious, philosophical and personal perspectives. Some of the greatest opponents of euthanasia are in fact agnostics or atheists. Real life experience, such as the death of family members, has greatly influenced my thinking. When you hold your father in your arms as he dies, as I did, you have ample opportunity to reflect on death and dying.

What also shapes my thinking on this issue of euthanasia is a sense of history, knowing a little of what has happened in other places over time. The member for Fannie Bay rejected the allegation that he was a Nazi. I do not believe he is a Nazi and I think the label was unfair and uncalled for. However, it needs to

be remembered that, while the practice of mass murder in Nazi Germany differs from what is proposed here, that very genocide began with the active killing of the severely ill and built on earlier proposals advanced by leading German doctors and academics in the 1920s before the Nazis took power. It may be of interest to members to know that those early proposals were limited to the incurably ill and mandated safeguards such as review panels. Members do not have to accept my word for it. Any serious student of euthanasia should read the book, *The Nazi Doctor: Medical Killing and the Psychology of Genocide*, by R.J. Lifton, who traces the significance of concepts such as 'life unworthy of life' and 'killing as a therapeutic imperative' in removing social and psychological barriers against killing and advancing the Nazi program of genocide. As Lifton observes in his book, 'the medicalisation of killing - the imagery of killing in the name of healing - was crucial to the terrible step'.

My point is that, whilst this legislation and its mover do not contemplate such a terrible turn of events, the fact is that it has happened, barely 50 years ago. Territorians should make no mistake about what is intended by this legislation. They have already the right to have withdrawn or withheld life support systems in accordance with accepted ethical and medical standards, as well as their own instructions. They have the right to make a directive that instructs that they are not to remain on life support systems in the event that they are unconscious or comatose. That existing law contrasts sharply with euthanasia whereby one person deliberately brings to an end another person's life.

There has been a certain simplicity about the way this whole debate has been approached. No doubt, members have heard people say that it happens anyway and therefore why not legalise it. The simple fact is that there is a huge difference between helping a person to die as opposed to killing someone. I believe that distinction has been lost on the proponents of the bill. The moment that you legalise doctors killing their patients, even with their consent and with benevolent motives, you cross an important threshold. You debase the currency of human life. The potential for error and abuse, the risk to vulnerable individuals and the profound effect on society's values present the most compelling reasons against allowing assisted suicide and euthanasia.

I turn now to the clinical background to euthanasia. Terminally ill patients who seek suicide or euthanasia often suffer from a treatable mental disorder, most commonly depression. When these patients receive appropriate treatment for depression, they usually abandon the wish to commit suicide. Depression is distinct from the normal feelings of sadness generally experienced by terminally ill patients. It is a myth that major clinical depression ordinarily accompanies terminal illnesses. Uncontrolled pain, particularly when accompanied by feelings of hopelessness and untreated depression, is a significant contributing factor to suicide. However, my readings and discussions with others confirm the view that medications and pain relief techniques now make it possible to treat pain effectively for most patients. The real problem is that severely and terminally ill patients generally do not receive adequate relief from pain. There is no doubt that a large number of cancer patients suffer from unrelieved pain and that is more a reflection on the support that we have provided such people rather than a justification for killing the patient. The pervasive inadequacy of pain relief and palliative care in current clinical practices, including a lack of professional knowledge and training, unjustified fears about physical and psychological dependence, poor pain assessment, pharmacological practices and the reluctance of patients and their families to seek pain relief, all contribute to a belief that euthanasia is the only way out. It is not. You do not solve the problem by killing the patient.

Under existing Northern Territory law, competent adults have already a firmly established right to accept or reject medical treatment, including life support systems. In the Northern Territory, competent adults

have the right to give directives for treatment to be used in the event that they lose the capacity to make medical decisions for themselves. For all those people who telephoned talkback radio and wrote letters to the editor supporting such measures, let me assure them that those rights exist already. People have been confused about what is already in place as opposed to what is being promoted. Further, the provision of pain medication is legally acceptable, even if it may hasten the patient's death, if the medication is intended to alleviate pain or severe discomfort and not cause death, and is provided in accordance with accepted medical standards. There is a clear distinction between the right to refuse treatment and the right to kill yourself or to be killed by others. In that way, current legislation reflects a deep respect for individual autonomy as well as maintaining concern for the welfare of individuals nearing the end of their life. Be assured, my fellow Territorians that, in the abstract, euthanasia sounds like a wonderful idea but, in a practical sense, it would be a disaster.

I turn now to the issue of autonomy which has been defined as 'the rights of the individual'. No absolute rights attach to any individual - you or me. Whilst you might embrace the notion of individual liberty and the freedom to make personal choices, the simple fact is that these rights or responsibilities are accompanied by commitments to promote the overall good of society and to protect vulnerable individuals from harm. The exercise of autonomy or the rights of the individual must be balanced against other fundamental values embraced by society, including our reverence for human life.

This has been a debate with slogans. The proponents have said: 'If it is not for you, it is not for you'. This issue is not deserving of such glib, superficial slogans. Stand back and examine that proposition carefully. Why not legalise the sale of heroin? Why not permit people to sell themselves into slavery or bondage so that they can provide for their families? Why not let people mutilate themselves if that is what they want to do? After all, 'if it is not for you, it is not for you'. You do not have to be a Catholic or, for that matter, an adherent of any faith to value human life or to reject such slick and transparent slogans. I simply do not believe that one person should be able to assist another to die or to kill another person even if it is for benevolent motives.

I am even more troubled by the prospect of 'medicalising' the practice - in other words, allowing it to become the norm of medical practice that doctors can kill a patient. I believe that doctor-assisted suicide and euthanasia violate values that are fundamental to the practice of medicine and the patient-doctor relationship. I can accept that there is an argument that providing a quick death for some patients represents respect for their autonomy as patients and that the doctor is demonstrating care and commitment. However, even if you accept that proposition, you have to balance it against the risks of the legislation, and I turn now to the risks of the legislation. I do not propose to address the specifics of the 17 clauses or the numerous amendments that are now being offered. Rather, I make the observation that legalising euthanasia would pose profound risks to many patients. What leads me that conclusion? Experience tells me that an ideal set of safeguards theoretically articulated in legislation is not sufficient when it comes to actual practice. No matter how carefully guidelines are framed, assisted suicide and euthanasia will be practised through a prism of social inequality and bias that characterises the delivery of services in all segments of our community, including health care. The practice will pose the greatest risk to those who are poor, elderly, members of a minority group, or without access to good medical care. The simple fact is that the growing concern about health care costs increases the risk presented by legalising euthanasia. This cost consciousness will not be diminished and may well be exacerbated by health care reforms. Clinical safeguards have been proposed in the legislation to prevent abuse and errors yet I have no confidence that those safeguards will be realised in many cases.

In debating an issue like euthanasia, frequent reference is made to dramatic individual cases. Who can argue with the imagery of the gaunt, depressed and long-suffering terminal cancer patient? But, we have to look beyond that imagery and ask what it would mean for the state, in this instance the Northern Territory, to sanction assisted suicide or direct killing under the auspices of the medical profession. Like others participating in this debate, I feel deep compassion for patients in those rare cases when pain cannot be alleviated even with aggressive palliative care. I also recognise that the desire for control at life's end is widely shared and deeply felt. However, as a community, we have better ways to give people greater control and relief from suffering than by legalising assisted suicide and euthanasia. It would have been far better had we exhausted palliative care and pain management measures before leaping into the realm of assisted suicide and euthanasia. On their own admission, most doctors are not trained to diagnose depression, especially in complex cases such as patients who are terminally ill. Even if diagnosed, depression is often not treated. In elderly patients as well as the terminally and chronically ill, depression is grossly under-diagnosed and under-treated. The presence of such unrelieved pain increases that susceptibility to suicide. The under-treatment of pain is a widespread failure of current medical practice with far-reaching implications for proposals to legalise assisted suicide and euthanasia. Make no mistake, if assisted suicide and euthanasia are legalised, it will blunt our perception of what it means for one individual to assist another to commit suicide or to take another person's life. Over time, as the practices are incorporated into the standard arsenal of medical treatments, the sense of gravity about the practices would dissipate.

It has been said that relatively few people would take advantage of this legislation and that point was made by a number of speakers. If the abortion legislation is any indication, one cannot accept that statement with any confidence at all. Much has been made of criteria and safeguards. Let me say now that they would prove very elastic in clinical practice and in the law as long as policy hinges on notions of pain or suffering because they are not containable. Neither pain nor suffering can be gauged objectively, nor are they subject to the kind of judgments needed to fashion coherent public policy. Euthanasia to cover those who are incapable of consenting would also be a likely, if not inevitable, extension of any policy permitting the practice for those who can consent.

Those concerns are heightened by experience in the Netherlands where the practices have been sanctioned legally. Although Dutch law requires an explicit request for euthanasia by the patient, a national study by the Dutch government found that, of approximately 3300 deaths annually resulting from mercy killing, 1000 deaths from euthanasia occurred without an explicit request. Dwell upon that alarming figure! There were 1000 deaths where euthanasia was not requested. In other words, despite all the assurances, in the Netherlands, euthanasia has moved from voluntary to involuntary. In an alarming number of cases in the Netherlands, if a doctor decides that the patient should no longer live, then he or she is dead. Even more alarmingly, in some cases, doctors provided assisted suicide in response to suffering caused solely by psychiatric illness, including severe depression. By way of example, in 1993, a 50-year-old woman, who had lost both her sons and who had been beaten repeatedly by her husband over a 25-year period, was euthanased because of her chronic depression - not because of a terminal illness. Let me give an even worse example. A Dutch court found recently that a gynaecologist, who had admitted euthanasing a deformed 3-day-old baby girl at the request of her parents, was innocent of any wrongdoing. The verdict set a new legal precedent in the Netherlands' liberal euthanasia policy. The mercy killing of newborns is now acceptable in the Netherlands.

Is that the type of practice that Territorians want to see in our community? I can hear the proponents of euthanasia now: 'It will never happen here'. That is what the Dutch said 5 years ago and yet, when Dutch

authorities were challenged about this example and others, their simple response was that the practice of euthanasia had evolved. It certainly has. It is a very good illustration of how elastic clinical practice and law become over time. The Dutch euthanasia experience lends support to the 'slippery slope' argument. As the 1000 cases of unrequested killings graphically illustrate, guidelines have been widely disregarded. These deaths were not an aberration, nor were the patients killed by a minority of maverick doctors. The survey found that a majority of doctors admitted that they either had killed without request or would be prepared to do so. Within a remarkably short period of time, the Dutch have proceeded down the 'slippery slope' from voluntary to non-voluntary euthanasia.

Let me debunk this notion that euthanasia empowers the terminally ill. The fact is that, based on the experience in the Netherlands, euthanasia does not result in greater patient autonomy, but in doctors acquiring even more power over the life and death of their patients. Doctors will do what is routinely called for in good medical practice - they will make a recommendation. Doctors know what is best for their patient, and some will act accordingly. Helping a patient to die with dignity is different from killing a patient in the name of compassion. In helping a patient to die, the doctor accepts but does not cause the patient's death. And what of the role of the relatives? There is a real danger that a right to die may all too easily become a duty to die. Severely ill patients depend on others, not only for physical care but for conversation, respect and meaningful human interaction. In some cases, family members may encourage patients to choose the option of dying. More commonly, even without such pressure, a patient may assume that friends and family regard the choice to remain alive as irrational and selfish. As expressed by one commentator:

The patient may rationally judge that he is better off taking the option of euthanasia even though he would have been best off not having the option at all. ... to offer the option of dying may be to give people new reasons for dying.

Let me share with members something which I was deeply ashamed of at the time. I recall that, when my father lay dying, after yet another call to the bedside, when doctors failed yet again to predict when he might die, I said in my anguish: 'Why doesn't he get it over and done with it?' I was deeply ashamed at the time of having said that, but I am told, and in fact I was told at the time, that it is was a not uncommon reaction. Relatives often suffer as much as the patient. The anguish and suffering of relatives is not, however, an argument for euthanasia. Last week, a letter was circulated in the Chamber in support of euthanasia. It set out to relate a real life experience. It was principally about the relatives and not the person who was dying. Without realising it, the person who wrote the letter was, in fact, underscoring the point that we should not kill patients - our loved ones - simply to comfort the relatives and the bystanders. A right to die becomes a duty to die.

I regret that I have run out of time, and I conclude my remarks there.

Mr PALMER (Karama): Mr Speaker, this bill and the proposed amendments to it purport to support the rights of the terminally ill. To that end, and in the minds of many, the bill probably achieves what it sets out to do. Several months ago, if asked in conversation what my views were, I would have tended to support the principle of voluntary euthanasia. However, since that time, the debate and my views have come a long way.

The public debate has ranged from the religious, philosophical and humanistic viewpoints through to the medical and clinical arguments about the dying process and the dignity, or lack of dignity, attached thereto along with the pain or amelioration of pain encountered in that process. The debate itself has touched the very core of our society and civilisation and has pondered the question of the rights of the

individual versus the rights or greater good of the community or society in which the individual lives. Dare I say that greater minds than those assembled here have in the past, and no doubt will in the future, continued to address that issue. Indeed, in the United States of America, the argument rages around the rights of the citizenry to carry arms. Obviously, no thinking Australian would advocate the introduction of gun laws similar to those that pertain in most states of the United States. It is a clear example of an instance where the rights of society should take clear precedence over the claimed rights of the individual. Conversely, no one would suggest that the state should dictate to the individual or interfere with the individual's right to practise the religion of his or her choice, and that is notwithstanding the fact that the history of man is sadly littered with the atrocities of sectarian violence, and that reasonable argument can be made and sustained in support of a single religion state.

If the question we are addressing today were as simplistic as deciding between who possessed the greater right, the issue would be fairly clear in my mind. Unless it can be clearly demonstrated to the contrary, the rights of the individual should remain supreme. If I were convinced that the principle enunciated by the member for Fannie Bay and other supporters of the bill - that its implementation would affect only those terminally ill patients of sound mind who opt to avail themselves of its provisions - was set in concrete and not subject to further tampering or interpretation, I would be inclined to support the rights of the individual. Unfortunately, the history of legislation and the experience of legislators is that, no matter how clear the intent and no matter how vehemently assurances that a particular item of a statute is fixed and cannot be tampered with, those clear statements of intent and those assurances cannot be relied on. The courts of this and other countries continue to show a sorry propensity to indulge in what they call euphemistically 'advancing the law'. The danger inherent in any piece of legislation is that, over time, the courts take opportunities to usurp the power and role of the parliament and to advance the law beyond what was intended. In this instance, that makes me extremely uncomfortable as a legislator. There are those who, in the course of the public debate, have even lost sight of the intention of the bill or, even more disturbingly, are already advocating the advancement of the law.

Amongst the countless letters and submissions we have no doubt all received, one stuck in my mind as the thin end of the wedge, and that was from a Territorian and professional person who is known to many in this House. It outlined the circumstances surrounding the death of a person who was obviously very dear to the writer. The nub of the submission was that the family suffered distress and agony at the sight of their beloved, physically although painlessly, fading away. He is already advocating that others have rights in relation to the death of an individual. Once the parliament or the courts or private citizens begin to argue that others have rights which must be recognised aside from those of the patient, the much-touted rights of the individual are beginning to be lost. No person, other than the patient, has a stake in the terms and conditions of his or her demise.

Even more frightening than the gradual and inevitable erosion of the rights of the individual will be the imperceptible yet real pressure on the terminally ill to relieve their family and friends of the burden of their continued presence. No matter the reassurances, no matter the expression of love and support, there will be some who, although dearly holding on to life, will succumb to those pressures. I wonder how many of the supporters of this bill support it on the basis of the pain and distress they have gone through, when witnessing the death of a loved one. I also wonder, somewhat more cynically, how many are motivated by the personal inconvenience of it all, although I might say that, in relation to the latter, I would certainly hope it is none.

Much of the debate in the preceding months has centred on the dignity of death. There is no dignity in

death. There is only dignity in life, and it is only in life that dignity is maintained. Much can, and should be done to maintain the dignity of life. Until, in the Northern Territory, we can say that we have implemented a regime of best practice palliative care, until we can say that we have done our utmost to preserve the dignity of the patient and until the medical profession is forced to hold its hands up in defeat, we should discontinue our pursuit of this course. I for one am a person who can be swayed by the arguments of those best placed to know. In this instance, those best placed to know are obviously the medical practitioners who are involved on a daily basis. Nothing presented to me in the literature to date has convinced me that the medical profession in the Northern Territory, or indeed elsewhere, is prepared to raise its hands in defeat. With the advances made in medicine over the past 2000 years, one can only believe that any humanitarian need for euthanasia is diminishing daily.

This bill was first presented as a private member's bill subject to a conscience vote. Almost immediately, the debate became lost in the realms of populist politics. Each side set about outdoing the other in the collection of signatures and the presentation of petitions. If the issues before us were simply those of populist politics and of little consequence to the future of our society, if it were a clear and simple issue of individual rights, if what was being proposed could be undone simply, perhaps the question of a conscience vote would never have been raised. I recognise that we are all elected to represent the views of our respective electorates but, balanced against that, we are obliged individually also to consider issues that are brought before us. On election, we either swear an oath or make an affirmation that we will render true and faithful service. You cannot render true and faithful service to anyone or anything unless you are firstly true and faithful to yourself. In what has been agreed is a matter for a conscience vote, you cannot vote against what is your personal ethics or conscience. I do not claim any high moral or ethical ground. At the end of the day, we are not entitled to question each other's conscience, nor are we entitled to belittle each other in respect of the processes we each used in arriving at our respective positions. As a matter of the rights of the individual, we are obliged to respect the right of others to their opinion. My conscience, being partly a result of my upbringing, partly a result of my life's experiences and partly a result of the arguments put in relation to this bill, does not allow me to vote in support of it.

I would not expect anything I have said here today to influence any member in their vote. Nor has anything I have heard so far moved me from my position. That is not to say that, in future, I might not be of a different mind. It is simply that I am not convinced, either as a matter of conscience or as a matter of science, that I should support this bill.

Mr MANZIE (Sanderson): Mr Speaker, I rise this evening to contribute to this debate after spending a great deal of time on researching, talking, thinking and reading about the subject. One can read extensive and detailed literature in support of both sides of an argument. I have spoken to individuals who have strong religious beliefs and to individuals who have strong ethical beliefs. I have spoken to individuals who have suffered the despair of seeing loved ones die in front of them in ways that they have found most distressing. I have witnessed circumstances where death has occurred with comfort and with dignity. I have had to search long and hard to reach a decision as to which way I would vote in relation to this bill. I believe it comes down to the individual having the right to die as comfortably as possible and to die in circumstances that allow that process to be completed with dignity. For those reasons, I will support the bill.

It is important to look at the circumstances surrounding this matter. First of all, we should be quite clear on what our present circumstances are. At present, there is a practice which is accepted by most as being pretty reasonable, and it is one which is reasonably common among doctors who are involved with the

dying process. The submission to the select committee by the AMA details it quite succinctly. I quote from the submission:

The major confusion in the professional mind is related to whether or not the common death practice in Australia is euthanasia or not. This practice involves the use of larger amounts of medicine in the immediate peri-death period to deal with otherwise uncontrollable pain and discomfort. This practice is often the cause of accelerated death, and 19% to 40% of doctors consider this action to be the equivalent to euthanasia. Since the motivation for their action is to relieve pain, and not to kill the patient, this is certainly not euthanasia as many texts such as the following will demonstrate.

There follows a quote from Sir Thomas Percival in Medical Ethics, 1803:

When medicines administered to a patient with an honest design, to produce alleviation of his pain, or cure of his disease, occasion death, this is misadventure, in the view of the law: and the physician or surgeon who directed them, is not liable to punishment criminally.

The submission went on:

In the situation that the doctor does administer medicines to procure death as a primary goal then this is true active euthanasia. This means that identical actions with identical outcomes can on the one hand be considered good palliative medicine and on the other euthanasia!

Those are the circumstances that presently exist. Doctors believe that, if they are acting with the patient's comfort foremost in mind, and the provision of drugs, which aims to ensure that comfort and pain minimisation are maintained, hastens the patient's death, that is okay provided they did not intend to cause death. That is the view of the local branch of the AMA, and it is the view of a number of doctors to whom I have spoken. However, it is not the view of the law. The law is very clear. Section 154 of the Criminal Code states:

Any person who does or makes any act or omission that causes serious danger, actual or potential, to the lives, health or safety of the public, or to any person (whether or not a member of the public) in circumstances where an ordinary person similarly circumstanced would have clearly foreseen such danger and not have done or made that act or omission, is guilty of a crime and is liable to imprisonment for 5 years.

Subsection (3) states: 'If he thereby causes death to any person, he is liable to imprisonment for 10 years'.

It refers to 'any act where an ordinary person, similarly circumstanced, would have clearly foreseen such danger and not have done or made that act'. It is quite clear that a doctor is well-qualified to know the quantity of a drug that would cause death. Any reasonable person would be able to ascertain the end result. Intention is not required to prove that that section has been contravened.

Mr Perron: They break the law every time.

Mr MANZIE: They break the law when they follow the procedure which the AMA pointed out to the committee is something that is carried out by 19% to 40% of doctors. That means that, at present, one doctor with no checks - there is no requirement for 2 doctors or a psychiatrist - can proceed. There is no requirement for the patient to make a request. In other words, the patient may not have any idea that this process will occur to bring about their death. There is no requirement anywhere for the doctor to be sure that there is a terminal illness. There is no test that the doctor has to carry out to ensure that in fact the patient is dying. There is no need for the doctor to establish that there is no suitable treatment. The major point is that the patient is not empowered in relation to that decision. Finally, it is against the law.

We live under a system that we call 'the rule of law'. Under that system, we believe that no one is above the law. Politicians are not above the law. Judges are not above the law. Police are not above the law. Why should doctors be above the law? Why should we have a set of circumstances whereby we turn a blind eye to what is being practised? It is not proper. I would be interested to hear if the member for Grestrey believes that the AMA submission is correct. If the submission is correct, he has then to interpret the law and I would like to understand how he believes that doctors can be above the law. I am not criticising doctors for doing this. I am pointing out that it is against the law, and nobody appears willing to address that. I do not think it is proper that doctors should have to break the law in their dealings with their patients. However, it is very clear that they are breaking the law. It is a simple fact.

Should we prosecute the doctors or should we change the law? Why should we change the law? A factor that has been missing from this debate is the human element. We have heard very little of what is involved in dying in agony. We are not talking about large numbers of people dying in agony. We are not talking about the bulk of people who go through the process that we will all eventually go through. We are talking about a very small group of people. Some say that up to 5% of people can suffer terribly. Others say that it is between 1% and 2%. We have a number of people who, under our present system of palliative care, still suffer a terrible set of circumstances when they die. They do not die in comfort. They do not die with any dignity. They die in agony.

It is important to realise that doctors accept the fact that not all types of pain can be controlled through modern palliative care. Most members are aware of certain illnesses because the details were circulated, but I believe it is important to mention a few of them: raised intracranial pressure due to inoperable brain tumour, infiltrating head and neck cancers, lung cancers, mesothelioma, recurrent bowel obstruction due to widespread abdominal cancer, pelvic cancer, severe chronic polyarthritis with joint disintegration, spinal cancer with nerve-root pain, vertebral collapse, and inoperable bladder cancer. Those are simply a few of the diseases that, under certain circumstances, cannot be controlled even with the most modern palliative care. Patients can find themselves in excruciating agony and, as politicians, we must take account of that and we need to be very sure about what the community wants. I do not believe we have the luxury to sit in this House and ignore community views. We are elected by the community and the people who elect us expect us to promote their views and carry out their wishes.

When I stood as a candidate at the last election, the platform did not include the concept of euthanasia. I was not able to say to my constituents that, if they elected me, I would support the Rights of the Terminally Ill Bill. I have circulated the bill and explanatory notes to all my constituents and asked if they wanted any further information. To those who requested additional information, I forwarded 2 papers in support of euthanasia and 2 papers against euthanasia. I also polled 500 households in my electorate, and 81% were in favour of the provisions of the bill, 15% were against and 3% were uncertain. That certainly sent me a very strong signal.

As I said earlier, we seem to have forgotten one group of people while we have been debating this issue. We have forgotten those people who are dying in agony. It is important to remember that the provisions of this bill relate only to those people who are dying. It does not relate to those people who may recover. It does not relate to those people who are sick. It relates to people who are undergoing the dying process. Death is inevitable ...

Mr Bell: This goes for all of us.

Mr MANZIE: The member for MacDonnell jokes and laughs about it! It is more serious than that, and I believe we should be focusing on what we are talking about here. We are talking about people who are dying a miserable death in circumstances where there is no suitable pain relief. We are talking about circumstances which are not pleasant. We are talking about a lack of dignity, about misery and about a level pain that I am certainly not in a position to describe adequately. Some of the submissions to the committee gave an indication of the horrific ordeal that some people experience.

I was quite moved by one submission to the committee from a Mr Chapman. He described the terrible circumstances of the death of his wife from cancer which occurred over a number of years. Her ordeal began in 1988. In February 1993, she was admitted to Darwin Private Hospital, to die there. However, that process took a further 60 days. The submission details notes from a diary that Mr Chapman kept. I will read a couple of extracts. On day 40:

She experienced severe pain in the lower back and behind the left knee. After being helped from bed to go to the toilet, she could not bear any weight on her feet during her return. She was extremely distressed by the pain. A hot pack and Panadol gave no relief. Her sobbing and crying continued for more than half an hour. Omnopon was then prescribed and the pain abated by 0610 hours. The daily dose of MS Contin was increased as the doctor thought the sudden deterioration in her mobility could indicate bone fracture in the legs or pelvis. She was X-rayed later that morning. No fracture was detected but extensive metastatic decline of bone tissue was confirmed. From this time onwards, she was washed in bed.

Day 58:

Her condition had deteriorated further. She experienced pain and distress whenever she moved. Top-up injections of morphine were given whenever she became restless. Her bladder was washed out again and a catheter found to be blocked with sediment. She seemed comfortable during the afternoon. At 1945 hours, a nurse again tried to administer Epilum syrup, but she seemed almost comatose and had great difficulty in swallowing.

That woman died on day 60. To think that she had to suffer for that time in agony is most distressing.

I urge all members to read about what actually occurs and gain some idea of the suffering that some individuals have to endure. It certainly means that the philosophies that we seem to be debating so matter-of-factly take on new meaning. That submission to the committee carried considerable detail. I found something else from Mr Chapman which I believe is quite pertinent. I quote from page 111 of the submissions. It is headed 'To kill or not to kill?':

Homo sapiens is a great killer. We kill other animals by the billion for our food. We kill our fellows by the million for other reasons. We will kill for territory and for sex. We will kill for convenience and for self-interest; for fun and for revenge. We will kill for fear that others will kill us. We will kill for ideas. Think of an idea, noble or ignoble, and someone will kill or be killed for it. Create the circumstance and we are all killers. Our killing is ritualised, sanctified, glorified or vilified, depending on the circumstance. Nothing, no code of ethics, no moral scruple, no taboo has been able to stop the killing. The long-standing 'thou shalt not kill' proscription of Christian and other codes of human behaviour and now enshrined in the UN code of civil rights, which states that 'every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life' ... is flouted daily around the world. It is much easier to get people to shoot their neighbours than to love them.

It goes on:

Though many are the reasons for which we will kill our fellows, to kill for kindness is not among their number.

That is most pertinent, Mr Speaker.

Another submission came from a Mrs Coward of New South Wales. She witnessed 4 of her close relatives and 3 friends suffer and die from terminal illnesses. In relation to her husband, she wrote the following. This is at page 406 of the submissions:

Husband - brain tumour. Loss of all motor functions very undignified death and although in a palliative care hospice I maintain he died of thirst because he couldn't swallow without choking. We fought hard together during the 15 months of his illness, but he should not have had to be subjected to living through the last few weeks, stripped of all quality of life in an undignified manner. My husband wished to end it all many times but other methods were bizarre and he wished to die in a dignified, controlled manner and begged for my help many times. I suffer with guilt that I did not have the tools and knowledge to help my mate of 32 years.

On behalf of my late husband, relatives friends and myself I do hope this bill will be passed

...

The bill we are debating relates to real people. It relates to people who are dying. It does not relate to people who may die or who are seriously sick or who feel down. It relates to people who are dying, for whom the process is well and truly under way, and the intention is to allow those who will suffer or are suffering agony to die in comfort and that those last few weeks of agony are removed. It is very important that we keep in mind the individuals who will be relieved of an agonising few days or few weeks if this bill is passed. It behoves us to bear in mind that we are talking about people. We can talk about many areas, but we should not deny a dying individual the right to make a choice about whether or not their death should be comfortable. The day that we deny the right of the individual to make a choice, the day that we impose our view on others in relation to their suffering, will be a day that I will not be proud to be associated with.

We know the present law is being flouted and most of us accept that as being an appropriate process. The AMA is quite pleased to point out publicly that it has a process, and it excuses the breach of the law by its members by saying that they have 'no intention'. However, as I pointed out, the law does not allow that process. We know that it is occurring. Why should doctors be forced to act in an illegal way and why should they do so without any safeguards? Why should we have a situation where doctors do not have to justify their actions? Why should we have a situation where the patients do not have the right to say what they want? They may not want their death accelerated. They may not want the treatment if they know that it will hasten their death. Regardless of that, they should have the right to play a part in it.

There has been a great deal of comment on this matter. Someone said that death is a time for rejoicing and a time for joy. I do not believe those who are dying in agony would agree with that sentiment. The member for Brennan spoke about euphemisms. He referred to a soldier and to the member for Greatorex who is a doctor. He asked why a doctor or a soldier would oppose this legislation. He said it was because both soldiers and doctors have a 'duty of care' in respect of human life. I believe that is a euphemism for 'I have no compassion for those who die in agony because my personal philosophy should be imposed on others'. I do not believe that we have the right to impose our own philosophy on others, but rather that

individuals should have the right of choice. If it does not suit them, people do not have to make that choice. If they are in difficult circumstances where life, their most precious possession, becomes so wretched and full of pain that they request that it be ended, why should those in good health and good circumstances insist that they should persist in agony and suffer to the end? I commend the bill to honourable members.

Mr ADAMSON (Casuarina): Mr Speaker, this legislation has been introduced in most unfortunate circumstances. It has been rushed, it has been badly drafted and it ignores serious concerns highlighted in a large number of respected studies. Furthermore, so many amendments are now proposed to it, that it will not end up as the piece of legislation that has been debated in our electorates. The amendments have the potential to tighten up certain areas, but would considerably weaken others.

Some have said that my opposition is based solely on my religious beliefs. They are wrong. It is unfortunate that some have tried to disenfranchise me in this debate simply because of my religious beliefs. I am personally against euthanasia. This legislation can be opposed just as easily on practical grounds. I wish to ask honourable members of this Assembly one question: are you confident that we can pass a safe law? By 'safe', I mean pass a law that enshrines safeguards that guarantee a person's freedom of choice, within reason, and their freedom from coercion, clinical depression, foul play, and the legal concerns raised by so many studies. Until we can overcome the recognised medical and legal difficulties, we should all oppose moves to legalise euthanasia.

This bill fails to take adequate account of concerns raised in other important parliamentary studies into the legalising of euthanasia. Those studies did not lack the political will for change, but they identified ethical, practical and legal difficulties. It has been argued that we should not follow blindly what other jurisdictions have done or have not done, and that is fair enough. We are Territorians first and foremost and we are legislating for all Territorians regardless of what is said and done in other jurisdictions. However, we would be foolish to ignore the valuable studies that have been done elsewhere on this subject, as the proponents of the legislation have done. It is only commonsense for both sides of the debate to call on the advice of recognised experts even if they lack a Northern Territory postcode. Honourable members who support this bill may dismiss the concerns I raise, but the onus should be on them to prove why they should be dismissed. To quote Dr Brian Pollard, a medical practitioner of over 30 years experience, who has been responsible for establishing the first full-time palliative care service in Sydney's teaching hospitals:

One of the main reasons why euthanasia law has never been passed anywhere, despite many attempts to do so, is that the patient's ability to consent freely can never be guaranteed.

As legislators, we have a responsibility to pass responsible laws. That does not involve hastily patching up a faulty bill with a series of bandaids, in this case a packet of 50, hoping that, at the end of the day, it might just turn out to be a decent bill. This proposed law provides next to no safeguards, simply a handful of requirements. As I stated earlier, I believe it is important that the work of other parliaments and other jurisdictional authorities not be ignored because there have been a number of excellent reports. The committees involved were well-resourced and diverse in their make-up, but the one thing they all had in common was that they all rejected the legalisation of euthanasia. Almost all did so unanimously, despite many of the committees having a significant number of members who favoured the concept of legalising euthanasia. They rejected it because they recognised the real medical and legal difficulties.

Perhaps the best report of all was conducted by the House of Lords Select Committee on Medical Ethics. This committee was constituted of members who were for and against the concept of euthanasia. It noted

unanimously in its 1993-94 session:

That prohibition [of intentional killing] is the cornerstone of the law and of social relationships. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia.

The Social Development Committee of the Victorian parliament held an inquiry into 'options for dying with dignity'. The first recommendation in its second and final report could not be clearer:

That it is neither desirable nor practicable for any legislative action to be taken establishing a right to die.

What does this bill do to overcome the concerns raised by those 2 committees? The practical difficulties these reports have identified have not been adequately addressed in this legislation. Other significant reports have brought down similar recommendations. The New York Task Force on Life and the Law reported:

Members of the task force hold different views about the ethical acceptability of assisted suicide and euthanasia. Despite these differences, they unanimously recommended that existing law should not be changed to permit these practices.

That committee also included a significant number of members who favoured euthanasia, yet they unanimously rejected the legalising of assisted suicide. Why do we believe we have found a secret where others have not? Others have rejected the legalising of euthanasia, not as a result of any lack of political will, but because of their responsibility as legislators to pass good laws. We are acting hastily at the expense of caution.

I turn to the bill itself. As I have stated, I believe the bill is badly drafted. It carries the amateurish brush strokes of the Voluntary Euthanasia Society of Victoria. Nick Tonti-Filippini, one of Australia's leading bioethicists, commented:

The bill is a drafting disaster - drafted in obvious ignorance of the complexity of the area. Its overall effect is in fact to greatly diminish the legal protection of the rights of the sick and dying.

In my opinion, one of the main practical reasons, not yet fully addressed, remains in the area of assessing patient consent. Dr Brian Pollard pointed out:

The most glaring medical deficiency of the bill concerns its failure to take account of the documented close relationship between the desire for suicide and mental illness.

This very concern was also identified by the House of Lords:

Even apparently clear patient requests for cessation of treatment sometimes stem from ambivalence or may be affected by an undiagnosed depressive illness which, if successfully treated, might affect the patient's attitude.

Can doctors, with 5 years experience, be reasonably expected to identify these mental illnesses? We are putting them in the unreasonable position of performing the job of a specialist, a situation almost unprecedented in a society such as ours. Dr Pollard stated:

The evidence is overwhelming that the bill would permit unnecessary but preventable deaths ... the presence of subtle depression is difficult to detect, even for an expert, and often escapes detection even in those already under medical care. General practitioners may find it almost impossible to be sure about.

I am aware that one suggested amendment requires at least one medical practitioner to hold special qualifications in psychiatry. This is the closest attempt that I have seen to introduce a safeguard in relation to this bill. But, good as it is, I do not believe it adequately addresses the fact that more study is required to accurately assess the mental state of a patient. This is supported by Hendin and Klerman who are quoted in a submission to the select committee:

There is still too much we do not know about such patients, too much study yet to be done, before we could mandate psychiatric evaluation for such patients and define conditions under which assisted suicide would be legal.

Why do we believe we have found the way to safely legalise euthanasia where others have counselled caution?

The House of Lords also sounded a number of notes of concern in relation to patient consent. Paragraph 199 of its report stated:

The Home Office suggested that the potential for abuse was great, that directives might be written 'under false pretences or improper pressure' and that the practical difficulties of regulation were significant.

I wonder what advice government departments in the Northern Territory would offer.

I would like also to quote a leading international expert who supports voluntary euthanasia and who is mentioned in the report from the Northern Territory Select Committee on Euthanasia. The committee refers to the House of Lords report and quotes Professor Ronald Dworkin, Professor of Jurisprudence at Oxford and Professor of Law at New York University, who stated: 'I am in favour of choice because people disagree about what kind of death is meaningful for them'. However, in that very same report, the House of Lords committee noted: 'Professor Dworkin considered that it would not be possible always to be totally confident that a request for euthanasia was truly voluntary and not the result of pressure or coercion'.

Mr Perron: How confident can you be that no one will be killed in a road accident?

Mr ADAMSON Where is the freedom of choice? Even the American Suicide Foundation noted:

... at least 90% of patients who desire death during a terminal illness are suffering from a treatable mental illness, most commonly a depressive condition. This is not a diagnosis which can be made by the average doctor unless he or she has had extensive experience with depression and suicide. The diagnosis is frequently missed, even in those already under medical care.

Is 5 years experience as a medical practitioner enough to allay those concerns? Surely not. However, I believe it gets even worse because, under this legislation, a person can be diagnosed as suffering from a treatable clinical depression yet be deemed to be 'of sound mind' for the purposes of this bill. Are all members aware of that? It is that same depression that even the American Suicide Foundation acknowledges can be treated medically in over 90% of terminal cases.

The New York State Task Force on Life and the Law clearly acknowledged the difficulties in legislating freedom of choice:

In the course of their research, many task force members were particularly struck by the degree to which requests for suicide assistance by terminally ill patients are correlated with clinical depression or unmanaged pain, both of which can ordinarily be treated effectively

with current medical techniques. As a society, we can do far more to benefit these patients by improving pain relief and palliative care than by changing the law to make it easier to commit suicide or obtain a lethal objection.

Once again, how is it that we have found a solution that enables us to legislate where others have wisely advised caution?

I want to discuss briefly the ethics involved in legalising euthanasia. As members are aware, the Australian Medical Association states that euthanasia is unethical. Would we pass a measure in any other field which, in the opinion of the industry peak body, was unethical? I think not. The House of Lords committee was in no doubt as to how big a role the British Medical Association should play in any debate on legalising assisted suicide. Its report noted:

Some people may consider ... that we advocate leaving too much responsibility in the hands of doctors and other members of the health care team. They may argue that doctors and their colleagues are no better qualified than any other group of people to take ethical decisions ... But no other group of people is better qualified to do so. Doctors and their colleagues are versed in what is medically possible, and are therefore best placed to evaluate the likely outcomes of different courses of action in the very different circumstances of each individual case. By virtue of their vocation, training and professional integrity, they may be expected to act with rectitude and compassion.

Even some who do not have an ethical problem with euthanasia urge caution. The New York task force noted:

Some members do not believe that assisted suicide is inherently unethical ... Nonetheless these members have concluded that legalising assisted suicide would be unwise and dangerous public policy.

The House of Lords committee:

... we believe that any decriminalisation of voluntary euthanasia would give rise to more grave problems than those it sought to address.

I turn now to the matter of public opinion. There is little doubt that the majority of people in the western world favour the concept of voluntary euthanasia. I agree that the people of the Territory, and more specifically the people in my own electorate, are in favour of voluntary euthanasia. However, I am just as certain that, when there is a community debate on the legalising of assisted suicide, some of that support turns to concern. The best-documented examples come from the United States. As in Australia, the polls there regularly indicate strong support for voluntary euthanasia. However, on each occasion that an American state has debated the specifics of legislation, that support has eroded.

In 1991, voters in Washington State rejected Initiative 119 which would have legalised physician assisted killing. The initiative was defeated 54% to 46%. A year later, in 1992, a similar proposition was put to the people of California which surely must be one of the world's most liberal societies. Although it incorporated stricter controls than the Washington legislation, the voters of California had grave concerns about the legal implications and threw out the proposal - again by 54% to 46%. In Oregon, in November 1994, the polls indicated overwhelming support for the legalising of euthanasia, but the vote was a cliffhanger. That one was passed by 51% to 49%. I would like to turn my attention for a few moments to the Voluntary Euthanasia Society of Victoria (VESV) because that organisation has played such a large indirect role in this debate. One of 2 submissions made by the VESV was a book by the darling of the society, Dr Helga Kuhse. I believe the thoughts of Dr Kuhse and her colleague, Peter Singer, are

frightening. Let me quote from Kuhse and Singer's book 'Should the Baby Live?' They write:

... there is a limit to the burden of dependence which any community can carry. If we attempt to keep all handicapped infants alive, irrespective of their future prospects, we will have to give up other things that we may well regard as at least as important.

I find those ethics frightening. Equally frightening are the thoughts expressed by Singer in his book Practical Ethics:

When the death of a defective infant will lead to the birth of another infant with better prospects for a happy life, the total amount of happiness will be greater if the defective infant is killed. The loss of a happy life for the first infant is outweighed by the gain of a happier life for the second. Therefore, if killing the haemophiliac infant has no adverse effect on others, it would, according to the total view, be right to kill him.

That is the future, according to the ethical world of Kuhse and Singer. By all means let us debate euthanasia or palliative care. While I welcome arguments on both sides, I do not welcome the ethics of Kuhse and Singer.

At the risk of repeating myself, if we are to legalise voluntary euthanasia, we have a responsibility to get it right. There are so many fundamental flaws in this bill that it deserves to be opposed, regardless of one's personal beliefs. The bill does not offer adequate safeguards in the area of patient consent. While there remain areas of concern - legal, ethical and medical - freedom of choice is not guaranteed. Accordingly, this bill should be defeated.

Mr FINCH (Leanyer): Mr Speaker, for 10 years or more, it has been my belief that the right of the individual prevails. From listening to the arguments in this debate, I must say that I respect absolutely those who put their viewpoint with the courage of their own convictions - those who have, according to their own beliefs, a firm position. I do not quite relate to those who want to use as their crutch the argument of automatic religious advice, those who want to argue their versions of ethics, those who want to hide behind the detail, or lack of detail, in this bill or those who want to use, from either side of the argument, statistics in one way or another. As the ultimate cynic about statistical information, I assure members that is no way to hide. Nor do I relate to those who hide behind expert external views on this issue - you can find views to send you in either direction if you seek hard enough and long enough - or those who want to argue on the basis of precedents from parliaments in other countries. I say to them that they are here to judge for those people for whom this bill will be applicable - and no one else.

Like that of most members of this parliament, my conviction of 10 years is based as much on personal experience as on anything else. When I entered into this debate some 2 months ago, members may recall some of the castigation of the motion that I moved in this House - a motion that would have given the people of the Territory at least some say on this bill. From the beginning, I was disappointed that there was to be no plebiscite whereby we would obtain the views of the people. Certainly, these had to be informed views, but at least we should have heard what the people were saying. Some members - even some members opposite who share my views on this issue - castigated me for voting for the select committee even though I had no faith that it could serve anything other than a peripheral purpose. Secondly, they castigated me for calling for a professional poll to canvass the views of Territorians. While I am not wounded by that vote - I think it was lost 19:6 - I was attempting to do at least what I thought was ...

Mr Bell: A few people were not here. You did not have the numbers.

Mr FINCH: That is true, but it does not change my view. In this debate, you must have the courage of your personal convictions. That is the bottom line. Leaning on some crutch of a side issue - this is all too hasty, or this has too much or too little detail, or this all relates to ethics or religion or the expert views of other people - is twaddle. It is not fair dinkum. My role for my electorate, as I saw it, was to try to obtain people's genuine views on this issue. Anyone who knew me or took the trouble to ask me would have known what my view has been, not only from the time of the introduction of this bill but from 10 years before that. Such people would have known my view but, apart from that, I kept my own counsel. I wanted genuine feedback from my constituents as to what they thought. If I had declared, as some members of this House did, that I was for or against the legislation before canvassing the people's views, their views would have been prejudiced obviously by my stated position.

I sought a survey - and I thought that was a reasonable proposal - that would have been held after considerable debate in the community. It would have been quite comprehensive - perhaps a 30% sampling which would have given a coefficient of error of only 1% to 2%. Some argued that 10% of Territorians are not on the telephone and therefore could not be canvassed by that method. That would not have had much effect on the coefficient of error. I did not say that we should ignore their views. I said that we should find a supplementary means of determining the views of those people who, in the main, are traditional Aboriginals living in remote areas. I did not turn my back on their views. What I was saying was that at least the views of 90% of Territorians ought to be taken into account. We should listen to them even if we did not agree with what they had to say. From the very beginning, I wanted to hear what my electorate had to say. The figures from my electorate are no different from those gathered in any other of the suburban surveys that were undertaken.

In relation to the committee, I said from the beginning that it would be a receptacle for various views, mainly from lobby groups and mainly from interstate. Nevertheless, I felt it would be good in that it would provide an opportunity for any person who felt aggrieved to appear before the committee. Fundamentally, I thought the people of the Northern Territory would want the opportunity to have a say and to be heard.

I accept the genuine position of individual members who have spoken in this Chamber. They are entitled to their views. When I first entered this parliament, probably in my first or second sittings, I quoted a piece of advice that I had learned from my grandfather who also was a politician. Maybe he sat on the other side of the fence, but he was a man for whom I had enormous regard. He said to me when I was a young fellow: 'You need to understand and respect the other person's point of view even though you might not always agree with it'. That advice has been as beneficial to me as any other in my political career.

In this debate, there is no doubt that we are influenced by our personal experiences. We all have our own set of ethics, our own interpretation of Christianity or community belief, and we are influenced by our personal experiences. I have been blessed in that most of my family have not been exposed to the great personal tragedy of lingering suffering at the end of their lives. Personally, I can look at death and I can look it square in the eye. I have done that a bit. People can say that it is easy for me because my old ticker will trip out and I will go quick smart. However, I despair for those who linger and for those who feel that they want another way.

I will not start to think about the experiences of my wife. I will not reflect on them other than to say that, in 13 years with the Northern Territory Anti-Cancer Foundation, her exposure to personal tragedy and to

people who have died unceremoniously would exceed that of 10 doctors. That was a burden that she carried for 13 years. In a way, it was a burden that I shared because it was not easy for her. It will not be easy for the next group of people who care for that single classification of people among whom there are a few who may want to take advantage of this bill.

We have heard arguments put about indecent haste, but what would change the views of members here? Whatever the time frame, we would still have those who are absolutely convinced that this is the right way to go, those who are absolutely convinced that it is not and those who, in 3 years time, will still be dancing around in the middle saying: 'But, but, but'. I do have a difficulty even with those who say 'but' because they are probably confused in their own mind. I am clear about where I am coming from.

One of the other arguments is that somehow suffering at the end of your life is an ennobling experience. I do not have a great problem with pain. I believe I have a very high tolerance level of pain. However, I do not find that it is an ennobling experience. I would hate to think how I would be if I went beyond simply the pain question to the other demeaning components of ultimate death. Whom does it ennoble? Is it the person suffering? Is it the witness? 'He died such a noble death. That is good for him. I am still here'. I do not think that is such an ennobling experience.

The question of morality has been raised. I believe that, like the Christian ethic, morality is very much a matter of personal interpretation. Something that I have taken great exception to in this entire debate is that, if one advocates accelerating one's death or making it easier, one is judged to be immoral. In respect of the suggestion that one classification of morality is superior to another - and there are probably 5 million variations - I ask who is to judge.

Like many members, I was lobbied from far and wide. I read the first 50 letters from interstate and decided that was enough. However, I took note of every letter, every telephone call and every representation from people within the Territory, particularly those from my constituents. In the end, it is a little like the Greenpeace movement. Whilst Greenpeace has a fundamental, philosophic correctness in terms of preserving the environment, its methodology sometimes goes over the top. That is its prerogative. That is its strategy and tactic. It might convince some, but there are many others who are turned off by it. I am turned off by some of the arguments of some of the zealots who oppose this bill. We have been told that, if we vote for the bill, we will be classified as Nazis. The choice of words of some of the opponents was extraordinary.

There was the argument about the state of mind of the person who takes this significant decision in their life. All of those in that category are said to be suffering from depression. How else would one feel when faced with a horrible death? I cannot imagine how one could be excited about it. Thus, because they are depressed, they should be ignored. I must say to the opponents of the bill that of course people are depressed when they are bound to die. This legislation applies only to the individual who predictably is going to die. It does not apply to anyone else. You have to measure what - and this is where the professional advice comes in - you ought to be doing against that background of a natural, depressed state.

There was discussion as to whether this legislation would apply only to Territorians. You cannot pass legislation here that would exclude people from other states. In the early days, a concern was expressed to me that this was a commercial deal relating to increasing tourism and the economic returns to doctors. I said that that was nonsense. I took a position in the early days that we ought to try to contain it to Territorians. However, logically and constitutionally, that would be impossible.

There has been reference to members making a decision based on their political future. Members have come to this debate from both ends in terms of numbers. There are those who say that they will vote on the basis of the majority view in their electorate. I understand from earlier debates that some have another point of view. It does not matter to them that 80% of their electorate is in favour of the bill because, according to their theory, that 80% will not get cranky or hold it against them. They are persuaded more by the 20% or 25% who are opposed to the bill. That is an individual decision also. If honourable members want to take the pragmatic view that it is ultimately the votes that count, be that on their conscience. I do not question the conscience of those who reject it on the basis of rational, well-considered arguments. To those on the middle ground, who will vote on the basis of the statistics, I say that I recognise that that is an approach, but I do not believe that, in this instance, it is the way to go.

We heard a great deal about the medical profession and Dr Chris Wake of the AMA. I think he has gone a little over the top and perhaps is a Greenpeace activist in disguise. He tries to express the old medical view that the doctor knows best. I have the utmost support and respect for the medical profession. I have a member of it in my family. I have the same professional respect for architects, engineers, lawyers and other professionals.

Mr Ede: Don't take it too far.

Mr FINCH: I will not take it too far. That respect has a dividing line. Those in the community, who have developed their expertise and have excellent professional and ethical objectives, are to be admired. However, their role is ultimately to do what the consumer, the member of the public, desires. If a doctor gives you advice that you do not like, you do not take it. If an engineer tells you to do something and you think he is wrong, you do not do it. To those like Dr Wake, who set themselves up on a pedestal and say that they are doctors and therefore they are on the right hand of God, I say phooey. I do not believe that he has any greater say in this debate than any one of my 4500 constituents.

Members of the medical profession have a role to play, if they wish to play it. If they do not, they should stay out of the exercise. I believe they have a role, but only in terms of the detail, the practicalities and the final regulations. In the end, it is the individual patient who is empowered, not the doctor. He is an adviser. He is a practitioner. He is a deliverer, but he is not empowered with the decision. The decision belongs with the patient.

Dr Wake made great play about palliative care. However, I am not sure which direction he is coming from because, as I recall it, when the Northern Territory Anti-Cancer Foundation first advocated many years ago that the Northern Territory needed greater palliative care facilities, who ran away at 100 mph? Dr Wake!

Mr Perron: He keeps changing around.

Mr FINCH: Where was he when the debate started? It is very awkward for me to make such personal criticism, and I would not have done it a month ago. I would not even have contemplated it 2 months ago, but the nonsense that I have heard from Dr Wake in the last month causes me to say that I believe that, in their life, a person must have a standard and a conviction, and must stick with it. If Dr Wake is so convinced that palliative care is the be-all and end-all - although he said 2 weeks ago that it is not the panacea - where was he 8 years ago when the Northern Territory was in the position to move forward on palliative care? End of personal criticism.

Mr Bell: What do you mean by where was he?

Mr FINCH: Where was he? He ran away at 100 mph - that is where he was.

Mr Bell: Why?

Mr FINCH: Because he did not have the courage of his convictions. All of a sudden, he has changed to suit some other agenda, an agenda not shared by all members of the AMA - and the AMA has only 50% of the medical practitioners in the Northern Territory in its membership. Whom is he speaking for and on behalf of? I say himself! And I say that he has some thinking to do about the ethics of this whole issue.

Members have been nitpicking about words. If they want to nitpick about words and clauses, all they are really attempting to do is escape from their individual responsibility in this matter. I can accept a genuinely expressed view that a member is opposed to this bill for moral, ethical or any other legitimate reasons - end of story - but let's not dance around about why we are voting for it or even against it. Some members have told us to 'think about the doctor'. If the doctor is not in it, he is out of it. If he does not want to be part of it, he will not be part of it. If the nurse does not want to be part of it, she will not be part of it. If the family do not want to be part of it, they do not have to be part of it. This is all about the individual. To suggest that individual rights equal selfishness is the height of hypocrisy. Nothing can be more fundamental in this life than a person's individual rights.

There are those who espouse the 'crack in the door', the 'slippery slide' argument. Obviously, that aspect is up to this Legislative Assembly. Some of us will be here for a while, some of us will be here longer and others will follow. However, it will be this Legislative Assembly that will put the shutter down where the shutter belongs. The bill we are debating at the moment and the amendments to it that are proposed contain safeguard after safeguard. I admit that I do not mind how many safeguards there are in this legislation because that is probably very healthy. However, not one of those safeguards can be lifted without the majority endorsement of this House.

The member for Nhulunbuy spoke about his survey of - I think he said 3 - Aboriginal communities. He named them. From that survey, he has concluded that 100% of Aboriginal people are opposed to this bill. You wonder why people shake their heads. He believes that the Aboriginal view is 100% against this bill because he has been to 3 communities. He says it is against the Aboriginal culture. I do not put myself up as an expert on Aboriginal culture. I have been around in the Territory for 20 years and I keep saying that I know enough about it to know that I do not know much. However, if he thinks that he has it by the throat, let him explain about 40 000 years of culture - and we are not talking about voluntary euthanasia in some of the practices, but involuntary euthanasia. Would he want to leave someone out in the desert without any water, because they are old and frail? Would he want to do something about twins, or a boy or a girl? Voluntary euthanasia? Not really. This view is put to us by the member for Nhulunbuy. He has been in town for 10 minutes and has visited 3 Aboriginal communities, and he is expert enough now to say that 100% of his Aboriginal constituents are against it. Nonsense! The member says that Royal Darwin Hospital will be vacated because doctors will have suddenly a licence to kill. Talk about terminology! When it comes down to it, the terminology used by many in this Chamber has been extremely provocative, to say the least.

Many other issues need to be canvassed and I hope we will have the opportunity to do that in the committee stage. If not, it will not be the first time that I have stood in here on a losing side. I have a couple of questions for the Nervous Nellies. How many more safeguards do they want to ensure the

protection of whom? Whom are we here to safeguard? Even if I am voting for only 5 Territorians who wish to benefit from the provisions of this legislation, I will vote for their freedom and for their opportunity to have their say and to exercise their will.

Mr EDE (Stuart): Mr Speaker, it has been said that politics makes strange bedfellows. I certainly do not agree with everything that has been said by members who have spoken, but some very impressive comments have been made about the sanctity of life. Many members have spoken about that. Life is wonderful and a wondrous thing. We should explore it, enhance it, enjoy it, protect it, glorify it and celebrate it. However, quite naturally, we tend to turn away from death. Because we love life, that is what we want to celebrate. When we hear sombre stories about long and painful deaths, we say that that will not apply to ourselves or our families. We believe that it is something that happens to someone else. I suppose the same applies with the volunteers in our armed forces. In their enthusiasm to join up and go out to fight for their country, their families and the things they believe in, they turn away from the ugliness of death on the battlefield and what it can mean. They have to blank that out. They know it happens in theory and in practice, but it cannot be personalised.

We do not like to consider the possibility of a painful, ugly, lingering near-death that may persist month after month, year after year. We cannot bear to contemplate that that could happen to ourselves or, worse still, to our loved ones. The vast majority of deaths are, as the member for Nhulunbuy described, painful times, sad times, but times of reconciliation and times of putting things in order before the final passage. As I propose to see it amended, this bill is certainly not for those people. The vast majority of people will have nothing to do with this legislation. It does not recognise them and they will not countenance it. However, there is another substantial group of people who will not simply slip away beautifully in the arms of their family. Such people will require substantial quantities of drugs to alleviate the pain of their passage. In many cases, those people have choices under the *Natural Death Act* but, under this legislation, as I propose to have it amended, they will have the choice of euthanasia.

I would like to make my position clear at this point. I will be voting in support of the motion that the bill be read a second time. That is not because I support the bill as introduced by the member for Fannie Bay. I do not support that bill because I believe it is fatally flawed. The member for Fannie Bay is proposing a number of changes to that original bill, many of which I agree with. I will support the motion for the second reading because I believe this legislation must be debated in committee. The first speaker in this debate, the member for Nightcliff, said that one day we would have euthanasia. He went on to say that we need to determine what we can do when there is no longer any means of relieving a person's suffering and that person wants their life shortened. If that is what members believe is the situation, they should vote for the motion for the second reading.

The debate we are engaged in now is not about the minutiae of the bill. It is a time for indicating proposed amendments and discussing the general principle. At the end of this debate, we will be voting on that principle. In the committee stage, members will have the opportunity to scrutinise the bill, clause by clause, line by line, and agree to or oppose the specifics of this legislation. They will have the opportunity to debate some 50-odd amendments. At the end of that process, members will have the opportunity to decide whether the bill, as amended in the committee stage, is something they can support in its totality. That is the choice that members will have. I urge them not to chop off debate at this stage. We are all aware that this issue has to be addressed. If this parliament does not address it, it will be addressed by other means. It is being addressed right now by doctors and others who are acting without the guidelines of legislative fiat.

The form of the bill that I can support will incorporate the amendments that have been circulated. I do not believe in a broad, unrestrained right for the individual to ask someone else to assist them to die. I do not believe in that. However, I believe that a set of guidelines can be established that will provide sufficient safeguards to give a legislative framework to the so-called double effect. I do not believe this is something that we can leave to the doctors. I would not trust every one of them to look after my constituents in that regard. I am not prepared to stand aside from this and say that this killing is something that the doctors will decide on: 'We are the lawmakers, but we will not touch it. You can decide what is fair and reasonable in that batch of killings'. I could not do that and remain a member of parliament. At the moment, we have no guidelines in that regard. We have no process that will ensure that the patient's will is being followed. We hear stories about situations where, for the very best of reasons, having talked about it with the family, the doctor has agreed to administer an enhanced dosage such that the double-effect comes into play and the person dies. However, the person who died was not part of that process. They did not say yes or no. They became the victim. That is the current situation. Is that something that we intend to allow to continue? That person may have had very deep-seated and strong feeling about why they did not want that to occur, regardless of the pain or of the length of time that the dying process was taking.

We all like to subscribe the very best of intentions to the family in that situation. People talk about the family gathered around, grieving for the person who is going through what they see as an extremely painful process. We like to think that they always make such decisions for the very best of reasons. The sad fact is that that is not always true. It may be that there is a holiday in the offing or something that cannot be deferred. Various matters may be affecting the family that may lead to the decision to suggest to the doctor that the time has come when more drugs should be supplied until the person dies.

We have heard a great deal about the 'slippery slope'. The current situation is the slippery slope. We have the 'slippery slope' now. If we do not put some velcro on that 'slippery slope', if we do not put a legislative framework in place to stop the drift, it will continue. There is nothing that states that what is considered appropriate by the medical profession at the moment will apply in 5 to 10 years time. We have seen gradual drifts in many other areas. We need to place some velcro on the 'slippery slope' and that velcro is an act of parliament. That act of parliament must set not only the limits but also the safeguards that must apply. Only in that way will we be able to protect not only the patients, but also the doctors.

We should remember that the doctors are also at risk in this current situation. They are people who are going blindfolded into this area - hearing from colleagues in dark corners somewhere about things that have happened, hearing half-truths about particular people and certain instances where a patient was given an additional dose and died, and trying to come to grips with the issue themselves. They are operating in an ethical and legal vacuum. Would we be doing the right thing by them by simply allowing this situation to continue without any legislative action? We would not be. The double effect is that process by which, towards the end, a doctor increases the dosage of morphine or whatever to a point where all pain is relieved. However, he can expect also that death will result. Everybody knows that it happens now. More and more doctors have explained how it happens. I do not believe that we can simply turn a blind eye to it.

I do not know whether we will be able tonight to find the correct balance, the safeguards and the parameters that will satisfy all or the majority of us. However, let us move the argument forward. Let us get past the second reading in order that we may begin to examine some of these issues. It has been

argued that, if we legislate, somehow somebody will come along after us, amend the legislation and free it up. However, there is far more danger in not legislating than there is in legislating. At least, we have a public process whereby people can talk about it and discuss any moves. At the moment, it is occurring in dark corners among doctors who cannot discuss openly what they are doing.

As I would like to see it drafted, the legislation would cover the double effect where a person has been in palliative care and their condition has reached the point where the doctor says that nothing more can be done. There are people who have said that palliative care can alleviate all the pain and suffering associated with dying. There are others who say that is not so. I do not believe that, when palliative care can no longer assist, when the measures prescribed do not have the desired effect, the patient cannot be helped. I do not accept that. I believe we can draw boundaries around that to give legislative effect to the double effect. We can define the process leading up to that and legalise that occurrence. We can take into account the other situation where the double effect is attempted, but does not work. That has occurred in relation to certain diseases, whether it is because of the location of the illness or because the person has built up a resistance to morphine over the period of palliative care. In those 2 instances, I believe we can legislate. Some will argue that that is a very narrow view of the issues, but it is the extent of my support for the principle of euthanasia. In fact, I go further than that. If there is a period of remission - and this does occur in instances and against all medical expectations - the patient must reconfirm their request for termination.

I want to address some of the amendments that I will be proposing. I am doing it only because it may help reassure some of those who have said that they cannot support this bill because it does not contain sufficient safeguards. In the amendments I have circulated, the safeguards they are talking about exist. If they do not quite like the wording, if they think that the hurdles should be a little higher, they should say so. Let us work through that in the committee stage.

It has been said that some expert psychological assessment is needed of patients who request termination. There is a problem relating to people who are suffering from treatable clinical depression. I have proposed an amendment which states that the second medical practitioner has to hold a Diploma of Psychological Medicine or its equivalent as a minimum qualification. According to the Australian and New Zealand College of Psychologists, that would be an appropriate person to examine the illness and determine, as well as the issues relating to the first medico, that the patient is not suffering from a treatable clinical depression. That depression should be treated first. When the depression has been treated, if the person still wants help in dying, the process can begin again.

I do not believe that distress should be a factor. Pain or suffering should be the only 2 criteria. The current wording in the bill is 'pain or suffering or distress'. In those circumstances, distress on its own would become a second component of the illness and I believe it is too imprecise. From the definitions in Shorter Oxford Dictionary and elsewhere, distress is very difficult to define separately from suffering and its inclusion could make it much more difficult to obtain the more accurate interpretation.

I will also propose an additional provision which will require that the medical practitioner be satisfied that the patient has considered the possible implications of the decision for his or her family. I do not mean that a person has to obtain the permission of every one of their family, but I believe that someone must be satisfied that the person sat down and thought the issue through. The person should consider how it will affect their family, think about their children and work through those processes before they make this decision.

Another matter was raised in the poll that we spoke about earlier. I will propose a double cooling-off period - a period of 7 days between the time when the patient makes the request and the time when the certificate is completed - that will provide time for people to think it through - and an additional period of 48 hours from that point until the assistance can be rendered.

Those safeguards will address some of the concerns that people have raised. Another safeguard is critically important in a society such as ours which has a large proportion of people for whom English is not the first language. I refer members to my proposed interpreter clause. It requires that, at all stages, there must be present a person with a level 3 certificate from the National Accreditation Authority for Translation and Interpreters. That person has to explain and sign the documentation.

If the patient's medical practitioner has no special qualifications in the field of palliative care, another doctor will have to provide information. Whether that is the second medical officer or someone else, the patient must have full knowledge of the palliative care options. If, at that stage, the patient opted for euthanasia, there would still be a minimum of 48 hours before the procedure could become operative. In fact, in most instances, the delay would be much longer because it could not occur until the person had had palliative care and that palliative care can no longer alleviate their pain and suffering to a level acceptable to them. The other proposal is one that I mentioned earlier - where remission occurs, the process has to start again.

These issues have been raised with me and, together with some others that have been raised by the committee, they are acceptable to the member of Fannie Bay. I believe they will provide us with very substantial safeguards. Members may believe that the total package is not quite right or that it could be reframed in some way. Let the bill pass the second reading and proceed to the committee stage. If necessary, members can always move to report progress so that matters can be examined with the lawyers. However, I urge them not to kill it off at the second-reading stage. We heard the member for Port Darwin say that, irrespective of what it is called - euthanasia or assisted suicide - it is killing. What is happening at the moment is killing. That is what doctors are doing, and we are turning a blind eye to it. I was very disappointed by some of the comments made by the member for Port Darwin. He could not resist putting the knife into the man who put him where he is today. However, I suppose it is a matter of young dogs and old dogs and every dog having his day. As I said, politics makes strange bedfellows.

I do not agree with all the logic of some of the supporters of this move nor do I deny all the arguments of its opponents. I am saying that members should not let pure populism, their belief as to what their electorate is saying, dictate the way they will vote. We are not in the parliament to follow slavishly the wishes of the electorate on every issue. If we did that, we would be totally inconsistent. We would want fewer taxes, more services, public hangings tomorrow and floggings the day after. There is a role for looking at the issues and at what the people believe. You can only move a certain way in front of the crowd, but do not become a slavish follower and, because the people want hangings for this or that, take that on board. Members can obtain the knowledge. They have access to extensive facilities, such as libraries etc, to obtain the specialist knowledge they need and then they are able to use that knowledge to educate their electorates if they believe that the people have it wrong.

Certainly, I can be accused of not following my electorate's position in this regard. If I raise it with most of my constituents, they say that it is foreign to them and not something they can countenance. When I see the situation in my electorate, I feel the hackles rise. I begin to feel that I could use this as a means of taking revenge. I could take revenge on a number of members on the front bench opposite who, over the

years, have not supplied my constituents with the resources that they deserve. However, whom would I be helping in the end? The reason why I am not doing that is because I believe we are here also to serve the Northern Territory as a whole. We are here to do what we believe in. We hope that, in the final analysis, our electors will look at the totality of our actions when they make their decision at the ballot box.

I believe we must legislate. I do not believe that a person can accept that they are governed by the law if they do not accept the need to legislate in this area. Not to legislate is to allow this whole area, where there is homicide, where there is killing, to simply drift. It will drift with medical fancy and with what is accepted among a group of people. That would allow the common law to somehow develop. However, I have always believed in codifying the law. This is an instance where it needs to be codified.

The other argument is that we should not be the first to legislate and that we should be frightened of what has not been done elsewhere. If our predecessors had believed that 100 years ago, when we were part of South Australia, we would still be waiting for the mother of parliaments to decide to give the vote and the right of representation to women. Let us get the legislation into the committee stage at least. In that way, ours will be the first jurisdiction ever to get such legislation to the committee stage and debate the issues.

Mr MITCHELL (Millner): Mr Speaker, I rise tonight to do my job as the elected representative of Millner and to contribute to the debate on the member for Fannie Bay's Rights of the Terminally Ill Bill. In speaking, I intend to be as objective as possible on the issue of voluntary euthanasia. Having listened to the debate over the last 3 months, I have come to the conclusion that, whatever anyone wishes to prove, there is some expert or some report or some statistic that will prove their point. In the end, quoting somebody as the expert in the field has limited value because they all have the agenda of either supporting or opposing the legalisation of voluntary euthanasia. Therefore, in my speech tonight, I will not quote anyone to substantiate a point of view, nor will I rely solely on the findings of a particular report. What I intend to do is discuss the issues that have assisted me in coming to a decision on how I will approach the bill.

In relation to voluntary euthanasia, there are only a few facts which I believe one can take at face value. Those facts are: firstly, voluntary euthanasia occurs within our community today; secondly, best palliative care practices do not relieve all the pain for all terminally ill patients to a satisfactory degree, and it should be noted that this is conceded by anti-euthanasia groups; and, thirdly, the polls indicate that a significant majority of Territorians and other Australians support the concept of voluntary euthanasia.

Mr Stirling: And that makes it right?

Mr MITCHELL Beyond these facts, both sides of the argument are able to produce appropriate statements to support their contradictory points of view, including the member for Nhulunbuy.

In my job as the representative of the people of the Millner electorate, I have the responsibility to: firstly, research the issues surrounding voluntary euthanasia; secondly, listen to the presentations of the expert witnesses in the debate; thirdly, seek the opinion of the people I represent and be satisfied that they are informed; and, finally, make a decision. With all indications being that a significant proportion of the population supports the concept of voluntary euthanasia, I believe it is our duty to consider the legislative requirements for voluntary euthanasia.

During the euthanasia debate, I have canvassed the opinion of the electorate as much as possible and,

over the last couple of weeks, I have conducted a phone poll of the Millner area and electorate. As late as last Monday night, I conducted a phone poll in my electorate and I have been given the very clear message that 70% want voluntary euthanasia, 25% do not and 5% are uncertain. Monday night's polling brought the total to approximately 350 people polled by phone. I have spoken to a further 300-odd in small groups at the doorstep or through people contacting my electorate office. The message was very clear: 'We want it. It is your job to get it right'.

Due process dictates that we must address the details of this bill and that we must amend it to ensure that it is the best piece of legislation that we can create which deals with legalising euthanasia. For this reason alone - and it is regardless of my own feelings on the concept of voluntary euthanasia - I believe we must make the attempt to design the legislation. If, at the end of the day, we are unable to design satisfactorily and agree upon the details of the legislation, then so be it. However, we must make the attempt at least.

The debate in the Territory on this bill over the last months has been comprehensive. The quantity of information that has been forthcoming has been amazing and, whilst much of it has been lobby group propaganda from all sides, the end result has been a complete coverage of the issue. I believe, as I am sure many of my colleagues believe, that 3 months-worth of intense debate of the issues surrounding voluntary euthanasia has given each member all the information required to make an informed decision. The involvement of interstate and overseas lobbyists, all of whom are completely familiar with all the arguments supporting their particular viewpoint, ensures that we have all the information that we can get. The well-oiled arguments have been developed over several years and ensure that the 25 members of this Chamber will be able to make a fully-informed decision on the proposed bill.

The debate on the bill and euthanasia has seen the activation of a great many lobby groups - Operation TAIPO, LIFE, Doctors' Reform Society, Northern Territory AMA, religious groups, voluntary euthanasia societies etc. In our democratic process, these groups have a right to express their views and I applaud them for fighting for what they believe in .

Let me turn now to some of the issues with respect to euthanasia that I would like to address. Whilst, in the end, our focus must be brought back to the contents of the bill, it is obviously important to discuss the issue of euthanasia. I am pleased to say that I believe the debate over the last month has well and truly aired the issues involved with voluntary euthanasia. Throughout the debate, several key issues with respect to voluntary euthanasia generally, and specifically if implemented in the Northern Territory, have been raised. I believe that, in representing my constituents in this parliamentary forum, I must again raise these issues in an objective manner. As members of this Chamber well and truly know, the Netherlands is the only place in the world where euthanasia is practised openly. I use the word 'openly' for 2 reasons: first, euthanasia is still illegal in the Netherlands and, secondly, euthanasia is unquestionably practised everywhere else, including Australia and the Northern Territory. Within this debate, and within any of the interstate and international debates on euthanasia, the Netherlands experience has been quoted continuously and misquoted by every conceivable lobby group. Whatever point the pro- or anti-euthanasia lobby groups wanted to make, they then attached an example from the Netherlands.

The debate in the Territory quickly reached the stage where I had to ignore what every second or third party or journalist or whatever said. Everyone had their own agenda which they pushed wholeheartedly. However, I could not simply ignore the Netherlands experience because it is the only country with voluntary euthanasia and the only place which may give us some indication of where the Northern Territory would go by passing the Rights of the Terminally Ill Bill. For this reason, I believe the issue of

euthanasia in the Netherlands must be assessed when considering voluntary euthanasia for the Territory. Two fundamental points led me to the conclusion that voluntary euthanasia in the Netherlands is working appropriately. Firstly, the Rummelink Report, which is the most comprehensive study to date by far on euthanasia and the rigour of which it is difficult to question, stated that 1.8% of deaths in the Netherlands were the result of euthanasia. An additional 0.3% of deaths were due to physician assisted suicide. In total, the percentage of deaths in the Netherlands which would come under the constraints of the member for Fannie Bay's proposed bill is 2.1%.

Mr Perron: 16 people.

Mr MITCHELL 2.1% is not the epidemic that some of the anti-euthanasia lobby will have people believe is the case in the Netherlands.

A second figure from the Rummelink Report, which I feel it is important to highlight, is the number of explicit requests for euthanasia not granted. The figure of 4000 requests not granted showed that only one-third of euthanasia requests were granted. The low figure indicated that there has been no reduction in the value placed on human life in Dutch society. It is necessary to understand that these are the important figures in the Rummelink Report with regard to the Rights of the Terminally Ill Bill. The other figures in the Rummelink Report are not affected by whether voluntary euthanasia is legal or not. The second point to consider with respect to the Netherlands is that, if the anti-euthanasia lobby is correct and involuntary euthanasia is rife in the Netherlands, why isn't there public uproar? If involuntary euthanasia were prevalent, the public would definitely be up in arms and the practice of voluntary euthanasia would be removed.

The Rummelink Report figures support the notion that voluntary euthanasia in the Netherlands is succeeding. Only 6300 people from a population similar to Australia's requested euthanasia and 4000 of those requests were denied. The small number of requests in the Netherlands and the fact that only one-third of requests were granted also demonstrates that there has been no 'slippery slope' effect in the Netherlands. There has been no lessening of the value placed on life in the Netherlands. While the pro- and anti-euthanasia lobby groups would be able undoubtedly to come up with more compelling arguments, I believe that these 2 indisputable facts indicate that voluntary euthanasia in the Netherlands works and works according to the wishes of the Dutch public.

I turn my attention now to palliative care. However, before I do so, let me first state the aim of palliative care. Palliative care is for terminally ill people who are not going to get better. Palliative care is for people who are waiting to die. The important issue of palliative care in this debate has 2 distinct areas. The first is the role palliative care takes in the dying process and the second is the lack of palliative care in the Northern Territory. The member for Fannie Bay has recognised that there is a lack of palliative care and I believe that improving palliative care is now well and truly on the agenda of all 25 members in this House. Improving palliative care in the Northern Territory will not replace the need to provide to some people the option of voluntary euthanasia.

The fundamental point with respect to palliative care treatment of the terminally ill is that not all pain is relievable. This means, and this is conceded by anti-euthanasia lobbyists such as Dr Robin Bernhoft, that some people die in pain. This is unacceptable. It is not possible to convince the majority of people that these people should suffer because legislating for volunteer euthanasia may lead to some unproven 'slippery slope' effect. At the start of the debate, the member for Fannie Bay circulated a list of diseases the symptoms of which are difficult or impossible to relieve with palliative care. In the following 3

months, the anti-euthanasia lobby has not challenged the validity of this information. It has not produced a documented response to this list of diseases. The anti-euthanasia lobby has accepted this list and I must assume therefore that the identification of the diseases and their accompanying symptoms is correct. To me, this is proof that there are terminal diseases with which palliative care does not deal adequately and which make the dying process painful.

One term used in this debate which is linked to palliative care is 'pharmacological oblivion'. This process is where palliative care requires rendering a patient unconscious until they die. To me, the justification for this is purely for the conscience of the doctor. The terminally ill patient does not benefit. To all intents and purposes, the patient's life ends the moment he or she becomes unconscious. This type of palliative care - and I understand it is an accepted palliative care technique where pain cannot be relieved - is only for the doctor. Let me restate my point: the best palliative care does not relieve all pain in all terminally ill patients.

This brings me to my own personal experience. Even though the member for Nhulunbuy said quite correctly recently that I was elected less than 12 months ago, I will inform him that I have lived in the Millner area for well over 20 years. When I was a young person, I delivered newspapers in the Millner area. At that time, I met a family who still live in Millner. Within the space of 6 months last year, that family lost 2 members. This was one of the most compelling arguments put to me because the person involved is an extremely strict Catholic whom I have known for approximately 30 years. This person told me that her father died quite a few years ago and, as he died, he was comfortable because all the palliative care worked. Her 35-year-old brother died at the beginning of last year and he too was comfortable right up to the minute at which he died. A second brother, aged 36 years, died towards the end of last year. I knew this bloke as a friend and I saw him go down in just a few short months. He was a good man and he died in agony. No level of palliative care or drugs worked for him. He was begging for help right up until the last minute. If he was given drugs, he would fall asleep and dream and his dreams were horrific. He imagined that animals were tearing at his flesh and all manner of other unspeakable things. This lady said to me that God would not have wanted her brother to die like that. I will leave it at that.

One of the first arguments that the member for Fannie Bay and the pro-euthanasia lobby groups used in this debate was that public opinion and the polls indicated overwhelming support for voluntary euthanasia. The polls I refer to are those that have been done occasionally by the professional polling organisations and published in The Australian and in Time magazine. The evidence was pretty clear cut and showed that 80% of Australians believe that people should have the option of voluntary euthanasia at the end of their lives. If 80% of the public want the option of voluntary euthanasia, as legislators it is our duty to deliver voluntary euthanasia. The anti-euthanasia lobby's response was to question the validity of the polls, to question the way they were worded and to question the ability of the populace to understand such a complex issue. I do not believe that we can question the results of the polls. Many of the polls were done by professional pollsters who are paid to ensure that the polls reflect community opinion. Do not shoot the messenger simply because you do not like the message.

The other issue the anti-euthanasia lobby raised was that people do not truly understand voluntary euthanasia and what it means. This is an interesting point. Could people truly not understand euthanasia? I do not believe that that is the case. The fact that there have been so many surveys, with so many different formats and with so many different questions, but all producing high levels of support for voluntary euthanasia, demonstrates that the public understands the issues involved with voluntary

euthanasia. The variety of questions also demonstrates that people are able to decipher the content of the questions. It is something akin to finding a synonym. If you are able to find alternatives for a word, that demonstrates an understanding of the meaning of the word. The same holds true for understanding the meaning of voluntary euthanasia.

I do not wish to pre-empt debate on particulars of the bill as I hope that we have enough members in the Chamber who believe that the due parliamentary process should be allowed to occur and that the bill will reach the committee stage. At this stage, I will comment on amendments proposed to the bill that have given me further confidence that the legislation will work appropriately if passed.

I believe the amendment to include the stipulation that medical practitioners must have been practising for a continuous period of not less than 5 years is important to ensure our new doctors are able to experience the demands of doctoring before they have to decide whether they will participate in the euthanasia process. In relation to the 24-hour cooling-off period between signing of the certificate and the voluntary euthanasia of the patient, I believe the doctor and patient will probably have had discussions with respect to euthanasia long before the signing of the certificate, but this amendment will give some reassurance to people concerned about how doctors will go about the process. Any suggestions of a longer cooling-off period would be designed to make the legislation unworkable for those people most likely to use voluntary euthanasia. The average hospice stay is around 17 days and a cooling-off period longer than that, or even approaching that time limit, would not be feasible without taking the option of voluntary euthanasia away from some people who would want it.

Amendments are proposed for the involvement of the coroner and further processes for recording the number of euthanasia cases. Information is to be available to the Attorney-General on request. This will ensure that the parliament will have the information necessary to review the effects of this legislation, if it is passed.

Mr Deputy Speaker, on behalf of my constituents, I support the bill.

Mrs HICKEY (Barkly): Mr Deputy Speaker, this must be one of the most extraordinary days in parliamentary life in the Northern Territory, and it will certainly be a very long time before we see another like it. I believe the time and effort expended on this is in inverse proportion to the effect the proposed legislation will have on most Territorians. If passed, the legislation will affect, at most, a handful of people each year. The Northern Territory figures for road deaths and deaths from lung cancer, heart disease, alcoholism and violence are among the worst in the world yet, despite our small and relatively young population, the resources of this parliament have been tied up on an issue that will affect but a few of our citizens, and that is to say nothing about the political wisdom of a Chief Minister introducing a private member's bill on such a contentious issue at the end of his career. However, when this very momentous day finishes, it will not matter why the member for Fannie Bay embarked on this course, nor what it has done to the parliamentary wing of his party, nor how much effort has been expended on behalf of how few because, if the legislation is passed with the amendments proposed, this will have been a good day's work in this House.

Of course, there will be ramifications for other legislatures if this bill is passed, but that should not deter us from taking an action we consider to be right, in the interests of our citizens and workable. All members have received volumes of submissions expressing every point of view from all over the country and several from overseas. These have been produced in a variety of forms ranging through glossy publications, printed books and expensively produced letters from organisation such as the Right to Life

Association, the churches and some medical lobby groups. I was touched particularly by the handwritten letters and those typed on old manual typewriters. Their authors are often elderly, and clearly they have gone to some pains to send individual letters to each member of this House. After receiving several scores of these items of mail, I detected from comments therein that there are some widespread misunderstandings among the people who have written about the intent and contents of the bill. All the arguments came down to a very few essential points, either in favour or against the bill. I will outline them as follows.

There was opposition from religious groups and individuals on the ground of the sanctity of life and the injunction 'thou shalt not kill'. There was opposition from medical people on the ground that the practice of medicine is founded on the preservation of life. Some stated that good palliative care can relieve all but a very few cases of pain and suffering. From Aboriginal people, there was opposition on the ground that euthanasia is in conflict with traditional culture and practice, and that people will be frightened to seek medical help if the legislation is enacted on the basis that they may be involuntarily euthanised or persuaded to participate.

All those who wrote to me or spoke to me, expressing their viewpoint and seeking to influence my viewpoint, deserve commendation. These days, it is all too easy to believe that the public is apathetic. I thank the people of the Barkly, in particular the members of the Full Gospel Business Men's Fellowship International in Tennant Creek, members of the Yapakurlangu Regional Council, Father Brian Ahearn from the Catholic church, doctors, nurses, elderly residents and the people from many of the communities, large and small, for sharing their thoughts with me. Many told me moving stories of the lives and deaths of their loved ones. This is clearly a matter that people feel very strongly about.

I do not believe that commentary from interstate should be dismissed simply because it emanates from somewhere other than the Northern Territory. Beyond doubt, what we decide today will impact on other legislatures, and that is another reason why we should not resile from our intention of voting on this issue today. In his rambling discourse, in which he seemed to be having 2 bob each way, the member for Nightcliff suggested that we will need to make some decision on euthanasia at some time, but not yet. I believe that, if this bill is defeated, it will be a very long time before the matter is raised again in the Northern Territory. I believe also that the delay between the passage and the commencement of the legislation will address the concerns of those who consider that this issue has not been debated properly in the Northern Territory. I very strongly support that amendment. However, I do not believe we should resile from voting on this issue today.

I will not elaborate on the religious or medical objections. I respect the religious objections, but I do not believe that they should prevent the passage of the legislation. As the essence of the legislation lies in its voluntary nature, it offers choice to those seeking to access it. Those who find it repugnant or against their beliefs have but to ignore it. I have a great deal of sympathy with the medical objections, and I would like to acknowledge here the efforts of the president of the Northern Territory Branch of the AMA, Dr Chris Wake, who has been very conscientious in speaking individually to each member, and sometimes more than once, to put forward the AMA's very cogent arguments. Those medical practitioners who choose not to be involved in the practice of euthanasia should have their wishes respected and upheld, and there would be no coercion for them to become involved. On the other hand, they should not believe that, because they have been the gatekeepers to medical assistance, the arbiters of care, they should also be the deciders of the fate of the sick and dying. Ultimately, it should be the decision of the dying.

I turn now to the matter of palliative care. While I agree that we need better palliative care in the Northern Territory, we also need a hell of a lot of other resources in the health area. I do not want to see scarce resources allocated away from existing programs to appease the demand for palliative care. This should be an add-on, and I hope it is shown as such in the budget for all to see. Whilst I agree with the need for palliative care, I do not agree that, if it is available, our concerns will be largely addressed. People should have other options than palliative care. The Rummelink study showed that only 5% of patients described pain as their reason for seeking euthanasia. The majority said it was a hopeless, pointless and unbearable situation that made them desire a quicker end.

My most pressing concern relates to the concerns of Aboriginal people because I represent a constituency that has a very large number of Aboriginal people. The population mix is probably about 50:50 in my electorate. Overall, in the Territory, a quarter of our population is Aboriginal, and I doubt that the polls, official and unofficial, that have been conducted on the topic of euthanasia, have canvassed the views of many traditional Aborigines. However, some of the more cogent arguments against enactment of the proposed legislation are coming from that quarter. This does not depend solely on opposition to the concepts proposed, but also on perceptions of what this legislation may mean. As have other members with bush electorates, I have spoken to many constituents about the bill, but this is a totally new concept for people to come to grips with.

As the member for Arnhem pointed out very eloquently, people out bush do not know enough about this legislation and consequently they distrust it. It certainly requires explanation, possibly in language and by a trusted person. It also requires a period of delay whilst the appropriate people are consulted and the community has an opportunity to undertake full discussion. In the absence of those factors, one of 2 things can happen: either people will have an imperfect grasp of what the legislation intends and how it will be implemented, or nothing at all will be known about it. In either case, the natural instinct, when faced with the unknown or the imperfectly known, is for people to say that they are not prepared to make a judgment until they know more about it.

My experience with the Aboriginal people I have consulted is that, in the first place, they find death a distasteful subject to talk about and that they would rather reject the notion than be required to make an immediate decision either for or against euthanasia. However, I believe we tread on shaky ground if we say unequivocally that everyone in the Aboriginal community is implacably opposed to it and that it flies in the face of traditional culture. I have had some diametrically opposed positions put to me about traditional practice. Some have denied that death, other than through natural causes, is in any way a part of Aboriginal culture. Others have admitted - and this is in the central Barkly area, but I do not think it is confined to that area - that sometimes old people become too ill to live long and they just want to return to their country and be allowed to die alone. Sometimes a person will end their own life by killing themselves in very extreme circumstances, or they will simply not take food or water and allow themselves to pass away. In those communities, no judgment is passed on those who choose to end their lives in that way. Only today, a person, who is intimately involved with the care of aged Aboriginal people, quoted to me several instances of people choosing to end their lives by living their last days alone in their country, knowing full well that they lacked medical assistance and that they would die as a result of their actions.

Having said that, certainly no one has ever suggested to me that ending a life with the help of a third party has ever been a part of Aboriginal culture. There is already fear of the unknown when visiting medical premises. I believe most of us have felt unease at some time when visiting a doctor or when

entering hospital. Once in a hospital bed, there is an inevitability about one's institutionalisation and, to refuse to conform, to question a doctor's or nurse's directions, to ask for clarification about what is being done, requires a level of energy and self-assurance that we often lack when we are sick and worried.

I have no sympathy with the actions of opponents of the bill who have put their arguments against the legislation in terms guaranteed to cause anxiety and fear in vulnerable and impressionable people who have not had the opportunity to hear another viewpoint. In my own electorate, one person, who purports to be a good Christian person, visited Aboriginal people and sought to persuade them to his point of view about the bill. Some days later, an elderly and very senior Aboriginal woman in my community came to my office. She was terrified out of her mind because she had to go to hospital. She said she did not want to go there because they would give her 'that poison'. To my mind, that is absolutely criminal.

Mr Perron: Despicable.

Mrs HICKEY: People identified as good Christians generally have the respect of the community, black and white, as being at least honest and truthful and they are often believed. In this case, and I hope it is an isolated one, a frail old lady was terrified by what had been told to her. It will take a very long time for that type of misinformation to be corrected and that is one of the reasons why I strongly support delay of the commencement of the legislation until Territorians everywhere can be informed properly about it.

In summary, Aboriginal objections to the bill can be listed as follows. Firstly, to end a life voluntarily is contrary to traditional culture and practice. Secondly, the involvement of a third party may attract blame and consequences such as payback could follow. Thirdly, any death occurring, where a doctor has been in any way involved, may attract accusations that euthanasia had been practised, whether or not there is any basis for such accusations. Fourthly, traditional Aboriginal people are already wary of hospitals, and the perception that they could have their lives terminated involuntarily will result in even greater reluctance to seek medical help. Clearly, this could have a very negative effect on the health of those Territorians who are in the greatest need of assistance in our community.

I respect Aboriginal spirituality and culture and I believe that, whilst the concept of euthanasia is unacceptable to many Aboriginals, amendment 31.18 as circulated is important. That amendment provides that a medical practitioner shall not assist a patient under the act unless he or she is satisfied that the patient has a sufficient grasp of the English language to understand the consequences of his or her request for assistance and, where English is not the patient's first language, the patient shall be given interpretive assistance to enable them to have that understanding. For those for whom English is a second language or even a third language, interpretive assistance will have to be given. The Leader of the Opposition mentioned this as another hurdle or barrier, if you like, to overcome in the case of unintended or misunderstood requests for assistance to die. Of course, this amendment provides protection also to other people from non-English-speaking backgrounds.

While on the topic of assistance and sympathetic consideration for those who do not communicate fluently in English, it is important to bear in mind other aspects of care. This point was made to me by an Aboriginal person who said that the wish of the dying person to be returned to their country to end their days is often ignored by medical and other authorities who may tell the patient that they are too ill to be moved or that they will be better off in hospital. In the same way that this bill seeks to give people choice as to the time and method of death, it is important to ensure that we afford people the choice as to their place of death. If someone wishes to go home from the hospital and, by doing so will shorten their life, once that has been explained to them, I believe their wish should be respected. It is possible to discharge

oneself, but that does not happen very often. People are in awe of the medical authorities and afraid to express their wishes. Thus, many Aboriginal people die surrounded by strangers in unfamiliar surroundings, and often in misery. If choice is what we are trying to provide in this legislation, we should ensure that choice is provided wherever possible.

Let me be unequivocal. My personal position is that a person's life is their own to do with as they will and as their circumstances allow, provided that they harm no one else by their actions. The latter is a critical factor. The definition of 'harm' can be broad or narrow. There is physical harm, economic harm and emotional harm. In a just society, clearly we aim to minimise the negative consequences of a person's actions on the rest of society or on other individuals. It is rare that our actions do not impact on others. Most people take into consideration the feelings of their loved ones when making momentous decisions, but should they be required to? We cannot stave off death indefinitely and, even though our death will cause distress to those left behind, will that distress be greater because the death is hastened and voluntary? If it is, should that be a determining factor for the terminally ill person who is seeking choice in the timing of their death? I believe the decision is ours, and ours alone, to make. Most, if not all, of us will consider the feelings of our family. Some of us may hasten our death to spare others further anguish from watching us suffer. Others may choose to linger on because they know that euthanasia is repugnant to their loved ones. That should be a personal choice. We are all aware of people who, at the end of their lives, have turned their faces to the wall and given up the will to live. That too can cause anguish for those left behind. Death, however it occurs, is inevitable for us all. In the scheme of things, our lifespan is such a little thing, whether it be three score years and ten, or less or more.

I have no religious beliefs. Death holds no terror for me, merely a mystery over which I have no control. I would not like members to think that I have no appreciation of the spiritual aspect of our nature. It is simply that I can reach no conclusions about it. I am first and foremost a practical creature. I am content to leave my fate to the future. However, as a thinking being, I do have some control over this life and whether I wish to continue with it. If, at some stage, I need to involve a third party in the process of euthanasia, I contend that, with their support and agreement, I should be able to do so and be assured that they will not suffer legal sanctions as a result. I have said from the outset that, while wondering about his political judgment in introducing it, nevertheless I support the intention of the member for Fannie Bay's bill to assist the terminally ill person to make an unfettered decision to end their life in the face of pain and suffering, and to allow for that death to be assisted.

I believe the bill, as originally introduced, was hastily conceived and had no chance of success. However, the select committee has provided a raft of proposed amendments. I believe that, with those and a few others that will be introduced in the committee stage, the legislation will protect the weak and defenceless against exploitation or hasty decision-making and will provide severe penalties for those seeking to profit in whatever way from the demise of a terminally ill person. It will provide protection for the medical professionals, on the one hand, against pressure to be involved with assisting a terminally ill person to die if that is against their beliefs or wishes and, on the other hand, against legal sanctions if they choose to assist a terminally ill person to die.

I wish to acknowledge and thank those of my constituents who offered me counsel, and took the time and made the effort to speak to me and give me their views on this matter. I did not reach a conclusion easily as to whether or not to support the legislation. At a personal level, I was able to make an almost immediate decision and, once the committee had provided its recommendations to tighten the terms under which euthanasia could be provided, that strengthened my resolve. I was never swayed by

arguments based on any religious precept of the sanctity of life. In my view, more wars have been waged in the name of religion than for any other reason. More people have been killed in these wars and more atrocities performed in the name of the Almighty than bears thinking about. I believe strongly in upholding the sanctity of another's life, in defending it and preserving it if that is what the other person requires. For instance, I am and I will remain totally opposed to capital punishment. However, this proposal is something very different. It relates to a person's right to determine their own destiny within very narrow boundaries.

The member for Nightcliff mentioned the common law. He seems to believe that we should continue on our current course. We know that euthanasia occurs de facto. He believes that is probably the better way to go rather than to legislate within narrow boundaries. At the moment, there is certainly no doubt that people's lives are shortened by the actions of doctors with the sanction of the patient and possibly with the sanction of their relatives, friends and loved ones. The problem is that it happens in secret. These people are not able to be open about it. They are unable to say they have chosen a particular day on which to say goodbye to their family and loved ones. It has to happen in secret. It is a criminal activity. Death should be something which, if possible, can be celebrated, can be participated in with the family in an open way without fear that there will be some legal consequences resulting from it. This should be something that people are able to do without feeling guilt about it. It is something they should be able to do in the open. That is why I believe that we need to take this step to afford protection and comfort in order that people may do this without concern that the people who have helped them will be left to face legal consequences.

I do not have the luxury of an urban constituency. I wish in this case that I did because my constituency is probably fairly evenly divided on this issue. Barkly is an electorate where the margin is always very narrow - 33 votes the first time I was elected and 99 the second. If I were looking to represent the views of the majority of my electorate, I would have an enormously difficult job. As things are at the moment, I would say that Aboriginal people are opposed to the bill on various counts, such as those I outlined, and the non-Aboriginal community generally is in favour of it. Like the member for Arnhem, I feel that, on this occasion, I have to cast a conscience vote. The amendments proposed to the bill will narrow its focus to a point where Aboriginal people need be in no fear that, in hospital, they will be subjected either to pressure or to unintended use of euthanasia because they have insufficient knowledge about it or because the doctors have a power of life and death over them. What we will put in place will protect them from that. I believe that euthanasia is occurring at the moment anyway. In the current situation, doctors have considerable power, perhaps too much power. This will narrow the focus to the point that there is absolutely no doubt that it is the patient alone who makes the decision and nobody else plays God on their behalf.

We should vote for this bill and the amendments proposed to it. The few Northern Territorians whom this is likely to affect will thank us in years to come. In saying that I am mindful of the fact that many people are worried, upset and concerned about the ramifications of this legislation. It is not an easy task for us, the 25 members of this parliament, to make a decision on this matter. Many a time I wished to God that the member for Fannie Bay had never introduced his bill, but I am sure that I would not be alone in that regard. It has forced us to a consideration of ethical issues that go very far beyond the scope of what a parliamentarian is normally expected to contemplate. However, the member for Fannie Bay has introduced it, and this is an issue of great importance to many people around the globe, not merely in the Northern Territory.

We need to make this legislation as carefully crafted and as safe as we possibly can. At the end of the day, we need to vote on it and not dodge this issue as many would like to do. Clearly, world opinion is changing and that is evident in the Northern Territory, in South Australia and in the ACT where these issues are now being raised. The member for Wanguri mentioned that, in the past, issues such as abortion and slavery were unable to be debated in the public arena. If we resist this issue at this stage, it will certainly return at some future time. Having said that, however, unless we vote on this matter now, it will be a long time before the Northern Territory starts down this path again. It is not an easy road and, while I wonder at the political wisdom of the member for Fannie Bay, I applaud him for taking on this issue and fighting it through to its conclusion. He has stuck to his guns, and that is something that all politicians can learn from.

In the end, if we try to have 2 bob each way, if we try to determine which of our constituents will or will not be in favour of the legislation, our indecision will be evident to all our constituents. They will see us as politicians who bend with the wind. Obviously, those of us who belong to political parties have to toe a party line on many issues but, where we have a free conscience vote, I believe our mettle is really tested. This is one issue that has certainly done that in the Northern Territory. I hope the bill will pass with amendments.

Mr BELL (MacDonnell): Mr Speaker, I do not believe that, in the absence of excruciating, unrelievable pain, we are acting beneficently towards a patient by assisting suicide. Whether that suicide is self-inflicted or carried out medically, that is a fundamental belief of mine and it is the position that I adopt in the debate on this bill. It is very important to make quite clear at the outset what our underlying assumptions are in this debate. My underlying assumption is that this is not acting beneficently towards terminally ill people who feel that they lack dignity. I will come back to that word 'dignity' in a moment. My belief is that the death of any man, woman or child diminishes me because I am involved in humankind.

In listening to the many views that have been expressed in this debate over time, I have been surprised that the phrase 'death with dignity' keeps recurring. It is one that needs to be nailed. I have tried to garner views as widely as possible. I congratulate the select committee on the work that it did. I have some criticisms, but I believe it did its work diligently and has produced a document that assists the Assembly in clarifying its thinking.

But, to return to the phrase 'death with dignity'. I have not heard other speakers say this and I have not heard it mentioned in the public debate, but it is my very strong belief that human beings enjoy dignity at every time of their life. They enjoy it as infants, they enjoy it as young adults, they enjoy it in their more mature years and they enjoy it in their old age. I am chilled by the idea that we should be encouraging anybody who is sick and frail to believe that they are failing to contribute. I will not go into a litany of my own experiences but, like most people my age, I have seen my share of terminally ill people. It is a firm conviction of mine that those people continue to contribute to my life and to the lives of all of us, simply by being there. We recall the rich lives that they have led. We do not see them simply as frail and sick, as if that were all that is known about them.

To allow death that is not natural, death that is assisted, because some people are depressed or believe that they are no longer functioning in the way they were at the peak of their strength - and heaven knows there are a few of us in this Assembly who are doing that any longer - if that is to be our yardstick, we are dehumanising people. We are treating people as less than the rich human beings that they are because

we carry with us our memory not only of our own actions but of the actions of those around us. We carry with us knowledge of the contribution of people right around the world. For that reason, I say that the death of any man, woman or child before their time and in unnatural circumstances diminishes me because I am involved in humankind.

There are 2 fundamental assumptions. Once you understand which assumption you accept as the more important, it is easier to debate this issue. A number of speakers who have spoken in favour of this legislation put very high up the list the right of the individual to choose their means of death. I am tolerant of that viewpoint, but I do not share it. I believe the countervailing attitude, that I am diminished by an unnatural, premature death, is a higher value. It would be of great assistance to this debate if we were to clarify our underlying assumptions in those terms. The committee's report went some way towards - but not quite far enough - disambiguating those 2 underlying assumptions and making it quite clear what the 2 competing values are. In its executive summary, the committee nailed it down: 'If it were possible to summarise this complex debate, it would come down to the rights of the individual being predominant ... versus the argument that the common good of society as a whole takes precedence over the rights of the individual'. That comment is of great assistance in clarifying the 2 underlying assumptions, but I do not believe that the committee did as good a job as it could have done in stating the underlying value that I bring to this debate. I have attempted to state that underlying value in humanist terms. I can state it in Christian terms as well. In humanist terms, the term 'beneficence' is used - to do well by one's fellow man. What is considered to be doing well by one's fellow man is a value judgment. My value judgment in humanist terms, of acting well to one's fellow human beings, is not for people to be encouraged or authorised to end their lives in unnatural circumstances.

I concede that there is a moral dilemma in those circumstances where somebody is suffering excruciating unrelievable pain, but there is a long step from that moral dilemma which was raised in very graphic circumstances by the member for Brennan from his military background - and, like most of us, I have never been confronted with that moral dilemma - to legislating in this way. I do not believe that the principle of this bill, of authorising assisted suicide - or, as has been suggested, of suicide carried out by the terminally ill patient themselves in the manner of Dr Kavorkian in the United States - is acceptable as an underlying value.

In addition to the committee's report, I have been assisted by *Willing to Listen, Wanting to Die*, edited by Helga Kuhse. I had a strong feeling of disagreement about this issue of the individual's right to death with dignity. I refer to a very moving article in this book by Mary Mortimer who described the death of her husband. He was Associate Professor of Government and Dean of Economics at Sydney University. He was 53 years old when cancer was diagnosed. I do not intend telling the whole of that story. This account says:

Professor Mortimer greatly feared losing his dignity, indeed losing his mind. He was afraid that the end of this life would be humiliating and that our memory of him would be of a sick, incapable, irrational patient rather than the full human being he was in our lives.

That makes me weep. I will tell you why. I wonder what can be done to reassure people who are terminally ill that they remain worthy human beings. Undoubtedly, in the closing stages of a terminal illness, somebody who has been a professor of government and a dean of economics will not be functioning in the same way as they were. But, they have around them loved ones and friends and there can be no doubt that they are worthy human beings. 'Death with dignity' - let us look at that word 'dignity'. It comes from the Latin word 'dignitas'. Underlying that is the adjective 'dignus' meaning

'worthy'. People do not attain worthiness from themselves. They attain it from the people around them. They may be deteriorating but, in the minds of those people around them is a memory of their actions and their thoughts and their words in which they will always be worthy. That needs to be said time and time again in this debate. It needs to be said as an antidote to the view that we are alone, we are individuals and we are choosing our time of death. In that view, there is an element of contempt for the people around us that I regard as a matter of concern.

Mr Perron: What about the contempt towards the terminally ill person in your attitude?

Mr BELL: You will have a chance to sum up.

I am chilled by that. I will give another example. There is a very moving anecdote by Terry Evans in this book. He talks about the 'cacoathanasia' of Uncle Albert. Cacoathanasia is the inverse of euthanasia - 'caco' is the Greek word meaning 'evil'. Thus, it is an evil death. He gives a very moving account of his Uncle Albert who had a colostomy and was so offended by this that he attempted suicide with a 12-gauge shotgun and died as a result:

Albert had had a long and healthy life until his 80s. The cells in his bowel tissue went haywire. He had cancer. Needless to say, doctors did what they always do - they operated. They removed what they could and fitted Uncle Albert with a colostomy. He was appalled. It was so undignified to be getting around with a bag of excrement hanging off his body. ... One day the pain in his guts became so excruciating and the bag so humiliating that he went into the washhouse, loaded his old 12-gauge, which had not been used for years, and shot himself in the stomach. He subsequently died.

Those are moving accounts. To my mind, that means that our support mechanism for people undergoing colostomy procedures are inadequate. We have failed if people believe that they lack dignity because of those operations. The death of any man, woman or child diminishes me because I am involved in humankind. I simply feel utterly uncomfortable with those views.

I want to talk about my role as a parliamentarian in this debate because there have been a number of comments about how parliamentarians should go about their job. Views have been expressed by some speakers that parliamentarians should simply be 'spokesdigits'. They should simply work out what the numbers are in the electorate and put their hand up accordingly. I have never shared that view. I believe basically that electoral politics is one of the most exciting and challenging businesses. It is a matter of balancing the numbers with personal conviction. Hopefully, most of the time, your personal conviction follows where the numbers are. That has been my fortunate experience in 14 years in this game, certainly in the electorate if not necessarily elsewhere. I was concerned that some speakers in favour of the bill have said simply that the electorate thinks this and therefore they will vote accordingly. I am deeply concerned about that. That brings me to the next issue which is the nature of the public debate. I believe that public debate on this issue has been too hasty, despite the excellent work done by the committee in clarifying some of the issues. The raft of amendments before the Assembly betokens too hasty an effort. I do not believe that the consultation process has been adequate.

That brings me specifically to the *Natural Death Act* which is entirely unmentioned in this bill. I draw the attention of honourable members to that act which has a provision which will be overridden effectively by this bill. The *Natural Death Act* provides that nothing in it should authorise an act that causes or accelerates death as distinct from an act that permits the dying process to take its natural course. I really wonder about the motives of the member for Fannie Bay in that he has failed to refer to

the need to override that particular provision in the *Natural Death Act*. As I recall, the member for Fannie Bay did not speak in the debate on the Natural Death Bill whereas I contributed to the debate and did considerable work on the distinction between active and passive euthanasia. In fact, I find it very interesting to hear the support for this bill from the member for Sanderson. In the debate on that bill, I said that we were legislating for passive euthanasia and the member for Sanderson, the then Attorney-General, was aghast. He told me not to mention the word. Indeed, the term 'euthanasia' was never mentioned by the member for Sanderson. However, he has apparently had his 'road to Damascus' experience and he is now gung-ho in favour of it. That is an interesting change of attitude.

The approach of Aboriginal people is an important issue. I have agonised over this. I have taken the position of responding to representations from my electorate. I have not taken a high-profile, public position on this debate. I have answered the people who have made representations to me, either for or against, and they have been multitudinous as all honourable members have said, but I have had a great deal of trouble with representing the views of Aboriginal people because I know what their feelings are in respect of these matters. I point out that the idea of authorising a person to kill somebody else at some time in the future is difficult at best and, at worst, it is anathema in that context. I note the committee's finding in that regard: 'The committee believes that the government will need to explain clearly the current situation to Aboriginal communities, whether or not the bill is passed'. I believe that will be a difficult task. I had toyed with the idea of trying to put on the Assembly record a Pitjantjatjara account of some of the principles and some of the issues that I have already referred to. The sheer difficulty of doing that and the ease with which those comments would be misunderstood, because of the sheer alien nature of the policy behind this bill, has dissuaded me.

I believe this bill will be defeated, and that it should be defeated at the second-reading vote. I will explain some of the issues involved to clarify them in the terms that the committee has suggested. There has already been discussion about palliative care. I do not believe that there is much that I can add in that regard. I am already on record expressing my concern about the lack of palliative care in the Northern Territory. If any good purpose has been served by this debate, it has been to raise the level of the understanding of needs in that regard.

One of my chief reasons for objecting to this bill is the lack of clarification of the categories of people to whom it applies. The distinction between people who are in pain and people who have come to believe that life is no longer worth living is not clear in the public mind. As I have said already, in those circumstances where the *Natural Death Act* applies and where people are able to take advantage of living wills to remove life support systems, that area has simply not been clear in the public debate. The committee has drawn attention to that. It said, at page 30 of its report:

It became clear to the committee as it moved around the Territory taking evidence that there was very little awareness of the provisions under the Natural Death Act.

That is a matter of considerable concern to me.

I wish also to raise the religious position. I have endeavoured to base my comments essentially in humanist terms. The Christian positions have been very unreasonably, and in some cases contemptuously, derided by speakers in favour of this bill, and I have found that personally offensive because I believe that there are a number of religious positions in relation to this bill. Of course there is a conscientious religious position that supports it. I draw to the attention of honourable members the attitude expressed in an article in *The Age*, on 28 April, by Dr Francis McNab, a Uniting Church minister and executive director of the Cairnmillar Institute, Melbourne, supporting the principle of euthanasia

from a religious point of view. Equally, in the Helga Kuhse volume, a friend of mine, a Uniting Church minister, Reverend Ken Ralph, puts forward a Christian position in support of euthanasia. The Christian position against euthanasia has been ably described by the member for Port Darwin as being a fundamental commitment that 'thou shalt not kill', and that committing suicide or assisting suicide is fundamentally and morally wrong.

Mr Ede: Hanging?

Mr BELL: That is absolutely right, but I am not sure that it is a good example because we oppose hanging these days.

The Christian position that I have adopted in that regard is acting in love for the terminally ill person. I have mentioned the moral dilemma of the terminally ill person who is excruciatingly and unrelievably ill. That is a difficulty, but I do not believe that it is acting in love or acting in beneficence, in humanist terms, to encourage, to permit or to authorise death under the circumstance of somebody simply being terminally ill within 12 months of that period. I have said a number of times in this debate that the premature death of any person diminishes me, because I am involved in humankind. That particular phrase will be well known to members. In concluding my comments, I can do no better than give the full quote from John Donne's famous meditation:

No man is an island, entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friends or of thine own were. Any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee.

Dr LIM (Greatorex): Mr Speaker and Territorians listening to the broadcast of this debate, I rise tonight to speak against the Rights of the Terminally Ill Bill. In support of my thoughts on this issue, I remind members again that I come to this place with 32 years of medical knowledge and clinical experience and, before that, my university training. In those 23 years as a doctor, I have spent part in post-graduate intensive care, psychiatric and oncology training. For over 20 years before my election to this Assembly, my work included operating theatre and intensive care duties. I have seen my share of the dead and dying.

In the first instance, I would like to thank the member for Fannie Bay for raising the issue of euthanasia. I believe this exercise has heightened awareness throughout the Territory not only of this issue, but of the related issues of palliative care and end of life decisions. It is not for me to ponder the member's reasons for introducing this bill. I believe it is timely for us to debate this issue, but not timely to introduce this legislation. Unfortunately, the debate on this bill and on the wider issue of euthanasia has been confused by the various definitions of 'euthanasia'. Mention was made by the member for Nightcliff and others of the Coalition Against Euthanasia's qualitative research through a reputable polling agency. That indicated that the level of understanding of the issue in the community is confused and, at best, low.

Various amendments are proposed to the bill. There are amendments based on recommendations of the select committee, amendments to the amendments from the proponent of the bill and amendments from the member for Stuart and others. All these introduce new elements, thereby adding further to the confusion on the issue. Even I am confused by all of these changes. I believe we need to understand that the bill, as it was introduced by the member for Fannie Bay and to which he spoke in his second-reading speech, is no longer the bill contemplated for passage through this Assembly. Community consultation

over the last 3 months or so was based on the bill introduced in February. The community has not had an opportunity to scrutinise the proposed amendments, and we should all be concerned about that. In his second-reading speech, the member for Fannie Bay said:

In some circumstances, life can be shortened for the terminally ill. They can refuse medical treatment, operations, life support systems and resuscitation, thereby bringing about an earlier death. Our *Natural Death Act* allows a competent adult to designate that others can make a decision to accelerate death for them by switching off life support equipment.

I draw the attention of honourable members to the words 'to accelerate death'. In making that observation, the member demonstrated the widespread lack of medical knowledge about the process of dying and intervention in medical care. In a similar vein, the philosophers, such as Dr Helga Kuhse and Professor Peter Singer who are supporters of the bill, have conveniently ignored the fact that it is a disease process that kills the patient and not the withdrawal of life support systems. In her submission to the Select Committee on Euthanasia, Dr Kuhse claimed all deaths are human initiated. She said:

There are few life-threatening conditions today where some treatment or intervention could not delay the moment of death. As a consequence, many patients will die only after the decision has been made to allow death to occur. This means that death is very often the result of a deliberate human decision.

She argued out of medical context. Medicine does not preserve or prolong life. If the person is going to die, it will happen despite all the modern technology. Withdrawal of life support systems or the non-administration of medication, which can combat infective, degenerative or cancerous processes, does not hasten death. Death will occur as a natural progression of the disease. Treatment may cure or retard the disease process. On occasion, the body is able to fend off life-threatening diseases on its own without any treatment. Therefore, I argue that death is never the result of a deliberate human decision unless, of course, we are talking about homicide, suicide or euthanasia.

I will explain it in another way. A patient, who is suffering a terminal illness, enters a phase where his or her life is threatened. In other words, the dying process starts. The killing agent could be an infection, a cancer, a haemorrhage or an injury to a vital organ. With support, whether it be in the form of antibiotics, blood transfusion, chemotherapy, radiotherapy, intravenous drips or even ventilators, the dying process is retarded. The treatment is sometimes successful, the dying process is stopped and life continues. If the treatment is not successful, the dying process continues. When it is assessed that a treatment is futile, it is withdrawn. The patient is not killed. The patient dies as a natural progression of the disease. A doctor's omission of treatment can bring about death only if there is a disease that will kill the patient in the absence of treatment. The doctor's omission of treatment will not affect a healthy person, but a doctor giving a lethal injection will kill both a healthy and a sick person, and the doctor is responsible for that action.

Let me relate 2 stories of men who were victims of 2 separate motor car accidents. They were patients of mine when I was an intensive care resident many years ago. The story will illustrate that withdrawal of support systems is not killing the patient. The first patient was brought into the Intensive Care Unit. He had suffered major head injuries. Attached to him were several intravenous drips and he was ventilated artificially. The tube into his windpipe, or trachea as it is called medically, was as much to help him breath as to protect his lungs from gastric contents. Let me explain. When a person is unconscious or comatose, there is no gag reflex. The gag reflex is an involuntary protective action which occurs in the upper airway when a foreign body enters it. An endotracheal tube will prevent gastric contents, such as

food and acid, from entering and permanently damaging the lungs. Thus, when a patient is unconscious, it is important to insert an endotracheal tube to protect the lungs and to allow ventilation.

The patient's respiration was maintained by a ventilator. Unfortunately, in spite of all we did over several days, he remained unconscious. The hospital's consultants pronounced him brain dead and sought his family's permission for kidney donation. Permission was granted. We maintained the living body until a suitable recipient was found. As a junior member of the intensive care staff, I was given the task of taking the patient to the operating theatre once the recipient had been surgically prepared. Once there, I was to remove all life support from the patient, pronounce him dead at the appropriate time, and then permit the salvaging of his kidneys. At the appointed time, I trundled the patient into the theatre. I removed all the intravenous drips and the endotracheal tube. Normally, when an endotracheal tube is removed from a patient who is on a ventilator, respiration stops. The heart stops beating shortly after that and death ensues. In this instance, when the endotracheal tube was removed, the patient commenced breathing on his own - something not anticipated by anyone. We had previously tested him without the ventilator and, each time we had turned it off, he had stopped breathing. This time, he did not. Five minutes passed, and the patient continued to breath. Another 5 minutes passed, and there was no change. At the end of the third 5 minutes, I advised the surgical team that it was not possible for them to proceed to salvage his kidneys. I reinserted all the necessary tubes and drips and took him back to the Intensive Care Unit. I learned later that he was discharged from the Intensive Care Unit several months later.

I have recounted that story to demonstrate that, had this bill been law at that time, I would have been told to give him an injection of a drug of some kind so that he would die rapidly and allow the surgeon to remove the kidneys from him. In the early years of my ethical and medical development, I would have had to comply with orders given to me by my seniors. The consequences of that action would have been devastating both for me and for my patient.

In the second case, the patient was also brought into the Intensive Care Unit in a comatose condition. He was treated with the same degree of urgency and skill. His respiration was being maintained by a ventilator. The patient was nursed in the Intensive Care Unit for several days. He was fed through intravenous lines into large veins in his chest. His physical needs were looked after. He remained unconscious the whole time. After about 4 days and a battery of sophisticated tests, the specialists came to the conclusion that further care was futile as, to all intents and purposes, the patient was dead. A medical decision was made that all support systems would be withdrawn. However, the family would not allow the withdrawal to occur. They maintained a vigil around the bed 24 hours a day, watching our every move whilst we did what we could to provide nursing care for the body. Nothing else we did benefited the patient. All the staff, myself included, knew the patient was dying., We could smell the degeneration of the patient's body, but the family refused to give up hope of his recovery. After several more days, the heart degenerated to a point where it could no longer continue to beat. It was only then that the family accepted that their loving son was dead. With that patient, whether or not we continued life support would not have made any difference to his survival. It was the injuries, the disease - using the term in its generic sense - which killed the patient. The withdrawal of life support would not have killed the patient. Indeed, in this instance, we did not withdraw life support.

Let me now reflect on some of the comments made by several members today, including members of the Select Committee on Euthanasia. Several members quoted Dr Roger Hunt quite freely, citing him as the authority on palliative care. Let me enlighten honourable members about the position that the doctor holds in the palliative care field. Dr Hunt graduated from Flinders University in 1980. In other words, he

has been in medical practice for about 15 years, the first 2 years of which would have been spent as a junior resident at a teaching hospital doing the equivalent of an apprenticeship. He has no post-graduate degree. I assume he has done some palliative care training, but I find no reference to that in his curriculum vitae in the Medical Directory of Australia.

Looking back over his oral and written submissions, he never claimed to be a specialist in palliative care, and I believe we should not assign that status to him. Dr Roger Hunt is the only palliative care practitioner - the only one - who has professed on the public record the view that euthanasia is part of palliative care, and that pharmacological oblivion is the therapeutic method of dealing with pain and suffering in terminal care. No other submission, written or oral, describes pharmacological oblivion as a therapeutic measure. When I personally checked with palliative care specialists, no one agreed with that method of treatment. Dr Hunt practises this form of therapy. He then claims: 'Palliative care is simply a slow form of euthanasia'. He tries to rationalise that the logical end to palliative care is pharmacological oblivion and euthanasia. That is deceitful.

Mr Perron: No, that is not true.

Dr LIM: What he does is abhorrent to most palliative care specialists. What the others do is provide the patient with sedation to a level that produces sleep, a level of sleep from which the patient is easily rouseable. The patient may be awakened at any time to participate in his or her own nursing care, breathing and coughing exercises or even to receive visits from relatives. There is no oblivion from therapeutic measures. When satisfactory sleep is added to adequate pain relief, patients become less stressed. They are able to move around. They do not lie in a bed in a state of oblivion. As well as improving the quality of life, the ability to move around may diminish death-accelerating complications such pneumonia, bed sores and thromboses. Dr Hunt is isolated from his palliative care colleagues in his personal position on palliative care, pharmacological oblivion and euthanasia. It must surely tell members that he is going in a tangential direction. Therefore, I advise honourable members to take his advice guardedly.

In relation to comments about psychiatry, Dr Christopher Ryan was the psychiatrist referred to by the member for Nightcliff. Let me read what the good doctor said:

Work that has been done supports the notion that suicidal ideation in the terminally ill population is frequently not the product of a carefully considered and recent decision. If a desire for death in the terminally ill were usually the result of recent decision-making, then one would expect that both completed suicide and an interest in euthanasia would occur most often in the latter stages of illness. This would be the time when pain and suffering is at its worst and when there is little to look forward to. In fact, however, completed suicide is most common in the first year after diagnosis in the terminally ill.

The member for Stuart spoke about using psychologists to assess depression. Psychologists have no place in the diagnosis of depression. Members who have studied psychology or who have read some of the books by Dr Elisabeth Kubler-Ross would know that, when a person is told that they have a life-threatening disease, they go through a range of emotions. They go through an initial phase of denial, during which they reject all evidence that the diagnosis is correct. That is a phase when they say: 'No, it is not me; it cannot be true' or 'The X-rays have been mixed up; they are not mine' or even 'The tests are wrong; they are not mine'. Following a variable interval, when denial can no longer be maintained, it is replaced by feelings of anger: 'Why me? What have I done to deserve this?'. This is a difficult phase for all of those around the patient. Nobody can do anything, or do enough, for the patient. When the patient

can no longer rail and rage about his illness, when he is no longer able to deny the disease, his anger is replaced by a great sense of loss. He grieves for his loss - his loss of a future, his loss of a job and the financial drain of his illness. This is the phase that Dr Ryan described as the time when suicide is most common. Dr Kubler-Ross wrote in her book *On Death and Dying*:

If the patient is given enough time and has been given some help in working through the previously described stages, he will reach a stage during which he is neither depressed nor angry about his 'fate'. He will have been able to express his previous feelings, his envy for the living and the healthy, his anger at those who do not have to face their end so soon. He will have mourned the impending loss of so many meaningful people and places and he will contemplate his coming end with a certain degree of quiet expectation. He will be tired and, in most cases, quite weak. He will also have a need to doze off or to sleep often and in brief intervals, which is different from the need to sleep during the times of depression.

It is a gradually increasing need to extend the hours of sleep, very similar to that of the newborn child but in the reverse order. It is not a resigned and hopeless giving up, a sense of 'What's the use?' or 'I just cannot fight any longer'.

It [meaning the acceptance phase] is almost void of feelings. It is as if the pain had gone, the struggle is over, and there comes a time for 'the final rest before the long journey'.

It is important that we ensure that patients are helped through these phases and given time to ensure that they have the opportunity to come through that depression phase when they are most likely to seek suicide or request euthanasia.

I mentioned in a previous speech that I believe that this debate comes down to 3 major points, the first of which is the issue of self-autonomy versus the common good. I believe that proponents of the bill have not considered the wider ramifications of self-autonomy. Developed to its ultimate end, self-autonomy can be observed only as far as society allows, with the provision that an individual's action does not adversely impact on it. Euthanasia involves at least 2 other people: the assisting doctor and the second doctor. It is thus no longer a matter of self-determination, but a social decision between 2 or more people that one of them is to be killed.

Mr Perron: Who all agree.

Dr LIM: We have made a shift from the patient's right to self-determination to the doctor's right to kill the patient. That is contrary to what the member for Fannie Bay suggested in his second-reading speech: 'Under the proposals contained in this bill, a person asking for assistance to accelerate death is in total control of the process'. In reality, the patient is not in control of any process. I quote from Daniel Callahan, the director of the Hastings Centre:

People suffer, but suffering is as much a function of the values of individuals as it is of the physical causes of that suffering. Inevitably, in that circumstance, the doctor will in effect be treating the patient's values. To be responsible, the doctor would have to decide, on his or her own, whether the patient's life was no longer worth living ... [But] there is no way of measuring or judging the claims of patients that their suffering is unbearable. And, if it is difficult to measure suffering, how much more difficult is it to determine the value of a patient's statement that his or her life is not worth living? ... Euthanasia is not a private matter of self-determination. It is an act that requires 2 people to make it possible, and a complicit society to make it acceptable.

I say to you that life is not ours to have or to give away. Life just happened. We neither asked for it, nor were we given it as if it were a present for us to dispose of as we wish. In my view, life is something that is on loan to us, to care for in the best way we can. If we fail to care for it, it is taken away from us early. If we care for it, we may have it for 70 years or so, at the end of which it is then taken away. I believe society holds the right to all life. We as individuals do not hold that right. I will not go further into this point of the debate as my time is limited and other more eloquent speakers have addressed it. I will repeat only that life is not ours to give and take. Further, if the proponent of this bill really believed in self-determination, then any competent person should have the right to be killed by a doctor, for any reason that suited them. If the member believes in the relief of suffering, then it seems cruel to deny it to anyone, including the incompetent.

The member for Sanderson quoted from a list entitled, 'A synopsis of disease and symptoms which are at best difficult, at worst impossible, to control with modern palliative care'. I suggest that the list was produced by a doctor - it was circulated under the name of the member for Fannie Bay - but it is now quoted parrot-fashion without any medical understanding. This list is emotional blackmail and is taken out of the context of everything medical. It should be treated as such and totally ignored.

Mr Perron: Rubbish.

Dr LIM: I want to speak now about the double effect where the intent to treat a symptom is confused with the intentional killing of the patient. When doctors like Dr Hunt, and non-doctors like Dr Kuhse or even the members for Wanguri and Stuart, talk about the double effect, they work on the premise that, because the outcome is the same - that is, the patient dies - whether or not there is an intention to kill is irrelevant. It indicates that either they do not understand the matter or are deliberately misleading the argument.

For me, as a doctor, it makes a big difference. At the start of an illness which requires medication, in particular pain-killing medication such as morphine, only a small dose may be required. As the pain level increases, the dosage of the drug is also increased. In the early stages of treatment, the window of safety is wide. With usage of the drug, tolerance to it develops. Thus, for the same net effect of pain relief, a larger dose may be required. The window of safety is now smaller. It is not possible to know what the upper limit of this window of safety is. It varies with the size, the gender and the frailty of the patient. The intention in determining the dosage given to the patient is to alleviate suffering. The dosage may - and I repeat 'may' - tip the balance with the patient, but that is never the intention. If the dosage is within the window, then we have achieved the desired effect of alleviating suffering. The patient is alive and awake. As for the argument that to turn off a ventilator is to shorten life, I have already spoken about that.

Professor David Kelly, a proponent of euthanasia, was cited to have quoted John Stuart Mill. What was omitted was what he said himself in November 1994 at an international seminar on the legal aspects of euthanasia:

There must be an observable harm to society, and that harm must outweigh the harm that is involved in denying people their freedom ... I have no doubt at all that legalising active voluntary euthanasia will lead to a strong demand for legalising active non-voluntary euthanasia - that is, allowing for the relevant type of decision to be made by others on behalf of those who, because of their age or for other reasons, are not able to make the choice for themselves ... Indeed, I would welcome it as entirely appropriate ... Otherwise we would be

guilty of discriminating against those who are unable to make the choice for themselves. We would be continuing to condemn them to the very harm which we believe is unacceptable to impose on people.

That brings me to the 'slippery slope' argument. The member for Fannie Bay failed to demonstrate that there are adequate safeguards in the bill - hence the amendments. He stated only that we 'should consider the narrow focus of the bill'. Since the onset of this debate in the public arena, there has been a multitude of recommendations from the report and everywhere else that changes need to be made to provide better safeguards. It is ironical that, when I posed the question to Dr Kuhse during her appearance before the select committee, she thought otherwise. I quote the relevant section of the transcript:

Dr LIM: The question that was asked first was: 'Are there any weaknesses in the bill that you can see now, that need to be tightened up?'

Dr KUHSE: I have not really seen any weaknesses. It is a good bill as far as I can judge. I had an extensive look when it first came out and when it was redrafted, and again last night and over the weekend. It seems to me that it is a good piece of legislation. Large parts of it have actually been lifted from the Victorian draft bill, which was drafted by Professor David Kelly, the former Chairman of the Victorian Law Reform Commission. To the extent that these bits conform to the Victorian legislation, I think they are already pretty good. They could not have had a better judge than David Kelly. I was one of the people who worked with him on those clauses. So on the face of it, it seems pretty good.

We are all concerned that the effects of this bill cannot be contained. We need to ask ourselves whether or not it is likely that, once society has sanctioned the killing of the terminally ill, pressure will mount to extend the law to allow the killing of handicapped babies, comatose accident victims, the mentally ill, and persons who incur high public expense for medical treatment. How could involuntary euthanasia be controlled? Some members say that we need to legalise euthanasia because it is already happening today. The inference is that, if we legalise it, we can then control it. Let us take a moment to ponder this further. Members claim that there are doctors who are performing active, voluntary euthanasia.

Mr Perron: And involuntary euthanasia.

Dr LIM: They are saying that there are doctors in practice who are prepared to step outside the law to perform illegal acts because they disagree morally with the current laws regarding the killing of patients. These doctors are now prepared to put themselves above the law. They believe they have the right to act outside the law because the law is inadequate and immoral. What safeguards would there be to ensure that these doctors would remain within the new law? If these doctors are already of the mind that they will step outside the law if the law is inadequate or immoral, then they will still step outside the law if they consider that the new law is still inadequate or immoral.

The bill relies on the integrity of the medical practitioner to maintain honesty within himself or herself and to comply with the laws of humanity - laws developed over centuries of philosophical thought. I say that it is not possible to trust doctors - and I am one of them - with such profound responsibility. Philosophically, these doctors see themselves as the moral guardians of society, making their own laws according to their conscience. They do not see that they have to comply with society's laws. They will always do as they wish, according to their conscience. No legislation will control this cohort of practitioners. These hands have healed, these hands have delivered innumerable babies, and these hands have retrieved many a patient who would have had an untimely death. These hands also have the power

to kill. These hands can be the hands of any doctor in the world. This Assembly must not tarnish these hands with the legally sanctioned power to kill.

Dr Kuhse and those espousing her beliefs would say that voluntary euthanasia raises no new issues and that there is no 'slippery slope'. In her defence, she claims that we cannot use the Dutch studies, such as the Rummelink Report, as it is the only one of its kind and therefore no figures compare with it. She ignores completely the subsequent studies done by John Keown, Brian Pollard and even the Dutch researcher, Paul Van Der Mass. Dr Kuhse and her co-worker, Professor Peter Singer, have supported the extension of euthanasia to include many other categories of 'deserving people'.

There are certain things people should expect from their politicians. We should care more about our constituents than about ourselves. We should care more about what is right than what is popular. I vote with my conscience, and I am fortunate in that I find my electorate supports my view. The eyes of the nation and the world are upon us. We are called on to make a decision tonight that will change forever the social fabric of humanity. Greater bodies and legislatures have considered this matter, including the House of Lords Select Committee on Medical Ethics. For these reasons, I beseech members to defeat the bill.

Mr POOLE (Araluen): Mr Speaker, I believe that this debate really seeks answers to the following questions. Do human beings have a right to control the circumstances of their death, or should it be left to God or nature? What is the role of law or government in enforcing public morality or in accommodating moral choice? Can a legislative system respect individual autonomy yet, at the same time, protect those who are less able to exercise their autonomy - the mentally incompetent or ill, the disabled, the elderly, the socially disadvantaged, the depressed? These are the questions that I believe we should be focusing on today in this parliament.

Over the past few months, as Chairman of the Select Committee on Euthanasia, I believe I have looked at all the arguments and thought deeply about whether or not the Territory should change its laws to allow assisted suicide or voluntary euthanasia. Like the estimated three-quarters of the population in support of the bill, I felt that, under specific conditions, dying individuals should be able to request help from doctors to end their lives. However, I sometimes wondered whether allowing such a choice might alter our society in a way that we would all regret. Some opponents of this bill have expressed concerns that what started out as voluntary euthanasia could become involuntary euthanasia. Human beings, particularly politicians, have a natural tendency, perhaps even a compulsion, to make decisions for the good of others. It is called paternalism, and I assure you it is alive and well.

There were suggestions that euthanasia might become the cost-effective treatment of difficult or hopeless terminal illnesses, which would then force suffering individuals to justify their desire to stay alive. This is the so-called 'slippery slope' argument. Others worried that factors such as poor care, loneliness, isolation and the meaninglessness often experienced by the dying, disabled or the elderly, might motivate requests for euthanasia and that our society, in its laziness, might then never address the underlying problems that fuel those requests. For those reasons, the select committee made major recommendations in relation to palliative care. That is why many people's hearts say 'yes' to euthanasia in principle, but their heads say, 'I am not sure'.

The committee identified people who supported legislative change, but who did so only subject to caveats, subclauses and restrictions. Even for supporters, the need for appropriate safeguards is paramount. The committee responded to this by recommending extensive amendments to the bill. Like

most people, while I support individual autonomy, I worry about possible abuses. I believe the only way this issue will be resolved is if it can be demonstrated that a system of voluntary euthanasia can be introduced safely. Having said that, the question must be asked: is our present situation safer than that proposed in that bill? The answer is, I believe, emphatically no.

In our society, no one may counsel, aid or abet a suicide. To do so is a crime punishable by imprisonment. No one may deliberately take the life of another even for compassionate reasons or at the person's request. To do so is first degree murder which is punishable by life imprisonment. It really does not seem fair, does it? Prompted by mercy and compassion, you can kill a person at his or her earnest request, and that is murder. Prompted by rage and anger, you can kill a non-consenting victim, and that can be manslaughter.

The reality is that our laws against assisted suicide and euthanasia are ineffective laws which are applied unevenly, if at all. When cases of euthanasia occur, the legal system is not keen on investigating and prosecuting. In essence, we look the other way. We hear no evil, we see no evil and we speak no evil. This can only foster disrespect for our laws. It is really the equivalent of backyard abortion. There is ample evidence that it is being done. The fact is that doctors in Australia regularly give doses of pain-killing drugs to patients with terminal illnesses in the full knowledge that the drug will lead to their deaths. Quite frankly, the proposition that such deaths are simply a side effect of pain management and do not constitute euthanasia is nonsensical. In some of these cases, the patient will have asked the doctor for assistance to die. In other cases, they will not have asked or possibly were incapable of doing so. However, in each case, the doctor has had full knowledge of death being the likely consequence of the medication and, to my mind, that amounts to euthanasia, both voluntary and involuntary.

I am not criticising doctors who carry out such acts. There is no question in my mind that they have acted with compassion and professionalism. Nevertheless, the fact remains that people are being killed on a regular basis without the protection of any regulatory regime. Opportunities for exploitation are always greatest when things are done secretly - where there are no guidelines, no second opinion, no records kept, no reporting and where people are even afraid to talk about it. That is the situation where people will be driven by their consciences or other motivations. They may make a right or wrong decision, and nobody will even know.

Those who speak in favour of euthanasia often raise the Dutch example of a compassionate, working policy. Those against euthanasia tell stories of wide-scale involuntary killing in Holland, and of elderly people who end up being afraid to go to hospital. I believe the truth lies somewhere in between. The Netherlands' ambiguous, 'illegal yet tolerated' approach evolved as a flawed compromise due to political reluctance to deal with an issue that increasingly faced doctors, the courts and the public.

Rather than import the Netherlands' model to the Territory, I believe the member for Fannie Bay has drafted a better model, based on the rights of the individual and free choice. In the Netherlands, the boundaries of euthanasia have had to be tested over some years, with some subsequent controversy. The Territory legislation has been drafted with appropriate safeguards already in place to avoid such difficulties. Critics cite controversial cases in the Netherlands, raised from time to time by a coroner to a prosecutor, as proof that euthanasia is out of control. Others contend that the scrutiny of these cases is simply setting the borders of euthanasia.

The 'slippery slope' referred to in the Netherlands can be seen not to be downhill but uphill, because of the increased awareness of the requirements, the increase in the number of doctors reporting and the

increased awareness of the danger of life termination without request. Nonetheless, the acceptance of euthanasia is very high among the Dutch population. Personal autonomy is highly prized, and a whole range of behaviours are tolerated, provided those individual rights do not infringe on the rights of others. Problematic cases of involuntary euthanasia, which I believe happens fairly regularly in Australia, should not be the reason to forbid voluntary euthanasia. The Territory has the opportunity to draft better legislation requiring safeguards and strict guidelines to be in place prior to any consideration of voluntary euthanasia.

The debate on euthanasia in the Territory has highlighted the fact that many people are unaware generally of any options available at the end of life to avoid a drawn-out, high-tech death. The Northern Territory's *Natural Death Act* provides for a signed and witnessed declaration that can give advance directives, detailing the individual's desire for medical treatment, in particular whether they wish to refuse life-support treatment. When they do not know what a loved one would have wanted, families often feel compelled to agree to treatment or life support in case they appear to be callous or unloving.

As a result of the focus on euthanasia worldwide, there has been a call for increased public education on the options, and a higher profile has been given to the provision of living wills. Recently, in the Netherlands, a public service advertisement ran in newspapers and on television throughout the country. It urged people to write out a living will, detailing what they would like to happen if they became sick or incompetent. They should discuss their wishes with their families and their doctors and carry the wills in their wallets. Remarkably, the advertisement was sponsored by the pro-life Patients' Rights Association and the Voluntary Euthanasia Association. These diametrically opposed groups worked together with the Ethical Advertisers Association to produce that campaign. Most people use the living will to refuse life-sustaining treatment. However, the documents are equally valuable in ensuring that people who want life-sustaining treatment receive it. That is the crux of the whole issue. It ensures that all people have their own wishes respected, regardless of what is chosen.

In the Territory, people can carry their living will but, under this proposed legislation, there is no need to carry a 'do not kill me' card because euthanasia could and would occur only on request. I like the idea that people write down what they want. I like the idea that they discuss it with their family. I like the idea that they discuss it also with their doctor. Whether somebody wants euthanasia or whether they want to be treated to the very last moment, the important fact is that they let people know and that their wish is respected.

Supporters and opponents of the bill in the Territory have urged that palliative care be made the superior alternative to legalising the right to die. Many have implored members not to change the law, but to throw their support behind palliative care. Unfortunately, I do not believe that palliative care alone is the answer. Palliative care focuses on keeping the dying patient comfortable, not on treatment to cure the illness. It aims to relieve the patient's suffering, pain and symptoms by giving medical, physical, emotional and spiritual support to patients and their families. I have the utmost respect for this field of medicine and the dedication that practitioners show. I am convinced that, where possible, the principles of palliative care should be applied to all dying Australians. Unfortunately, like the physical resources needed, medical research devoted to palliative care has not been sufficient. Better drugs, which have fewer side effects, are needed to relieve the distressing symptoms of dying. There needs to be treatments for uncontrolled vomiting, itching, constipation and the terrifying sensation of choking and suffocation that can come in the final days. Patients should not have to be drugged to the extent that there can be no meaningful interaction with their family.

The question then arises as to whether the government allows euthanasia before the inadequacies of palliative care are addressed? Palliative care practitioners contend that legalising euthanasia would prevent any further improvements taking place, but I do not accept that argument. In the Territory, we have seen already that the debate on this legislation has been the spur to ensure that palliative care receives the recognition and the awareness it needs.

Experience in the Netherlands also supports this notion. Goaded by international criticism that palliative care in the Netherlands was inadequate, there has been a concerted effort to improve the situation. Every regional hospital and cancer centre in the Netherlands now has a fully-funded pain control team, with funding designated in the health budget. Every physician has a 64-page manual on pain management. Likewise, independent groups are founding hospices, backed by donations and government funding, to offer an alternative to euthanasia. Palliative care should not be pitted against euthanasia but both should be part of the continuum of care for the dying. Palliative care should be a part of the process, but may not necessarily be the final answer.

The issue of euthanasia as it relates to AIDS patients has been raised. I was interested to see an interview with Dr Sven Danner, the director of an AIDS clinic in the Netherlands. Danner says almost 100% of his patients want to discuss euthanasia with him early in their care and seem to be reassured when he advises them of the specific conditions under which they can receive it. Many newly-diagnosed patients state adamantly that they will ask for euthanasia long before they get to the end-stage of AIDS but, as their disease progresses, their perspective changes. Danner says:

They realise that the decision is irreversible and that life itself has value. Gradually many of them find there are more things that make life worth living - renewing ties with their family, with their friends. And then, well, they cling to life more than they would ever realise.

A specialist in infectious diseases, Danner contends that one can be a doctor on the cutting edge of medical science, yet still believe euthanasia is a compassionate adjunct to one's profession:

I feel it is part of my duty not to abandon my patients when I have nothing else to offer them. Nevertheless, here at the AIDS unit, euthanasia is a rare event.

Many medical professionals believe that good research and good palliative care cannot exist in a climate that openly accepts euthanasia. However, Danner feels that the opposite is true - indeed, that research and palliative care benefit:

To be comfortable with euthanasia, you have to feel you are offering the best of palliative care, or chances for improvement. That is the only climate in which euthanasia can or should exist.

Danner points out that, in the 10 years that the hospital has been operating, only 12 cases of euthanasia have been performed, under the strict guidelines set out, among more than 1500 patients. However, to be fair, independent surveys show that some 35% of AIDS patients, in the very late stages of the disease, seek respite through assisted suicide or euthanasia in their own home and, if possible, aided by a family physician.

This perspective is important because it removes some of the hysterical suggestions that have been made about the Territory facing an avalanche of AIDS sufferers if this bill is passed. There may well be some additional AIDS sufferers coming to the Territory to undertake voluntary euthanasia, but any suggestion that our hospitals are about to be clogged with AIDS patients waiting for voluntary euthanasia is alarmist and unsubstantiated.

One point I would like to make relates to the role of the churches in the public debate on this issue in the Territory. It is one thing for the churches to preach to their congregations about the morality of particular behaviour. Logically, that is and should be the role of any religious organisation. However, what I believe is unacceptable is when the churches attempt to force their view on the wider population, regardless of whether that view is widely accepted. The bottom line is that this bill is about personal choice. It is not the province of the churches to prevent people, who do not follow their teachings, from having access to such a choice. Clearly, the bill will make no impact whatsoever on the right of Christians of any denomination or the followers of other religious faiths to hold on to their religious beliefs, and to die as they see fit in accord with the will of their particular God. There is no compulsion or direction in the legislation. The provisions of choice and free determination clearly exclude a believing Christian from even thinking about the legislation, as far as they themselves are concerned, if it becomes law. Honourable members might reflect on the fact that religious belief is a personal matter, and that our modern community comprises individuals who owe allegiance to a multiplicity of faiths or to none. Darwin is the most multicultural city in Australia, with citizens from over 60 different ethnic backgrounds. To suggest that any one religious organisation or even a group of organisations represents the moral views of the wider public is clearly nonsensical. Certainly, it is true that there was a period in Western European history when the law of the Christian church and temporal law were parallel. Such societies now exist only within the historical record and it is not appropriate today to assert that a belief held by one group of individuals should be legislated to affect all individuals.

There is also no evidence to support the contention that all Christians or all followers of other faiths are opposed to voluntary euthanasia - quite the contrary. In fact, it is clear that many practising Christians, including Catholics and members of other faiths, desire the decriminalisation of medical assistance to hasten death. If this bill is invalidated on religious grounds, it will be seen in the community as a decision to impose and impinge on the individual rights of members of the public - that is, the perception would be created that a minority religious view had dictated to the majority that the majority could not have the opportunity or the right to exercise a personal choice.

A similar argument applies to the contention that the bill is not culturally compatible with Aboriginal people. The statute books undoubtedly contain many laws that are not culturally compatible with traditional Aboriginal lifestyle. In this instance, the difference is that the provisions of this legislation would have no impact on the Aboriginal community unless and until an Aboriginal person elected freely to exercise his or her options under the legislation. It can be said also that the majority of people in the Territory do not live according to the dictates of Aboriginal custom, Aboriginal law and Aboriginal tradition. Accordingly, the same principle should apply - that is, the beliefs of one group are not a valid or sufficient reason to deny the rest of the community specific rights, especially when the matter centres absolutely on free will and independent personal choice.

Honourable members might also consider the point that cultural beliefs and social standards change over time. One witness, who is experienced in Aboriginal health matters, pointed out to the committee that infant male circumcision, a traditional practice, was now being performed in many cases in hospitals and under general anaesthetic, at the choice of the Aboriginal families involved. It is not impossible or even unlikely that, over time, a safe and effective system of euthanasia will become accepted by Aboriginal people. At the very least, it should not generate unreasoning fear.

I cannot stress too strongly the need for this parliament to come down on the side of personal choice. I am disturbed by the number of honourable members who have decided against this bill on religious

grounds. I am equally concerned about honourable members who have claimed to support the bill, but who have tried then to find a fault with it rather than vote for it. This bill presents absolutely no justification for any honourable member to force his or her religious beliefs on any other member of the community. Similarly, all honourable members know that we can make this legislation work and work well if we believe in it. As responsible representatives of a diverse community, our choice must be for personal choice.

I remind honourable members of the words of David Kelly, the former Chairman of the Victorian Law Reform Commission: Put simply, the only justification for restricting freedom through law is to prevent harm to others. Even then, the harm to others must outweigh the harm to restricting freedom ... The fact that euthanasia happens to be illegal is irrelevant. The law itself has to be justified. If it can't be, it must be changed.

Finally, I would like to cite the case of Sue Rodriguez, a Canadian who was suffering from a terminal illness and who, in 1993, applied unsuccessfully to the Supreme Court of Canada for the right to die. I would like to quote from Lisa Hobbs Birnie's biography, *Uncommon Will: The Death and Life of Sue Rodriguez*. In her book, Birnie - and it should be noted that she did not approve of assisted suicide - writes at the climax: 'If you were surrounded by love, by a family that hugged and kissed you and brought you hot soup, and a husband that held you precious, brought you flowers, rubbed your back, Sweet Suzie, would you be doing this?' 'I don't know ... I don't know', Sue is quoted as replying, hardly able to 'breathe for grief', Birnie writes. That charged moment has now been interpreted by some to mean that Sue's decision to die was not a rational choice and that somehow that confession removes the justification of her crusade. 'It was obvious that she came from a dysfunctional family, that she was a deeply unhappy person and in great need of control', one palliative care physician said. Another said: 'Sue may have had pain and suffering, but it wasn't physical pain, it was emotional suffering from the breakdown of her marriage'.

These comments mirror a point repeatedly raised in the bioethics literature on euthanasia and assisted suicide - true autonomy is not possible. No choice is ever made independent of who we are, what our experiences have been, and who the people are who are around us. Whilst that is true, it should not prevent individuals from having free choice - the freedom to weigh the circumstances, assess the realities of their lives and choose the best option for themselves. In this case, Sue knew she could not change her circumstances. And she knew she was dying. The only thing she could change was how she died.

At some time in our lives, we will all die. If we are lucky, we will die quickly or peacefully. If I do not die by accident, I hope that I will pass away comfortably, looked after by caring professionals and surrounded by the people that I love. Unfortunately, however, some of us will have an end that is anything but peaceful. We may suffer relentless vomiting, nausea or breathlessness. Our pain may be agonising. We may have to be sedated into oblivion for days or weeks or, in some cases, even months. Some of us may want to fight on to the end, getting every drop that we can out of the precious gift of life, despite the pain or the discomfort. However, I am sure many of us may want to say goodbye to life on our terms and in our own time. We may want the freedom to weigh the options before us and then make an earlier but more peaceful exit. Surely we should have that choice.

There should never be a right or a wrong way to die. One death should not be called 'dignified' because the person swallowed pills and another 'undignified' because he or she struggled to the bitter end. Dignity in death is solely to be defined by the individual and his or her own set of values. Undignified deaths are

those in which the moral values of others are imposed on the dying individual, against the values, the judgment and the wishes of the patient.

A safe and effective approach to euthanasia should ensure that the doctor and individual explore, in openness and honesty, how external influences, family pressures, unhappy marriages, the need to be in control, exert their force on the request for euthanasia and what, if anything, can be done about it. Legalising euthanasia will give patients the freedom to talk about options. That does not mean euthanasia will result. Instead of the doctor responding with, 'Sorry, it is illegal', it would be likely that he would say, 'Yes, it is possible if you really need it, but let's talk about it'.

No doctor should ever be obliged to fulfil a request for euthanasia with which he or she does not agree or which he or she feels is misguided or inappropriate. Both the doctor and the patient should feel that, together, they have reached the right choice, the best choice, and a rational choice, weighing all the circumstances. I believe that, in this case, the right, best and rational choice is freedom of choice. I urge all honourable members to vote in favour of the personal choice and rights of their constituents. I support the bill.

Mr McARTHUR (Goyder): Mr Deputy Speaker, I take this opportunity to speak in this debate, though not because I have any new arguments to bring to the attention of honourable members - I think all the relevant arguments have been aired during the debate so far. However, lest honourable members should be in any doubt as to my position in relation to legalising euthanasia, I feel obligated to put my views on the record. I have no difficulty in standing up in this House and stating clearly that I am deeply opposed to the proposition of euthanasia. Over the 3 months since the member for Fannie Bay introduced this bill, I have willingly made my position known to all who have asked. When asked whether I might change my view if my electorate indicated its support for euthanasia, I have readily said no.

Members have been given the right of a conscience vote on this matter. If this right had not been offered, it would have been taken, so certain am I that this proposed legislation is wrong in intent, flawed in principle and divisive in nature. I make no secret of my religious conviction - in fact, I am proud to claim it. However, I refute claims that that is the sole basis of my objection to this bill. We commence each day in this Assembly with the Lord's Prayer. Do we pay lip-service only to that very powerful prayer? 'Our Father ... Thy will be done ... for the true welfare of the people of the Northern Territory'. Those are the words we use, among others, to put a frame around the decisions we make in this place. Westminster democracy is based on these Christian principles and ethics, to build an environment in which all people prosper and the weak are protected.

When I entered this parliament 11 years ago, I made no secret of my position in this regard. I believe that adherence to these principles is a positive asset to any politician. There has been an attempt by proponents of the bill and its supporters to hijack the high moral ground in this debate. Comments such as - and I quote in general terms - 'if a democratic vote were to be taken, the bill would be made law', or 'if there were fewer Catholics in this Assembly, the bill would be passed', are unworthy of this place and of the person who made them. Certainly, they are not reflective of true democracy. I believe this bill will not be passed, not because of a handful of Catholics or a lack of democratic principle, but because a majority of members like myself will have reached the view that the proposal is based on the flawed principle that we have a right to destroy ourselves regardless of the effect that action has on others. No amount of playing at the edges with amendments can make this proposal sound or just law, and that is because it lacks the principle of equal justice for all.

The fact that we have before us today some 50 proposed amendments should set the alarm bells ringing. When it was introduced in February, it was said that the bill was sound and that there were no loopholes. Why then this flurry of amendments? How sure can anyone be that even this is the final position? The fact remains that we cannot be sure. If this bill becomes law, the only certainty we will have is that the next step on the slope will be easier to take. That is the nature of the beast of government. No amendment to a law which is based on an unsound principle will make that law sound or just.

Until a few short months ago, I was poorly informed on the subject of euthanasia. The subject had never been raised with me in 11 years of representation here. There was no need to inform myself, as no one was demanding it. If nothing else, the member for Fannie Bay has forced members of this Assembly and our constituents to think about the potential of euthanasia legislation. I have read reams of papers with arguments for and against legalising euthanasia. The most cogent arguments appear in a handful of papers, most of which appeared in the early days of the debate. Very few powerful new points have arisen on either side in recent times. I can say only that the more I read, the more convinced I become that the basic principle in this bill is flawed, not because of its wording - words can be made right - but because wrong principles cannot be made into right principles. As politicians, we are accused too often of lacking integrity or moral principles. For those who argue that, as politicians, we are elected only to reflect the views of our constituents, I can say only that you cannot have it both ways. If I am to subject my understanding and informed position on this legislation, which leads me to oppose it, to the perceived wishes of my electorate - and I certainly do not concede that the majority of informed constituents support the bill - then I would be living up to the poor opinion in which politicians are held generally. I have discussed the legislation, and my position on it, with a significant number of my constituents and others. It saddens me to say that the majority of those people were poorly informed on the extent and the potential ramifications of the bill.

What I have found is that relevant information on the ramifications, and advice on the provisions already in existence under our *Natural Death Act*, have largely satisfied the concerns of the majority with whom I have conferred. The *Natural Death Act* passed through this House without major dissent only 6 years ago. While, in my view, it meets the expectations of many people who had initially indicated support for voluntary euthanasia, its existence and its provisions are not widely known. However some members may wish to paint it, the *Natural Death Act* does not provide for euthanasia in the generally accepted meaning of that term. There is a significant and basic difference between the killing of a terminally ill patient, and removing life-support systems from a person who does not have the capacity to live without this extraordinary measure. There is also a significant difference in deliberately killing a terminally ill patient and providing pain-killers to that patient sufficient to suppress pain even if the pain-killer may shorten the patient's life. That is why this action should be a matter between doctor and patient, and not one for legislation.

The Northern Territory Criminal Code does not condone the killing of any person for any reason. In this, it does not differ greatly from criminal codes in other jurisdictions. In essence, this proposed legislation must override our Criminal Code in order to legalise the taking of life in certain circumstances - in this instance, taking the life of a mentally competent, terminally ill person. For many, this seems to be a reasonable concept. However, any reasonable person will understand that this is the quantum leap. From this point, change to include other groups of people will be easy - the mentally ill, the incompetent, the juvenile, the frail-aged. It is simply too fearsome to enter this domain. If even one unwilling person suffers under this law, the price is too high.

I ask members to consider this. If it is sound practice, if it is ethical to kill a terminally ill person who seeks this end, why is it not ethical to kill a healthy person who seeks death? Of course, neither one nor the other can be justified on ethical or on moral grounds. What is just for one should be just for all. This legislation does not meet that simple test. The proposal is flawed fatally, and must be rejected.

Mr PERRON (Fannie Bay): Mr Speaker, a number of members find themselves in a dilemma over the issue before us. Indeed, I find myself among that group. Today, I will damage relationships that I value deeply. My dilemma is whether to rest my case, and not further bruise those relationships, or press ahead and try to achieve a needed reform that will diminish misery and suffering for a very small number of unfortunate citizens to whom palliative care is no comfort.

When I announced my intention in February, I said that it would be difficult to keep the debate focused on what I proposed and not on what it was alleged that I proposed. That has proved to be true. The campaign against the bill has turned dishonest. The campaign by the AMA and Right to Life groups at least has been dishonest and, whoever told traditional Aboriginals that we would round up the sick people and put them down ought to be ashamed of themselves. In fact, the print media advertisements of the opponents of the legislation summarise the unsatisfactory and dangerous situation which exists today, and which has been exposed during this debate. Academic research, individual testimony and the confession of honest doctors in Australia has revealed that euthanasia is practised widely in this country. What we do not know is how prevalent it is and what percentage of it is without patient consent.

Obviously, I have some sympathy with doctors who help suffering patients to die. What worries me, and it should worry every politician, is that there are no witnesses. Indeed, there must not be witnesses because the action is illegal. There is no second doctor to confirm the prognosis. There is no requirement for psychiatric counselling or other specialists. There is no cooling-off period. There is no control over the method or substance used. There is no telling the coroner. In fact, it is imperative that the coroner not be informed of the real cause of death. Of particular concern is that the patient's consent is not required. Each of those grave concerns - and those were the grave concerns, with the exception of the patient consent, that the dishonest advertisements claimed about the bill - applies to the illegal practice of euthanasia, assisted suicide and mercy killing in Australia today. That was a dishonest campaign.

With its head in the sand, the AMA does not want the lid lifted off this Pandora's box. It tells us to leave it to the doctors - 'Don't you worry about that'. A doctor who kills a patient with an overdose is safe from the law if he or she says their intention was to relieve pain. That is what is said, of course, if ever the question is asked. I find it curious that the AMA says also that the problem with the decriminalisation of voluntary euthanasia is that some doctors cannot be trusted. It is okay, therefore, if untrustworthy doctors practise unregulated, illegal euthanasia - and even the national president of the AMA admits to doing it - but to require patient consent and competency, information on alternatives, a right to withdraw consent, a second medical opinion, the keeping of records and the informing of the coroner, would be, as their advertisement says, 'bad law'. However, the president of the AMA states that doctors will ignore the current law at their discretion. At the moment, they do not have to worry about the rules because there are no rules. No wonder they want to maintain the status quo.

When asked about the estimated 2% of patients who have difficulty having their symptoms alleviated, the AMA president stated: 'My attitude is that, in those cases, if assisted death is not an unreasonable course in the mind of the doctor, let those individual patients, their families and their doctors make those decisions and let it occur. Technically, it would be illegal but somebody would have to record it and

register a complaint. Now if you do your job properly, there is no way the family is going to complain'. He said police would not lay charges if the doctor could prove that he had the family's backing and had sought the proper expert advice. That sounds to me like the way the Mafia avoids prosecution - get the family to keep their mouths shut. We have the outgoing president of the AMA, who admits himself to assisting on request 2 patients to die. He acknowledges that it was illegal. He will not give anyone the details to have the matter pursued. He is only doing what the 7 doctors in Melbourne did subsequently, to prove the point that it is happening in Australia today. It is happening without any regulation at all, and they want to keep it exactly that way. They really do not want the lid of this Pandora's box lifted.

As expected, the Christian churches are major opponents of the bill, but members should not think that citizens who regard themselves as Christians all oppose this measure. While 77% of Australians identify with a religion, 81% of Australians also support voluntary euthanasia. Obviously, many who hold religious faith also support this legal reform. Catholic doctors, Catholic nurses and academics have spoken out in support of it. We are a particularly diverse society. We tolerate a whole variety of religious and cultural practices and, if no harm is done to others, so we should. However, we Australians do object to others telling us that we should live by their beliefs and their moral values.

A smokescreen has been created today by some members who profess to have concerns about the adequacy of safeguards and uncertainty about competence in predicting life expectancy when, in fact, they have a fundamental religious objections to the legislation. I have no problem with that. I said in my second-reading speech 3 months ago that I respect the right of anyone to have strong religious faith. Some members certainly have that, and I respect them for that. However, if they cannot support the principles contained in this bill under any circumstances, then they should say so, as the member for Goyder did a few moments ago. They should not try to fool Territorians into thinking that they have studied the subject closely to see how adequate safeguards might be adopted to make voluntary euthanasia acceptable when even extraordinary measures would not convince them to change their mind. We could amend the bill to restrict voluntary euthanasia to patients who had been assessed by 2 psychiatrists, 2 specialists in the disease, 2 palliative care experts and to require a 3-month cooling-off period, the approval of next of kin, 3 witnesses, self-administration of the drug, that the whole process be videotaped and that it be done with the concurrence of a Supreme Court judge, and they would still not agree to it. They should at least acknowledge it! Why beat about the bush? If they oppose voluntary euthanasia because it would offend their religious beliefs, they should say so. I believe people respect the stance taken by those like yourself, Mr Speaker.

Those who cannot vote for this bill and whose constituents overwhelmingly want them to do so have a very real political problem. In my view, those members should consider taking the middle ground. They should absent themselves from the Chamber when the division is called and abstain from voting one way or the other. Abstention is a legitimate parliamentary option. Indeed, I have taken it myself on one occasion and I believe the member for Nelson said that she has taken it on one occasion as well.

In this debate, there has been criticism about the number of amendments proposed to the legislation. The members for Port Darwin and Greatorex said that, with so many amendments, the community has been misled somehow and we should not proceed with it because it will not be the same bill that was introduced into parliament in February. I say that they are weeping crocodile tears. Every one of these amendments has stemmed from the community consultation process and most of them from the select committee's own report after 3 months of moving around the Territory and spending about \$120 000 on gathering community opinion. Each of these 50 or so amendments will strengthen the safeguards in the

legislation. The only purpose to be served by putting them to the community in a new composite bill will be to increase community support for the legislation. It can only swing some of the people who are undecided into supporting the bill. None of the amendments would change the view of a single hard-line opponent, and I acknowledge that. However, let us not have any of this nonsense that, because there is a whole raft of amendments, it is improper to proceed today. That is exactly why we had a 3-month delay.

I appeal to those members who oppose the right of choice to reflect for a moment on their presumptive and patronising attitude. What makes you so much smarter or wiser or of higher intellect or of higher moral integrity than the tens of thousands of Territorians in the community who want the right of personal choice that this proposal will provide to them? Why don't you listen to the 70-year-olds, 80-year-olds and 90-year-olds - the citizens who have written to you about their daily anxiety over the possibility of a lingering and miserable death? You all had the letters because they went to the select committee and were distributed to all members. They appealed to you all to understand that the option of voluntary euthanasia would relieve them of a great burden and that they could face each day with the comfort of knowing that they will not experience the suffering that they have witnessed in others. I am sure we all received letters that had an impact on us. Those were moving letters from the elderly who would find comfort in the mere fact that they would have an option. They are in reasonable health today, but they experience anxiety every day over the knowledge that the ageing process cannot be halted. Their great fear is that, when they fall ill and their time comes, they may have a bad death. The mere fact that the option is available - and hopefully never to be taken - would relieve those elderly people of a great burden in their everyday life. They do not fear death, but they fear the way death will come.

At least 2 Territorians, who are terminally ill today, have appealed to you to give them some hope of a modicum of dignity and a minimum of pain near the end. How can you look those people in the eye and say: 'No. As long as there is a flicker of life in your decaying body, you must stay with us. You have no choice'? How can you tell them that you know better than the doctors, the nurses and the palliative care experts who have a lifetime of experience with the dying, and that you know better than the judges, the lawyers and the academics who support voluntary euthanasia? It is not a field of support that is limited to the supposedly uneducated masses which is the impression that I gain from the attitudes of some members. If this Assembly votes to negate the bill, we will be telling the electorate that we prefer subterfuge to transparency. We will be telling Territorians that they will get no help from us. We will be telling doctors that, if they are to satisfy patient requests, they must engage in the deception of secret euthanasia or, alternatively, they must fail their patients and reject their pleas for help to die.

In these few moments before we vote on the second reading, let us not think of the terminally ill as 'patients', as they are so coldly described in the bill. The terminally ill are mothers, fathers, brothers, sisters, sons, daughters, wives and husbands - they are the flesh and blood of their kinfolk. In suffering, like us all, they embrace with tears, fears and sadness. They are not just 'patients'; they are people. Mr Speaker, they are people like you. They are people like me. They are people like all those people in the public gallery. They are people like all those in the corridors and offices of this building. They are people like all of those in the streets. That is what we are talking about - real people. Let us allow each of them a personal choice. The freedoms that Territorians enjoy all their life should not come to an end just because life does.

The Assembly divided:

Ayes 13

Noes 12

Mr Bailey

Mrs Braham

Mr Coulter

Mr Ede

Mr Finch

Mrs Hickey

Mr Lanhupuy

Mr Manzie

Mr Mitchell

Mrs Padgham-Purich

Mr Perron

Mr Poole

Mr Setter

Mr Adamson

Mr Baldwin

Mr Bell

Mr Burke

Mr Hatton

Dr Lim

Mr McCarthy

Mr Palmer

Mr Reed

Mr Rioli

Mr Stirling

Mr Stone

Motion agreed to; bill read a second time.

Mr BELL (MacDonnell): Mr Speaker, I move that so much of standing orders be suspended as would prevent my moving that the committee stage of this bill be later taken.

Mr STONE (Port Darwin): Mr Speaker, I move that the motion be put.

Motion agreed to.

Mr SPEAKER: The question is that the motion be agreed to.

Motion negatived.

In committee:

Clause 1 agreed to.

New clause 1A:

Mr PERRON: Mr Chairman, I move amendment 31.1.

This will insert a commencement clause which will give the government the ability to delay the commencement of the legislation until it is satisfied that the necessary regulations have been prepared. It will provide it also with the ability to put in place whatever training programs it deems necessary. It will enable further education or information-gathering processes. It is generally acknowledged that education campaigns in the community are necessary, particularly given some of the awful stories that have been spread in some Aboriginal communities. The fear should be eliminated as best as we can manage it. The commencement clause will provide the government with complete control in that regard.

Whilst I have foreshadowed that I will not be here for much longer, Mr Chairman, I imagine that these matters could take some time. I suppose it is no longer for me to put a time on it.

Mr BELL: Mr Chairman, I am utterly amazed that the member for Fannie Bay is prepared to pass what will be a world-first and then say that the rest of the team can look after it because he is going. I am

simply not prepared to accept that this bill should become law under those circumstances.

Mrs Padgham-Purich: He told us that he was leaving.

Mr BELL: That is right, and that is why I voted against the motion for the second reading. That is why I am opposing this amendment. We have the champion of this bill saying: 'It is a bit too hot for me to handle, boys. You grab it'. Absolutely fantastic!

Mr Perron: Don't be such a wimp. Take up the challenge!

Mr BELL: I took up the challenge. I gave my second-reading speech, and the speech writer who drafted your offensive summing up on the second reading ...

Mr Perron: I wrote it myself, thanks very much.

Mr BELL: I find that difficult to believe because most of the correspondence has been prepared and answered by your multitude of staffers. Your cute little trick of announcing your resignation this morning, and saying that somehow this no longer had a chief ministerial imprimatur is to fly in the face of the extraordinary effort put in on this bill by your office over the last 3 or 4 months. As far as I am concerned, it is not good enough for you to tell us at 9.45 am that you intend to give the game away and, at 11.20 pm, to vote against the motion that the committee stage of the bill be later taken, and then to have the gall to move a commencement clause that you did not even think about in your original bill. In this world-first, you are saying that you will not be here, but the government can commence it whenever it likes.

This clause is offensive. I believe the member for Fannie Bay's behaviour has been utterly self-indulgent. If he is going to run with this, he should have the guts at least to stick around until it is bedded down.

Mr EDE: Mr Chairman, the member for Fannie Bay has made a very valid point about the potential for misinformation to be disseminated in relation to this bill. I would like a member opposite who will have continuing authority - the Leader of Government Business or the Deputy Chief Minister or whoever - to give me an assurance that, if the bill is passed, members representing all sides of the House will be involved in discussions in relation to the information campaign that must be developed for those areas before the legislation is commenced.

Mr STONE: Mr Chairman, to the extent that I can, I will make my position very clear. I am opposed to this legislation but, in the event that it succeeds, that is the will of the parliament. There would be no attempt in any way to obstruct or circumvent subsequently what was passed by this Chamber. In respect of an assurance that we would cooperate in developing and implementing appropriate programs, the member has my assurance that that would occur. Does that satisfy the question?

Mr BAILEY: Mr Chairman, I believe there is some hypocrisy involved in the attack on this clause. As has been stated by the Leader of Government Business, if the bill is passed, it will be implemented. That will be the will of the parliament. If the people who have spread lies in the community about the implications of the legislation insisted on its being commenced immediately, that would cause damage. If the member for MacDonnell believes the member for Fannie Bay is running away by leaving the commencement date open, I would be happy for the Assembly to set a commencement date, whether it is in 6 months or 12 months time or whenever. Given the arguments of the opponents of the bill, one would think that they would consider it important to ensure that all the safeguards, education programs etc are

put in place before the legislation is commenced. In fact, there seems to be hypocrisy in that this was added, as much as anything, because of the misinformation that was being circulated after the introduction of the bill.

Mr Stirling: The lack of an education program to tell anybody.

Mr BAILEY: If that is the case, allowing a delay before the legislation is implemented will give time for an education campaign to be run and for the misinformation to be corrected so that people will know that they will not be killed if they go to hospital. People who have run lines of that kind have created considerable concern in the community. It is important to include a commencement clause because it will improve the bill. In that way, we will be able to commence the legislation when we are ready. It will be worse if there is no commencement clause. If some members do not intend to support the bill, that is fine but they should not try to make it a worse bill in the process.

Dr LIM: Mr Chairman, in effect, that was my suggestion at the hearing in which Dr Roger Hunt was the witness. I suggested that there be a moratorium on the legislation for 6 to 12 months to allow medical practitioners and other health care providers to come up to speed on palliative care techniques and methods of killing patients. I suggest that a minimum period of 6 months be provided for in the amendment in order to allow time for the public to be informed and for medical practitioners, nursing staff and other health care providers to be instructed in techniques of palliative care and euthanasia. Having said that, I still will not support the bill. However, in the event that it is passed, I believe that is extremely important.

New clause 1A agreed to.

Clause 2:

Mrs HICKEY: Mr Chairman, I was to move amendment 32.1 in the event that the bill and the amendments proposed by the select committee were insufficiently compelling to allow the legislation to proceed. However, following the second-reading debate, I believe there is sufficient support for the amendments circulated by the members for Fannie Bay and Stuart to enable the bill to pass.

Mr Chairman, I seek leave to withdraw amendment schedule 32 standing in my name.

Leave granted.

Mr PERRON: Mr Chairman, I move amendment 31.2.

The amendment seeks to omit the definition of 'medical practitioner' and insert in its stead a definition of 'illness', and a definition of 'medical practitioner' which expands the current provision in the bill to ensure that both of the medical practitioners are involved in this process.

Mr CHAIRMAN: Honourable members, the purpose of amendment 31.2 is, as explained, to omit the existing definition of 'medical practitioner' and to insert a new definition of 'medical practitioner', together with a definition of 'illness'. With the concurrence of the committee, in dealing with the amendment, I intend to put separate questions for: firstly, omitting the existing definition of 'medical practitioner'; secondly, inserting the definition of 'illness'; and, thirdly, inserting a new definition of 'medical practitioner'.

Dr LIM: Mr Chairman, I have great difficulty with this amendment. The proposed definition of 'medical

practitioner' requires that a medical practitioner have experience of not less than 5 years. I suggest that 5 years experience is inadequate. This implies that a 30-year-old medical practitioner has adequate and satisfactory clinical experience and expertise ...

Mr Finch: You did.

Dr LIM: ... to make such serious end of life decisions. When the select committee's report was tabled, I said that it was necessary that the person have at least 10 years experience. That is essential; because 5 years experience is inadequate. A 30-year-old person would not really understand end of life decisions. It is too major an area.

Mr CHAIRMAN: The question is that the words proposed to be omitted be omitted.

Amendment agreed to.

Mr CHAIRMAN: The question is that the definition of 'illness' be inserted.

Amendment agreed to.

Mr CHAIRMAN: The question is that the definition of 'medical practitioner' be inserted.

Amendment agreed to.

Mr PERRON: Mr Chairman, I move amendment 31.3.

This amendment seeks to add a definition of 'terminal illness'. The inclusion of such a definition was a recommendation by the Select Committee on Euthanasia. This definition of 'terminal illness' has been crafted specifically for this bill.

Mr BELL: Mr Chairman, the term 'terminal illness' is a central issue in this bill. I simply record in the committee stage that what is defined as a 'terminal illness' represents a fundamental problem as far as this bill is concerned. I mentioned in my second-reading speech that there is a moral dilemma in relation to excruciating and unrelievable pain associated with death. In relation to this very broad definition of a 'terminal illness', associated with a 12-month period, I point out that I simply and fundamentally disagree that it should come within the purview of this bill in this way. There is no fiddling at the edges with the definition of what may or may not be a terminal illness that I believe is acceptable. Obviously, 13 members of this Assembly think that the right of people to choose the way they go is a fundamental right, and there are 12 members who are of the view that that is not on. I am one of those. I simply place on record that the definition of 'terminal illness' in this bill is unacceptable to me. I presume it is unacceptable to the other members who voted against the bill at the second-reading stage.

Dr LIM: Mr Chairman, the new definition of 'terminal illness' increases substantially the scope of the bill by removing the 12-month limit. Illness now includes any injury or degeneration of mental or physical faculties. It means a description of old age or ageing. 'Terminal illness' now means any injury or degeneration which would result in death, perhaps in 20 years time. The proposed definition uses the expression 'without the application of extraordinary measures'. That can involve the treatment, however simple or ordinary, for the injury or degeneration being refused by the patient or perhaps the patient, because he is depressed and wishes to die, refusing the treatment. This means that the person who is clinically depressed after a serious injury - and depression is not uncommon, at least in the initial period after serious injury is sustained - or who is depressed and dependent on a simple life-saving treatment for

survival, such as insulin for diabetes, may refuse the most ordinary life-saving treatment and still qualify for euthanasia under this legislation. It would be unwise to support this because it would open it up to anybody at any time.

Mrs BRAHAM: Mr Chairman, the committee recommended the insertion of this definition so that the bill is would be consistent with the *Natural Death Act* which is already on the statute books. That is why the definition is proposed.

Mr EDE: Mr Chairman, the member for Greatorex is unwise if he does not read amendments and clauses in the legislation in the context of other clauses.

Mr Perron: That is right. It has to be read in the context of clause 3.

Mr EDE: Exactly.

Mr Stirling: Clause 3 will go if this amendment is successful.

Mr EDE: It would also assist him if he read it in the context of proposed new clause 6A under my amendment 33.13. That takes it to the point where palliative care has failed. His problem in relation to clinical depression is handled by new paragraph (c) to clause 6 in my proposed amendment 33.3. Hopefully, that will solve the 2 problems the member for Greatorex raised.

Mr BELL: Mr Chairman, this is part of the 'slippery slope' argument. As far as I am concerned, we have a bill that stipulates a 12-month period, but now we have a definition of 'terminal illness' that excludes that aspect.

Mr Bailey: This amendment cuts that out.

Mr BELL: That is fine. I am delighted that you are happy with that.

These amendments are so prolix. Members of this Assembly are legislating what is a world-first yet, from February to May, they have been unable to come up with a clear definition of 'terminal illness'. Such legislation does not deserve to be passed.

The committee divided:

Ayes 16

Noes 9

Mr Bailey

Mr Adamson

Mrs Braham

Mr Baldwin

Mr Coulter

Mr Bell

Mr Ede

Mr Burke

Mr Finch

Dr Lim

Mr Hatton

Mr McCarthy

Mrs Hickey

Mr Rioli

Mr Lanhupuy

Mr Stirling

Mr Manzie

Mr Stone

Mr Mitchell

Mrs Padgham-Purich

Mr Palmer

Mr Perron

Mr Poole

Mr Reed

Mr Setter

Amendment agreed to.

Clause 2, as amended, agreed to.

Clause 3:

Mr PERRON: Mr Chairman, I invite defeat of clause 3. On the defeat of clause 3, it is my intention to move a new clause 3.

Mr BELL: Mr Chairman, may we have an explanation of the proposed new clause 3 before we gun this through? He is no longer Chief Minister. He is doing this as a private member. After his second-reading summing up, I think I am entitled. He was highly personal.

Mr CHAIRMAN: Order!

Mr PERRON: Mr Chairman, at this time, I am inviting defeat of clause 3, and the new clause has not been moved. For the information of the member for MacDonnell, proposed new clause 3 will eliminate the difficulties associated with tying the request for assistance to a specific life expectancy time limit. This new clause, in conjunction with the definition of 'terminal illness' and clause 6, means a patient cannot receive assistance unless his or her medical condition is such that there is no treatment available to effect a cure, and treatment is confined to the relief of pain or suffering or distress with the object of allowing the patient to die a comfortable death.

In other words, the combination of these items with the proposed new clause 3 will eliminate the 12-month period in the bill. The criticism of the 12-month period by some was that someone might apply to be assisted the day after the 12-month period commences. It was not tying the eligibility for assistance to the condition of the patient, but more to expectancy of life which, as we are all aware, is difficult to predict. The amendment is along the lines of the recommendation by the committee which intimated that the 12-month period had problems associated with it. Indeed, any time period would have problems associated with it - whether it is 6 months, 3 months or 3 weeks, there is a difficulty. This amendment will solve that problem.

Mr BELL: Mr Chairman, my objection to this clause is the same as my objection to the definition of 'terminal illness'.

Clause 3 negatived.

New clause 3:

Mr PERRON: Mr Chairman, I move amendment 31.4.

This inserts a new clause 3 for reasons I have just explained.

Mr STIRLING: Mr Chairman, when explaining the reason for this amendment, the member for Fannie

Bay talked about the difficulty with the 12-month period. He has argued previously that each of the amendments proposed tonight will make this legislation safer, tighter and more acceptable to those who may otherwise be opposed to it. The original bill had 3 references to the patient being likely to die within 12 months - in clause 3, which has been negated, in clause 6(b) and in clause 6(c). Further amendments will remove all reference to that 12-month period. There will no longer be even that 12 months as a safeguard. I believe that, far from tightening the legislation, these amendments from the member for Fannie Bay will make it far more loose and far broader. On those grounds alone, this amendment ought to be defeated, as should subsequent amendments.

I wish to point out how difficult this committee stage will be when a member can make a misleading statement, which is accepted by the committee, that the definition of 'terminal illness' in this bill is consistent with that in the *Natural Death Act* when it clearly is not. At the end of this process, the *Natural Death Act* will have a definition of 'terminal illness' and, if this is passed, the Rights of the Terminally Ill Act will have a separate and completely different definition of what constitutes a 'terminal illness'. What act will people want to operate under? How on earth will these definitions apply when the same term, 'terminal illness', is defined totally differently under 2 separate laws?

Mr Perron: For the purposes of the act.

Mr HATTON: Mr Chairman, in respect of the comments by the member of Nhulunbuy, this clause and the definition of 'illness' should be read in conjunction with the proposed clause 6(b) which in fact is ...

Mr Finch: 6(c)

Mr HATTON: The bill has 6(b) - 'within 12 months'.

Mr Stirling: That is to be defeated later.

Mr HATTON: Subclauses 6(b) and 6(c) both have references to '12 months'. I am not as concerned about the issue of 12 months. because I believe that, if that is to be dealt with, it can and should be dealt with in relation to clause 6. My particular concern with this proposal - and I do not have an amendment - relates to the request for assistance to voluntarily terminate life. An issue of public debate is whether or not a person has been encouraged or induced to request euthanasia. It would be advisable to include, as an additional paragraph in this clause, words to the effect that it shall be an offence for any person to advise, suggest or otherwise initiate discussion of or in any way induce a person to undergo euthanasia. A penalty of \$10 000 should be attached to that offence as a clear indication that it must be a voluntary request by the patient, not somebody pointing out the option to them or the family suggesting to them, consciously or unconsciously, that their worth is not as it should be and that perhaps ... Members interjecting.

Mr HATTON: If we must have legislation, we may as well try to do something with it.

Mrs HICKEY: Mr Chairman, initially, I was in favour of the type of amendment that the member for Nightcliff has suggested. However, I believe now that it would be too constraining. People at any stage of an illness, not only a terminal illness, will seek advice from a medical practitioner and want to discuss the issues with them. An amendment of the kind suggested by the member for Nightcliff would be far too constraining and, as other members have interjected, it would be unworkable.

New clause 3 agreed to.

Clause 4:

Mr EDE: Mr Chairman, I move amendment 33.1.

This is really the nub of my amendments. We will go into detail later, but I will explain this now in order that some members may see the philosophical content of what I am talking about. This amendment seeks to insert the words, 'but subject to section 6A'. Clause 4 relates to the response of the medical practitioner to a request. The practitioner may assist, provided he or she is 'satisfied that the conditions of section 6 have been met'. This amendment seeks to add 'but subject to section 6A'. I will be moving an amendment later to insert a new section 6A:

A medical practitioner shall not assist a patient under this act if, in his or her opinion and after considering the advice of the medical practitioner referred to in section 6(1)(c), there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient.

Thus, the medical practitioner will not be able to act until such time as the palliative care options have been exhausted. Having done that, if there is a remission, the medical practitioner cannot ignore it and continue the process.

This is a substantial focusing of the legislation which will solve the problems of the member for Grotorex and some other members who are worried that this will be used to move away from palliative care and down this other road. This will mean that the palliative care road must be followed.

Amendment agreed to.

Mr EDE: Mr Chairman, I move amendment 33.2.

This will allow for reconsideration at any time. If, at any stage through the whole process, the medical practitioner believes that the conditions that applied in respect of all of those things that have been certified no longer apply, they can stop the process.

Amendment agreed to.

Clause 4, as amended, agreed to.

Clause 5:

Mr PERRON: Mr Chairman, I move amendment 31.5.

This adds a subclause (2) to clause 5 providing that a doctor may not unknowingly benefit from assisting a patient. The suggestion arose that he might benefit through an undisclosed provision in the patient's will. This amendment will mean that any benefit bestowed, with or without the knowledge of the doctor, is forfeit.

Amendment agreed to.

Clause 5, as amended, agreed to.

Clause 6:

Mr PERRON: Mr Chairman, I move amendment 31.6.

This amendment strengthens the conditions which must exist before a doctor assists a patient. The patient must be dying, there is no acceptable cure and the medical care is limited to allowing the patient to die a comfortable death. Severe pain, suffering and/or distress must also be present. These provisions avoid suggestions that patients may be assisted to die while there is still some hope of a cure. Medical treatment to cure the patient must have ceased because the situation is hopeless.

Mr CHAIRMAN: For the information of members, I point out that the effect of passing this amendment will be to make the requirement for paragraph (f) superfluous.

Mr BELL: Mr Chairman, in the bill before us, one of the conditions under which a medical practitioner may assist is that the medical practitioner must be satisfied on reasonable grounds that the patient is suffering from a terminal illness and is likely to die within 12 months as a result of the illness. There is no reference to that in the amendment before us. Clause 6(b) states now that 'the medical practitioner is satisfied, on reasonable grounds, that (i) the patient is suffering from an illness that will, in the normal course and without the application of extraordinary measures, result in the death of the patient' - that is the Natural Death Act thing - '(ii) in reasonable medical judgment, there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure; and (iii) any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress with the object ...' There is no reference to the 12 months requirement.

Mr Perron: That is right.

Mr BELL: It is quite broad. It is the same 'slippery slope' argument. I will be seeking a division on this amendment. I will do that whenever this issue arises. I am not happy with the redefinition of the 'terminal illness' provision. We have it again in this new clause. We are talking of 'pain, suffering and/or distress'. How can the courts interpret that, if interpretation is necessary? We are not talking about excruciating ...

Mr Ede interjecting.

Mr BELL: It is defined somewhere?

Mr Manzie: 'Distress' is to be removed by an amendment from the member for Stuart.

Mr BELL: Mr Chairman, may I have clarification? We have an amendment 31.5 from the member for Fannie Bay which includes the reference to 'pain, suffering and/or distress'. Is that to be deleted?

Mr EDE: Mr Chairman, the person who is making the application can say that they are experiencing pain, suffering and/or distress, but the doctor himself, if my amendments are accepted, cannot use distress as a criterion - only pain and suffering. I agree that the 12-month provision is not appropriate.

Mr HATTON: Mr Chairman, by the deletion of the 12 months, combined with the new definition of 'terminal illness', there is no doubt that the person must have an illness which 'without extraordinary measures' will result in the death of the patient. That is unquestioned.

In this bill, clause 6(b)(iii) states: 'any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress with the object of allowing the patient to die a comfortable death'. That could have a 5-year time frame. It is possible that the patient could be distressed about their terminal circumstances, but without any pain or any suffering. In the proposed amendment that the member for Fannie Bay referred to, he uses the expression again: 'Severe pain, suffering and/or distress'. They can be read independently or in combination. Consequently, a person who is in distress and

terminally ill, irrespective of the prognosis of life expectancy, can request voluntary euthanasia. This does not tie it down to the final stages of terminal illness. It does the opposite.

Mr EDE: Mr Chairman, I assure the member for Nightcliff that I agree with him to the extent that I do not believe that distress should be a ground in this regard. If my amendments 33.4 and 33.5 are not accepted by the committee, I have advised that I will vote against the entire bill. Those amendments will delete the words 'or distress'.

Mr STIRLING: Mr Chairman, the member for Nightcliff put it very well. What I was trying to say earlier, and he said it much better, is that this broadens the intention of the bill. My problem with the '12 months' is that it is impossible for a doctor to predict accurately that a person will live 9 months, 10 months, 11 months or whatever. That was my problem with it. I was not uncomfortable with it from the point of view that it gave added protection. However, the subsequent amendments remove all reference to the 12 months and we are left with 'pain, suffering and/or distress' with the possibility that 'distress' will be deleted by another amendment later.

To pick up what the member for MacDonnell was saying, what objective measurement do you have for the degree of pain or suffering? These are very subjective and cannot be measured. This has broadened the intention and, as the member for Nightcliff said, it could be 5 years.

Mr PERRON: Mr Chairman, I have told the member for Stuart that I am prepared to accept the deletion of the word 'distress' even though it will leave situations of extreme distress, not necessarily involving pain, in which I believe people could legitimately have an argument for voluntary euthanasia. I am prepared to leave those situations to be caught perhaps by the 'severe pain' and 'suffering' criteria. Motor neuron disease could be an example where there could be gross distress without pain.

Paragraph (iii) refers to the fact that the patient is in a situation such that treatment is limited to treating their pain, suffering and distress. The member for Stuart will move later to remove 'distress' as an eligibility criterion for assistance. This is describing the state the patient has to be in before they can even put up their hand. You cannot have it 2 ways. You cannot delete the time period, because the doctor might be wrong in his prediction, and replace it with a condition of the patient. We are trying to move to a stage where everyone is comfortable that the patient is not asking unreasonably for the right to voluntary euthanasia. Under these new definitions, that condition is that all treatment for cure has actually ceased, not simply been assessed as not working very well.

Mr Stirling: There may be no cure.

Mr PERRON: All treatment for a cure for the disease must have ceased totally. The only care the patient is receiving is to make them comfortable until they die. Why would you want to stipulate time periods after that? Provided that, in the doctor's opinion, they are suffering unbearably or unreasonably, surely that is a time when a person ought to be able to have that option. We are talking about control by the patient and the patient determining what is an unacceptable quality of life.

All the medical books will tell you that pain cannot be measured. If you tell the doctor that you have a crook back, he cannot say whether you have or not. He can require you to do a few exercises that will make you twinge if your back is crook, but pain cannot be measured. People's tolerance to pain varies markedly. Some people cannot tolerate relatively mild pain whereas others may have some inner strength that would enable them to withstand even torture.

The point of this process is that it is the patient who will decide when their life is so unbearable that they want to end it all. However, so that it is not *carte blanche*, we are putting all these controls in place. Please do not attempt to constrain the suffering patient. Have some faith in the 2 doctors. I know the AMA said that some doctors are not to be trusted, but we must have some faith. This system will be full of safeguards, particularly if all the amendments are agreed to.

Mr HATTON: Mr Chairman, I would like to ask the member for Fannie Bay why, with this carefully considered series of amendments, he has not made a similar change to subclause (c) in his amendment schedule which does refer to 12 months.

Mr EDE: Mr Chairman, it is my amendment in which subclause (c) still includes '12 months'. I have advised various members that I intend to seek leave of the committee to delete that from the amendment.

With my amendment, the patient will have reached the stage where palliative care is no longer able to deal with their pain and suffering. At that point, '12 months' becomes meaningless. By retaining it, all you would do is provide a fertile field for the lawyers to muck about with the issue. If there is a particular disease where this could happen year after year, you would never be able to stipulate 12 months and the person might have to exist for 5 or 10 years.

Mr Perron: In unacceptable suffering to the patient.

Mr HATTON: I understand the point that the member for Stuart is making. In the second-reading debate, the member for MacDonnell made the point about the moral dilemma in respect of a patient in the final stages of terminal illness in unremitting and unrelievable pain and suffering. That is where the moral argument is in favour of a form of euthanasia or assisted suicide. It is a pity that the member for Barkly did not proceed with her amendment because it would have removed any potential for someone to argue that a doctor committed involuntary euthanasia.

Mr Ede: You could have denied her leave and taken it over yourself.

Mr HATTON: Be that as it may, the honourable member chose to withdraw her amendment in that regard.

My point to the member for Fannie Bay is that, having amended clause 6(b) to make this definition, he is now inconsistent with clause 6(c). His amendment schedule does not encompass it.

Mr PERRON: No. My amendment 31.8, by omitting all words after 'illness and' and inserting in their stead 'in his or her prognosis' eliminates the 12 months totally.

Mr STIRLING: Mr Chairman, I am not comfortable with this at all. I appreciate what the member for Fannie Bay is saying and his intention to keep this narrowed to the person in the final stages. However, it does not say that at all. Paragraph (ii) states, 'there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure'. There are diseases for which there is no cure whatsoever at this time.

Mr Finch: Exactly.

Mr Perron: You want them to suffer for 20 years?

Mr STIRLING: The patient could be 5 years from dying and could be accommodated under the

provisions of this bill. It leaves me most uncomfortable that we would be broadening the provisions to this extent.

Dr LIM: Mr Chairman, I am new to this process and I need some guidance. Clause 6, as amended, states in paragraph (b)(i) that the 'patient is suffering from an illness'. When we look at the amended definition of 'illness', it includes 'injury or degeneration of mental or physical faculties'. It is not talking about terminal illness at all. Nowhere in paragraphs (i), (ii) or (iii) of subclause (b) is there reference to 'terminal illness'. My reading of subclause (b) is that it is open to interpretation that a person who is not terminally ill in the ordinary meaning of that term can qualify for euthanasia. **Mr Perron:** That is not true. You have to read 3 clauses together.

Mr Bell: Tell us which ones.

Dr LIM: It only says that the patient 'is suffering from an illness' that may require 'extraordinary measures'. Clause 6 relates to the conditions under which a medical practitioner may assist a patient to end his or her life, provided the stipulated conditions are met. The first is in paragraph (b)(i) - the patient is 'suffering from an illness'. The illness could be anything.

Mr Perron: No.

Dr LIM: The second is in paragraph (b)(ii) - 'in reasonable medical judgment, there is no medical measure acceptable to the patient'. What does 'acceptable' mean? If the patient says that they do not want to be treated for pneumonia because ...

Mr Perron: Thank goodness you are a doctor and not a lawyer. Please read the words - 'result in the death of a patient'.

Dr LIM: If you are not treated with penicillin for pneumonia, you will die.

Amendment agreed to.

Mr CHAIRMAN: Honourable members, the committee has before it 3 proposed amendments to paragraph (c) - 31.7 and 31.8 from the member for Fannie Bay, and 33.3 from the member for Stuart. I draw the attention of the committee to the opinion of the Parliamentary Counsel that the amendment to be moved by the member for Fannie Bay and the new paragraph proposed by the member for Stuart may contain some conflicting elements. The member for Fannie Bay.

Mr PERRON: Mr Chairman, I would like to consult with the member for Stuart for a moment.

Mr EDE (by leave): Mr Chairman, I move amendment 33.3. I further move that the amendment be amended by: inserting after 'medical practitioner' (first occurring) the words 'who is not a relative or employee of, or a member of the same medical practice as, the first medical practitioner and'; and inserting after 'as a result of the illness and' the words 'has confirmed the first medical practitioner's prognosis and'.

The clause will now read: '(c) a second medical practitioner, who is not a relative or employee of, or a member of the same medical practice as, the first medical practitioner and, who holds a diploma of psychological medicine or its equivalent, has examined the patient and has confirmed the first medical practitioner's opinion as to the existence and seriousness of the illness, that the patient is likely to die as a result of the illness and has confirmed the first medical practitioner's prognosis and that the patient is not

suffering from a treatable clinical depression in respect of the illness'.

Members will note that that inserts a number of safeguards. It will ensure that the doctor cannot make an arrangement with a relative or partner in the same practice etc. It is clear that the second practitioner has to confirm the prognosis of the first one. It also addresses the matter of treatable clinical depression. The member for Grestorex voiced the concern that the patient might be in a condition of treatable depression. The intention of this amendment is that a person with psychological qualifications will be able to determine whether that is the case and, if so, the patient will be treated for that condition to ensure that depression is not colouring their decision.

Mr BELL: Mr Chairman, apart from my continuing objection about the removal of the 12-month provision, which I still regard as part of the slippery slope, I ask the member for Stuart what constitutes a 'diploma of psychological medicine'.

Mr EDE: Mr Chairman, it should be 'psychiatric'.

Mr Bell: Good grief!

Mr EDE: Mr Chairman, I apologise. It was supposed to be 'psychiatric medicine'. We approached the Australian and New Zealand College of Psychiatrists seeking its advice on finding a middle ground between a person not being a fully qualified psychiatrist but having psychiatric qualifications. They said that a diploma of that nature was available and that that would be an appropriate middle ground.

Mr Stone: You would want a psychiatrist rather than a psychologist.

Mr EDE: I want somebody with qualifications in psychiatric medicine, not psychology. They have to be a medical practitioner.

Dr LIM: Mr Chairman, a psychiatrist is a fellow of the Australian and New Zealand College of Psychiatrists. A diploma of psychological medicine is a short diploma course which allows a medical practitioner to practise with expertise in psychiatry. However, that 'psychiatrist', if we call him that, has no expertise in palliative care, nor does he have any expertise in oncology. We will have a general practitioner and a psychiatrist deciding that a patient is ready to be put down. It is very important to have adequate specialist expertise to ensure that the patient is diagnosed appropriately, and that all palliative care facilities and services are provided before the patient looks at having himself or herself terminated. Either doctor has to be a specialist.

Mr Ede: Look at amendment 33.13 which will insert a new clause 6A.

Dr LIM: You are jumping all over the place.

Mr EDE: Mr Chairman, I have great sympathy for the member for Grestorex. I had that trouble in the committee stage when I first came here. The new clause 6A provides that, if neither of the 2 medical practitioners has expertise in palliative care, another medical officer has to be brought in who does have expertise in palliative care. You need to read the amendments beforehand and do your homework.

Mr Stirling: If you had done your homework, we would not have this number of amendments before us!

Mr HATTON: Mr Chairman, I understand the intention of the member for Stuart. It is laudable that he is trying to put into the legislation a process of psychiatric assessment of the mental state of the person

making a request for voluntary euthanasia. His solution excludes the second medical practitioner's opinion on the prognosis for the terminal illness and replaces that with what is essentially a psychiatric assessment. I know that a psychiatrist is also a doctor and has medical qualifications. It is where they differ from psychologists.

Mr Stirling: No. It is a medical practitioner, with a diploma of psychological medicine or its equivalent.

Mr HATTON: Mr Chairman, I support the member for Greatorex. Based on the views expressed in my electorate and elsewhere, people thought that there would be some requirement for confirmation of the diagnosis and prognosis by a specialist in the field of the particular illness or disease. There is no provision in this legislation for specialist confirmation. The obvious response to that criticism is that a person diagnosed with, for example, cancer would go, in the normal course of events, to a specialist for confirmation of the diagnosis and for treatment etc. That being the case, there should be no difficulty in building into the legislation a requirement that the diagnosis and prognosis be confirmed by a specialist in the relevant field.

In the case of the specific request for euthanasia, I believe there needs also to be a psychiatric assessment. The amendment proposed by the honourable member refers only to 'clinical depression' rather than a 'clinically treatable mental condition'. There are more circumstances than clinical depression, and I refer to some of the documentation that has been circulated to all of us. Among it is a reference to the effects of delirium.

Mr Perron: Are you saying that a head doctor will not look at the condition of the patient?

Mr HATTON: You are writing this law. I am simply telling you that it refers specifically only to depression. I am suggesting that the member for Stuart may wish to broaden that to ensure the mental competence ...

Mr BAILEY: That is covered. If you are suffering from delirium, you are not competent and in sound mind at the time when you are suffering from delirium. Therefore, the person is covered by the requirement that they be competent and of sound mind.

Mr BURKE: It has to be diagnosed and recognised.

Mr HATTON: I am saying to the member for Stuart that, rather than tying it merely to 'clinical depression', it should be tied to a 'clinically treatable mental condition'. I am trying to introduce some practicality into it.

Mr EDE: Mr Chairman, I understand what the member for Nightcliff is saying. It is my view that that is taken up in the provision that says that the person has to be competent etc. **Mr Hatton:** Consistency is a good reason to do it, isn't it?

Mr EDE: They cannot start the process until such time as that requirement is met outside of the process. I am concerned that, when matters of that kind are included in the written law, the danger is that people will say that something was not specifically included and that fact must mean something of itself. Therefore, by requiring that the patient be competent, that whole area is covered. If that requirement cannot be met, they cannot avail themselves of the legislation. If they have treatable clinical depression, they can take the first step to access the process, but they can go no further with it until that condition is treated and rectified.

Mr Hatton: What about treatable clinical delirium?

Mr STONE: Mr Chairman, if the member for Stuart is looking for psychiatric assessment, having listened to the member for Greatorex, why not omit the words 'holds a diploma of psychological medicine or its equivalent' and insert in their stead 'is a member of the Australian and New Zealand College of Psychiatrists'?

Mr EDE: I think there are 2 currently in the Territory. That would be almost impossible to satisfy. That qualification is extremely high. When we rang the college, I was told that it did not consider that it required a full fellow of the college to identify treatable clinical depression. It thought that this intermediate ground was sufficient for the purposes of this legislation.

Mr PERRON: Mr Chairman, I agree entirely. My personal view is, and I know that it will not prevail, that 2 ordinary doctors, with a minimum of 5 years experience, would be able to determine adequately whether a patient is dying and that all medical treatment for the cure of that patient has stopped. They are supporting this person in a palliative care environment only while they die. This matter could not have come to this point in the process unless the person were in that situation.

Mr Stirling: Why didn't you write that into the bill if that was what you meant?

Mr PERRON: It is all there. Have you read it?

Mr BELL: Mr Chairman, would you clarify for me what is the actual motion before the committee?

Dr LIM: Mr Chairman, the member for Stuart tells us to look at amendment 33.13. Let us do that. Amendment 33.13 reads:

6A. Palliative care

(1) A medical practitioner shall not assist a patient under this act if, in his or her opinion and after considering the advice of the medical practitioner referred to in section 6(1)(c), there are palliative care options reasonably available to the patient ...

Mr Chairman, if both the general practitioner and the psychiatrist are not palliative care experts, how are they to say that palliative options are reasonably available to the patient?

Mr EDE: Mr Chairman I draw the attention of the member for Greatorex to amendment 33.11:

Where a patient's medical practitioner has no special qualifications in the field of palliative care, the information to be provided to the patient on the availability of palliative care shall be given by a medical practitioner (who may be the practitioner referred to in subsection (1)(c) or any other medical practitioner) who has such special qualifications.

Dr Lim: Or any other medical practitioner?

Mr EDE: It has to be somebody who has the special qualifications needed to enable him or her to provide the information on palliative care.

Mr FINCH: Mr Chairman, I believe we are going right over the top with this second medical practitioner requirement. There is no graduate of a medical school in Australia who does not have a reasonable level of psychiatric medical training in their undergraduate course to the extent at least that, if

they find themselves out of their depth, they are able to refer matters on.

I am not sure what we are trying to demonstrate. I have the distinct feeling that those who are advocating that the second doctor be a psychiatrist with very high qualifications are really seeking to kill off the fundamental ability of people to take advantage of the bill that we have generally agreed on. We seem now to be seeking to tighten up the process under the legislation to the point where it will become totally impracticable. I am happy to accept some reasonable wording, such as 'who holds appropriate qualifications, including psychiatric medicine'. However, I believe that is as far as we should go. It is going over the top to expect that somebody should be a member of the Australian New Zealand College of Psychiatrists. That is taking it too far.

Mr HATTON: Mr Chairman, my view in relation to this is simple. The member for Fannie Bay referred to a medical practitioner with a minimum of 5 years experience. The only medical practitioner in the Assembly says that 5 years is inadequate, but it appears that no one cares about his view. He says 10 years would perhaps be more appropriate, but no one seems to care about that either. Let us put that aside.

The provision states that the process may be followed where, among other things, the second medical practitioner makes the diagnosis and prognosis that the person has a terminal illness and is likely to die, and there is nothing to be done to treat the patient who will die. It seems to me more than reasonable to say that such a diagnosis and such a prognosis should be confirmed by a specialist in the field. I am sure that, if a doctor said I had cancer or whatever and that I would die in a year, I would want a second opinion, and I would want it from a specialist. I believe that is the normal course of events. I cannot understand the resistance to requiring a second opinion on the diagnosis and the prognosis in this legislation.

A third point, which I think the member for Stuart is attempting to combine with that second opinion, is the fact that, when a person makes a specific decision that they want to be euthanased, it is reasonable to have an expert assessment of their mental state, and whether they are in a clinically treatable condition.

Mr Finch: How much faith do you have in a psychiatrist?

Mr HATTON: In respect of diagnosing psychiatric concerns, much more than I would have in a GP. It is fairly straightforward. A doctor says you have a terminal illness, you are about to die, and you will go through all kinds of pain and suffering. Why not require to have that confirmed by a specialist in the field so at least someone with expertise is stating that that is the case? The patient may say then that he or she has had enough, and does not want to endure the pain and suffering. That is when you will find out whether the person is making a reasonable and rational decision from a basis of competency.

Mr PERRON: Mr Chairman, it is very easy to say we will insert a statutory requirement that cannot be evaded in any circumstances, and that that loophole will be closed. I guess it might be a reasonable clause if you lived in New York or somewhere else where you had access to experts in every disease in the world. We are trying to create a reasonable law for Territorians, given our circumstances. I know that our circumstances are not ideal. It would be nice to have on the payroll of our hospitals one of every type of specialist that exists. A clause such as that suggested would then be fine. However, we do not have them and we must be realistic.

Like the member for Nightcliff, I suggest that, when a person is diagnosed as being terminally ill - and I am talking about long before they reach a stage where all treatment has ceased and where patients are

being kept full of morphine so that they do not go crazy - they will be consulting specialists. If we do not have one, PATS will send them south.

Mr Hatton: The Territory government will pay for them to go south.

Mr PERRON: Exactly. We do it today. We will pay for the patient to go to Melbourne. That is 2 years, say, before the person has reached a stage when all medical treatment has ceased because they are dying - the point where no other treatment has any worth at all and all that is being done is keeping the body warm until the person dies. Do not start requiring more specialists at that stage because that would be absurd. At that stage, I am certainly against having the psychiatrist to ensure that the person is not unreasonably depressed. Obviously, they would be depressed. I would be pretty depressed, as would most people when they reached that stage. They are working out whether they are bordering on the absolutely irrational in their request. I do not think we need to go beyond 2 doctors of 5 years experience. I am happy to require some extra qualifications, but I believe the requirement should fall far short of a psychiatrist.

Mr REED: Mr Chairman, I do not think we have many psychiatrists in the Northern Territory. I understand further that this legislation originally contained the word 'psychiatrist' but that this was altered to 'psychologist' because of the small number of psychiatrists. We are starting to develop legislation on the run. If that is the case, I suggest that we could be placing patients at risk. At times, because of the remoteness of the Northern Territory and the difficulty of recruiting specialists, there could be none. In fact, there might ...

Mr Ede: You are wrong in your basic premise.

Mr REED: It could be totally impracticable or inoperable.

Dr Lim: I agree.

Mr EDE: The member's basic premise is wrong. There never was any reference to a fully-qualified psychiatric practitioner in any of my circulated amendments. The reference is to a medical practitioner with some psychiatric qualifications. And that was too imprecise - 1 year, or 5 years, or what? Thus, we found that the Diploma of Psychological Medicine is appropriate.

Dr LIM: The practitioner has done 2 years training in psychiatric medicine.

Members interjecting.

Dr LIM: Firstly, he or she qualifies as a medical practitioner and then spends 2 years training under a psychiatrist in order to gain a Diploma in Psychological Medicine. Thus, the practitioner is half a psychiatrist. The practitioner understands enough about psychological medicine and, as a medical practitioner, is able to administer medication. That is a help. They do not have to be a Fellow of the Australian and New Zealand College of Psychiatrists. We are talking about a halfway psychiatrist. Even then, we would have trouble attracting them to the Northern Territory.

Mr BELL: Mr Chairman, it is fairly clear to me that there is a real definitional problem here. I suggest that it is about time we reported progress. It probably should have been done about an hour ago. This bill cannot be amended on the run because there is a need to make a further reference. There needs to be another substantial amendment to make it clear, under cross-reference with the medical registration legislation, exactly what is meant. This is a unicameral parliament. We do not have the checks and

balances of a House of review. At 12.45 am, with definitional problems such as this, there is a serious problem in continuing to legislate on this basis. There needs to be another amendment or at least a redrafting. We cannot do it on our feet here.

The member for Stuart has said that, in any case, 'psychological' has to be replaced by 'psychiatric' ...

Members interjecting.

Mr BELL: Sorry. That highlights the problem. There needs to be a further amendment that cross-references this very specifically to the medical practitioners legislation.

Mr Ede: A Diploma of Psychological Medicine is a recognised qualification. It is well-known and ...

Mr Perron: We accept that.

Mr BELL: Mr Chairman, I move that the committee report progress and seek leave to sit again.

Motion negatived.

Amendments to the amendment agreed to.

Amendment, as amended, agreed to.

Mr PERRON (by leave): Mr Chairman, I withdraw amendment 31.9.

Mr EDE: Mr Chairman, I move amendment 33.4.

Amendment agreed to.

Mr PERRON: Mr Chairman, I move amendment 31.10.

To the clause requiring the medical practitioner to inform the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, this amendment adds 'counselling and psychiatric support and extraordinary measures for keeping the patient alive'. The amendment is self-explanatory, and places a quite significantly greater burden on the doctor to inform the patient of the options available to them.

Dr LIM: Mr Chairman, looking at clause 6(e), what happens if a doctor, who is treating a patient, does not recognise that the patient is depressed and therefore does not provide advice?

Mr Finch: You can have advice whether you are depressed or not.

Dr LIM: All right - provided the patient is being given that information.

Mr PERRON: Mr Chairman, the member really has to read these things fairly closely. The doctor may have no expertise in counselling and psychiatric support. He may think that the patient is totally sane, reasonable, rational and balanced. Notwithstanding that, he has to tell the patient that psychiatric counselling is available. As for the extraordinary measures for keeping the patient alive, members should understand that that is primarily machinery. If the patient is dying and receiving palliative care only, the doctor can explain that life-support equipment could be used when the heart stops and that that could keep the patient going for another month. He must inform him of those options and that extraordinary care is available.

Mr BELL: Mr Chairman, clause 6 provides these various conditions under which the medical practitioner may assist. In my view, both medical practitioners - the medical practitioner referred to in subclause (b) and the shrink in subclause (c) - should inform a patient of the nature of the illness etc. There should be a statutory requirement on both practitioners.

Mr Chairman, I seek leave to move that the words 'the medical practitioner has' be replaced with the words 'both medical practitioners have'.

Mr Ede: What amendment are you talking about?

Mr BELL: We are on amendment 31.10, aren't we?

Dr LIM: Mr Chairman, clause 6(1)(e), with the member's suggested amendment, would read:

(e) both medical practitioners have informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive that might be available to the patient.

Mr PERRON: Mr Chairman, I am trying to be reasonable, and I think this is becoming absurd. The whole basis of this legislation is that the patient has his or her medical practitioner. If they are lucky, it is the medical practitioner who has been treating them for some time. If they are lucky, that practitioner will have had over 5 years experience otherwise they may need to dispense with that person's services under these tough rules that we are creating. With the second medical practitioner, the flavour of it all is to confirm the diagnosis and prognosis and whether the patient needs psychiatric counselling or whatever, and the second medical practitioner is required to hold those qualifications if the first one does not, and so on. However, what we are talking about now is becoming absurd.

What is being proposed is simply that, when the first medical practitioner walks away from the patient, the second has to walk up and run through exactly the same process. He has to confirm the diagnosis of the same illness, the prognosis which is that the patient is dying and make the same assessment of the mental state of the patient. There is no point to it all.

Mr BELL: We are talking about safeguards. Under paragraph (c), a second medical practitioner has examined the patient and has confirmed the first medical practitioner's opinion as to the existence and seriousness of the illness and that the patient is likely to die as a result of the illness. That is required under paragraph (c). I am simply saying now that what is required of the medical practitioner under paragraph (e) should apply to both practitioners referred to in paragraphs (b) and (c).

Mr FINCH: Mr Chairman, it is very simple. The primary medical practitioner, the one looking after the patient in the first place, has to ensure that all these requirements are met and all these subsequent advices and opportunities are given to the patient. He then advises the second medical practitioner of what has been done and what has not been done. The whole process does not have to be gone through again. That would be a nonsense. This is an absurd and interruptive suggestion by the member for MacDonnell.

Mr BELL: Mr Chairman, we have been at this now for 14 hours and I am sick and tired of listening to the member for Leanyer heaping gratuitous defamatory comments on various people under the cloak of parliamentary privilege. When I put forward a constructive proposal, I do not expect, in what has been essentially a constructive debate, to attract a response of that kind.

Let me make it quite clear to the member for Leanyer and to the other members of the committee that what I was saying was that the requirements placed on the medical practitioner in paragraph (e) have to be placed on both practitioners, not simply the practitioner initially involved. I put that as a constructive proposal and I resent the suggestion from the member for Leanyer that I am putting it forward for obstructionist reasons. I am trying to make the best sense, on the hoof, of what I regard as wrong legislation. I am trying to provide some better safeguards.

Leave denied (Mr Bell's amendment).

Amendment agreed to.

Mr Perron: Mr Chairman, I move amendment 31.11.

This amendment will omit paragraph (f) from clause 6(1).

Amendment agreed to.

Mr EDE: Mr Chairman, I move amendment 33.6.

Proposed new paragraph (ga) states:

(ga) the medical practitioner is satisfied that the patient has considered the possible implications of the patient's decision to his or her family.

If you like, this amendment will provide middle ground between those people who say that every man is an island and those who say that no man is an island. It is a requirement that the medical practitioner be satisfied that the patient has considered the possible implications and whether the patient has discussed the implications and thought about the issues involved. The person may say they are totally divorced from their family and will not advise them or may decide that they want to go through that process before proceeding. That is a matter for the patient, after working through those issues.

Amendment agreed to.

Mr PERRON: Mr Chairman, I move amendment 31.12.

The amendment omits from subclause (1)(h) the word 'competent' and inserts in its stead 'of sound mind'. The proposal is to use terminology similar to that used in the Natural Death Act.

I know that I argued earlier that it was acceptable to have a definition of 'terminal illness' in each of those acts without the definitions being the same. The *Natural Death Act*, in particular, contains a very particular definition relating to life-support machines. However, the fact that there are different definitions of 'terminal illness' does not mean that the description of the state of mind of the patient should not be made uniform.

Mr HATTON: Mr Chairman, could the member for Fannie Bay explain the legal implications of the differences between the descriptions 'competent' and 'of sound mind'? What differences are there?

Mr PERRON: Mr Chairman, from my discussions with legal people, I understand that both terms could be regarded as having the same meaning. The argument put to me to change from 'competent' to 'of sound mind' is that, if we had 2 different definitions in Territory legislation and a matter came before the court, the judges might want to know why the legislators put different tests of the relative sanity of a patient in 2 different pieces of legislation. They may consider that there must be a reason and attempt to

find a difference between the 2 terms. I understand that they are the same.

Dr LIM: Mr Chairman, I would like the member for Fannie Bay to explain how and where 'of sound mind' is defined in any legislation in the Territory.

Mr PERRON: I do not think you will find a definition of 'of sound mind' in any Territory legislation. The member for Port Darwin says that it may be included in the Mental Health Act. However, I understand that phrases of this kind are well-recognised terms in law. There is an understanding of what they mean. It is not the kind of term that would be defined necessarily in legislation.

Mr STIRLING: Mr Chairman, when he spoke a minute ago, the member for Fannie Bay provided very compelling reasons why there ought to be the same definition of 'competent' or 'of sound mind' in the Rights of the Terminally Ill Bill and in the Natural Death Act. Surely the same grounds apply to the definition of 'terminal illness', regardless of the fact that, in the case of the *Natural Death Act*, we are talking about the patient being taken off life support equipment and machinery. That definition reads:

'terminal illness' means such an illness, injury or degeneration of mental or physical faculties

-

(a) that death would, if extraordinary measures were not undertaken, be imminent; and

(b) from which there is no reasonable prospect of a temporary or permanent recovery, even if extraordinary measures were undertaken.

I ask the member for Fannie Bay what problem there is with applying that definition of what terminal illness is in the Rights of the Terminally Ill Bill.

Mr PERRON: Mr Chairman, my first problem is that we are a long way away from the definition of 'terminally ill'. That was dealt with very early in this committee stage.

Mr Stirling: However, there is a question of consistency here.

Mr PERRON: Mr Chairman, the Select Committee on Euthanasia recommended the inclusion in the legislation of a definition of 'terminally ill'. It may even have suggested the definition in the *Natural Death Act*. However, the advice given to me by the Parliamentary Counsel was that it was not a suitable definition in that the definition in the *Natural Death Act* is specifically for those circumstances where a person, who is on a machine or about to go on a machine, is having their third party options exercised for them etc, as compared to this situation. In this legislation, reading the definition of 'terminal illness' on its own does not tell the whole story. It has to be read with clause 3 and parts of clause 6 which set out the reasons for which a patient can make a request to a doctor for assistance in the first place. It is a combination of several parts of this legislation together that makes it a unique circumstance of a patient.

Clearly the definition of 'terminal illness' in the *Natural Death Act* would not fit. In that act, it means 'such an illness, injury or degeneration of mental or physical faculties (a) that death would, if extraordinary measures were not undertaken, be imminent ...' The words 'be imminent' mean that, apart from the extraordinary measures, death would occur. That definition is useful only for a person on a machine.

Dr LIM: Mr Chairman, we need to look at this expression 'of sound mind' a little more closely. A person who is 'of sound mind' can be depressed. A depressed patient can be absolutely 'of sound mind'. How then do you say to a patient: 'You are of sound mind, and you have decided that you want to be put down.'

I will put you down, depressed or not'. That is a problem. I quote from Dr Danuta Mendelsohn who stated:

The expression 'of sound mind' is meaningless and, under the Diagnostic and Statistical Manual of Mental Disorders, it does not refer to it, nor has this phrase been used for modern psychiatric textbooks or manuals for many years.

'Of sound mind' is no longer a clinical definition.

Mr Finch: No, but legally it is.

Mr Perron: It is a legal definition.

Mr BAILEY: I have some difficulty with the member for Greatorex who says he has difficulty understanding how amendments affect later provisions in the bill.

On the one hand, we have a definition that states that, before a person can ask to be euthanased, they need to be of sound mind. 'Of sound mind' is a definition used in relation to matters such as making a will. In other words, a will can be challenged in a court and a case can be made that the person making the will was not 'of sound mind' when making it. Thus, it could be argued in court whether or not the definition 'of sound mind', which is used in many other areas, stands. On the other hand, we have passed an amendment providing that the second doctor must have some psychiatric qualifications and that the patient must have a terminal illness and not be suffering from a treatable clinical depression in respect of the illness. We are at the stage where we have the braces, the belts, the rope, the super glue and the staples, and the member for Greatorex is still worried that his trousers will fall down. 'Of sound mind' provides for the patient's awareness of what they are asking for at the time when they seek assistance.

Mr Ede: There is a body of common law on the subject.

Mr BAILEY: We have passed amendments to provide all these requirements. The patient has to be in the late stages of a terminal illness and palliative care has been offered, but is not working. The psychiatrist is there to ensure that the patient is not suffering from a treatable depression. Those things are to be done to ensure that the person is not making the wrong decision. The person with psychiatric qualifications must have at least a Diploma of Psychological Medicine. The *Natural Death Act* does not define sound mind, but it is something that is understood in common law. All the safeguards are there.

Amendment agreed to.

Mr EDE: Mr Chairman, I move amendment 33.7.

The effect of this amendment is to put the initial cooling-off period in place. In the normal course of events, it is unlikely that the process would occur in less than 7 days. However, it has been put to me that this could be a 'slippery slope' argument as well. People have said that the Territory could become some kind of processing point where a person could be assisted to die in the course of a day without those involved really considering what they are doing. This amendment requires that, irrespective of how long the other things take, there has to be a minimum of 7 days between the patient's request and the signing. The patient has several days to think further about their decision.

Mr HATTON: Mr Chairman, why did the member for Stuart choose 7 days? The Oregon legislation has a provision for a 15-day cooling-off period and that was subject to criticism as being too short. The recommendation was that it be at least 5 weeks.

Mr PERRON: Mr Chairman, I was going to ask the member for Stuart to give consideration to reducing it rather than, as proposed by the member for Nightcliff, increasing it.

Mr Hatton: I simply asked a question.

Mr PERRON: I am bearing in mind that there is a second cooling-off period. This first one is for 7 days between making the request to the doctor for assistance and signing the paper. The second one is after the signing. After signing, there is a period of 48 hours before the patient can actually receive the assistance. Thus, it is really 9 days minimum between the patient deciding that they want help and the help being provided.

My proposal was for a 24-hour cooling-off period between signing and assistance. The longer period will encourage people to request assistance earlier than they might otherwise in the knowledge that there will be a 9-day period before assistance is provided. I was working on the basis that people will opt for life as long as they possibly can. Well people do not want to die. Sick people do not want to die. There may be a person who is genuinely attempting to tough it out. However, the pain and suffering becomes so horrendous that they cannot bear it any longer and request assistance. This would see a 9-day period before that can be given.

I encourage that assistance be provided as late as possible and as close to death as possible. Hopefully, people will be assisted to die only a matter of hours or a couple of days before they would otherwise have died. Given the education campaign in relation to the legislation, it is likely that the patient would be aware of the whole process. The longer the cooling-off period, the earlier they will make the request. We will be encouraging people to sign up earlier than they would if there were no cooling-off period. They will want to have the form signed.

Mr HATTON: The member for Fannie Bay raises an interesting point. He is focusing on the final stage of terminal illness. Maybe we ought to redefine the circumstances to that final stage of terminal illness, when death is imminent. The only other place in the world that has some legislation in place is now facing massive constitutional challenges. It stipulated a 15-day cooling-off period and that was criticised as being too short.

Mr EDE: Mr Chairman, let us bear in mind that this whole process cannot begin until such time as palliative care has been exhausted. When the patient arrives at that point where palliative care has been exhausted, they may not be capable physically of going through this process. I am not advocating a reduction in the period. I want the patient to be able to think about it, discuss it with their family etc. Whichever way we go, there will be particular circumstances where people will be in pain and suffering for a period that is longer than anyone would have liked. I am trying to find a balance.

Mr PERRON: We have brought it down from 7 days plus 7 days.

Mr Ede: Yes. My original proposal was 7 days before and 7 days after. When I reconsidered, I wanted to retain the 7 days before the final signing off of the form. The subsequent period is not as relevant. It is necessary to have a couple of days to ensure that a particular case ...

Mr Perron: Make it 24 hours.

Mr EDE: I told a few people that I would make it 48 hours.

Mr MANZIE: Mr Chairman, I seek clarification. The amendment relating to palliative care states: 'A medical practitioner shall not assist a patient under this act if, in his or her opinion and after considering the advice ... there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering ...' It has to be past the stage where there is no more ability to alleviate that pain and suffering. Are we saying that we should waiting a further 7 days after that?

Mr Ede: No. That other process comes first.

Mr STIRLING: Mr Chairman, I accept the point that the hope would be that the patient would seek this very late in their illness and that the effect would be to shorten life by a few hours or a day or 2 at the most. If that is the member for Fannie Bay's sincere wish, the relevant words from the definition in the *Natural Death Act* would seem to be entirely appropriate - that is, that 'death is imminent'. If he does have a difficulty with that, I take it that he is not really sincere that this will apply only to those people who are very close to death.

Mr BAILEY: Mr Chairman, both the member for Nightcliff and the member for Nhulunbuy are picking up bits and pieces and putting them together to fulfil their needs.

Mr Hatton: What?

Mr BAILEY: They are attempting to fulfil their need to defeat the bill. We have changed it from a time frame to a state of decline in the medical condition. The patient has to reach the stage where the pain and suffering is no longer bearable and palliative care is no longer working. In effect, there is a slope from being healthy to being dead. That slope can be either quite steep and short or quite long. We are saying that the patient has reached a level where there is no possibility of their rising above that level. When the patient reaches that stage, death may be only a few hours or a few days away. Some members are saying now that those people who have gone below that level of pain and suffering will have to wait 7, 9 or 15 days for relief of that pain and suffering even though it is unbearable. Many of them will be dead before the cooling-off period expires.

On a much slower slope, the patient will reach that stage and will continue in a very poor condition for a long period. Thus, it is not necessarily the case that all patients in that condition will die within 9 days. That is where the members who are trying to defeat the bill are trying to misrepresent the concerns over the time before the euthanasia may be carried out.

Mr HATTON: Mr Chairman, the member for Wanguri has misrepresented me. I have problems with the legislation which I expressed in the second-reading debate. However, if this legislation is to go through, I will try to obtain something through this legislative circus that is occurring tonight that has some sense of coherence to it. In fact, I asked a simple question based on the fact that the only other legislative model in the world had a different solution. I asked the reason for the honourable member's solution. It was not a value-loaded question. I have not had an answer. Quite frankly, all we have heard about is horsetrading by the member for Stuart and the member for Fannie Bay - the former wanted 14 days and they settled on 7 days. They split the difference. The matter of imminent death was raised by the member for Fannie Bay. He said that he was talking about people right at the end of their lives. I said that, if that is the case, why didn't he define it that way.

Dr LIM: Mr Chairman, I believe that I can explain the 15 days in the Oregon legislation. Dr Carole Gill, the clinical psychologist, is actually a disabled person. She has considerable skills in the counselling of patients with terminal illness. She commented that 15 days was too short a period. Her reason was that

most crisis intervention models allow a minimum of 5 weeks for resolution of acute emotional disorder attending major personal loss. If a person is diagnosed at that moment to be depressed or to have some other psychiatric condition, it requires time to work through that. In my experience, it takes at least 14 days.

Mr EDE: Mr Chairman, that matter has to be resolved beforehand. We have dealt with that already. The 7 days is a minimum. Amendment agreed to.

Mr EDE: Mr Chairman, I move amendment 33.8.

This is a technical change to paragraph (j).

Amendment agreed to.

Mr PERRON: Mr Chairman, I move amendment 31.13.

This again replaces 'competent' with 'of sound mind' for reasons already given.

Amendment agreed to.

Mr EDE: Mr Chairman, I move amendment 33.9.

This inserts a new paragraph (ka) providing that, where an interpreter is required to be present at the signing of the certificate of request, the certificate of request must be signed by the interpreter, confirming the patient's understanding of the request for assistance. This is the double-check. Basically, it is the doctor checking on the interpreter and the interpreter checking on the doctor to ensure the 2 work together.

Mr HATTON: Mr Chairman, I note that the member for Stuart's proposed subclause (3) refers to an interpreter who holds a level 3 accreditation from the National Accreditation Authority for Translators and Interpreters. Given the 24 Aboriginal languages, Portuguese, Greek, Chinese, Vietnamese and other languages that are commonly used in the Northern Territory, is the member for Stuart aware how many level 3 accredited translators there are in the Territory? If no such translators are available, will that preclude access to euthanasia services for all those people who cannot gain access to the appropriate translator services?

Mr EDE: Mr Chairman, the member is referring to subclause (3) which is to be dealt with later.

Mr Hatton: They interrelate.

Mr EDE: Very briefly, the member is saying that very few people hold this qualification. In relation to what I shall describe as 'ethnic languages', he is correct. In relation to Aboriginal languages, I have been unable to find one. Courses are beginning to be developed only now. That means that, for every legal purpose, no Aboriginal person, whose first language is an Aboriginal language, will be able to access this program for a matter of years.

Mr HATTON: I understand the same applies to other languages. I am advised that there are no level 3 qualified interpreters in Portuguese or Timorese. If there are no interpreters available, that ethnic group will not have access to euthanasia services. Is that the essence of what the honourable member is proposing?

Mr Ede: If they cannot satisfy this qualification, you are correct.

Mr PERRON: Mr Chairman, that is only rightly so. Given the paranoia over language, because this is a life and death issue, you would not allow anyone to access assistance who did not absolutely understand what they were accessing. I know that it would not accommodate the Aboriginal languages, but a person may bring in an interpreter from somewhere else even though that would be expensive.

Mr HATTON: I was not arguing against the clause. I was simply ensuring that honourable members and those in the public gallery who have a particular interest in this legislation are aware of its effects and the complications involved in developing euthanasia legislation in the absence of appropriate support services.

Mr BELL: Mr Chairman, the Department of the Chief Minister advertised earlier this week for interpreters at the hospital in Greek and Chinese languages. Apart from the issue of the number of level 3 interpreters that are available, we should be a little more specific in respect of, say, Mandarin and Cantonese.

Mr STIRLING: Mr Chairman, I have read transcripts of court hearings where interpreters were simply not available for particular Aboriginal languages and the whole case was being heard in English which, for some of these people, is a third language. When they are asked double-barrelled questions, which require a yes or no answer, and they are not even clear what they are answering, they often answer yes because they think that is what they are expected to say and what people want to hear. If interpreters have not been available for people in that situation in a court of law over the years, there has to be massive resourcing in this area to ensure that interpreters are available for people who want access under this legislation. Very little has been said about the expense of palliative care. I do not believe it is as high as has been suggested in some quarters. This has considerable potential for a great deal of expense for government as well. If it is not done and the interpreters are not provided, there is a very serious gap in this.

Mr EDE: Mr Chairman, the member for Nhulunbuy is quite correct. This results from discussions in communities in my electorate. I found - and it was mentioned also by the member for Arafura - there was a difficulty in translating concepts that do not have the same meaning among different cultural groups. I was not prepared to have a provision that required simply that there be an interpreter. I have used interpreters regularly since 1966. I am used to it, but I know the great difficulties that exist with it. A person who has an extremely high level of qualifications is necessary for something of this nature. I am aware that such translators and interpreters are not available at this time.

This is something that is not only for this legislation - probably least of all for this legislation. There are needs in other areas on which we should be focusing. By the time the services are developed to meet the needs of the courts and other medical services, a body of people will start coming through.

Mr HATTON: In defence of the government, Mr Chairman, I should note that, through the Office of Aboriginal Development and other government departments, we are working on a program of developing interpreter and translator services. I was merely making the point that, while this is a critically important clause for those of non-English-speaking background, of whatever ethnic or racial background, its effect will be to preclude, for the foreseeable future, a significant number of people from gaining access to this legislation.

Mr Ede: That is true.

Amendment agreed to.

Mr PERRON: Mr Chairman, I move amendment 31.14.

The reason for this is to capture non-financial benefits and prohibit them.

Amendment agreed to.

Mr CHAIRMAN: Two proposed amendments - 31.15 from the member for Fannie Bay and 33.10 from the member for Stuart - relate to the time lapse since signing the certificate of request. As the 2 amendments propose a different period of time, I intend to deal firstly with 31.15.

Mr PERRON: Mr Chairman, we are trying to reach a compromise. I am prepared not to move my amendment.

Mr EDE: Mr Chairman, I move amendment 33.10

We have already discussed this. It is a second time-out period of 48 hours which has to be the minimum period from the signing of the certificate to the actioning of the request.

Amendment agreed to.

Mr PERRON: Mr Chairman, I move amendment 31.16.

The new wording ensures that the process remains patient-driven, and that there is no assumption that, because a patient is physically and mentally deteriorating and may be increasingly unable to communicate, the patient has changed their mind. The assumption should be that the reverse is true. This is very important. We do not want to fall into the trap that, with all the various approvals in place, the patient deteriorates mentally and becomes increasingly incoherent, allowing an assumption that he or she has changed their mind. This paragraph results from legal advice provided to the committee. Unless the patient has given the medical practitioner some reason to believe that they have changed their mind, there should be no assumption that they have. I believe it would be a terrible travesty if we started having doctors pull back right at the time when assistance was about to be given.

Mr HATTON: Mr Chairman, I understand the motivation of the member for Fannie Bay. I would feel much more comfortable if this paragraph, rather than stating that the patient had not indicated a change of mind, stated that the patient had confirmed their view.

Mr Perron: Are you going to have a competency test?

Mr HATTON: No. You are saying the patient has not changed their mind and therefore it should proceed. I am saying that the patient should be asked whether they still want to go ahead with it.

Mr Perron: What if he cannot talk? This is very serious. The patient is deteriorating.

Dr LIM: Mr Chairman, that is precisely the point. In effect, clause 6(m) allows the doctor to decide whatever he or she chooses because, once the patient is no longer able to communicate, the doctor assumes that the prior request is what the patient wants. It might not be the case, and the doctor needs to determine that. How do you know that? How many people in this room would have witnessed 5 people close to death? How many people have really come that close to the death of a patient, or a loved one, more than 5 times in their lifetime?

Mr Manzie: I have.

Dr LIM: There would not be many. I am saying that it is very dangerous for the doctor euthanasing a patient when he or she cannot clearly elicit from the patient that that is their choice at that moment. The patient must make that choice at the moment when the act is done.

Mr PERRON: Mr Chairman, there are only 2 proposals before this committee, one is in the bill and one is in this amendment. They are somewhat similar, but the amendment emanates from the select committee. I commend the select committee for its work and the seriousness with which its members approached their task and their report. I believe this is the better clause. The member's requirement - that the patient has to be competent at the time of assistance - is not even before this committee.

Mrs BRAHAM: Mr Chairman, Guy Riley was the lawyer who provided that advice to the committee. He said:

We suggest the clause be redrafted so at the time of assisting the patient to end his or her life, the medical practitioner must not have been given any indication by the patient that he or she no longer wishes to end his or her life. The onus must be on patients to indicate that they have changed their minds, rather than the doctor having to decide if the patient still wishes to continue.

That is clearly spelt out in that letter for anyone who wants to look.

Amendment agreed to.

Mr PERRON: Mr Chairman, I move amendment 31.17.

It has been argued that there should be limitations or restrictions on the methods that a doctor may use to assist a patient to die. This amendment requires doctors to consider pharmaceutical advice and enables regulations to be drawn up to control or guide doctors who intend assisting a patient.

People said there were no controls in that regard and therefore the doctor could kill the patient with a shotgun. I thought that bizarre, but we are trying to accommodate everybody here. However, we need to be mindful not to be too prescriptive by tying the hands of doctors in respect of methods and substances. Every patient is different in size, weight, condition, tolerance etc and these judgments are best left to doctors.

Mr BELL: Mr Chairman, who would make the prescribing guidelines?

Mr PERRON: It will be done by the Department of Health and Community Services through its consultative processes, but I am not sure what they are.

A member: It will be prescribed in the regulations.

Mr BELL: Thus, it will become a requirement for tenure of the position of Chief Medical Officer to agree with the public policies behind the Rights of the Terminally Ill Bill? The Chief Medical Officer will be required to prescribe guidelines and medications to kill people.

Mr PERRON: Mr Chairman, it says 'such guidelines, if any, are as prescribed' and 'shall consider appropriate pharmaceutical information'. I am advised that drugs suitable for exiting life, as distinct for alleviating pain - far more efficient drugs - are available to doctors today. They may be used in smaller

quantities for other purposes, but they are very efficient killing drugs. It is not as if some new drug has to be brought into Australia for doctors efficiently and effectively to help a patient die in comfort.

However, the Commonwealth Drugs Evaluation Unit and the federal Department of Health and Human Services have informed me - I spoke to the head of the unit - that, if a drug company approaches the federal government with a new drug that it claims is suitable for this purpose, it will be evaluated by the federal Drugs Evaluation Unit. Recommended guidelines will then be distributed with that product to doctors - that is, government-recommended dosages and so on. It will only ever be a recommendation because the government does not tell doctors how to treat patients. Doctors have their own techniques, and some are better than others.

The member may be taking things a little too far were he to suggest that my protections in this legislation for persons who do not want to participate in a life-ending process, in assisting a patient to die, who have an automatic right to say no and not to be pursued or penalised in any way, would extend to an officer in the Department of Health and Community Services who is asked to prepare regulations. Is the legislative draftsman covered for amendments to this act if he opposes the principle? Where do you stop?

Mr Bell: A good question. That is what we have been asking for the last 14 hours.

Mr PERRON: Surely we can expect the community to discuss it and people who are employed by the taxpayer should be expected to do their job of running the government. When it comes to the point of physically assisting a patient, then we can draw a line allowing conscientious objectors to object. However, we do not let off the man who paints speed limit signs on Bagot Road simply because he disagrees with them.

Mr Bell: The analogy really does not stand up.

Mr PERRON: It was off the top of my head - give us a go!

Mr BELL: Okay. I believe there is a hell of a lot of this bill and this debate that is pretty much off the top of the head, particularly given the fact that it has only been going for 4 months. I want to place on record my repugnance at the institutionalisation of the means of developing and publishing the particular pharmaceutical requirements in this way. I point out that this amendment will require a senior bureaucrat to agree with the policies behind this bill. That is contrary to what was said at the second-reading stage. If you accept the underlying principle of the right of people to choose, and the right of doctors to treat or not treat, what you are saying with this amendment is that people appointed as the Chief Medical Officer will have to support the bill or they will not keep the job.

Mr BAILEY: Mr Chairman, I was involved in some of the debate relating to the inclusion of this clause. Without this clause, it would be possible theoretically that, after a person had gone through all the required process to apply for voluntary euthanasia, and the doctor had done all that was required, the doctor could use a pillow or a shotgun or whatever to end the person's life.

In many areas, regulations prescribe certain actions. Regulations prescribe what prison officers are permitted to do or use to subdue prisoners who are behaving improperly. There is a current debate relating to bouncers in hotels and clubs and the means they may use to enforce the liquor regulations. Similarly, regulations apply to the police and so on. There is controversy about the conditions under which a pregnancy may be terminated. Regulations and legislative guidelines provide for circumstances in which a pregnancy may or may not be terminated by suitably-qualified people. In this case, we are

providing for legally assisting a person to end their life.

This clause provides that, when a person is to be assisted in that regard, it has to be done within certain stipulated conditions. They cannot be smothered with a pillow or killed with a shotgun. The means of assistance will be stipulated and a qualified practitioner will be asked to determine the most appropriate medical means of ending that person's life. On the one hand, there are objections that the provisions are open-ended and, when efforts are made to contain them and define the parameters, we are told that a person cannot be asked to do that.

The member for MacDonnell and others want it both ways, and it is crazy. Even if a person is against the legislation in principle, that does not mean that they cannot indicate what are the best parameters within which it should be carried out if it is to be carried out. The member for Greatorex disagrees in principle with the legislation, but he has said repeatedly that, if we are to do it, we must ensure that it is done in the best possible way. That is what this clause is attempting to do. I am sure that, if he were the Chief Medical Officer and he were asked to indicate the most appropriate procedures for the implementation of this, his answer would be consistent with everything else he has said on the subject. He might say: 'I disagree totally with this being carried out. However, if the law determines that it is to be carried out, this is the best way of doing it'.

Mr BELL: I am sure that is an easy moral position for the member for Wanguri to adopt. What I am saying is that stipulating that any employee in the public service be required to do what they regard as anathema is contrary to the expressed intention of the member for Fannie Bay and the people who voted in favour of this. I object to that. The solution is not to provide a regulation-making power by this amendment, but to schedule it in the act in the way that we schedule drugs under the Poisons and Dangerous Drugs Act. It is wrong in principle to require a particular public servant to prescribe.

Mr EDE: Mr Chairman, may I just clarify something? I wonder if the member for MacDonnell believes that, under this clause, a person is actually prescribing medicine.

Mr BELL: No. We are providing a regulatory power to the Chief Medical Officer who may disagree in principle.

Mr EDE: It is not to the Chief Medical Officer, but the government. The minister will find the expertise within his department to determine the guidelines. It may even go to the federal government for it to suggest the form of words that the Territory government is looking for. The guidelines will be published in the NT Government Gazette.

The committee divided:

Ayes 19

Noes 5

Mr Bailey
Mr Baldwin
Mrs Braham
Mr Burke
Mr Coulter

Mr Adamson
Mr Bell
Dr Lim
Mr Rioli
Mr Stirling

Mr Ede
Mr Finch
Mr Hatton
Mrs Hickey
Mr Lanhupuy
Mr McCarthy
Mr Manzie
Mr Mitchell
Mr Palmer
Mr Perron
Mr Poole
Mr Reed
Mr Setter
Mr Stone

Amendment agreed to.

Mr EDE: Mr Chairman, I move amendment 33.11.

This amendment inserts proposed subsection 6(2) which provides for the circumstance where the medical practitioners who are involved already in this process do not have special qualifications in the field of palliative care:

(2) the information to be provided to the patient on the availability of palliative care has to be given by a medical practitioner (who may be the practitioner referred to in subsection (1)(c) or any other medical practitioner) who has such special qualifications.

Mr BELL: Once again, Mr Chairman, I ask the member for Stuart what constitutes special qualifications in the field of palliative care.

Mr EDE: Mr Chairman, I understand that some of the people who made representations to the committee are accepted in the profession generally as being specialists in that area.

Mr BELL: We have the same problem here as we had with the Diploma of Psychological Medicine. On the basis of the debate, I was prepared to accept that it was capable of some kind of interpretation, but this is so vague. I was prepared to accept the advice of the member for Greatorex in respect of the distinction between specialist psychiatric qualifications and a lesser qualification of a Diploma of Psychological Medicine. However, I am not prepared to accept a vague term like this. It would be derelict to leave in legislation a term that is incapable of interpretation by the courts.

Dr LIM: Mr Chairman, I am sorry, but I was interrupted earlier. I did not quite hear what the member for Stuart said about the definition of a palliative care expert.

Mr EDE: I was asked what qualifications were acceptable. We are talking about somebody with special qualifications in that field. There are qualifications that people can gain in that field. If they have those qualifications, they will be acceptable.

Dr LIM: Mr Chairman, I am glad that, in his explanation, the member did not use the word 'oncologist' because an oncologist is a specialist who deals ...

Mr Perron: We did not use that word. Please do not waste time.

Dr LIM: It is quite different. A palliative care specialist is a physician and therefore he is a Fellow of the Royal College of Physicians. Some have extra training in palliative care. There is no degree or diploma at present that people can obtain for palliative care.

A member: Thus, it is experience.

Dr LIM: It is not experience. It is in-service training and specialisation through apprenticeships with other palliative care experts.

Mr Perron: The wording is all right then.

Mr BELL: Mr Chairman, perhaps the chairman of the select committee or one of its members can enlighten us as to any deliberations they have had in relation to palliative care. If there is no recognised speciality - and post-graduate specialities for medical practitioners are emerging - before this provision is passed, I want to know its actual status. I presume a college of palliative care specialists is envisaged. If that is not the case, I believe we should know.

Dr LIM: Mr Chairman, there is an association of hospice and palliative care experts. I cannot recall its name, but there is an organisation of which palliative care experts are members.

Mr STIRLING: Mr Chairman, the member for MacDonnell's point highlights the vacuum of information in which we are operating in some of these areas. The committee heard a great deal of evidence from specialists in palliative care. They indicated that there is a real scarcity in Australia of people trained in palliative care. It is not something that is picked up in medical training to any great degree. The effect of this amendment, and I support its passage, will be to delay the commencement of the legislation. If there is a commitment to this provision, the government will need to have palliative care experts on hand.

Mr Perron: Or bring them up.

Mr STIRLING: Or bring them up. The committee was told that they are simply not available in Australia at the moment. It will take time for them to become available if they cannot be brought to the Territory on a permanent basis. I support the amendment, but it may well delay the commencement of the legislation by as much as a further 12 months.

Mr PERRON: Mr Chairman, I suggest to the member for Stuart that, if we added the words 'in palliative care as are prescribed' at the end of his proposed subclause (2), the regulations could prescribe the qualifications that would be acceptable.

Mr EDE: That is acceptable to me. I will seek leave later to amend the amendment accordingly.

Dr LIM: Mr Chairman, the body I referred to earlier is the Australian Association for Hospice and Palliative Care. If the amendment provided the palliative care expert must be a member of that association, that would lock it in.

Mr Perron: Are you sure they have to be qualified to be a member?

Dr LIM: In the first instance, they must be a medical practitioner. I am not sure whether Dr Hunt is a member of the Australian association, but he was the president of the South Australian branch. If he has been excluded from that organisation, the government must question why it is using such a person to

provide all its instructions.

Mr BAILEY: Mr Chairman, I do not believe that palliative care as such is a college of medicine. There are no specific qualifications such as apply with psychiatry, paediatrics etc. People come to it from a variety of medical training backgrounds and become practising specialists in palliative care, not defined as qualified specialists. I suspect that this is more an association which is joined by people working in the hospice and palliative care area who have a common interest, not necessarily because they have qualifications. There may be some restrictions on that. I believe we should provide for the regulations to define the necessary palliative care qualifications. Whether it is membership of the association or prescribed qualifications should be dealt with in the regulations. It may not be totally appropriate to name such an association, which is not a professional college, in the legislation itself.

Mr HATTON: Mr Chairman, this illustrates one of the great difficulties in debating the process of establishing euthanasia in the absence of adequate and appropriate palliative care. We do not even know how people go about obtaining qualifications in palliative care. It is extraordinary. We are saying that people must have reasonable palliative care before they can opt for euthanasia, but those services are not available here and the parliament does not even have information before it on how people gain qualifications in palliative care. We do not know whom to recruit.

I cannot confirm this, but I understand there are some 20 accredited palliative care training courses in Australia, 14 of which are provided by the Royal Prince Alfred Hospital in Sydney. I believe they are 2-year, full-time courses with a follow-up 2 years. It is like an internship, an apprenticeship, to gain qualifications in palliative care. If we are to address the palliative care issue, it is important to have it defined properly in the legislation. It would help a great deal if we actually knew what we were talking about. This legislation is being rushed through. This parliament and the people of the Territory do not have the information or the services which everyone agrees must be the precursors of any consideration in this regard.

Mr FINCH: The great procrastinator! If ever I saw a dodger in my life, it is the member for Nightcliff. Let us get on with the job. As the member for Stuart has agreed, we can deal with this very simply by prescribing by regulation. Let's get on with the job. Prescription by regulation is the appropriate way to go.

Mr HATTON: I will not react to that. The member for Leanyer lives in a simplistic world of black and white where he does not have to think or worry about details and there is no need for any consistency in the law. The member for Leanyer has been rubbishing and joking all night. That is how much he cares about the technicalities and details of legislation. His problem is that he views consideration of such matters as procrastination. I do not agree with the legislation but, if it is to be passed, I will attempt to make it as consistent and coherent as possible. This legislative circus in which we are indulging tonight is not assisting that process.

Dr LIM: Mr Chairman, I think the Australian Association for Hospice and Palliative Care is appropriate. Let me quote from the oral submission provided by Professor Ashby, formerly of Adelaide, and now the Director of Palliative Care, Monash University. He stated:

Perhaps the easiest thing for me to do at this point would be to say that I was involved with the drafting of a policy statement on voluntary active euthanasia for the Australia Association for Hospice and Palliative Care. I do not appear today as a spokesman for that. Indeed, I hold no elected office in that

organisation at the present time, although I have in the past. I was requested by the executive to produce a discussion document and a draft policy. That has now been adopted in Victoria and I think it is well on the way in other states and territories. As I was responsible for drafting that policy statement, it might perhaps be helpful if I briefly go over it because it does broadly define my view on this issue.

He went on to talk about palliative care. That body appears to be accepted nationally as one that can state that a person has the expertise.

Mr PERRON: Mr Chairman, I do not think the honourable member is right because I am pretty sure I am a member of it. The Australian Hospice and Palliative Care Association has branches in all states and is an organisation that works hard for hospices and now has a policy on voluntary euthanasia. It is an association like the Anti-Cancer Foundation.

Mr EDE (by leave): Mr Chairman, I move that the amendment be amended by adding at the end 'in the field of palliative care as are prescribed'.

Amendment to the amendment agreed to.

Amendment, as amended, agreed to.

Mr EDE: Mr Chairman, I move amendment 33.12.

We discussed this earlier. Where the person who is required to communicate with the patient does not share the same first language as the patient, the assistance shall not be provided unless an appropriately-qualified interpreter is present.

Amendment agreed to.

Clause 6, as amended, agreed to.

New clause 6A:

Mr EDE: Mr Chairman, I move amendment 33.13.

This inserts a new clause 6A:

(1) A medical practitioner will not assist a patient under this act if, in his or her opinion and after considering the advice the medical practitioner referred to in 6(1)(c), there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient.

(2) Where a patient has requested assistance under this act and has subsequently been provided with palliative care that brings about the remission of the patient's pain or suffering, the medical practitioner shall not, in pursuance of the patient's original request for assistance, assist the patient under this act. If subsequently the palliative care ceases to alleviate the patient's pain and suffering to levels acceptable to the patient, the medical practitioner may continue to assist the patient under this act only if the patient indicates to the medical practitioner the patient's wish to proceed in pursuance of the request.

Mr HATTON: Mr Chairman, the amendment refers to palliative care options being reasonably available. Does one presume therefore that there are to be palliative care services available which a person can reasonably access? Will the absence of those services - and I believe it is the unanimous view

that there are no reasonable palliative care services in the Northern Territory - negate the effect of this clause? Because the palliative care process will not be available, the clause will be circumvented.

Mr EDE: It is my view and the view of those who have worked on this that this clause will put massive pressure on the government to provide palliative care. Legislation will have been passed through this parliament and the pressure will be on the government to provide the palliative care facilities necessary to allow the legislation to operate. I made this quite clear to the member for Fannie Bay in my discussions with him.

Mr HATTON: Can the member for Fannie Bay advise what budgetary provisions are available to implement these provisions? If no palliative care facilities are available, the only option available to these people would be euthanasia.

Mr PERRON: Mr Chairman, I believe some people have in their minds a distorted view of what palliative care is, and that might not be limited to members in this Chamber. As I understand it, palliative care is a number of services from different disciplines which are brought together and provided in a hospice situation. It does not necessarily have to be in a hospice situation. Palliative care services are offered in the Northern Territory. There is nothing magic about palliative care in the sense that the drugs are available and there are trained nurses, visiting clergy, family rooms etc. It would be wrong to assume that no palliative care is available in the Territory on the basis of the current debate that our palliative care facilities are deficient.

As I read this clause, the doctor has simply to know what is available in the Territory and interstate. I do not see that as a major problem. The doctor can inform the patient that they can be sent to Mt Eliza or wherever and they may be able to ease their suffering for a period. This treatment has to be acceptable to the patient, and reasonably so. Whilst I am sure the government will find some resources to increase the palliative care that is available in the Northern Territory, these clauses simply provide that the doctor has to know about them all and advise the patient of the options.

Dr LIM: Mr Chairman, I disagree with the member for Fannie Bay. Palliative care is not something we do to obtain fuzzy, warm feelings. It is not patting the patient on the head. It is not a couple of nurses visiting the patient in the hospital, at home or in a hospice situation. Palliative care experts are highly trained to decide the required dosage of various drugs to relieve pain, depression, suffering and distress. It is not simply a matter of looking after the patient, caring for them and helping them to maintain their dignity. That is not palliative care.

Mr Perron: But it includes that.

Dr LIM: It includes that, but there is much more than what the member for Fannie Bay described. To say that we have palliative care in the Northern Territory is wrong. We need specialist practitioners, not only nurses but doctors as well. The doctor in Darwin at present is a half-time general practitioner doing some palliative care work, not a palliative care specialist. That person has not had the training which palliative care specialists have had. We must be serious about providing palliative care.

Mr Perron: I agree, but we are talking about this clause.

Mr EDE: If someone says that they have no choice but to take the road of euthanasia because this government has not provided reasonable palliative care options, it would be on the front page of every newspaper. 60 Minutes would send up a team and there would be massive pressure.

Dr Lim: The question has not been answered.

Mr EDE: I have set up the legislative framework to put the pressure on. It is up to your side of the House to find the funds in the budget.

New clause 6A agreed to.

Clause 7:

Mr PERRON: Mr Chairman, I move amendment 31.19.

The word 'orally' is omitted purely on the basis that a patient may not be able to communicate orally, but may be able to communicate very adequately in writing or by sign language. The word 'orally' is quite improper.

Amendment agreed to.

Mr EDE: Mr Chairman, I move amendment 33.14.

This relates to a patient who is unable to sign the certificate of request. The clause, as amended, will read:

If a patient, who has requested his or her medical practitioner to assist the patient to end the patient's life, is physically unable to sign a certificate of request, any person who has attained the age of 18 years, other than the medical practitioner referred to in section 6(c) or a person who is likely to receive a financial benefit directly or indirectly as a result of the death of the patient, may, at the patient's request and in the presence of the patient and both the medical practitioner witnesses (and where, in accordance with section 6(2) an interpreter has been used, in the presence of the interpreter), sign the certificate on behalf of the patient.

This adds a number of additional safeguards.

Amendment agreed to.

Mr PERRON: Mr Chairman, I move amendment 31.20.

As is the case with the medical practitioner involved, a person who signs a request certificate on behalf of a patient who is unable to sign should not be permitted to benefit financially or otherwise from their actions. This amendment prohibits such benefits. There may be instances where this will have ramifications for the family or friends.

Amendment agreed to.

Clause 7, as amended, agreed to.

Clause 8 agreed to.

Clause 9:

Mr PERRON: Mr Chairman, I move amendment 31.21.

This amendment is self-explanatory. It replaces 'financial benefit the person would otherwise obtain,

directly or indirectly, from' with 'financial or other benefit the person would otherwise obtain, directly or indirectly, as the result of'. This is similar to a previous amendment. The addition of the words 'as a result of the death of the patient' merely corrects the English.

Amendment agreed to.

Clause 9, as amended, agreed to.

Clause 10:

Mr PERRON (by leave): Mr Chairman, I move amendments 31.22 to 31.25.

It is proposed the coroner be provided with more detailed records of the patient's illness and actions taken to comply with the procedures laid down in this act. This will mean the coroner will have a complete record to study, not merely the certificate of request and the death certificate which currently is all the bill requires to be sent to the coroner. By this amendment, a complete file must be provided to the coroner. The amendments include a penalty, which was not in the bill, for failure to properly keep, prepare and deliver the appropriate records to the coroner. The coroner will receive quite detailed information on every case of assisted voluntary euthanasia that occurs. He can seek to investigate further any aspect of the case.

Amendments agreed to.

Clause 10, as amended, agreed to.

Clause 11 agreed to. Clause 12:

Mr PERRON: Mr Chairman, I move amendment 31.26.

In clause 10, we expanded the records to be kept to be forwarded to the coroner. Clause 12 requires that the complete records relating to the terminal illness and death of the patient be sent to the coroner.

Dr LIM: Mr Chairman, I would like the member for Fannie Bay to consider an inclusion to his amendment. When the death certificate is sent to the coroner by a practitioner who had been looking after the patient for the previous 3 months, there is no requirement on the coroner to investigate that case. In the case of euthanasia, where the death of a patient is by a deliberate act, it might be worth considering that a coroner should be instructed, as a matter of course, to investigate the case and then to report to the Attorney-General in due course. Without expecting a full investigation by a coroner each time a case of euthanasia is permitted, there is no way of ascertaining whether appropriate procedures had been carried out. I can see the possibility of doctors falsifying medical records and death certificates in the way that has been occurring in Holland. Be that as it may, if the coroner were instructed to investigate each case, that would be a further safeguard. If we are to protect patients, I believe that would be a worthwhile safeguard to incorporate into the member for Fannie Bay's amendment.

Mr PERRON: Mr Chairman, I know what the honourable member is saying. We are talking about a serious matter. This is new legislation and leading-edge social reform. We expect that only a few people will take advantage of the legislation. The coroner will receive a comprehensive file on each case. We can expect that the coroner's constable will make a thorough job of examining it. We certainly do not want to require the coroner to have a coronial inquiry into every one of these deaths. However, if there is any suspicion that foul play or the wrong thing has occurred, he would hold a full coronial inquiry. As

explained to me, the 3 functions of the coroner are to identify disease, to determine the time and manner of the death of the deceased and to determine the reasons for death. All of those 3 principal functions of the coroner will be known in these cases. We know the identity of the person. We know the time and manner of death because that will be documented in great detail by the doctor, including that the patient died of a lethal substance and not from other things. As for the reasons for the death, the details will be in the comprehensive medical files forwarded to the coroner.

The honourable member suggests that we should require the coroner to thoroughly scrutinise the files to determine whether anything is wrong. It is not a perfect world. If a doctor does falsify a file, one presumes that it is unlikely that the coroner will pick up on that falsified file. If the doctor said the fellow had cancer, whereas he had some other disease, and he had the other doctor sign off it as well - both doctors' reports have to be there - presumably the coroner would not find out unless there was some other reason whereby it came to his attention.

I do not believe we need any additional provisions for coronial investigations. His office is regarded as being very thorough. After 12 months or so, the legislation could be tidied up if that were found to be necessary. The coroner can report at any time at his own total discretion, as we will see in later clauses, to the Attorney-General who must table in this House within 6 sitting days the coroner's report on any matter relating to the operation of this act.

Mr HATTON: Mr Chairman, I discussed a matter briefly some time ago with the member for Fannie Bay and I will raise it in this context. I believe it would be an appropriate protection mechanism in any such legislation that, during the minimum cooling-off period of 7 to 9 days between the date of request and the date of euthanasia occurring, the information should be forwarded to the coroner in advance to give him the opportunity to review the file and satisfy himself that the appropriate procedures have been followed and that the patient's decision is a voluntary one. It is a bit late after the event.

Mr Perron: What if he is really busy?

Mr HATTON: You are saying that almost no one will use this.

Mr Perron: Not with this work, but with other work.

Mr HATTON: We are talking about what you described as leading-edge social reform. Much more care is taken prior to the event in countries that implement a death sentence. It would be a simple process for the file to be referred to the coroner for review.

Mr BAILEY: A coroner has a judicial role to investigate death. Take the situation where the coroner examines the files and determines that everything is okay. The euthanasia is then carried out. What if the family then claimed that there was something wrong with the decision? Who would investigate it? It would be investigated by the coroner who had said that it was all okay.

Mr Perron: That is right. You cannot use the coroner.

Mr BAILEY: You cannot use the coroner beforehand. The *Natural Death Act* comprises 3 pages and 7 sections and the coroner is not even mentioned in it. As far as I can see, under that act, all the doctor has to say is that the patient wanted to die and therefore he disconnected the life-support systems. In this instance, everything has to be documented in detail and forwarded to the coroner. Some of the points being raised by the opponents of this bill are ludicrous.

Mr MANZIE: Mr Chairman, the role of the coroner is to investigate death, not to investigate the preliminary circumstances. He is also there to investigate fires. You do not ring him up before you light a fire. There are very stringent safeguards here. We are involving more than one medical practitioner. We are requiring a signed certificate. We are requiring documented processes involving a number of people. All that information will be sent to the coroner. The coroner has to satisfy himself in relation to any death the details of which are forwarded to him, irrespective of whether it requires a coronial inquiry. If he decides a coronial inquiry is not required, that decision is taken on the evidence presented in that preliminary process. I am satisfied that the processes are very detailed.

In addition, the coroner will be able to report to the Attorney-General and the Attorney-General will have 6 sitting days within which to report to the parliament. That differs from the normal coronial process. To add a further requirement that the coroner should become involved before the process of assisting a terminally ill patient to die comfortably would not be very sensible. It would not achieve anything except interfere with the role of the coroner. It is contrary to his statutory role and it would be contrary to the wellbeing of the terminally ill patient. The protections exist already.

Dr LIM: Mr Chairman, the member for Wanguri should realise that comparing the *Natural Death Act* to this bill is like comparing a cap gun to a cannon. The *Natural Death Act* relates to a withdrawal of services. It has nothing to do with the active termination of somebody's life. It is very different.

Mr Perron: No, but it hastens it.

Dr LIM: You obviously did not hear my speech. That is your problem.

Mr Perron: I did, but I disagreed with it.

Dr LIM: I am the medical practitioner and you are not. You might disagree, but you do not deal with patients yourself.

As for the member for Sanderson talking about the file that goes to the coroner, what does it do? All it does is collect dust. The coroner should at least scrutinise the records. He has to do something. He cannot simply leave the records sitting there.

Mr Bailey: He has to.

Dr LIM: He has to take information about the person who has died, the cause of death and the certificate that was signed by the patient, 2 doctors and the interpreter. There is nothing more than that. The coroner does not scrutinise the medical records. That should be done. If you are serious about looking after the patient, which I suggest many in this Chamber today are not, then the coroner should be required to scrutinise the records. If he does not do that, there will be no way of determining whether or not malpractice has occurred.

Mr EDE: Mr Chairman, I am not going to make any derogatory remarks about the member for Greateorex - not a hint. More years ago than I care to remember - in fact, some 25 years ago - I had to fill out what were called certificates where a coronial inquiry would serve no good purpose. I can tell you that a pretty intensive investigation is done in these cases. This amendment requires that there be sent to the coroner 'so much of the medical records of the patient (including those required by section 10 to be kept) as relates to the terminal illness and death of the patient'. The coroner will obtain an excellent review which will be obtained from the medical practitioner who is providing the assistance.

Proposed new clause 12A will provide a feedback role for the coroner. The coroner will have the opportunity to provide feedback if he feels there is an area that may need to be tightened or whatever. I do not believe we can do much better than that.

Mr HATTON: It is interesting that there has been reference to the arrangements in the Netherlands being too loose yet even they require someone to check with the coroner in advance. It is a simple process. There is a 7- to 9-day cooling-off period. It is not a matter of investigating a death, but investigating the right for a death to occur and determining whether the procedures set out in the law have been carried out. This will be the first time in the world that a law of this nature will have been passed. If such a procedure is found to be too onerous, it can be amended later. However, in the meantime, I do not know why members would be fearful of providing that, during that 7- to 9-day cooling-off period, someone, whether it be a magistrate or some other person, should act as what I call the 'patient's friend' and check that everything has been done properly and that there has been a truly genuine and voluntary request by the person to be euthanased. If members think that is too hard ...

Mr Ede: How many people do you want in toto? We have 3. Do you want 3 more, or 10, or 20?

Mr HATTON: If the coroner examines the records and other material after the event and finds what appears to be an irregularity, the person will be dead already. Why not have the coroner do it beforehand?

Mr Manzie: There are heavy penalties for those who break the law.

Amendment agreed to.

Clause 12, as amended, agreed to.

New clause 12A:

Mr PERRON: Mr Chairman, I move amendment 31.27.

This inserts a new clause 12A which provides:

The coroner may, at any time and in his or her absolute discretion, report to the Attorney-General on the operation, or any matter affecting the operation, of this act and he shall, within 3 sitting days of the Legislative Assembly after receiving the report, table a copy of the report in the Assembly.

That tabling requirement period is shorter than the normal 6 days.

This proposal is designed to ensure continuous legal scrutiny of the circumstances of each assisted death, and quickly bring any concerns to the attention of the Attorney-General and the Legislative Assembly.

New clause 12A agreed to.

Clause 13 agreed to.

Clause 14:

Mr PERRON: Mr Chairman, I move amendment 31.28.

The amendment is self-explanatory.

Amendment agreed to.

Mr PERRON: Mr Chairman, I move amendment 31.29.

This amendment also is self-explanatory.

Amendment agreed to.

Clause 14, as amended, agreed to.

Clause 15 agreed to.

Clause 16 agreed to.

Clause 17:

Mr PERRON: Mr Chairman, I move amendment 31.30.

This is an urgent amendment to the immunities clause. It was pointed out to me that the indemnity clause went too far. In other words, basically it provided an indemnity for almost any action done in good faith during the course of an assisted euthanasia. This amendment reinstates the words that would require the doctors and other staff associated to act 'without negligence'. At one stage, the member for Stuart expressed some concern that this could result in a doctor being charged because they had not provided sufficient information about what palliative care options were available or had failed to complete some forms or whatever. I am advised that this is a very proper way to go about this because, if we pull back from this, we will be providing more immunity than we provide to doctors today. For example, the government receives writs occasionally in relation to doctors who have supposedly treated patients in a negligent way. Such matters are determined normally in court. It was described to me as a matter where the doctor does not have to be right, but has to be acting without negligence. It means that the doctor has to act in good faith and without negligence. If he breaches his duty of care, he is liable to be charged. It is right that, even in these situations, he should still have the onus on him to fulfil his duty of care and to ensure that he does the right thing.

Amendment agreed to.

Mr PERRON: Mr Chairman, I move amendment 31.31.

This amendment serves the same purpose as the previous one.

Amendment agreed to.

Clause 17, as amended, agreed to.

New clause 18: **Mr PERRON:** Mr Chairman, I move amendment 31.32.

This inserts a new clause 18 which contains the regulation-making power for purposes under this act.

New clause 18 agreed to.

Schedule:

Mr PERRON (by leave): Mr Chairman, I move amendments 31.33 to 31.35.

These are all consequential on amendments agreed to earlier.

Amendments agreed to.

Mr EDE: Mr Chairman, I move amendment 33.15.

This is the declaration by the interpreter who is required to make a series of undertakings in respect of the work that he or she has done in those situations where they were required to be present to state that the person signing the request, or on whose behalf it has been signed, is known to the interpreter, that the interpreter is qualified according to the act and has interpreted in connection with the signing of the certificate and that, in their opinion, the patient understands the meaning and nature of the certificate. This is designed to cover the range of issues that need to be covered for the interpreter. It is essential that we have a declaration of this nature to ensure that the interpreter is in no doubt as to what their job is and what they are to cover in that process.

Amendment agreed to.

Schedule, as amended, agreed to.

Title agreed to.

Bill reported; report adopted.

Mr PERRON (Fannie Bay): Mr Speaker, I move that the bill be now read a third time.

Mr BELL (MacDonnell): Mr Speaker, I move that all words after 'now' be omitted, and the words 'this day 6 months' be added pursuant to standing order 200.

I do not think I need to repeat the arguments as to why I am moving an amendment of this sort. I have participated as actively as the lateness of the hour has permitted in order to tighten up the safeguards in what I regard as an abhorrent piece of legislation. I do not believe this bill should receive its third reading, and I intend to seek a division on this motion.

I have a grave feeling of unease, not only about the principles involved in this legislation, but also about the indecent haste with which it has passed through this Assembly. I reiterate my argument that this is a unicameral parliament and that we do not have a House of review. There are no checks and balances applying. I do not believe that adequate consideration has been given to this bill. For those reasons, I indicate my opposition to the third reading by moving an amendment to it in those terms.

The Assembly divided:

Ayes 12

Noes 13

Mr Adamson

Mr Bailey

Mr Baldwin

Mrs Braham

Mr Bell

Mr Coulter

Mr Burke

Mr Ede

Mr Hatton

Mr Finch

Dr Lim	Mrs Hickey
Mr McCarthy	Mr Lanhupuy
Mr Palmer	Mr Manzie
Mr Reed	Mr Mitchell
Mr Rioli	Mrs Padgham-Purich
Mr Stirling	Mr Perron
Mr Stone	Mr Poole
	Mr Setter

Motion negatived.

Mr SPEAKER: The question is that the bill be now read a third time.

The Assembly divided.

Ayes 15

Noes 10

Mr Bailey	Mr Adamson
Mrs Braham	Mr Baldwin
Mr Coulter	Mr Bell
Mr Ede	Mr Burke
Mr Finch	Mr Hatton
Mrs Hickey	Dr Lim
Mr Lanhupuy	Mr McCarthy
Mr Manzie	Mr Rioli
Mr Mitchell	Mr Stirling
Mrs Padgham-Purich	Mr Stone
Mr Palmer	
Mr Perron	
Mr Poole	
Mr Reed	
Mr Setter	

Motion agreed to; bill read a third time.

SESSIONAL COMMITTEE ON THE ENVIRONMENT

Mr RIOLI (Arafura): Mr Speaker, I move that, pursuant to paragraph 2(b) of the resolution appointing the Sessional Committee on the Environment, the following matter be referred to the committee for inquiry and report: 'Recent reports of oil spillage associated with mining operations on Groote Eylandt'.

Most members will be aware of recent reports of oil spillage on Groote Eylandt and the conflicting explanations as to how long the spillage has been occurring. Members will be aware also of concerns expressed by Department of Mines and Energy staff concerning the process of company notification of environmental incidents at mining sites and at Groote Eylandt specifically.

I do not wish to take up much of the Assembly's time. However, I consider this an appropriate incident to

refer to the sessional committee for investigation and report. Departmental staff have expressed sufficient concern about the processes of environmental monitoring in relation to this incident to warrant an external review of the process being adopted. The Sessional Committee on the Environment is an appropriate body to undertake this review. Members will be aware that the most recent oil spillage at Groote Eylandt is in the process of being cleaned up. It will involve considerable time and expense to do this. The evidence points to the fact that there may have been an element of good fortune in this case in containing the environmental damage. Departmental officers are doing the best they can with current resources and within the legislative framework. However, doubts have been raised as to whether the Environmental Unit is adequately resourced and whether departmental guidelines on environmental protection can be improved.

This parliament has a Sessional Committee on the Environment which has been empowered to inquire into and report on matters relating to mining and the environment. Obviously, this is a case of considerable importance and it is perhaps a timely warning of the need to tighten procedures of notification, containment and rehabilitation of environmentally damaging incidents at mining sites.

There has been public concern about this incident. Some of it is without foundation, but some issues remain unresolved. The Department of Mines and Energy has revised its housekeeping procedures to apply to the Gemco Mine Development and Environmental Management Plan in 1995-96. The question is why we had to wait until an environmental incident occurred before these weaknesses in the environmental management plan were detected. There is concern that the accuracy limits permitted on instruments measuring fuel volumes are too broad. There is concern that they are too tolerant. Should tighter limits be applied to ensure detailed investigations begin at an earlier stage before any large discrepancy accumulates?

There are reports that oil leaks had occurred earlier at Groote Eylandt, in the early 1980s. Departmental staff are unable to say whether or not these leaks occurred. All they can confirm is that none was reported. Departmental staff have confirmed that previous bore holes have been tested in the area and there was evidence of hydrocarbons in that water. Departmental staff have said also they have not been happy with the speed, or lack thereof, with which environmental incidents have been reported by Gemco. The speed of investigation and reporting has not always been what could be described as overly rapid.

To give an example, in February this year, the department commenced investigations into claims of recent oil leakage on Groote Eylandt. It was not until November that the department received the consultant's report to the company on fuel management at the fuel depot. The last pressure test of the fuel lines was done in July last year. It is possible that the recently-detected fuel leakage has been continuous since July last year. If the hole in the fuel line had been any larger, we would have been facing a correspondingly larger environmental problem. Should we require fuel lines to be pressure tested at shorter intervals? Some of these questions will be addressed in the current departmental review of the Gemco Mine Development and Environmental Management Plan. Are these matters that need to be addressed also at other mine sites?

The reporting mechanism between Gemco and the department has been sufficiently poor for the department to find it necessary to instruct the company that all such environmental incidents must be reported immediately they occur. Why wasn't this the previous practice? Have reporting practices been tightened at other sites? There has been considerable public concern and media comment regarding the inadequacy of environmental monitoring at Groote Eylandt.

A review of environmental monitoring practices at Groote Eylandt by the Sessional Committee on the Environment would be able to address and allay community concerns that have been expressed, not the least of which have come from residents of Groote Eylandt. The Sessional Committee on the Environment recently completed a comprehensive review of environmental issues on the Mary River floodplain. The committee has amply demonstrated that it has the skill and the expertise to address complex environmental issues. A reference to the committee in accordance with this motion is well-justified and members can have confidence that the committee will do a fine job on such a reference.

Mr REED (Mines and Energy): Mr Speaker, we heard trumpeting from the member for Wanguri about how dastardly a deed this was and how environmentally damaging it has been.

Mr Stirling: When did you go there to have a look at it?

Mr REED: Mr Speaker, I will answer that interjection because it will be of interest to the member for Nhulunbuy ...

Mr Stirling: You actually went out there, did you?

Mr REED: I was there only a couple of weeks ago. Not only have I been there, but I do not think any of the members opposite have even sought a briefing from Gemco in relation to this matter.

Mr Stirling: You do not even know your Mine Management Act has been breached.

Mr REED: That is how interested they are. If they were interested in finding a solution on what they consider to be an important environmental issue, they would have had the good manners and the integrity at least to talk to Gemco. I am sure it would have been willing to talk to them and give them the facts. There were not many facts in the 5-minute presentation that we just heard relating to their concerns.

The only information that the member gave was a little detail that he managed to absorb from a briefing by the Department of Mines and Energy on 5 May or thereabouts. Not only did he not absorb much, but he has the hide to come in here and criticise the department for its inadequacies in dealing with the problem. If he had concerns about whether or not it had dealt adequately with this issue, why didn't he raise them at the briefing? That is the purpose of briefings.

Mr Stirling: Is that right?

Mr REED: If he does not have the integrity or the intestinal fortitude to ask for more information than the department was good enough to provide, if he does not have the nous to ask a few sensible questions, I suggest the Leader of the Opposition should examine the adequacy of the member for Arafura to undertake his task.

Mr Stirling: I asked you to look at the problem and you said there was no problem even though it was clear that your own Mine Management Act had been breached.

Mr REED: Carry on! I like it when you become angry, particularly at 3.30 am. You do it so well.

Mr Stirling: You do not even know your own act!

Mr REED: Mr Speaker, the motion proposes that the matter be referred to the Sessional Committee on the Environment for an inquiry. That is the magic word for members opposite - 'inquiry'. 'Let's have an

inquest'. 'Let's have a judicial inquiry'. 'Let's have a Royal Commission'. They have tried them all over the years. With every little problem, they want an inquiry. The fact is that no inquiry is required into this matter. It is a well-documented problem. There is a problem, albeit a small one, at Groote Eylandt in relation to a leak that developed in a fuel pipeline.

Mr Stirling: It would be a bigger problem if it were covered under the Water Act.

Mr REED: The great shame about this is that the company is mining in the order of 2 million tonnes of manganese a year. It is contributing significantly to the Northern Territory economy. Honourable members opposite had a concern about something that happened at the mine site. As a result of those concerns, the member for Wanguri has been rabbiting on radio about how terrible it is, how we should have an inquiry, how he should be involved in it and how other members opposite should be involved in it.

On what did they base this need for inquiry? They based it on reports from ABC radio, a very reliable source. They based it on reports from a previous employee of Gemco. Did they consider for a moment that this major company contributes significantly to our economy? Did they think that there might be a faint possibility that they would form a government one day and might have to work with this major mining company in the Northern Territory? If they had, they might have spoken to the mining company and established some liaison with it. They would have sought to determine whether what they had heard on ABC radio was factual and whether the comments of the past employee of Gemco were factual. Did they do that? No. They did not have the integrity even to speak to the company. They should be ashamed of themselves for it. It is the most sloppy piece of work by members of a parliamentary party and representatives of Territorians that I have seen in this Assembly for a long time. They are a shoddy lot.

Let me detail the sequence of events that occurred in relation to this matter. In February 1994, ABC radio and the 7.30 Report presented reports on environmental concerns at Gemco, including potential fuel leaks at Milner Bay. Site inspections by departmental officers - these are the officers of the Department of Mines and Energy whom members opposite believe are acting inadequately and improperly - conducted an investigation and failed to find any evidence of a fuel leak. On 15 April 1994, the then Minister for Mines and Energy was advised that the following allegations made to the media by Dr Rob Savory of Gemco and requested a comprehensive report from Gemco. In March 1994, the fuel pipeline in question was pressure tested and found to be sound. Officers of the Mines Division and the Environment Division, accompanied by the then secretary of the department, visited Gemco and carried out a comprehensive inspection of environmental management on 15 March 1994.

On 21 February 1995, an underground diesel pipeline from the main tanks at Milner Bay to the bowsers was excavated for replacement as part of maintenance operations and, during the excavation, a leak in the pipeline was identified. It was found, not because the mining company was trying to hide any problem, but in the normal maintenance program that the company was undertaking to upgrade its pipeline, its fuel delivery system and to ensure that everything was sound and that its maintenance program was in place. In doing that, it found a leak.

Mr Bailey: And it wasn't sound, was it?

Mr REED: I would have thought it was operating pretty successfully and pretty responsibly.

On 22 February, Gemco reported the diesel leak to the department, and it was directed to investigate the situation and report to the department. The incident on 24 February was reported by ABC radio and, on

24 February, a departmental environment officer, again one of those people the opposition thinks is doing an inadequate job, was sent to the site to investigate and report on the situation.

Gemco advised the department that the pipeline had been removed from service and that excavation below the pipeline trench identified diesel seepage. Dames and Moore, independent consultants, have started a drilling program. In fact, the member for Millner, himself a member of the Sessional Committee on the Environment, accompanied me on my visit to Groote Eylandt because of his interest in these matters. We not only met Gemco management and staff involved on this particular issue, but also representatives of Dames and Moore who were on Groote Eylandt on the day we were there. The consultant's preliminary investigation report was lodged with the department on 14 March. On 13 April, progress reports on the hydrocarbon contamination of Milner Bay oil storage areas was provided. No evidence has been found that hydrocarbons have impacted on the beach or marine environment. Hydrocarbon contamination appears to be restricted to a zone immediately above the watertable, with a layer of free hydrocarbons floating on the water up to 30 mm thick. There is no evidence of significant environmental damage or threat to human health, and the potential for future problems is minimal if the proper remediation strategy is followed. That strategy is being put in place and is being oversights by the independent Dames and Moore representatives.

The company's current proposed strategy is acceptable to the department and includes: prevention of discharge of hydrocarbons into the marine environment; recovery and reuse or disposal of free product; recovery and treatment of dissolved hydrocarbons; and treatment of contaminated soils. In April 1995, skimmer pumps were commissioned for hydrocarbon recovery.

The government does not support a reference to the Sessional Committee on the Environment to investigate this matter, firstly, because the Department of Mines and Energy has been kept fully informed of events in relation to this matter and believes that the company is acting responsibly and carrying out remedial action which we believe is appropriate and, secondly, because I would not be as discourteous as to send members from the opposition benches to Groote Eylandt to investigate this matter, as part of a sessional committee, when the member for Arafura has been so rude and has not even had the good grace to speak to the company.

Mr Speaker, I oppose the reference and I move that the motion be put.

Motion agreed to.

Mr SPEAKER: The question is that the motion be agreed to.

Motion negatived.

ADJOURNMENT

Mr STONE (Leader of Government Business): Mr Speaker, I move that the Assembly do now adjourn.

Motion agreed to; the Assembly adjourned. *Last updated:*
You are the visitor to this page.