LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

THE RIGHT OF THE INDIVIDUAL OR THE COMMON GOOD ?

VOLUME ONE

REPORT OF THE INQUIRY BY THE SELECT COMMITTEE ON EUTHANASIA

MAY 1995

Presented and Ordered to be Printed by the Legislative Assembly of the Northern Territory on 16 May 1995

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MEMBERSHIP

The Honourable Eric Poole, MLA (Chairman)

Mr Syd Stirling, MLA

Mrs Loraine Braham, MLA

Dr Richard Lim, MLA

Mr Maurice Rioli, MLA

Secretary:	Ms Pat Hancock
Research and Analysis:	Mr Larry Bannister
Administration:	Mrs Roseline Vogeli
Assistants:	Mrs Beryl Hellwig Mr Joshua Muirhead Mr Jason Barnes

TERMS OF REFERENCE

On the 22 February 1995 the Legislative Assembly resolved that:

(1) a Committee to be known as the Select Committee on Euthanasia be appointed to take evidence and submissions on the Rights of the Terminally Ill Bill 1995;

(2) unless otherwise ordered, membership will comprise Mrs Braham, Dr Lim, Mr Poole, Mr Rioli and Mr Stirling;

(3) the Committee be empowered to send for and examine persons, papers and records, to sit in public or in private session notwithstanding any adjournment of the Assembly and to adjourn from place to place;

(4) the Committee shall report to the Assembly by 16 May 1995;

(5) the quorum of the Committee be three Members;

(6) the Committee be empowered to publish from day to day such papers and evidence as may be ordered by it and, unless otherwise ordered by the Committee, a daily *Hansard* be published of such proceedings as take place in public;

(7) the Committee be provided with all necessary staff, facilities and resources and be empowered to appoint persons with specialist knowledge for the purposes of the Committee with the approval of the Speaker; and

(8) the foregoing provisions of this Resolution, so far as they are inconsistent with Standing Orders, have effect notwithstanding anything contained in the Standing Orders.

EXECUTIVE SUMMARY

There are few people in our community without a view on euthanasia. It has been the task of the *Select Committee on Euthanasia* to gather together those views, analyse them, and provide a concise summary for the benefit of the Members of the Legislative Assembly, so that a more informed debate may take place on the *Rights of the Terminally Ill Bill 1995* during the May sittings of the Parliament.

The fact that a number of liberal democracies around the world are currently debating the issue of euthanasia highlights the potential for social change in this area of public policy.

Whatever the personal views of the individual, it is a sign of the resilience of our form of government that what could be quite divisive and emotional views about euthanasia are being expressed in a forum of reasoned debate.

Nevertheless the question of legalising active voluntary euthanasia remains contentious. If it were possible to summarise this complex debate, it would come down to the rights of the individual being predominant (for those who favour this form of euthanasia), versus the argument that the common good of society as a whole takes precedence over the rights of the individual.

Complementing this debate and adding to its complexity is the question of intent. If it is the intention to alleviate pain, but as a result the patient dies, this is acceptable practice for those who joined the debate. If, on the other hand, the patient is assisted to die to alleviate their pain, then under current law and for those opposed to active voluntary euthanasia this is wrong.

There is little doubt in the Committee's view that should the Bill be passed it will change the relationship between doctor and patient. Medical practitioners will play a pivotal role in the practice of active voluntary euthanasia. The practitioner may have to declare their personal position on the matter to many of their patients, a situation that makes some medical practitioners uncomfortable.

The patient however may want to have assistance to die, without the professional providing assistance breaking the law. For these people euthanasia is an important 'insurance policy' safeguarding their quality of life.

Some fear that, notwithstanding the restrictions contained in the Bill, legalising active voluntary euthanasia will lead our community down the path of the 'slippery slope'. More vulnerable members of our society will yield to euthanasia, when in different circumstances other measures

could have been taken allowing them to live longer. People who hold this view claim that the practice leads to involuntary and non-voluntary euthanasia.

Others argued that with ever increasing demands for financial resources from a technologically driven health care system, and limited public funds to meet those demands, some rationalisation in health provision is inevitable. These people question the wisdom of spending scarce health funds on terminally ill patients who want to be assisted to die.

The Committee's view is that there are dangers for our society in following the economic line of reasoning too far. The decisions on resourcing our health system must be taken outside hospitals and other health care facilities. Decisions on treatment should not be based upon criteria such as the age of the patient or the funds available for treatment, but upon the needs of the individual at the time and the resources available to meet those needs.

There was a very clear call from the community that provisions in relation to scrutiny and penalties under the proposed legislation should be strengthened.

Aborigines have particular difficulties with the Bill. The Committee heard reports that already some Aborigines are afraid to attend health clinics and hospitals for fear of doctors having 'the power to kill'.

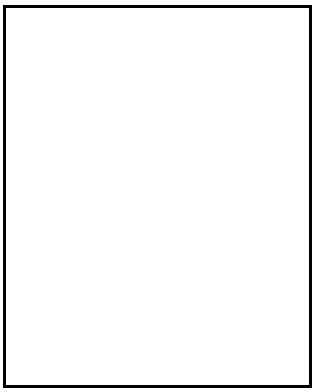
The intent of the legislation very clearly gives the power to the patient. Nevertheless, whatever the outcome of the Bill, any lingering fears among Aborigines about health care need to be quickly dissipated.

Special provision may be required for people whose first language is not English. It will be necessary to ensure that these people fully understand the provisions of the legislation, should it proceed, before seeking assistance to die if that is their wish.

An associated but separate issue is that palliative care services in the Northern Territory should be addressed. The Committee heard evidence that up to nine dedicated beds are required where the Territory has only one at present, located in Alice Springs. At the same time palliative care specialists are in short supply, an issue that the Committee believes should be addressed nationally.

Section 169 of the *Criminal Code* makes attempted suicide a crime. This would be incompatible with the proposed legislation on euthanasia. However, irrespective of the outcome of the Bill, it remains the Committee's view that Section 169 should be repealed. The Northern Territory is the only jurisdiction in Australia where attempted suicide remains a crime.

It was also clear to the Committee that the provisions of the *Natural Death Act 1988* making passive euthanasia legal were little known, and that these provisions should be widely publicised.



CHAIRMAN'S PREFACE

Matters of life and death affect each of us profoundly and in different ways. Sometimes those differences are stark and emotive, and at other times they are subtle but no less persuasive in influencing our personal views about the human condition.

The debate centres on whether or not we have freedom of choice in our (quality of) life, part of the ethos of individuality. The argument frequently used is that for those who do not want euthanasia this Bill is not for them, nor is it forced upon them.

On the other hand there are those who argue for the maintenance of (the right to) life irrespective of the human condition. For them this principle overrides individual choice in the interest of the common good, an interest that ultimately serves each of us.

In these circumstances it is difficult to ignore the view that euthanasia presents our community with complex ethical, legal, medical and spiritual concerns. The complexity is underscored by a pluralistic society, based upon many beliefs and value systems that exist side by side yet harmoniously in the Northern Territory.

The Committee was very much aware of this situation in setting about its work. Our objective was to listen to the views of the people on the *Rights of the Terminally Ill Bill 1995*.

At no stage did the Committee seek to influence the debate one way or the other. It has been our firm and clear intention to gather evidence and submissions so that an informed debate on euthanasia may take place during the May sittings of the Assembly. It has never been the intention of the Committee to make a recommendation on the matter.

Since the Honourable Marshall Perron, MLA, first announced his intention to introduce a private member's bill into the Legislative Assembly in February 1995, there has been much discussion in the Territory community and nationally about the matter. So much so that by May of this year three Parliaments have before them Bills dealing with euthanasia, with the South Australian Parliament and the Legislative Assembly of the Australian Capital Territory joining our own Assembly.

It is also notable that, apart from the Netherlands where euthanasia has been openly practised in one form or another since 1973, several States in the United States of America are in the process of debating laws on the related aspect of doctor assisted suicide. In Canada a report on euthanasia is due to be brought down by the Canadian Senate in May of this year. And last year the United Kingdom made a detailed examination of the issues through the House of Lords Select Committee on Medical Ethics. Other jurisdictions are considering the matter. Euthanasia is clearly a prominent issue internationally.

That the Committee got the response it did to the call for submissions is perhaps demonstrative of the social ferment surrounding euthanasia in the late twentieth century in a number of liberal democracies around the world.

The Committee was overwhelmed by submissions from within the Territory, and from the rest of Australia. More than 250 submissions were received from residents of the Northern Territory, and more than 1100 submissions in total were considered by the Committee in framing its report to the Assembly.

As is evident from the submissions a large proportion was from people simply stating their attitude for or against euthanasia. In considering the evidence the Committee has respected the validity of all views, giving credence to the one page submission as well as those which articulated longer and more developed arguments.

Furthermore the demand to appear before the Committee was high. In the month between mid-March and mid-April we sat for nine days of hearings in five urban centres and four rural communities, hearing evidence from over 100 people.

It is pleasing to say that, notwithstanding the relatively short time available to take submissions, no one was denied the opportunity to put their views to the Committee.

While we have made no recommendation to the Assembly on euthanasia, we have made a number of recommendations on the Bill should it proceed, as well as on related matters, with the pre-eminent recommendation addressing the often expressed need for better palliative care services in the Territory.

There was another often expressed need, that of allowing more time for the *Rights of the Terminally Ill Bill 1995* to be considered by the community at large.

I would like to thank the staff who assisted the Committee in the preparation of this report, including the staff of the Committee, and those from Hansard and other areas of the Legislative Assembly who assisted in the task.

The fact that the Committee was able to present an analysis of all the evidence within the required time frame is a tribute to the staff involved, and to the cooperative bipartisan approach of all Committee Members. This Committee has broken new ground in relation to the volume of evidence taken in the three months since its establishment.

It has been a privilege to chair the Select Committee on Euthanasia. I believe the Assembly chose wisely in selecting my four colleagues to this Committee, representing as they do a very good cross-section of the Territory in terms of backgrounds, skills, and ethnic composition.

I wish to express personal thanks to my fellow Committee Members for their dedication to what has been an arduous task, given the complexity of the issue and the time in which we had to report on the matter.

In conclusion the Committee extends its thanks to the many people who provided evidence to the inquiry in written form or orally. Many took the time to share their intensely personal and often painful memories which have shaped their attitude to euthanasia. Perhaps for some of these people it has been a cathartic process.

Hon. Eric Poole, MLA
Chairman

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This report contains material taken from submissions, and transcripts of oral evidence, the originals of which are stored in the Original Papers Collection, Legislative Assembly. Some may contain errors from the misreading of handwritten originals or from mistakes in transcription. Any differences are regretted but no responsibility is accepted for them.

At the time of drafting this report the transcripts of oral evidence were in verbatim form only. As a result, quotes taken from the oral evidence and published in Volume One may differ in minor ways from the same statements contained in Volume Two, the latter being based on edited transcripts.

1. Introduction

1.1 Background to the Inquiry and Appointment

On 1 February 1995 the Honourable Marshall B. Perron, MLA, announced his intention to introduce a private member's bill on euthanasia into the Legislative Assembly of the Northern Territory at its February 1995 sittings. The Bill entitled *Rights of the Terminally Ill Bill 1995* was introduced on 22 February 1995 (see Appendix A). Following Mr Perron's second reading speech, debate on the Bill was adjourned until the May sittings.

On the same day as the Bill's introduction, the Legislative Assembly on a motion from the Honourable Shane L. Stone, MLA, resolved to establish a *Select Committee on Euthanasia*, to take evidence and submissions on the Bill, and to report to the Assembly by 16 May 1995.

1.2 Role and Functions of the Committee

The Terms of Reference restricted the role of the Committee to the taking of evidence on the Bill itself. Unlike other inquiries such as those in Victoria, 1987, or United Kingdom, 1994, (see Chapter 4 for the terms of reference for these inquiries), the Committee did not have a specific charter to make recommendations for or against euthanasia, but to examine persons, papers and records, and to present evidence for the consideration of the Members of the Legislative Assembly.

The Committee was empowered to request various witnesses to appear before it, in public or private sessions, and to send for various papers and records which it considered relevant to matters contained in the Bill.

In terms of the disclosure of evidence provisions, Section 22 of the *Legislative Assembly (Powers and Privileges) Act* prohibits a person from publishing or disclosing documents or oral evidence submitted to the Legislative Assembly or a Committee of the Legislative Assembly, unless it has already been published, or authorised to be published, by the Assembly or an Assembly Committee.

The Committee considered that this restriction might be seen as a barrier to open discussion of the material presented or views expressed by witnesses. At its second meeting the Committee resolved that witnesses submitting evidence be authorised to publish or otherwise disclose documents or oral evidence submitted by them, unless otherwise determined.

1.3 The Conduct of the Inquiry

The Committee first met on 24 February 1995 and elected the Honourable Eric Poole, MLA, as its Chairman.

Advertisements were placed in the Northern Territory News and major regional Northern Territory newspapers advising of the establishment of the Committee and its role, as well as inviting written submissions. Information packs consisting of the Terms of Reference, the Bill (including explanatory information), and notes for the presentation of submissions to committees were dispatched to individuals and organisations on request. Details of the Committee's planned program of hearings in regional centres were promulgated.

As well information on the inquiry and the Bill was sent to all Aboriginal communities in the Northern Territory, together with an offer by the Committee to visit individual communities if any community so wished.

Follow-up contact was made with those communities that indicated interest in meeting with the Committee.

In view of the time constraints placed upon the Committee by the 16 May 1995 reporting deadline, the Committee set aside a two week period at the end March and early April for hearings. Advertisements advised that intending witness would need to have submitted written material by 24 March 1995, to enable it to be considered by the Committee prior to the public hearings being held.

The final date for all other written submissions was 21 April 1995 to enable sufficient time for their processing and incorporation in the record of the inquiry.

1.4 The Taking of Evidence

The Committee's consultations with organisations and individuals were in two parts. First, a number of witnesses was called to brief the Committee on the Bill and matters pertaining to euthanasia, and second, hearings were held in Darwin, major regional centres in the Northern Territory and a number of Aboriginal communities.

The Committee identified early in the inquiry areas of the debate in which it was considered they required further information and clarification.

Specifically, these areas included legal briefings on the Bill itself; the palliative care services currently available in the Northern Territory, and those provided elsewhere in Australia; bioethical

issues in relation to euthanasia; and differences in definition between active voluntary euthanasia and passive euthanasia, the latter being provided for in the Northern Territory by the *Natural Death Act 1988* (see Appendix B).

The following selected witnesses appeared before the Committee (see Appendix C):

- Dr J. I. Fleming, Director, Southern Cross Bioethics Institute (PH1-1)
- Dr H. Kuhse, Director, Centre for Human Bioethics, Monash University (PH2-1)
- Ms S. Trollope, Assoc. Dean of Law, Northern Territory University (PH3-3)
- Ms A. Black, Ms C. Pullen, and Mr M. Donald, palliative care nursing, Darwin region (PH3-8)
- Ms S. Clyne, specialist nurse in palliative and related care services, Alice Springs (PH5-9)
- Professor M. Ashby, Director Palliative Care, Monash University (PH12-3)
- Dr R. Hunt, Medical Coordinator, Southern Community Hospice Program, Daw Park Hospice (PH12-4)
- Dr J. Zalcberg, Director, Medical Oncology and Palliative Care, Austin Repatriation Medical Centre (PH12-9).

The Committee took evidence in public unless a witness requested that the evidence be given in private session. For the latter cases the evidence was given *in camera*. Given the overall sensitivity of euthanasia, and the sometimes very personal attitudes revealed by witnesses, all requests for confidentiality or anonymity were respected.

The Committee heard evidence as follows (see Appendix C for further details):

14 March 1995	Darwin	5 April 1995	Katherine
20 March 1995	Alice Springs	6 April 1995	Yirrkala Nhulunbuy
29 March 1995	Darwin	7 April 1995	Milingimbi Nguiu
3 April 1995	Hermannsburg Alice Springs	10 April	Darwin
4 April 1995	Tennant Creek		

1.5 Structure of the Report

The report is in three volumes, with the main report at Volume One summarising the evidence gathered by the Committee from oral hearings and written submissions, details of the practice and

inquiries into euthanasia in other jurisdictions, and the Committee's findings and recommendations. Appendix A of this Volume provides a copy of the *Rights of the Terminally Ill Bill 1995*; Appendix B provides a copy of the *Natural Death Act 1988* and Regulations; Appendix C provides a program of the taking of oral evidence; and Appendix D provides a summary of the evidence taken, cross classified to Volumes Two and Three. Appendix D also provides an elementary for and against analysis.

Volume Two is the Hansard record of all public hearings except those held *in camera* (the latter being at the request of the witness).

Finally Volume Three presents a record of all the written submissions received. It does not include submissions where the writer requested that the material be treated as being confidential, nor does it include published material which was incorporated in submissions. However the appropriate references are given.

2. Terminology

There is at times some variance in the terminology used by people when discussing euthanasia and related aspects. This can and does cloud the issues in relation to euthanasia. The terminology set out in this Chapter is that accepted and used by the Committee. It is not necessarily that of the witnesses, and thus may not have the same meaning in oral transcripts and submissions.

For the purposes of this report **euthanasia** is taken to mean assisting a person to die in an humane manner.

A distinction can be made between active and passive euthanasia.

Active euthanasia can occur in three different ways. If it is at the patient's specific request, where the person is competent, then this is called **voluntary** euthanasia. Alternatively if active euthanasia occurs where the patient is incompetent, this is termed **non-voluntary** euthanasia. **Involuntary** euthanasia describes the situation where a competent patient is put to death without that person's request or consent.

Passive euthanasia occurs in circumstances where life sustaining measures are withdrawn or withheld.

Where medication is administered as part of the treatment process or with the primary intention of alleviating pain, knowing that a possible outcome could be the patient's death, and death subsequently results, this is taken to be **double effect**.

Doctor-assisted suicide or physician-assisted suicide occurs when a competent patient requests assistance to die, and this is brought about usually through the provision of a lethal substance by the patient's doctor.

A **competent** patient is one who understands his or her medical condition, the prognosis of the disease by the doctor, and the risks and benefits associated with the treatment of the condition. A competent patient must be capable of making informed decisions about his or her treatment.

An **incompetent** patient is not competent, that is, he or she is incapable of making informed decisions about their treatment.

Assisting (to die) means the prescribing of a (lethal) substance, the preparation of that substance and/or the giving of that substance to the patient for self-administration, or the administration of the substance to the patient, or the withdrawal of support.

Terminal illness means an illness, injury or degeneration of mental or physical faculties such that death would be imminent unless extraordinary measures were undertaken, and from which there is no reasonable prospect of a recovery.

Palliative care is the process of treatment used in terminal illness with the primary aim of achieving comfort and symptom control. It is an holistic approach to care, including the physical, psychological, personal and social needs of a terminally ill patient and their family and friends.

Advance **directive** or living will refers to the certificate under the *Natural Death Act 1988*, whereby a competent patient states his or her preferences about medical treatment, or the withholding of certain treatment, in the event that they become incompetent.

The **period of terminal care** means that time after which any medical treatment is predominantly confined to the relief of pain, suffering and/or distress with the objective of allowing the patient to die a comfortable death; that is the period after the cessation of medical measures undertaken with the intention of effecting a cure from, or achieving a remission or retardation of, a disease process.

3. Evidence and Submissions

3.1 Preamble

It quickly became apparent to the Committee that there were few people in the community without a view on euthanasia. There was a large response to our call for submissions (see Section 3.10), and the level of public debate has increased markedly in the three months since the Honourable Marshall Perron, MLA, first introduced his private members Bill.

The Committee has been very much aware of the underlying current of social ferment that the question of legalising euthanasia has generated within our community.

Through the benefits of modern medical skills and technology, more and more people are living longer after experiencing serious illness or trauma. Together with a strong feeling of the 'autonomous individual', the debate about the practice of euthanasia has gained new prominence.

A number of people and groups commented on this aspect. One witness saw the process as being part of social change in the same way as the Federal *Sex Discrimination Act* brought social change.

Dr Hunt, a specialist with expertise in palliative care from South Australia, pointed to several change agents in the society, including the ageing population thinking more about death, the growing disenchantment with medical efforts to keep people alive when their quality of life is poor, and an increasingly educated and assertive population with a strong belief in the right to choose the manner of one's living and dying. For this witness, social change was characterised by the priorities of the 'baby boomers':

"...they're a part of that aging society and they've always carried political power with them ...from the time they were youths and being able to stop the Vietnam War, and now in their economic productive years, the economy is on top of the agenda, and as that population moves into old age, these sorts of issues [euthanasia] are going to be more prominent". (Hunt, 1995, Oral Evidence, Darwin).

For the Australian Medical Association (AMA) the debate is being driven by a number of societal features within our present community, including the decline of the christian church and the nuclear family, the 'boom' in information technology making the individual information 'rich' and therefore in a stronger position to question traditional authorities and institutions, and the growth of 'consumerism' in medicine.

The AMA went on to say:

"People are far more aware of their position in society and what it is that society owes to the individual member. As a community of individuals we have developed a sense of our own worth, a sense of our own autonomy, the right to make decisions for ourselves within the framework that society imposes... It is this new sense of individual rights coupled with the decreased influence of religion and the questioning of traditional authorities such as the doctor which has led to calls for euthanasia to be legalised."
(AMA, 1995, Written Submission).

Another palliative care specialist put the issue this way:

"...the idea that we can in some way sanitise death and turn it into some kind of calm, peaceful event I think is probably seeking too much control...we [the 'me' generation] are really used to having incredible control over our own destinies...we are lucky enough to live in a time and a society where we have probably never had better recognition of our rights and probably never had more control over our choices in life, but the idea that we have control over everything is quite illusionary...that somehow we can make the last bit of our lives as full of choices as the rest of our lives I think is fatally flawed."
(Ashby, 1995, Oral Evidence, Darwin).

For a number of residents of the Territory, the issue was less that of individual rights and more one of the rights of 'Territorians alone'. For them minimum residency requirements were necessary for eligibility under the proposed legislation.

Even though some residents of the Northern Territory were afraid that the Territory would become a centre for euthanasia in Australia, the Committee was not able to find substantial evidence in support of this contention nor to allay these fears.

Based upon experience in the Netherlands (Netherlands Ministry of Justice, 1991a), and on studies of the frequency of patient requests for euthanasia in the United Kingdom (Seale and Addington-Hall, 1995) and in South Australia (Hunt, 1995), it would appear that euthanasia may affect about two or three per cent of the population who die in any one year.

If it is assumed that the abovementioned proportion of deaths per year of the resident population of the Northern Territory were due to euthanasia, this would translate to around twenty (20) deaths annually. There are about 750 deaths each year amongst the residents of the Territory. Significantly the death rate is one of the lowest in Australia, reflecting a bias towards a migratory population of relatively young people moving to the Territory for work, and relatively old people retiring to places other than the Territory.

Another general concern from a resident of the Territory was that the Assembly had no mandate to consider the Bill. This view was supported in part by a number of submissions from within the

Territory calling for a referendum on the issue. The Committee rejects entirely the notion of no mandate.

Very soon after its formation the Committee realised the problem of communicating with some Aborigines, whose English may be a second or third language, on some aspects of the Bill. There are cross-cultural differences on the issue that will be discussed at Section 3.6. But even so, the theme of social change did not escape the Aboriginal population, at least in the view of one witness from Nhulunbuy with experience in Aboriginal Health matters:

"...in ten, fifteen or twenty years time I would predict that it is going to become more easily accessible in that there will be traditional people tapping into this [euthanasia]. I have no doubt. When I first came here who talked about infant male circumcision being performed in hospitals? That was pretty much unheard of. And yet now people are choosing to have that done in hospitals under general anaesthetic rather than the traditional way. So that is one of the changes." (Alexander, 1995, Oral Evidence, Nhulunbuy).

3.2 The Autonomous Individual versus The Common Good

The theme that most recurred in submissions and evidence before the Committee was the matter of the individual's freedom of choice, relative to the protection of the right to life for all members of the community in the interest of the common good. An associated, underlying theme was that of intent, whether, for example, in providing care it is the intent to assist the patient to die, or the intention was only to alleviate pain with death sometimes an outcome.

The choices available may range from palliative care only, through to the withdrawal or withholding of treatment, to active voluntary euthanasia or doctor assisted suicide.

For many who follow the line of the autonomous individual, in an ideal world a person may choose freely between any of these options. It is a non-restrictive approach.

But for those favouring the common good argument, the choice must be restricted to palliative care, or withdrawal or withholding of treatment (passive euthanasia). For this group it is very much a question of intent - with care intended to relieve pain and allowing the patient to die a natural death.

Euthanasia has the intention of bringing about the death of a patient, motivated by the need to relieve a patient's suffering. As Dr Fleming said to the Committee:

"...we need to be very careful when we deal with voluntary euthanasia, that we are talking about acts or omissions with the intention to bring about death. We are not talking about an act where the intention is to kill pain, but which might incidentally shorten life; there is no intention to kill the patient." (Fleming, 1995, Oral Evidence, Darwin).

For those with compelling christian beliefs the distinction is very important. Voluntary euthanasia is an affront to their fundamental beliefs. As the Anglican Bishop for the Northern Territory said:

"Our strong objection to 'voluntary euthanasia' arises from the fact that we have the fundamental belief that all life is God-given and that no-one has the authority to take the life of any innocent being, either with or without their consent."
(Appleby, 1995, Written Submission).

For others adopting an individual line, voluntary euthanasia was :

"...like an insurance policy: you probably won't need it, but if you do, the need can be overwhelming." (Oldham, 1995, Written Submission).

At present for those who wish to end their life when there is 'no quality left', they are faced with the dilemma of perhaps ending their life too soon while they are still capable of doing so.

One submission pointed out the tragic circumstances of the death of the philosopher Arthur Koestler, who took his own life when faced with Parkinson's Disease attacking his brain. His 55-year old wife assisted him, and then took her own life for fear of criminal prosecution.

The pro-choice group support the theme of wanting legislation enacted that allows the individual to make a choice (about the manner and timing of their death), without other parties who may assist being in breach of the law.

Law and intent constantly interacted in the evidence that the Committee heard in relation to this issue. For some no law is ever perfect, but to argue against a law that would benefit the majority because a few might abuse it, is no reason not to bring it in. On the other hand for some others making laws for those (few) who may suffer is a case of 'hard cases making bad laws'.

One Alice Springs resident put their case succinctly :

"Legislation formulated by democratic Governments has traditionally been for the common good. Governments which use their legislative power to single out individuals, for whatever reason, are Governments which have lost their moral mandate."
(Gardner, 1995, Written Submission).

A Katherine resident also favoured the common good argument with the statement :

"...liberty is only possible where prudence, duty and mutual respect are universal, otherwise restraints imposed by criminal law are indispensable." (Hillock, 1995, Written Submission).

And for a Darwin resident:

"Some who favour euthanasia talk of religious views being 'forced' on a majority. My views certainly have their basis in my convictions and beliefs as a Christian. But I reject the charge that my views are being forced on anyone. If they gain acceptance - well. But if laws are introduced contrary to Christian truth, in this country I have to make the best of it - while not ruling out continuing responsible objection to such laws."
(Butler, 1995, Written Submission).

Another considered that if it was good enough for society to allow the individual to dispose of material goods in whatever fashion, it should also recognise the competence of the individual to be able to identify the desired quality of life and when it should end. People have the 'moral right' to determine the manner of their lives, so too they should have the 'moral right' to determine the manner of their death.

Dr Kuhse summed up the debate over intent and the interests of the individual this way :

"...to kill a patient by administering a lethal, non-therapeutic drug, is wrong. To bring about the same consequence, of having a dead patient, by turning off life support is not wrong... I do not share this belief, but there are many people in our society who hold this belief... In the end one cannot argue about it, because these views are based on deep philosophical value judgements."(Dr Kuhse, 1995, Oral Evidence, Alice Springs).

The value judgements may be of those whose spiritual principles are deep rooted in Judeo-Christian culture, accompanied by a strong belief in the sanctity of life. This group has no objection to a situation where life support is withdrawn or attempts at pain relief results in death, but they strongly object to assisting the patient to die where the motive is to alleviate pain.

The alternative and irreconcilable position is that there is no difference. Whatever the approach, be it to withdraw life support, or attempt to alleviate pain resulting in death, or to assist the patient to die in order to alleviate pain, the result is the same. For one person the matter was very clear :

"Morally, there is no difference between Voluntary Euthanasia (administering a lethal drug), and Passive Euthanasia (withholding/withdrawing necessary treatment), if the intention in both cases is to cause death. Ultimately, if both acts cause the eventual outcome of death, with aspects of one being partially within the law, and the other completely illegal, why should the form which is painless and distress-free not be legalised?"
(Chin, 1995, Written Submission).

Kuhse also points out that it is the right of the terminally ill patient to refuse treatment, and as the law currently stands this is not perceived as being against the interests of the common good. Yet:

"This very same right is denied the terminally ill who are not 'fortunate' enough to require life-support which they can then refuse. This latter group of patients is being discriminated against." (Kuhse, 1995, Written Submission).

According to this view, from the point of view of the autonomous individual, terminally ill and suffering patients who want to end their lives painlessly have no rights in law.

3.3 The Doctor/Patient Relationship

Much was said about this relationship in evidence before the Committee. Based upon statements from professionals as well as members of the public, the Committee perceives that there has been a shift in the doctor/patient relationship, to one where the patient is much more informed and assertive about the treatment. As indicated in the introduction to this Chapter, the traditional paternalistic relationship between doctor and patient has evolved, so that today there is broad acceptance of the concept of informed consent to treatment, of the common law rights of the patient to refuse treatment, and of statutory laws such as the Territory's *Natural Death Act 1988*.

There were many people who continue to believe that medical practitioners take an Hippocratic Oath as part of their professional and ethical training. The taking of this oath for graduating medical practitioners fell into disuse more than a decade ago.

Nevertheless the ethical base of medical practitioners remains strong, albeit subtly different from the Hippocratic Oath, as illustrated in the code of ethics of the AMA in relation to the dying patient:

"Always bear in mind the obligation of preserving life, but allow death to occur with dignity and comfort, where death is deemed to be inevitable and where curative treatment appears to be futile." (AMA, 1992, p174).

A similar view to that of the AMA was expressed much earlier by the nineteenth-century English poet Arthur Clough:

> "Thou shalt not kill; but need'st not strive
> Officiously to keep alive."
> (Quoted in Kuhse and Singer, 1985, p76).

The people giving evidence on the doctor/patient relationship fell into three broad categories. First, there were doctors who were of the view that euthanasia would work against the relationship, although there were some notable exceptions to this broadly held view. The second category were potential patients who in the main favoured euthanasia but were concerned that the law should protect doctors from any criminal prosecution, and the third category were Aborigines who were very much concerned with the need to maintain and build upon the existing level of trust between doctor and patient.

The group *Doctors Concerned about Euthanasia* was worried about an attitudinal change in society resulting from the passage of the Bill that would 'irreversibly' change patient expectations of doctors. Doctors would face patients with serious illness with a more ambivalent approach, concerned that each question they raise may be interpreted as being 'loaded' by the patient. For example questions such as 'Do you ever think about dying?' currently framed to test for depression become much more difficult to discuss in a regime where euthanasia is permitted, according to this view. The Bill puts the emphasis on patient initiation in relation to euthanasia, but in the dynamic of the doctor/patient relationship this is much harder to distinguish, with some potential for the doctor being seen to lead where this may not be the intention at all. In the case of the AMA:

"Attempts to legislate the relationship between individual doctors and their patients creates an environment in which the doctor and the patient see each other as potential adversaries inevitably at the expense of the patient." (AMA, 1995, Written Submission).

One doctor highlighted what he saw as a potential polarisation of medical service, with people choosing their general practitioner on the basis of the latter's views on euthanasia according with their own.

It is also 'inevitable' in the AMA's view that there will be groups in the community who will not trust medical practitioners if they have 'the power of death over patients'. It would appear at present that Aborigines also fear this to be the case. However the intent of the legislation very clearly gives the power to the patient.

Nevertheless there appear to be fears about the Bill already taking hold in Aboriginal communities. As one witness from the Top End said:

"Doctors have got the power to kill. The implications of that are fairly large as far as Aboriginal health are concerned. People are already scared of going to the clinic, fronting up for things like routine injections. They would even be much more petrified of all the injections if they found out that doctors can kill by that means and there would consequently be a much lower compliance rate." (Amery, 1995, Oral Evidence, Nhulunbuy).

A similar view was expressed by Father Joe Brady from Santa Teresa in Central Australia:

"I also know how difficult it is to build up a good, open relationship between an Aboriginal patient and the doctor. The patient's suspicion can only be greater when it is known that doctors do have the power to terminate life, albeit in restricted circumstances. We have heard so much of the need for more and better health care for Aboriginal people. While that requires better health facilities, it surely demands a greater effort to promote more trust, more understanding and more openness between medical practitioners and their Aboriginal patients. I can say that many of the people from here who have to go to town to see a specialist or to have further treatment do so in great fear and come away so confused. I feel that the proposed legislation will only add to the turmoil." (Brady, 1995, Written Submission).

More will be said about this matter in Section 3.6.

For one general practitioner in the Territory the matter was one of duty of care. For that doctor the duty includes voluntary euthanasia if that was the 'absolute best thing for the patient and the family'.

Indeed the Committee heard evidence on a number of occasions that implied that some doctors, and for that matter other health care professionals, participated in the practice of euthanasia in the Northern Territory. The Committee recommends some caution in interpretation here, given that some of these people may have different concepts of what is and what is not active voluntary euthanasia. Nevertheless the point remains valid that we deliberately chose not to pursue this evidence in order to avoid becoming an investigative Committee.

Surveys of medical practitioners carried out in NSW/ACT (Baume and O'Malley, 1994) and Victoria (Kuhse and Singer, 1988) indicate that some doctors may participate in euthanasia. In NSW and Victoria, 28% and 29% of respondents respectively indicated that they have '...taken steps to bring about death' at some time during their career. Furthermore 58% of NSW doctors who responded and 60% of Victorian respondents want euthanasia made legal (Baume and O'Malley, 1994). In South Australia 45% of doctors responding to a survey thought euthanasia should be legalised in certain circumstances. (Stevens and Hassan, 1994).

The Committee advises caution in the interpretation of some surveys. The use and understanding of the terminology used in some surveys may convey a misrepresentation of the true picture. What is perceived as being voluntary euthanasia in some cases may in fact be passive euthanasia or double-effect.

One war veteran summed up the sentiments of many people when he said:

"At present a doctor puts his livelihood and good reputation on the line if he helps end the suffering of such a patient. How much better and easier for both doctor and patient if this were to be made legal, subject to all necessary safeguards."
(Clay, 1995, Written Submission).

The question of being 'easier' for the doctor is a moot point. It is difficult not to empathise with medical practitioners caught in the middle of the euthanasia debate. Whatever their personal views, the implication of any proposed law gives a primary role for the profession.

Without legislation some patients may face a death of pain and suffering, while the doctors who intervene to assist the patient to die walk in a legal 'twilight zone'. With legislation doctors will ponder on when and from whom the next request for euthanasia will come and how they may respond, with no two cases being the same. Their professional skills, integrity, and organisational capacities will be called upon to face situations that many have yet to confront. There is also the possibility of some subtle division occurring in the profession between those who provide assistance and those who do not.

There was a call for the form of assistance provided by the doctor to be more clearly defined. With no definition of 'substance', the form of assistance was somewhat open ended, according to informed legal opinion.

The question of what the death certificate should say as to the cause of death was also raised. In the event that euthanasia is carried out, the strict legal interpretation is that death resulted from the administration of a lethal substance, assuming this to be the technique. But what of the implications for such matters as a record of the family's medical history? It is necessary in the interests of future generations that the terminal illness also be recorded.

3.4 The 'Slippery Slope'

More often than not those who argue that the introduction of voluntary euthanasia will lead inevitably to non-voluntary and involuntary euthanasia point to the practice in the Netherlands as providing evidence for this contention. The Remmelink Report is often quoted in support of this argument (see Section 4.1.3).

Euthanasia remains a crime under the Dutch Criminal Code, and there are statutory provisions requiring all cases of euthanasia to be reported to the authorities. That there was one prosecution of a Dutch medical practitioner for euthanasia in the last decade up until the beginning of 1995 is notable. Equally notable is that there was a second prosecution recently, this time involving the death of an infant. In the Committee's opinion the practice remains controversial as any moderate reading of the literature in this area will demonstrate.

The Committee takes the view that an Australian survey, carried out along lines similar to that for the Remmelink Commission, would be very useful at this point in time. It would shed light on the incidence of all forms of euthanasia practised currently, some of which are illegal. It would also

provide an insight into modern day attitudes towards the practice to serve as a pointer to a possible future.

There is also the fear that the introduction of euthanasia will reduce the availability of palliative care in the community, encouraged by escalating cost pressures faced by a modern health system. The competing demands for the health dollar already pose a moral dilemma for decision makers. This could exacerbate the 'slippery slope', pushing people who may not otherwise choose it towards euthanasia.

The Committee believes that whatever the outcome of the Bill, Government must address the issue of palliative care in the Northern Territory. More is said about this in Section 3.7 below and in Chapter 5.

There appears to be a case for the argument that economic pressures can potentially lead to an abuse of euthanasia legislation. One person put the situation this way:

"The health budget is (unfortunately) limited. Thousands of dollars are currently being spent every day on keeping terminally ill people alive. Meanwhile many children suffer through the lack of basic medical services." (Jurkijevic, 1995, Written Submission).

Another view was even more forthright:

"I do not know whether you appreciate that about 50 per cent of the health dollar is spent on people who will be dead in 12 months. At the same time, there is no decent water supply in a place like Hermannsburg, where children under 5 years of age are ending up with stones in their kidneys. This occurred for a number of years. It should not happen to children of that age who do not have congenital defects. It happened because the water supply was so thick with solids. That is real health care to me." (Mason, 1995, Oral Evidence, Darwin).

It is the Committee's view that while this line of reasoning demonstrates a concern for our children, treating patients according to their remaining life expectancy presents dangers for our society. The decision to treat any particular patient within hospitals, or other health care facilities, should not be based upon such criteria as age or funding. It should be based upon the needs of the individual at the time and the resources available to treat the condition. For the decision to be based on any other criteria will almost certainly lead down the path of the slippery slope and should be avoided.

This same view was expressed by the House of Lords Select Committee on Medical Ethics when they said:

"...treatment limiting decisions... should depend on the condition of the individual patient and on the appropriateness to the patient of whatever treatment or methods of management are generally available, and should not be determined by considerations of resource availability." (House of Lords, 1994a, p57).

Dr Kuhse, an expert in human bioethics, questions the claim that voluntary euthanasia will lead to non-voluntary euthanasia:

"Why, then, should the acceptance of direct voluntary euthanasia or medically assisted suicide send a society down a slippery slope (when the acceptance of [withholding treatment and administration of pain control resulting in death] presumably does not), and why should it turn good doctors into unscrupulous people who proceed to terminate the lives of their patients without their consent? I don't know the answer - and must ask those who rely on 'slippery slope arguments' to provide it." (Kuhse, 1994a, p12).

On the other hand an Alice Springs submission took an entirely different view:

"The naivety of the supporters of the Bill in imagining that the legalised killing of some would not lead to the unauthorised killing of others is incredible. It is naive to imagine that people will always be 'reasonable', especially professional elites like physicians and nursing staff. Voluntary euthanasia cannot be quarantined from other acts of intentional killing as the Dutch experiment clearly demonstrates. Human rights are inalienable as well as inviolable. The right to life cannot be given up without threatening the right to life of other members of the community."(The Our Lady of the Sacred Heart Parish, 1995, Written Submission).

For several who wrote to the Committee the matter was one of never being certain of the voluntary nature of the patient's consent:

"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."
(Pollard quoted in Adamson, 1995, Written Submission).

In addition to the economic pressures in the health service that may have the potential to increase deaths beyond those of voluntary euthanasia, the Committee heard evidence that people who are not terminally ill may also feel threatened. In this regard the handicapped were particularly singled out. There was also the view that the measures could well apply to children as people became 'desensitised' to active voluntary euthanasia.

Another side of the 'slippery slope' debate relates to those outside the proposed legislation, but who could mount a sound case for inclusion. This group could include permanently and incapacitated people such as those suffering from multiple sclerosis or quadriplegia, but who are not terminally ill.

The AIDS Council of Central Australia has yet another perspective on the issue. Not only does the Council support the Bill, its view is that the provisions need to be extended to allow for advance directives. In these circumstances a terminally ill patient who was no longer competent could be assisted to die.

The alternate view to that of the AIDS Council of Central Australia is that such a provision would reinforce the ‘slippery slope’ argument.

3.5 Timing, Review and Scrutiny

3.5.1 Timing

Most concern in relation to matters of timing focused on the suitability of the period of 12 months (Clause 3), and the desirability of a 'cooling off' period between meeting the conditions for euthanasia and the actual administration of a substance.

Several submissions questioned the effectiveness of the 12 month period, particularly given the uncertainty surrounding medical prognosis. One informed witness, Ms Trollope, saw difficulty in putting 'mathematical figures' into the legislation in this instance. A better approach, according to her view, would be to redefine the concept to one of "unacceptable pain and suffering" rather than a specific time period.

A lawyer, Mr Guy Riley, nominated by the Law Society of the Northern Territory as a specialist advisor to the Committee, reinforced this view when he said:

"While the concept of 'unacceptable pain and suffering' may create problems for the draftsmen, I suspect that the twelve month test may create difficulties for the medical profession. Is there any need to impose a time limit?

"If the concept of 'unacceptable pain and suffering' is added as a necessary prerequisite, what does it matter how long it is going to take before the terminally ill die."

In order to avoid problems associated with the 'slippery slope' the Committee is of the view that euthanasia should only be allowed in the period of terminal care; that is the time from when active treatment of the disease or illness ceases and death occurs.

The period of terminal care means that time after which any medical treatment is predominantly confined to the relief of pain, suffering and/or distress with the objective of allowing the patient to die a comfortable death. This is the period after the cessation of medical measures undertaken with the intention of effecting a cure from, or achieving remission or retardation of, a disease process.

It is in this period that we believe that euthanasia should be available, if the Bill proceeds.

It is also notable that the intent of the legislation requires that the patient be competent when making the request, but is ambiguous on the competency of the patient at the point of euthanasia.

In relation to this point Mr Riley said:

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

"How can a prudent Doctor not have doubt that a patient in a coma still wishes to continue to die if that patient has lost the ability to think, let alone communicate his or her wishes.

"We presume that in many cases there will be a decline in the patient's mental faculties between the time of the request and the time that the medical practitioner is in a position to terminate the patient's life. Presumably it is not intended that a request made at the time the patient is in full possession of his or her faculties cannot be carried out simply because of a subsequent decline in the patient's health.

"We suggest this clause be re-drafted so that 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 a patient still wishes to continue."

In the view of this expert advisor, competency is clearly important at the time of approval, but cannot and should not be guaranteed at the point of euthanasia. To do it any other way would be illogical and impractical. The onus is on the patient to indicate a change of mind at the time. It should not be on the medical practitioner.

The Committee acknowledges that if this change to the Bill is accepted it would broaden the intent of the Bill to the extent that it may have the potential to allow for non-voluntary euthanasia. This would occur if the patient were to change their mind subsequent to receiving approval for assistance, but in the meantime loses the ability to communicate that view.

Notwithstanding the possibility of non-voluntary euthanasia occurring, on the balance of the argument the Committee supports the view of Mr Riley if the Bill proceeds. To do it any other way would exclude many of those people for whom the provisions of the legislation were intended; that is those who, by virtue of the progress of their terminal illness or the treatment for it, had crossed the competency threshold.

Following this course allows the patient to have the choice of remaining competent until the very last moment of their life, comfortable in the knowledge that their life will end soon after losing competency, and not prematurely.

The issue of a 'cooling off' period was also raised. One submission pointed out that even though Clause 8 provides for the right to rescind a request, the complementary provision of a 'cooling off' period is not provided for. If requests were to be acted upon immediately, the right to rescind provision would appear to be superfluous. An interlude prior to assisting the person to die is desirable having regard to both the painful condition of the patient and prudent practice. Further comment on this aspect is provided in Chapter Four.

3.5.2 Review

Several submissions and witnesses pointed to the need to exercise care in reviewing the decision of the first doctor. The need for a specialist opinion was most outstanding, but it was acknowledged that such advice is not always available in the Northern Territory. Nevertheless, as a witness said to the Committee:

"...I'm not sure that reality ought to always influence the refinement of the legislation... if you're putting in place a law, you ought to be satisfying yourself about the parameters of the law itself and not necessarily looking at the reality of the situation."
(Trollope, 1995, Oral Evidence, Darwin).

According to one general practitioner in the Territory, the lack of specialist advice is one reason for sharing experience within the profession, as part of the process of increasing knowledge about care of the terminally ill which would ultimately improve the process of review. This doctor has been able to '...offer pharmacological advice to other practitioners concerning the end stages of palliative care [but] there needs to be a body of medical knowledge concerning these matters as well as a supply of suitable medication.'

This same doctor believed that the second opinion should come from doctors of at least '5 or 10 years standing'. Perhaps even '...a resident of the Territory for at least ten years to avoid the 'fly-by-nighters''.

Certainly the Committee can see the desirability of imposing some minimum period of practice upon the second medical practitioner, and even upon the first where the administration of lethal substances is involved. Such practice usually involves specialist knowledge like that of an anaesthetist.

In the context of experienced practitioners, one witness with legal expertise said:

"It is, of course, not unusual in Australia for professional people to have certain limitations placed on them early in their career to control the over-enthusiastic or the person with lack of experience... Only practitioners with say, 5 years experience, ought to be taking these decisions under the Act."
(Trollope, 1995, Oral Evidence, Darwin).

Others saw the need for a review board, removing the responsibility for dealing with the certificate of request under the Bill from the medical profession untrained in legal matters.

3.5.3 Scrutiny

In the main, of those submissions that raised the matter there was criticism about the inadequacy of the provisions for scrutiny under the proposed legislation. The Australian Federation of Right to Life Associations put their view this way:

"There is no provision for independent scrutiny by the Coroner or a body such as a Guardianship Board or the Commissioner of Police or the Attorney-General or the Health Department, or anyone. A patient's signature could be forged. If you had two doctors practicing in partnership, this could easily be done."
(Australian Right to Life Association, 1995, Oral Evidence, Darwin).

Another person in a submission to the Committee, a doctor, thought that a 'Coroner's Constable' at least should be involved in a formal check of the qualifications of the two doctors involved.

For a third, the proposals were less stringent than the Netherlands, the only country where euthanasia is practiced openly and on a wide scale:

"While certificates of request need to be given to the Coroner, the Coroner will have no jurisdiction to investigate a death by euthanasia (unless in a particular case something happens to suggest to the Coroner that the Bill has not been complied with). In this respect, the Bill will make it more difficult to detect abuse than the procedures currently in place in the Netherlands. But even in the Netherlands, widespread abuse of guidelines for euthanasia is well known, largely because of the difficulty of detection."
(Clark, 1995, Written Submission).

There was an interesting exchange of views on whether or not the practice of active voluntary euthanasia should be legalised in order to make it more 'transparent' to the community at large, and therefore more accountable. This would also promote respect for the law given the alleged abuses that are currently occurring by some of our most respected citizens, notably doctors. (Kuhse, 1995, Written Submission).

For one, passing a law to bring euthanasia out in the open was a poor motive for changing the law, with the following analogy used:

"Domestic violence is something that until recently we did not know very much about. Most of it went on in the privacy of people's homes and it was only when it spilled into the street or a body emerged that the police were involved. Nobody suggested that as a way of gathering information about domestic violence that we actually legalise it".
(Ashby, 1995, Oral Evidence, Darwin).

For another:

"...domestic violence is an act against somebody's will. I mean it's a different type of act. It's more like rape. But with euthanasia, it's got as much to do with murder as making love has got to do with rape. You know, because its consented by."
(Hunt, 1995, Oral Evidence, Darwin).

Many giving evidence believed that the penalties under the proposed legislation were too lenient. One Central Australian resident summed up the collective view in relation to penalties for improper conduct when she said:

"The only part that I did not agree with was the penalty for improper conduct. I feel that this should be much stronger. It amounts to an attempt to murder, and should be penalised accordingly." (Schubert, 1995, Written Submission).

3.6 Aboriginal Concerns

Like many issues in relation to Aboriginal culture, it would be improper to consider that the culture, beliefs and practices in relation to death and dying were uniform across the Territory. This section makes some broad observations that may not be applicable to all Aboriginal groups.

It quickly became apparent to the Committee that there was some confusion and misunderstanding of the Bill among Aborigines. The North Australia Aboriginal Legal Aid Service (NAALAS) stated that euthanasia and suicide were not concepts that were well known and understood within the culture.

The people of Hermannsburg have no words in their language for euthanasia nor suicide for that matter. In the case of tragedies such as Aboriginal deaths in custody, these are not considered suicide but rather a part of the person being overcome by a bad spirit. Equally the people of East Arnhem Land were unfamiliar with the concept of suicide until very recently, according to evidence heard by the Committee.

Evidence was given that for some Aboriginal communities, old people who are ready to die will stop eating and drinking. The Committee were told they know that the time to die has come, and:

"...the earth knows. Mother Earth knows about that he's going to die, he's going back to her and that's one of the significance and we don't like to break that."
(Marika D, 1995, Oral Evidence, Yirrkala Dhanbul Community).

This decision is not taken by the individual in isolation from the rest of the family and clan, according to the Aboriginal Resource and Development Services (ARDS). Dying is seen as something occurring naturally, and intervention by an outside agent would be viewed as murder or sorcery, and thus illegal under Aboriginal law.

As Amery said:

"Any assistance by an Aboriginal person or non-Aboriginal person would be seen as murder. The reason why that would be seen as murder is because the Aboriginal person who would assist or non-Aboriginal person such as a doctor who would assist - who is guiding them? Who gave them the power to do that? How come they are giving the injection? Something else is happening. Another bigger part of the picture... so the doctor just becomes a pawn or a tool." (Amery, 1995, Oral Evidence, Nhulunbuy).

One witness at Yirrkala was unequivocal in his view of euthanasia:

"Ethnically, 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." (Wunungmurra W, 1995, Oral Evidence, Yirrkala).

The view was supported at Milingimbi:

"We do know that there are certain illnesses that are incurable, and we do understand that some of the illnesses have long suffering periods. We, as relatives, do not want or like the idea of euthanasia practised on our terminally ill relatives... We were never meant to be dressed in clothes, and we were never meant to be introduced to [inaudible] laws as
[inaudible], and taking tablets when we are sick, and working for money and living in a house that we have to pay to keep the electricity going. We were never meant to be living like that, but we do this thing because we are living in a western world. We were and are nomads. We were hunters, food gathers, ceremonial and cultural people."
(Gayngulpa, 1995, Oral Evidence, Milingimbi).

In the context of discussing euthanasia, one witness expressed his fear of modern medicine this way:

"If somebody is sick here or ill, it is really hard for a person to go to the hospital. Even whole families will not attend the hospital because they are scared of the doctors or nurses with pills or needles. So leave it out. Leave it to the community as it is now. Do not change everything. Just leave it to Yolgnu people as natural, as it is now."
(Maydjarri, 1995, Oral Evidence, Milingimbi).

Intervention by way of euthanasia, even if the individual consents to the practice, may result in retribution in the form of payback under Aboriginal law. As a witness at Hermannsburg pointed out:

"...I might sort of request that, but even though, you know, there's hundreds of families who ... going to say no, even though just one person say, 'Look, I want to pass on', But I don't think the other family would. See, we've got to look at all of that, there's not just one person concerned. Its the families too..." (Williams, 1995, Oral Evidence, Hermannsburg).

Payback may be against the person's close family relations for 'allowing' the person to die in such a way, according to evidence from Hermannsburg. It may even be against the interpreter or doctor involved, according to another witness from Nguiu on Bathurst Island.

A further concern in the context of payback was the ability of a third party to sign on behalf of the person (Clause 7). For Aboriginal people this would potentially expose the person signing the certificate of request on behalf of the patient to payback from the patient's extended family, unless agreement from all concerned had been obtained in advance. As an aside there was broader community concern about this aspect of the Bill, with stress placed on the need for adequate safeguards in the case of substituted judgements of this kind.

The NAALAS recommend that where approval had been obtained for euthanasia in relation to an Aborigine that a 'cooling off' period of seven days be observed before assisting the patient to die. If requested by the patient's family this should be extended by a further seven days, according to the NAALAS submission.

The NAALAS submission also pointed out that some Aborigines talk about meaning to '...kill a little bit' but not to '...kill the person dead'. If this was misinterpreted under the proposed legislation with the person requesting to be 'killed a little bit', ie. to go to sleep, but in fact being 'killed dead', the consequences could be 'disastrous', according to NAALAS.

There appears to be a view in the communities that the provisions of the Bill allowing 'doctors to kill patients' are already in place - 'bad news travels fast' - and that this will act as a discouragement for people to travel to hospitals for treatment for fear of '...being given a needle'. Such rumours need to be stopped quickly. The Committee believe that Government will need to clearly explain the current situation to Aboriginal communities whether or not the Bill is passed.

A major problem with the legislation in the view of Aboriginal representatives is the difficulty of communicating cross-culturally. The ARDS evidence points out that for a number of people in the bush, English is a fourth or fifth language.

NAALAS believe that the lack of interpreters in many languages means that there is no easy solution to the problem. Furthermore many people are not literate in their own language. A partial solution may be to translate the Bill and consent forms into a number of Aboriginal languages to be recorded on audio tapes. The point was complemented by a submission from Oenpelli suggesting the production of a plain English version. It would be an important part of implementing the legislation to ensure that consent was truly informed.

However the Uniting Church was pessimistic about communicating effectively, claiming:

"The history of health workers ability to educate Aboriginal people in health and hygiene matters is very poor. It is naive to believe that it will be possible to do any better in relation to this Bill." (Hall, 1995, Written Submission).

For a linguist working in the Top End:

"...most non-English speaking Aborigines in the NT are being denied the opportunity to make an informed response to this proposed legislation.' (Etherington, 1995, Written Submission).

The Committee constantly heard calls by Aboriginal representatives from the Centre to the Top End for more time to ponder the Bill in order to make a considered response.

3.7 Palliative Care

There was a high level of consensus about the need for the Northern Territory's palliative care system to be improved.

For some palliative care was seen as the logical alternative to euthanasia, for others there was the fear that with euthanasia legalised the level of palliative care services would decline, and for a small group euthanasia was seen as one facet of palliative care.

The issue of intent is just as relevant in the context of palliative care as it is with the earlier discussion about the individual versus the common good. The question of intent remains contentious.

As one specialist in palliative care put it:

"If a member of a health care team claims the intention of administering 'pharmacological oblivion' was purely to relieve the patient's pain and distress, then it is regarded as good palliative care and there is no legal problem. If another member of the team admits doing so with an intention of hastening the patient's demise..., then this clinician could be charged with murder. Two ludicrously different outcomes for these two members of the same team administering the same treatment to the

same patient, simply because of different expressions of intentions!" (Hunt, 1995, Written Submission).

For this same medical practitioner the principle of double-effect is '...a psychological defence mechanism which enables clinicians to intervene in suffering with life-shortening actions while appearing to defend the sanctity of life principle'.

While the AMA took a different view of double-effect, they too saw ambiguity in the interpretation of intent:

"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! Surely it is no wonder there is confusion in the medical mind. Doctors are not educated in the matter of ethics, medicolegal medicine or the dying patient. The expertise or lack of it that they exhibit in these matters is entirely a result of their own level of interest, studies and life experiences." (AMA, 1995, Written Submission).

The confusion is echoed in surveys about euthanasia, where people including doctors are sometimes confused about the difference between passive and active euthanasia, as discussed at Section 3.3 above.

The House of Lords Select Committee on Medical Ethics accepted the so-called 'double effect', whereby action taken to relieve pain results in shortening life, or results in death. As Lord Walton, the Chairman of the Committee, put it in the debate on the report (see also Section 4.3):

"...in the small and diminishing number of cases in which pain and/or distress cannot be satisfactorily controlled, the professional judgement of the healthcare team can be exercised to enable increasing doses of medication... to be given in order to provide relief, even if this shortens life. The essential question is one of motive. If the motive is to relieve pain and distress with no intention to kill, we regard this as being wholly acceptable, both in terms of medical practice and under the current law." (House of Lords, 1994d, p13474).

For palliative care nurses in the Northern Territory, their experience has been that when '...quality of life has been maintained or improved, patients have not requested euthanasia.' However there was an acknowledgment that in about four per cent of cases patients had a 'difficult death'. (Donald, 1995).

Specialists in palliative care point to a similar number of patients dying in pain. One specialist put the figure at between five and ten per cent. (Syme, 1995) Similar evidence has been given to other inquiries.

It is apparent that about one in twenty people suffer unrelieved pain during the terminal phase of their illness, irrespective of the quality of palliative and hospice care available.

In the opinion of some people, to accept palliative care is '...to take a path to prolonged suffering'.

A Territory doctor who requested that his submission remain confidential made the point that palliative care is not always capable of taking away all the pain and, at the same time, leaving the patient fully conscious - palliation leads to narcosis and under these circumstances '...palliative care is simply a slow form of euthanasia.'

This raises the issue of some people having a preference to die in a conscious state. As Pious XII said:

"It is not right to deprive the dying person of consciousness without reason."
(The Our Lady of the Sacred Heart Parish, 1995, Written Submission).

For those following this view:

"...it is very important to protect the moment of death, both the dignity of the human person and the Christian concept of life, against a technological attitude that threatens to become an abuse. Thus some people speak of a 'right to die', which is an expression that does not mean the right to procure death either by one's own hand or by means of someone else, as one pleases, but rather the right to die peacefully with human and Christian dignity."
(The Our Lady of the Sacred Heart Parish, 1995, Written Submission).

An expert in palliative care put the matter of pain control this way:

"I do not believe that it is any longer appropriate for palliative care workers to suggest that they can control all patient's pain, that they can give meaning to the end of life when the patient feels that their quality of life is so poor they do not wish to live any longer...Having said that, that is a relatively infrequent occurrence. It would happen in my practice, in my experience a handful of times a year, may be 10 or 20 not more and most of those requests are modified a few days later by a change in the circumstances, either that of symptom control or a better emotional and psychological adjustment in the situation, or maybe some readjustment of family dynamics or support that was not apparent before."
(Ashby, 1995, Oral Evidence, Darwin).

The lack of hospice care was considered a major flaw in the palliative care system of the Territory. As one doctor put it:

"How can the government possibly consider introducing the practice of euthanasia to the Northern Territory without first providing adequate palliative care facilities to the people it represents?" (Ingamells, 1995, Written Submission).

Many made similar remarks in submissions and oral evidence to the Committee. However some evidence from the United Kingdom suggests a different interpretation:

"The argument that good care, and, in particular, hospice care is effective in reducing the desire for euthanasia has been proposed as an argument against the legalisation of voluntary euthanasia. The findings suggest the picture is far more complex. People who received hospice care were, if anything, *more* likely to have respondents who felt that it would have been better if they had died earlier." (Seale and Addington-Hall, 1995, p581).

Seale and Addington-Hall found that 'good' care served to remind the patient of '...their declining ability to do things for themselves'.

The release from pain is not the only reason why patients want euthanasia. Dr Roger Hunt in discussing palliative care, quotes loss of dignity, being dependent on others, and tiredness of life as also being significant contributors. He goes on to say:

"In only 5 per cent of cases was pain the only reason." (Hunt, 1994, p134).

The Anti Cancer Foundation spoke for many in the community about the state of palliative care in the Territory:

- "Currently the Top End has no dedicated oncology unit or specialists. Clients and families face increased social and emotional upheaval when forced to seek treatment interstate. Departmental costs incurred in travel and accommodation are increasing.

- Provision of chemotherapy and radiotherapy will need to be incorporated in future development of hospital facilities. Centralisation of oncology services allows for staff specialisation, heightened staff morale and efficiency as well as more effective service delivery.

- Meeting the needs of palliative care clients is currently *ad hoc* and in an acute care setting. There is no dedicated palliative care unit or hospice. With future increasing needs, this lack of coordinated services and dedicated bed space will need to be addressed."
  (Anti Cancer Foundation, 1995, Written Submission).

Palliative care health workers supported the Anti Cancer Council's comments. Radiotherapy was prominent on the list given the high incidence of cancer in the community, and the current arrangements whereby people must travel interstate for treatment. It is considered a vital part of providing for pain relief.

In terms of dedicated palliative care beds, Professor Ashby quoted the ideal figure as being 50 beds per million people, which puts the Territory's bed requirement in this area at nine dedicated beds. Currently there is only one bed, in Alice Springs Hospital. For this witness the beds need not be located in hospices given the demand in the Territory, but:

"...there will be something to be said for the beds actually being located in small strategic numbers in the major hospitals of the Territory." (Ashby, 1995, Oral Evidence, Darwin).

Bed distribution needs to be addressed with around six in the Top End and three in the Centre. But the issue is not beds alone but staffing requirements:

"The issue is not so much bed numbers as the skill that exists when the person gets there. I have seen it as a problem in a number of isolated regional centres in rural Australia where a palliative care room is put in and a lot is invested in the fabric. They make lovely rooms and no doubt it is great but then you ask 'Well what kind of expertise is there?' "
(Ashby, 1995, Oral Evidence, Darwin).

Ashby points out that there are sessional appointments at Melbourne hospitals where the field of candidates is not large. In these circumstances the outlook for regional and rural Australia is grim. The full text of Professor Ashby's remarks in relation to palliative care is at Volume Two.

A number of general practitioners raised the problem of being able to get adequate supplies of appropriate drugs for palliative care, due to government imposed restrictions on volume supply at any one time. This was supported by a Melbourne specialist who said:

"...morphine is a strong pain killer for strong pain... but there are a lot of doctors, a lot of patients, and the community who do not accept that, and morphine means you are going to die so it is left till later. Morphine is addictive so it is left till later. It is hard to get. Governments, I do not know about the Northern Territory, but certainly the Victorian Government and the Federal Government make it hard to get enough quantities."
(Zalcberg, 1995, Oral Evidence, Darwin).

A more reformist view was expressed by one specialist, predicting that euthanasia would become part of the repository of options available to the medical practitioner in caring for the terminally ill, with the overriding goal of ensuring that the patient dies free of pain and suffering. In these circumstances euthanasia would be a last resort to other forms of palliative care such as the administration of pain killing drugs:

"I think patients should have access to the best of care, the best of terminal care, the best of palliative care, but I think if anybody's going to be in a position to judge whether a patient is reasonable in asking for euthanasia, I think it would be someone from palliative care because if there are other techniques for controlling the pain or if the patient's depressed, unusually depressed for a dying patient, the person who's experienced with terminal care should be able to judge that sort of thing... I think euthanasia will become in the palliative care repertoire of treatments eventually. That's my prediction; that it will be the last resort measure to relieve suffering at the patient's request." (Hunt, 1995, Oral Evidence, Darwin).

Dr Zalcberg made a distinction between palliative care and euthanasia when he said:

"Good quality palliative care is very expensive and I would hate to see that not happen at the expense of a Bill for euthanasia and I understand and care a lot about the few people that might be better off with it. But there are a lot of people who might get hurt along the way."
(Zalcberg, 1995, Oral Evidence, Darwin).

3.8 *Natural Death Act 1988*

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 1988*. Many people are unaware that they are entitled to make advanced directives under this Act, specifying that extraordinary measures should not be taken to maintain life in circumstances where the patient is suffering a terminal illness.

The *Natural Death Act 1988* allows passive euthanasia, whereby medical services may be withdrawn or withheld where the patient's condition is terminal.

3.9 Attempted Suicide

The Committee heard expert evidence from a representative of the legal profession on an anomaly being created in the law should the legislation be passed, and where attempted suicide remained a crime under the Criminal Code.

If the *Rights of the Terminally Ill Bill 1995* is passed, according to this expert view:

"...you would be creating a situation where the terminally ill patient is able to request that their life be terminated for distress, but an emotionally distressed person who seeks to terminate their life and is unsuccessful in doing so, then becomes, in theory, subject to criminal prosecution." (Trollope, 1995, Oral Evidence, Darwin).

The anomaly might be addressed by removing the provision for attempted suicide from the Criminal Code. The Northern Territory is the only place in Australia where it remains a crime.

A related issue raised by the same witness was the difficulty in drafting a provision to define 'distress'. Patients who are very ill are distressed not only because of their own predicament, but because of the effect that it is having on their family. For the medical practitioner, he or she must decide if the patient is distressed for themselves or for some broader reason.

However the Committee is of the view that the wording at Clause 6(f) to include '...pain or suffering or distress', is sufficient to eliminate any ambiguity.

3.10 Statistical Analysis of the Submissions

In the gathering of evidence for this report, 104 people appeared before the Committee, with 15 groups represented in this total. This number included both expert witnesses as well as people who wanted to put their personal views on record. Most of the witnesses had made written submissions to the Committee prior to their appearance.

A total of 1 126 written submissions were received, the great majority of which were from individuals.

An analysis of the information in Table 3.1 over and at Appendix D reveals the following with regard to the written submissions:

- Of the total 1 126 submissions, 255 submissions (23%) were received from residents of the Northern Territory;

- The Territory submissions were almost equally divided on the issue, with 122 in favour and 123 against. In ten submissions the position was not stated;

- The submissions are almost entirely from Australia, with only four from abroad, two from the United Kingdom and two from the USA;

- Overall 72% (814 submissions) were in favour of euthanasia or the right of choice of the individual, with 27% (300 submissions) opposed to the issue or the Bill itself;

- Outside of the Territory, most submissions were received from NSW (537), Victoria (120), and Western Australia (122);

- With regard to the submissions from NSW, 96% favoured euthanasia;

- In the case of Victoria, 92% opposed the Bill; and

- With those from Western Australia, 94% supported the Bill.

Table 3.1: Summary of Submissions Received by Geographical Distribution and Attitude

Place	*For*	*Against*	*Not Stated or In Camera*	*Total*
NORTHERN TERRITORY				
Darwin City				
Alawa	3	-	-	3
Anula	-	1	-	1
Brinkin	2	-	-	2
Casuarina	7	3	2	12
Coconut Grove	2	-	-	2
Darwin	30	17	5	52
Fannie Bay	3	1	-	4
Karama	2	-	-	2
Leanyer	-	3	-	3
Ludmilla	-	4	-	4
Millner	1	1	-	2
Nightcliff	5	5	-	10
Parap	3	-	-	3
Rapid Creek	2	3	-	5
Sanderson	1	2	-	3
Stuart Park	2	2	-	4
The Narrows	2	-	-	2
Tiwi	-	1	-	1
Wagaman	-	2	-	2
Wanguri	3	-	-	3
Winnellie	5	2	2	9
Woodleigh Gardens	1	-	-	1
Wulagi	1	-	-	1
Sub Total	***75***	***47***	***9***	***131***

Outside Darwin				
Alice Springs	20	43	1	64
Batchelor	1	-	-	1
Bathurst Island	-	1	-	1
Bees Creek	1	-	-	1
Daly River	-	2	-	2
Daly Waters	1	-	-	1
Goulburn Island	-	1	-	1
Groote Eylandt	-	1	-	1
Hermannsburg	-	1	-	1
Howard Springs	5	2	-	7
Humpty Doo	4	3	-	7
Katherine	2	6	-	8
Milingimbi	-	1	-	1
Noonamah	1	-	-	1
Oenpelli	-	2	-	2
Palmerston	7	4	-	11
Papunya	-	1	-	1
Port Keats	-	4	-	4
Santa Teresa	-	1	-	1
Tennant Creek	4	2	-	6
Yirrkala	-	1	-	1
Yulara	1	-	-	1
Sub-Total	***47***	***76***	***1***	***124***
NORTHERN TERRITORY TOTAL	**122**	**123**	**10**	**255**
OUTSIDE NORTHERN TERRITORY				
Australian Capital Territory	24	2	-	26
New South Wales	513	24	-	537
Queensland	21	21	-	42
South Australia	3	10	-	13
Victoria	10	110	-	120
Western Australia	115	5	2	122
United Kingdom	-	2	-	2
United States of America	-	2	-	2
Sub-Total	***692***	***177***	***-***	***871***
Not Stated	6	1	-	7
GRAND TOTAL	**814**	**300**	**12**	**1126**

4. Practice and Inquiries in Other Jurisdictions

4.1 The Netherlands

4.1.1 Background

The first case involving a doctor in the practice of euthanasia came to trial in the Netherlands in 1973. The doctor was given a one week suspended sentence, and since that time the practice has become increasingly more open.

While the Courts have been actively involved in euthanasia since the early 1970's, it was not until 1984 that a case was heard by the Dutch Supreme Court. In that year the Supreme Court accepted the principle of *force majeure* as a defence to the offence of euthanasia, finding that a physician's duty to abide by the law may be outweighed by the duty to help a patient who is suffering unbearably. Since then the courts have laid down a number of criteria by which it may be determined whether or not the emergency defence applies in a given case of euthanasia. The criteria include voluntary and persistent request, and intolerable suffering.

There have been three attempts to legislate on the subject of euthanasia since the Supreme Court decision of 1984. Bills were introduced in 1986, in 1987 and in 1993, each time failing. Euthanasia and doctor-assisted suicide remain technically illegal by statute, being criminal offences under the Dutch Penal Code.

Indeed, as mentioned at Section 3.4 above, there was one prosecution of a medical practitioner in the last decade up until the beginning of 1995, but in more recent times a second prosecution has occurred involving the death of an infant.

The abnormal position which the Supreme Court decision created has been partially redressed by another Bill passed by both Chambers of the Dutch Parliament by the end of 1993. The legislation did not change the Penal Code but amended the *Burial and Cremation Act* on disposal of the dead, setting down guidelines in law. (Netherlands Ministry of Justice, 1994).

Since 1 June 1994 it is a requirement under the law to notify the Dutch Authorities of all cases of euthanasia.

4.1.2 The Current Practice of Euthanasia

The regulations under the *Burial and Cremation Act* specify the reporting procedure which the doctor must follow when euthanasia is performed.

The legally based procedures require the physician to prepare a report to the local Coroner, who in turn reports his or her findings to the Public Prosecutor. The latter conducts an appraisal.

The physician is required to report on the following:

(i) The case history.

(ii) The request to terminate life, distinguished by termination where a patient is suffering from a physical disorder and by patients suffering from a psychiatric disorder.

(iii) Active termination of life without express consent.

(iv) Consultation with other physicians.

(v) Termination of life. (Netherlands Ministry of Justice, 1994).

Central to the regulations is the need for an 'explicit and repeated' request on the part of the patient for his or her life to be terminated. The doctor must be convinced that the request has been freely given. The patient's suffering, including but not limited to physical pain, must be such that it cannot be relieved by other means, and the condition must be terminal. Another physician with an independent viewpoint must be consulted. The case may not be reported as a natural death.

The Dutch view is that there are situations in which neither the doctor nor patient can see a way out other than by purposely accelerating the onset of death. As already stated, the courts have supported the view, based on a general rule of law throughout Europe whereby a person found to act under duress - or *force majeure* - need not be subject to punishment.

The ultimate justification for intervention is the patient's unbearable suffering. The regulations provide support to the physician where there is a hopeless emergency situation prevailing in a dying process, and in which the physician cannot refuse to render assistance to the dying patient.

The law in relation to the criminal code is upheld, with the Public Prosecutor deciding whether or not to institute criminal proceedings on the basis of the report submitted by the physician to the Coroner. Euthanasia remains an offence but the law allows for non-prosecution where the correct procedure is followed.

4.1.3 Incidence of Euthanasia and Related Practices

The Remmelink Report is often quoted in the literature regarding the incidence and practice of euthanasia in the Netherlands. The Commission of Inquiry into *Medical Practice with Regard to Euthanasia* was established in January 1990, and reported in September 1991. It was chaired by Professor Remmelink. (Netherlands Ministry of Justice, 1991a).

The Commission found that at the time of its inquiry there were approximately 130 000 deaths per year in the Netherlands.

Of this total 2 300 (1.8%) deaths were from euthanasia. A further 400 (0.3%) deaths were from physician-assisted suicide. More controversially 1000 (0.8%) deaths were from 'active shortening of life without special request', or non-voluntary euthanasia.

4.1.4 Period Between Request and Implementation

Research indicates that the time lapse between the *first discussion* and implementation of euthanasia or assisted suicide was highly variable. According to Van der Wal et al. (1992b) for 3% of cases the period was less than one day, and for about one in ten cases the elapsed period was more than one year.

On the other hand in more than one third of cases (35%) the time lapse between the *first request* until implementation was less than a week, and in more than three quarters of cases (77%) the time lapse was less than one month.

Finally, in more than nine out of ten cases (93%) the time lapse between the *last explicit request* and implementation was less than one week, with the majority (59%) occurring on the same day as the last request was made.

In the context of the Dutch experience it is notable that the House of Lords Select Committee did not consider the question of elapsed time between request and implementation. However, the Voluntary Euthanasia Society (United Kingdom) recommended in its submission to the Select Committee that euthanasia should be performed only if the patient had, at least 30 days earlier, signed a declaration requesting it, and currently repeated that request.(House of Lords, 1994b). Comparatively, in Oregon no less than 15 days must elapse between the initial request and writing of a prescription (State of Oregon, 1994). It should be noted that the Oregon law is under challenge currently (see Section 4.2.1).

4.1.5 Reasons for Requesting Euthanasia or Assisted Suicide

It would appear that for the Dutch, pain and suffering is not the only reason for requesting euthanasia or assisted suicide. Van der Wal et al. (1992b) found that in almost three out of five cases (59%) pain and suffering was mentioned as *the most important* reason for the request.

However, in almost one in four cases (24%) the *most important* reason was fear of or avoidance of humiliation. Furthermore this was mentioned as an *influential factor* in almost one in two cases (46%).

In only 2% of cases was 'no longer wanting to be a burden' given as the *most important* reason for the patient making the request, while in 22% of cases this was mentioned as an *influential factor* in the patient's action.

4.1.6 The Outcome of the Institutional Arrangements

The latest measures making reporting of euthanasia mandatory have brought the practice into the open, allowing the incidence of euthanasia to be monitored, and prompting discussion in the medical profession and more thorough consultation over proposed courses of action. This is particularly important for doctors in isolated practices, where some have admitted to errors of judgement in connection with euthanasia.

Dutch authorities are of the view that completely watertight safeguards against abuse cannot be devised, but nevertheless patient protection is strengthened by increased openness and debate.

However there is another point of view:

"It is difficult to determine how many cases of euthanasia satisfy the legal criteria, not least because it appears that the overwhelming majority of cases are falsely certified as death by natural causes and are never reported and investigated." (Keown, 1992, p67).

The Dutch Physician's League has pointed to some prospective patients, fearing they may be subjected to euthanasia against their wishes, or not receive adequate medical treatment, now insisting on written contracts before consenting to hospitalisation. The Royal Dutch Medical Association discounts this view, saying that relations between doctors and patients are very good, and that far from being afraid, most patients were reassured by the knowledge that euthanasia was available as a last resort. There was some acceptance of the view that the availability of euthanasia might act as a partial disincentive to the further development of palliative care in the Netherlands.

On another point, a recent article in *The Washington Post* quoted a Dutch physician as saying the Netherlands liberalisation has lowered regard for the patient's life, with the practice leading to 'permissive' practices in regard to euthanasia:

"The doctors, the nurses, the patients do [become permissive]. If death is an option, you don't need to make great efforts to help the patient day and night, to try and find a solution." (Washington Post, 31 January 1995).

For supporters the fact that only two doctors have been convicted, one of whom was gaoled, for illegal actions against terminally ill people demonstrates that there is no 'slippery slope':

"For there to be a slippery slope you need to see a lot of cases... The practice of ending life happens everywhere, even if it is only with morphine. So I would call the issue more slippery elsewhere than in a country where you can see what's happening."
(Washington Post, 31 January 1995).

4.2. United States of America

4.2.1 Oregon

In November 1994 the State of Oregon passed legislation making the practice of physician-assisted suicide for 'qualified' patients no longer an offence under the criminal code. Measure 16 was passed on 8 November 1994 by a margin of 51% in favour to 49% against.

The question put under Measure 16 was:

"Shall the law allow terminally ill patient's voluntary informed choice to obtain a physician's prescription for drugs to end life?"

The Oregon Law allows a terminally ill adult the choice on a voluntary and informed basis to obtain a physician's prescription for drugs to end life. (State of Oregon, 1994).

The person must be a resident of Oregon.

The Act removes criminal penalties for physician-assisted suicide.

The regulations require that:

(i) The patient must be diagnosed as having six months or less to live.

(ii) There must be two oral and one written request.

(iii) There must be a 15 day waiting period between the first and second request.

(iv) A second physician's opinion must be obtained.

(v) Counselling is required where, in the judgement of either physician, the patient has a mental disorder, or is suffering from impaired judgement as a result of depression.

The individual has the choice of whether or not to notify next of kin.

Health care providers are immune from civil or criminal liability where the regulations are complied with in good faith.

In terms of the currency of the request, no less than 15 days must elapse between the patient's *initial* request and the writing of a prescription under the Oregon Act. And no less than forty-eight (48) hours must elapse between the patient's *written* request and the writing of a prescription under the Act.

The written request requires two witnesses, with one witness neither related to the patient, nor entitled to any portion of the patient's estate, nor associated in any way with the health care facility where the qualified patient is receiving treatment. The patient's physician cannot be a witness.

All of the above procedures are required to be documented in the patient's medical record, including oral requests and the physician's offer to the patient to rescind the request.

The Northern Territory Bill is similar to the Oregon legislation in relation to the provisions dealing with wills, insurance policies, and immunities.

Legally backed euthanasia has yet to be practiced in Oregon. Opponents of the *Death with Dignity Act* have been successful in putting the law on hold, first with a temporary restraining order on 7 December 1994, the night before it was due to go into effect, and then with a preliminary injunction issued on 27 December 1994. (District Court of Oregon, 1994).

The District Court judge granted the preliminary injunction on constitutional grounds, finding that death in these circumstances 'constitutes an irreparable injury' and therefore 'irreparable harm to First Amendment rights could occur in the absence of a preliminary injunction'. First Amendment rights refers to those as set down in the Constitution of the State of Oregon.

The full trial on the constitutionality of the law commenced in the Oregon District Court on 18 April 1995. No matter what the ruling both sides have indicated they are likely to appeal, implying that the matter could take some time to conclude. Ultimately the matter may have to be resolved by the United States Supreme Court.

4.2.2 Other States in the USA

In recent times at least eight other States have considered propositions and legislation to decriminalise actions in relation to physician-assisted suicide where the patient is terminally ill.

Both Washington State and California put the question of physician-assisted suicide to voters in the early 1990's.

In the case of Washington State, Proposition 119 was put in November 1991. The question "Shall adult patients who are in a medically terminal condition be permitted to request and receive from a physician aid-in-dying?" was defeated 55% to 45%. (Rhein, 1992).

The initiative would have allowed the patient to make directives for aid-in-dying in a dignified and painless manner. It called for 'licensed personnel" to act in accord with the patient's wishes, but did not specify how it was to be done.

Despite the rejection of the proposal in 1991, the State is once again examining the issue with the introduction of a Bill entitled the *Terminally Ill Patient Act* in 1995. The Bill is being introduced by one member and is backed by the American Civil Liberties Union.

In November 1992 exactly one year after the Washington ballot, Proposition 161 was put to the vote in California.

The proposition would have required patients to express their wish for aid in dying more than once within a six month period. The request was to be in writing, and witnessed by two people who were neither relatives nor beneficiaries of the patient.

The measures would have required the doctors and hospitals to report to California's Department of Health services, citing age, diagnosis, and date of birth of the patient, but not the cause of death. The initiative expressly provided that aid-in-dying for terminal patients was not to be deemed suicide.

Proposition 161 was defeated 53% to 47%. (Rhein, 1992).

In 1995 a State Assemblywoman is carrying a physician aid-in-dying law in the California State Assembly on behalf of senior citizens.

The New York State Task Force on Life and the Law reported on euthanasia and assisted suicide in 1994. The Task Force found against a change in public policy, putting the view that:

"...the Task Force unanimously concluded 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 and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care." (The New York State Task Force on Life and the Law, 1994, p ix).

Recent consideration of the issue in the State of Michigan was instigated by the activities of Dr Kevorkian, the so-called 'Dr Death' of American medicine. Up until 1993 Michigan had no legislation criminalising assisted suicide, but in that year a statute was introduced banning the practice. In December 1994 the Michigan High Court ruled that the (State) Constitution does not guarantee a right to help in dying.

Elsewhere in the States of New Hampshire, Massachusetts, Wisconsin, and New Mexico, Bills have recently been introduced dealing *inter alia* with physician-assisted suicide.

4.3. United Kingdom

4.3.1 Background

The United Kingdom's position on euthanasia has been extensively documented in a recent report on the matter by the House of Lords (1994).

The Select Committee was appointed in February 1993, and was asked to consider two key matters:

- the ethical, legal and clinical implications of a person's right to withhold consent to life-prolonging treatment, and the position of persons who are no longer able to give or withhold consent (passive euthanasia); and

- whether and in what circumstances actions that have as their intention or a likely consequence the shortening of another person's life may be justified on the grounds that they accord with that person's wishes or with that person's best interests (voluntary, non-voluntary and involuntary euthanasia).

The Select Committee of 14 Lords was chaired by Lord Walton of Detchant, and its report was published in May 1994.

4.3.2 Report Findings in Relation to Euthanasia

After deliberating on the matter for a year, the Select Committee was able to reach a consensus recommending against the introduction of euthanasia. Its view was that society should continue to prohibit euthanasia, but that many factors were involved in this decision:

"The right to refuse medical treatment is far removed from the right to request assistance in dying... Our thinking must also be coloured by the wish of every individual for a peaceful and easy death, without prolonged suffering, and by a reluctance to contemplate the possibility of severe dementia or dependence... We gave much thought too to [the] opinion that, for those without religious belief, the individual is best able to decide what manner of death is fitting to the life which has been lived." (House of Lords, 1994a, p48).

Notwithstanding these 'very strongly held and sincerely expressed views' the Committee concluded:

"...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 which 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."
(House of Lords, 1994a, p48).

The House of Lords Select Committee was of the view that it was not possible to set 'secure limits' on voluntary euthanasia. While rejecting euthanasia the committee accepted the so-called 'double effect' whereby action taken to relieve pain results in shortening life expectancy, or results in death.

4.3.3 Evidence Before the House of Lords Committee: For and Against Euthanasia

In arriving at this view the Committee considered evidence from a broad cross-section of the community. Part of the consensus arrived at by the Committee was that alongside the principle that human life is of special value, there is also the principle widely held that an individual should have some measure of autonomy to make choices about his or her life. The question of individual autonomy is important as the relationship between doctor and patient has changed to one of partnership.

The Voluntary Euthanasia Society (United Kingdom) set out the philosophical background to the debate in its submission:

"In a world where birth control is an accepted and indeed indispensable part of life, where individuals aspire to make their own choices about education, career, marriage and lifestyle, and the common parlance is not of fate and God's Will but of opportunities and personal responsibility, a quiescent attitude to life's ending seems less logical than it did to previous generations. In addition, access to efficient medical treatment is now regarded as a norm: this has the dual effect of enhancing people's expectations of control over their own destinies while making it paradoxically more likely that the process of dying may be prolonged beyond their real wishes and needs... Having created the situation in which lives are routinely saved, transformed or prolonged by medical intervention, we can hardly pretend that the process of dying, and that alone, must be 'left to nature'." (House of Lords, 1994b, p85).

Much of the evidence heard by the Committee revolved around the practice of double-effect, as compared to voluntary euthanasia.

The United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) took the view that:

"The Council recognises ... the inconsistency in the existing law. Anyone who wilfully assists another person to die will be liable to be regarded by the courts as having acted unlawfully. Despite this, nurses see the same end result achieved throughout the country day after day by deliberate decisions not to prescribe treatment for infections and by the prescription of very large doses of potent analgesic drugs... Practitioners cannot but be forgiven if they find the present state of the law in this field both confused and confusing."
(House of Lords, 1994b, p139).

For this group the prohibition of euthanasia was 'no longer a sustainable position.'

A well-respected author on the issue, Professor Ronald Dworkin, emphasised the role of individual autonomy in the matter:

"I am in favour of choice because people disagree about what kind of a death is meaningful for them. I, myself, believe that what sort of a death is right for a particular person and gives the best meaning to that person's life, largely depends on how that life has been lived, and that the person who has lived it is in the best position to make that decision."
(House of Lords, 1994a, p23).

He advocated euthanasia as an option for those people who felt that to be kept alive in a situation which they found unacceptable would be harmful to their lives as a whole, cheapening what they had valued.

The counter view was put by a number of groups, including the British Medical Association (BMA), Healthcare Opposed to Euthanasia (HOPE), and a number of Bishops who summarised the position this way:

"A positive choice has to be made by society in favour of protecting the interests of its vulnerable members even if this means limiting the freedom of others to determine their end"
(House of Lords, 1994a, p24).

Arguments before the Committee for the *sanctity of life* principle were also led by the combined view of the Anglican and Catholic Bishops when they wrote:

"Life is to be viewed as His [God's] gift, given and taken again according to his sovereign will. It is thus not at the disposal of any human being."(House of Lords, l994a, p 24).

On the other hand the British Humanist Association suggested that the *sanctity of life* was not a principle on which legal structures should be based, depending as it does on a religious outlook that not everyone shared:

"...it is particularly hurtful to require someone who does not believe in God or afterlife to suffer intolerable pain or indignity in deference to a God or afterlife he does not accept."(House of Lords, 1994a, p24).

The doctor-patient relationship also produced a division of views, with the BMA arguing that:

"...if doctors are authorised to kill or help kill, however carefully circumscribed the situation, they acquire an additional role, alien to the traditional one of healer."
(House of Lords, 1994a, p25).

The Voluntary Euthanasia Society (VES) considered the existence of a trusting and open relationship between doctor and patient as being particularly important when the patient is terminally ill, and decisions must be made about towards the end of life. The VES suggested that:

"...any change making it easier for doctors openly to carry out their patients' wishes can only reinforce confidence on both sides."(House of Lords, 1994a, p25).

On the other hand some saw euthanasia as undermining the patient's confidence in the doctor:

"HOPE expressed doubts that society could ever be sure that a patient requesting euthanasia had made a choice that was 'free, fully-informed and rational'. They suggested that a patient's choice could be improperly influenced by depression, confusion, dementia, a feeling of being burdensome to others, or even by direct pressure from others."(House of Lords, 1994a, p28).

4.3.4 Pain Control and Palliative Care

The United Kingdom has a high standard of palliative care based on a well-developed hospice movement. The movement has both in patients as well as home support teams and day care facilities. As with palliative care in Australia, the approach to patients is an holistic one, meeting their physical needs as well as emotional, spiritual and social needs, although the United Kingdom system is more advanced than that in Australia.

Some put the view that euthanasia was anachronistic, saying that the growth of the hospice movement and advances in pain control made euthanasia unnecessary (LIFE).

On the other hand the British Humanist Society was of the opinion that despite admirable work by the hospice movement, there was still a need for euthanasia since hospices could not relieve all the suffering. A similar view was put by another expert witness who said that patients could reach 'a stage where they simply do not want to go on'often as much due to secondary conditions such as incontinence as because of pain.

The BMA acknowledge that pain and distress 'may be resistant to complete control', while the Royal College of Nursing (RCN) said that there was a 'large cohort of patients' dying in distress, but believed this was largely due to failure to implement appropriate palliative care.

For a Consultant Psychiatrist in Cancer Research at the Royal Marsden Hospital the issue was very much one of pain relief:

"I have seen many terminally ill patients and discussed their physical symptoms and psychological responses to their plight in detail.

"Based on my extensive clinical experience with terminally ill patients suffering from advanced cancer, it is my opinion that:

(1) Certain symptoms including breathlessness, nerve pain (eg tumour pressing on nerves, brachial plexus injury) cannot be adequately relieved by treatment even when given by specialists such as palliative care physicians and anaesthetists.

(2) There can be no doubt that great distress and suffering is unavoidable in these unfortunate circumstances.

(3) On many occasions, patients experiencing such severe, untreatable physical and emotional distress have told me they wish to die.

(4) Therefore, the humane course of action would be to allow such patients to die without needlessly protracting their agony.

(5) These clinical observations form the basis for my support for legalisation of euthanasia."
(House of Lords, 1994b, p221).

But a colleague disagreed. Speaking as Head of the Palliative Care Unit at the same Hospital, the specialist said that the number of patients in whom the symptoms cannot be controlled was 'very, very small'. The specialist found that there were 6 per cent of patients whose symptoms could not be completely alleviated "such that consideration of euthanasia is not necessary".

Dr J. S. Morley, Consultant in Neuropharmacology at the Pain Research Institute of the Pain Relief Foundation, Liverpool, saw the matter this way:

"In my opinion, the Select Committee should be wary of any claims that medical knowledge has advanced to such a state that there are now satisfactory means of ensuring that *all* those who are dying are kept free from pain or distress.

"Morphine, or its derivative heroin, remain the most potent of our pain killers in such tragic situations. About 4 000 patients are treated each year at our Pain Relief Centre, and more than 2 000 receive morphine or heroin. Within the large group that are referrals because of cancer pain, pain is usually relieved by giving morphine/diamorphine in adequate doses by mouth, or by new methods of administration - many of which were pioneered at our hospital - devised over the past decade. However, despite this progress, about 15 per cent of these patients are still not satisfactorily relieved of pain.

"So a dilemma of huge proportions faces a doctor when increasing doses of morphine/heroin fail to relieve, or worsen, the pains and distress of his dying patient, and there is no rationale for the use of other drugs." (House of Lords, 1994c, p287).

Dr Morley continued in a supplementary submission in response to the question of what proportion of terminally ill patients suffer unrelieved pain:

"There have been few objective studies. St Christophers Hospice claims adequate control in 95 per cent of cases. But what is adequate? St Christophers' figures show that 23 per cent of their patients had pain during the last 24 hours of life. During the period of terminal care (the time between the end of active treatment and death), the percentage of patients suffering 'severe and mostly unrelieved pain' was estimated to be 8 per cent at St Christopher's, 20 per cent at nearby hospitals and 28 per cent when the terminal care was at home.

“New treatments are continually emerging (eg where pain becomes uncontrolled by morphine. We are finding that a switch to the use of methadone is often effective). When these fail, there is no rationale for the use of non-analgesic drugs, and the strict interpretation of present law is that we must leave our patient ‘to get on with it’."(House of Lords, 1994c, p288).

This supports the view that even with the high standard of care in the United Kingdom, there remain about one in 20 people who die with their pain unrelieved.

4.3.5 The ‘Slippery Slope’ from the House of Lords Perspective

The position of voluntary euthanasia leading to involuntary and non-voluntary euthanasia may be encouraged in circumstances where health systems are subject to limited financial resources.

As one group concerned for the rights of the disabled said:

"It is not acceptable for treatment to be withdrawn on the ground of lack of resources. We accept that there may be some types of treatment which the NHS cannot afford. However, where treatment is available, it should be available to all regardless of disability.”
(House of Lords, 1994a, p23).

The (British) Department of Health put it this way:

"...resource allocation has no part to play in decisions concerning the withdrawal of an individual's life-prolonging treatment. The doctor is obliged to do the best he can for the patient under his care." (House of Lords, 1994b, p2).

and the BMA:

“..expressed concern that resource considerations would in future dominate decision-making, and stressed that medical judgments ‘should be made when clinically appropriate, not when funds run out’.” (House of Lords, 1994b, p54).

The report of the House of Lords Select Committee said that:

“Obviously, resources for health-care are not infinite... As medical technology becomes more sophisticated and therefore more expensive, difficult and at times controversial decisions must be made about priorities. An element of inequity is inevitable. The development of new treatments for example is particularly costly, and the very latest options will be available to few patients, though it may be hoped that they will lead the way for others.

"...decisions about the treatments which society can afford should be made elsewhere than in the hospital ward or the doctor's consulting room, and they should be made on the basis that such treatments as society does wish to fund must be available equally to all who can benefit from them. In particular we would emphasise that treatment-limiting decisions of the kind which we have discussed should depend on the condition of the individual patient and on the appropriateness to that patient of whatever treatment or methods of management are generally available, and should not be determined by considerations of resource availability." (House of Lords, 1994a, p57).

The report concludes that:

"...the rejection of euthanasia as an option for the individual, in the interest of our wider social good, entails a compelling social responsibility to care adequately for those who are elderly, dying or disabled... high-quality palliative care should be made more widely available by improving public support for the existing hospice movement, ensuring that all general practitioners and hospital doctors have access to specialist advice, and providing more support for relevant training at all levels." (House of Lords, 1994a, p57).

4.4. South Australia

The Parliamentary Select Committee on the Law and Practice Relating to Death and Dying was established in December 1990.

The Committee's terms of reference were to examine:

(a) the extent to which both the health services and the present law provide adequate options for dying with dignity;

(b) whether there is sufficient public and professional awareness of pain relief and palliative care available to patients facing prolonged pain in a terminal illness; whether there is adequate provision of such services; whether there is sufficient public and professional awareness of the *Natural Death Act* and if not, what measures should be taken to overcome any deficiency; and

(c) to what extent, if any, community attitudes towards death and dying may be changing and to what extent, if any, the law relating to dying needs to be clarified or amended.

The Select Committee issued three reports between October 1991 and November 1992. Key issues in the reports were the provision of medical powers of attorney and palliative care in South Australia. Little mention was made of euthanasia (South Australian Parliament, 1992b).

Another event of note occurred in 1991 when a survey of medical practitioners was carried out in South Australia, dealing with the management of death, dying, and euthanasia.

(Stevens and Hassan, 1994).

The survey produced some interesting results from about 300 returns, including:

- Forty seven percent of medical practitioners had received a request from a patient to hasten death by withdrawal of treatment, and the same proportion had received a request from the patient's family;

- Thirty three per cent had received a request from a patient to hasten death by taking active steps, and 22 per cent had received a request from a patient's family;

- Persistent and irrelievable pain, terminal illness and incurable condition were the most frequently cited reasons for the requests;

- Nine in ten practitioners thought the request to hasten death was rational;

- For active euthanasia, 18 per cent thought it was 'right', and a further 26 per cent said it was 'right' but only if requested by the patient; and

- Forty five per cent were in favour of legalisation of active euthanasia under certain circumstances.

On the 9 March 1995 a member of the South Australian Opposition, the Honourable J. A. Quirke MP, introduced a private members bill into the Parliament, to provide for the administration of medical procedures to assist the death of patients who are terminally ill.

The provisions of the Bill (South Australian Parliament, 1995) include:

- the patient must be diagnosed as suffering from a terminal illness likely to cause death within 12 months;
- the person may make a request in writing, or if unable, the request may be made orally;
- the request must be witnessed by a medical practitioner and one other adult;
- the request may be revoked at any time;
- euthanasia may be administered by either the patient or doctor using drugs, or by the withdrawal of treatment;
- a report must be made to the coroner within seven days, with the Coroner then informing the Minister; and
- death is taken to have been caused by the patient's illness.

4.5. Victoria

In December 1985 the Social Development Committee of the Parliament of Victoria was given terms of reference to conduct the *Inquiry into Options for Dying with Dignity*. The terms of reference included, *inter alia*:

- whether it is desirable and practicable for the Government to take legislative or other action stablishing a right to die;
- whether and under what circumstances, if any, a person should have a right to die; and
- the right of an individual to direct that in certain circumstances he or she be allowed to die, or assisted in dying and the form which such a direction should take.

The Committee reported in April 1987. It recommended against legislation establishing a right to die, finding that:

"...an individual's moral entitlement to die with human dignity was not synonymous with, or a euphemism for, euthanasia." (Parliament of Victoria, 1987, p138).

The Committee went on to say:

"...despite public opinion polls to the contrary, legislation to cover 'euthanasia' is not appropriate in Victoria." (Parliament of Victoria, 1987, p140).

The report devoted much of its writing to passive euthanasia and the right to refuse treatment, that is, circumstances in which life support procedures were to be withdrawn. This issue is adequately covered in the Northern Territory by the *Natural Death Act 1988*.

The report also recommended that concerned members of the public consider the value of appointing a person to act on their behalf, in the event of their incompetence, using the *Instruments (Enduring Powers of Attorney) Act 1981*. However this Act is primarily intended for property and financial matters.

Accordingly in 1988 the *Medical Treatment Act 1988* was passed, clarifying the law relating to the right of patients to refuse medical treatment, and enabling an agent to make a decision about medical treatment on behalf of an incompetent person. Further legislation was passed in 1990 entitled *Medical Treatment (Enduring Power of Attorney) Act 1990*, with the 1988 Act being treated as the principal Act to this more recent legislation. Essentially the 1990 Act set down the powers of an agent appointed in relation to a person's medical treatment in the event that the person concerned becomes incompetent. It also set down safeguards over the exercise of enduring power of attorney.

Controls are imposed on the patient advocate including limiting refusal to the patient's current condition, not giving authority to refuse nutrition and hydration, and giving any interested party the right to have the agent's position reviewed by the Guardianship Board.

4.6. Australian Capital Territory

The ACT Assembly appointed a Select Committee on Euthanasia in June 1993 to inquire into the Voluntary and Natural Death Bill 1993. The Bill had been tabled earlier in that year by the subsequent Chairman of the Committee, the independent Member Mr Michael Moore. The Committee reported in March 1994.
(Legislative Assembly of the Australian Capital Territory, 1994).

The Committee concluded that measures should be taken to strengthen palliative care and support passive euthanasia, but active euthanasia was not supported at that time.

The Chairman subsequently withdrew his Bill from the Assembly. It was drafted in similar terms to the current Northern Territory Bill. Mr Moore is scheduled to reintroduce the Bill into the ACT Assembly in May of this year, following the recent elections in that Territory and the change in the composition of the Assembly.

It is perhaps indicative of the times that by May of this year three Parliaments in Australia will have before them Bills dealing with euthanasia, in the Northern Territory, in South Australia and in the Australian Capital Territory.

4.7. International Public Opinion

There is a remarkable convergence of public opinion in relation to the question of euthanasia, at least in terms of the principle of the matter. The tables that follow illustrate the point.

Table 4 1: United Kingdom

Conducted by: National Opinion Polls Market Research Ltd, London
Commissioned by: Voluntary Euthanasia Society
Question: 'Some people say that the law should allow adults to receive medical help to an immediate peaceful death if they suffer from an incurable physical illness that is intolerable to them, provided that they have previously requested such help in writing. Please tell me whether you agree or disagree with this.'
Sample Frame: Adults aged 15 years and over, from households on electoral registers.
Results:

Year	***Number***	***Agree (%)***	***Disagree (%)***	***Don't know (%)***
1976	2125	69	17	14
1985	1709	72	20	8
1989	1960	75	16	9

1993*	2017	78	10	12

Source: House of Lords, 1994b, p271; except
* The 1993 Result for the United Kingdom: 1994b,p90

Table 4.2: United States of America

Conducted by: The Roper Organisation, New York City
Commissioned by: Hemlock Society
Question: 'When a person has painful and distressing terminal disease, do you think doctors should or should not be allowed by law to end the patient's life if there is no hope of recovery and the patient requests it?'
Sample Frame: Persons aged 18 and over, exclusive of institutionalised segments of population.
Results:

Year	***Number***	***Yes (%)***	***No (%)***	***Don't Know (%)***
1986	1998	62	27	10
1988	1988	58	27	14
1990	1978	63	24	13
1991	1525	68	23	8

Source: House of Lords, 1994b, p271

Table 4.3: Canada

Conducted by: Gallup Canada Inc., Toronto.
Commissioned by: A group of Canadian newspapers.
Question: 'When a person has an incurable disease that causes great suffering do you, or do you not think that competent doctors should be allowed by law to end the patient's life through mercy-killing, if the patient has made a formal request in writing?'
Sample Frame: Persons 18 years of age or over.
Results:

Year	***Number***	***Yes (%)***	***No (%)***	***Undecided (%)***
1968	705	45	43	12
1974	1047	55	35	10
1979	1031	68	23	9
1984	1050	66	24	10
1989	1029	77	17	6
1990	1051	78	14	8

Source: House of Lords, 1994b, p271

Table 4.4: Australia

Conducted by: Morgan Gallup Poll, Melbourne.
Commissioned by: Morgan Gallup Poll itself.
Question: 'If a hopelessly ill patient in great pain with absolutely no chance of recovering asks for a lethal dose, so as not to wake again, should the doctor be allowed to give the lethal dose or not?'
Sample Frame: People aged 14 or over.
Results:

Year	***Number***	***Give lethal dose(%)***	***No lethal dose(%)***	***Undecided (%)***
1962	2000	47	39	14
1978	1800	67	22	11
1983	1057	67	21	12
1986	1117	66	21	13
1987	1100	75	18	7
1989	1191	71	20	9
1990	1160	77	17	6
1991	1257	73	20	7
1993*	1326	78	15	7

Source: House of Lords, 1994b, p272, except
* The 1993 Result for Australia : *Time Australia,* 28 June 1993

The convergence at around 70% of the population in favour of euthanasia is observable from Tables 4.1 to 4.4. By the early 1990s public opinion in Australia, the United Kingdom, and Canada converged, with 78% in favour of some form of euthanasia, according to the public opinion polls carried out in those three countries. For the United States a lower proportion of the population, some 68%, favoured euthanasia (Table 4.2).

More recently in Australia, a Newspoll on euthanasia published in *The Australian* on 15 February 1995 showed that in February of this year 81% of people favour euthanasia, 14% were opposed, and 5% were undecided. The question asked by Newspoll was:

'Thinking about euthanasia, where a doctor complies with the wishes of a dying patient to have his or her life ended, are you in favour or against changing the law to allow doctors to comply with the wishes of the dying patient to end his or her life?'

The survey was based on 1 200 telephone interviews of adults aged 18 years and over.

In the Netherlands a recent opinion poll shows that the proportion of the population favouring euthanasia has declined from 78% in 1993 to 71% in 1994 (Nrc Handelsblad (NH), 2 March 1995). There is little supporting evidence currently available to confirm whether or not this is an established trend.

5. Concluding Remarks and Recommendations

Whatever the outcome of the debate on the Bill in the Assembly, the Committee takes the view that the public debate has been positive for at least a significant sector of the community. Too often in the past we as a society have tended to avoid the vital issues of death and dying. Debates such as this can only help in removing the stigma associated with dying that some of us carry, albeit subconsciously.

It also needs to be borne in mind that the debate has not been without difficulty for Aboriginal communities, and any lingering fears among Aborigines about the receipt of health care in particular need to be quickly dissipated.

The debate has exposed deep and emotional points of view, and stark differences in attitude, within the community. Despite this it is remarkable that the debate has been civilised. Perhaps this is in part due to the fact that we have been discussing a profound aspect of the human condition, one which has brought with it a strong underlying sense of humanity to all those participating in the inquiry, whatever their personal viewpoint on euthanasia.

The Committee has provided the Assembly with evidence and a record of the submissions it received. We recommend the following in relation to the *Rights of the Terminally Ill Bill 1995:*

5.1 A definition of terminal illness should be included, consistent with the *Natural Death Act 1988* [Clause 2];

5.2 The method of assistance should be clearly defined to be much more restrictive than it is at present. A regulation-making power at the end of the Bill will be sufficient to accommodate any measures, without being too descriptive of the measures;

5.3 The period of 12 months should be replaced with the period of terminal care [Clause 3];

5.4 Special provision is required for people with their first language being a language other than English, to ensure that only those people who fully understand the proposed legislation make use of the provisions [Clause 3];

5.5 A ‘cooling off’ period should be allowed for under the proposed legislation between approval and actually assisting the patient to terminate the patient’s life;

5.6 The penalties are too low for improper conduct. The monetary penalties should be removed and the Criminal Code should apply in all cases of misconduct [Clauses 5 and 9];

5.7 Only medical practitioners with at least five years' experience should make decisions under this proposed legislation [Clauses 4 and 6(c)];

5.8 There should be no business nor family association between the two medical practitioners. Only a medical practitioner independent of the principal medical practitioner should be allowed to give a second opinion [Clause 6(c)];

5.9 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, thus placing the onus on the patient to indicate that they have changed their mind [Clause 6(m)];

5.10 The Register of Death Certificate should record that the patient died as a result of euthanasia, which in turn was carried out as a result of the particular terminal illness, to ensure a complete medical history is maintained for the benefit of younger and future family members [Clause 11];

5.11 In all cases of euthanasia, due processes should be followed. The Coroner should scrutinise the professional experience of the medical practitioners (Recommendation 5.7), the independence of the relationship between the two doctors involved (Recommendation 5.8), and the deceased patient's medical record, in addition to the death certificate and the certificate of request; that is, the Coroner should scrutinise all provisions under this proposed legislation [Clause 12];

5.12 The term 'consent' should be changed to 'request' in Clause 14; and

5.13 A Commencement Clause should be included in the Bill to allow time for health care providers to inform themselves of the latest techniques in palliative care and euthanasia, and for any additional palliative care measures to be put in place.

Further recommendations of the Committee related to the Bill include:

5.14 The palliative care system requires urgent review to address staffing needs, including specialists and nurses, and dedicated bed requirements;

5.15 The Northern Territory request that the matter of increasing palliative care specialists in Australia be placed on the agenda of the Australian Health Ministers' Conference;

5.16 The Northern Territory request that the matter of the adequacy of drug supply for palliative care be placed on the agenda of the Australian Health Ministers' Conference;

5.17 Appropriate communication in Aboriginal languages should be prepared and distributed to Aboriginal communities as a matter of urgency to communicate to those communities the provisions of the Bill;

5.18 Other people who may also have difficulty comprehending the Bill should be identified, and appropriate communications provided for these people as appropriate;

5.19 Section 169 of the Criminal Code making attempted suicide a crime should be repealed; and

5.20 The provisions of the *Natural Death Act 1988* should be widely published throughout the Northern Territory.

This concludes the main report of the Select Committee on Euthanasia to the Legislative Assembly.

Ormiston Room, Parliament House, Darwin
16 May 1995

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APPENDIX A

Rights of the Terminally Ill Bill 1995

APPENDIX B

Natural Death Act 1988
and
Regulations

NORTHERN TERRITORY OF AUSTRALIA

NATURAL DEATH ACT 1988

No. 51 of 1988

TABLE OF PROVISIONS

Section

No. 51 of 1988

to provide for, and give legal effect to, directions against artificial prolongation of the dying process

[Assented to 17 November 1988]

1. SHORT TITLE

This Act may be cited as the *Natural Death Act 1988*.

2. COMMENCEMENT

This Act shall come into operation on a date to be fixed by the Administrator by notice in the *Gazette*.

3. DEFINITIONS

In this Act, unless the contrary intention appears -

"extraordinary measures" means medical or surgical measures that prolong life, or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation;

"recovery", in relation to a terminal illness, includes a remission of symptoms or effects of the illness;

"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.

4. POWER TO MAKE DIRECTION

(1) A person of sound mind who has attained the age of 18 years, and who desires not to be subjected to extraordinary measures in the event of his or her suffering from a terminal illness, may make a direction in the prescribed form.

(2) A direction under subsection (1) is of no effect unless witnessed by 2 witnesses who have attained the age of 18 years, neither of whom is the medical practitioner responsible for the treatment of the person.

(3) Subject to subsection (2), where a person who is suffering from a terminal illness has made a direction under this section and the medical practitioner responsible for the treatment of the person has notice of that direction, it shall be the duty of that medical practitioner to act in accordance with the direction unless there is reasonable ground to believe that the person -

(a) has revoked, or intended to revoke, the direction; or

(b) was not, at the time of making the direction, capable of understanding the nature and consequences of the direction.

(4) This section does not derogate from any duty of a medical practitioner to inform a patient who is conscious and capable of exercising a rational judgment of all the various forms of treatment that may be available to the patients' particular case so that the patient may make an informed judgment as to whether a particular form of treatment should, or should not, be undertaken.

(5) The Administrator may, by regulation, prescribe a form for the purposes of subsection (1).

5. ACT NOT TO AFFECT OTHER RIGHTS

(1) This Act does not affect the right of a person to refuse medical or surgical treatment.

(2) This Act (other than section 6) does not affect the legal consequences (if any) of taking, or refraining from taking -

(a) therapeutic measures (not being extraordinary measures) in the case of a patient who is suffering from a terminal illness, whether or not the patient made a direction under this Act; or

(b) extraordinary measures in the case of a patient who has not made a direction under this Act.

(3) A medical practitioner incurs no liability for a decision made by him or her in good faith and without negligence as to whether a patient -

(a) is, or is not, suffering from a terminal illness;

(b) revoked, or intended to revoke, a direction under this Act; or

(c) was, or was not, at the time of making a direction under this Act, capable of understanding the nature and consequences of the direction.

6. CERTAIN ASPECTS OF CAUSATION OF DEATH

(1) For the purposes of the law of the Territory, the non-application of extraordinary measures to, or the withdrawal of extraordinary measures from, a person suffering from a terminal illness does not constitute a cause of death where the non-application or withdrawal was as a result of and in accordance with a direction made under section 4(1) by the person.

(2) This section does not relieve a medical practitioner from the consequences of a negligent decision as to whether or not a patient is suffering from a terminal illness.

7. SAVINGS

(1) Nothing in this Act prevents the artificial maintenance of the circulation or respiration of a dead person -

(a) for the purpose of maintaining bodily organs in a condition suitable for transplantation; or

(b) where the dead person was a pregnant woman - for the purpose of preserving the life of the foetus.

(2) Nothing in this Act authorizes an act that causes or accelerates death as distinct from an act that permits the dying process to take its natural course.

NORTHERN TERRITORY OF AUSTRALIA

Regulations 1989, No. 14*

Regulations under the *Natural Death Act*

I, ERIC EUGENE JOHNSTON, the Administrator of the Northern Territory of Australia, acting with the advice of the Executive Council, hereby make the following Regulations under the *Natural Death Act*.

Dated 29 June 1989.

E.E. JOHNSTON
Administrator

NATURAL DEATH REGULATIONS

1. CITATION

These Regulations may be cited as the Natural Death Regulations.

2. FORM OF DIRECTION

For the purposes of section 4(1) of the Act a direction shall be in the form specified in the Schedule.

* Notified in the *Northern Territory Government Gazette* on 17 July 1989.

SCHEDULE

Regulation 2

NOTICE OF DIRECTION PURSUANT TO
NATURAL DEATH ACT

To: The Medical Practitioner responsible for my treatment at such time when I am suffering from a terminal illness*

I, ..., declare that I am of
(name of person making direction)
sound mind and have attained the age of 18 years AND in the event that I may suffer from a terminal illness* within the meaning of the *Natural Death Act* AND having the desire not to be subjected to extraordinary measures, namely medical or surgical measures that prolong life, or which are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of independent operation, or to particular extraordinary measures specified below, DO HEREBY make the direction that I not be subjected to -

± extraordinary measures generally

± extraordinary measures, being .....
(specify particular kind of measures)

Dated ..... 19.....

Signature of person making direction: .....

WITNESSED in the presence of 2 witnesses who have attained the age of 18 years

1 ..... 2 .....

....

....

(Name, address, occupation) (Name, address, occupation)

* Terminal illness means any illness, injury or degeneration of mental or physical faculties -

(a) such 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.

± Delete whichever is not applicable.

APPENDIX C

Places and Dates of Public Hearings
and
Names of Witnesses

Places and Dates of Public Hearings and Names of Witnesses

14 March 1995 Darwin	PH1-1	Fleming, Dr J.
20 March 1995 Alice Springs	PH2-1	Kuhse, Dr H.
	PH2-2	Gray, Dr J.
29 March 1995 Darwin	PH3-1	Australian Federation of Right to Life Associations - Smith, Mr G. - Kiely, Mr T.
	PH3-2	Right to Life Australia - Bernhoft, Dr R. - Tighe, Mrs M.
	PH3-3	Trollope, Ms S.
	PH3-4	Lawrie, Ms D.
	PH3-5	TIAP (Terminally Ill Act Petition) - Cracknell, Ms L. - Chapman, Mr A. - Lowe, Mr H. - Standish, Mr P.
	PH3-6	Mason, Ms E.A.
	PH3-7	Burrow, Dr J.
	PH3-8	Palliative Care Nursing, Darwin - Donald, Mr M. - Black, Ms A. - Pullen, Ms C.

29 March 1995 Darwin	PH3-9	Doctors Concerned About Euthanasia - Weeramanthri, Dr T. - Beaumont, Dr V. - Bromich, Dr A. - Giblin, Dr E. - Ashbridge, Dr D. - Selvanayagam, Dr S.
	PH3-10	North Australian Aboriginal Legal Aid Service - Hardy, Ms J. - Wilson, Mr H. Jnr - Walker, Mr M.
3 April 1995 Hermannsburg	PH4-1	Williams, Mr G. Blenner-Hassett, Ms G. Stewart, Ms H. Cox, Ms E.
3 April 1995 Alice Springs	PH5-1	Smith, Ms T.
	PH5-2	Aids Council of Central Australia - Cram, Mr P. - Vandermoran, Mr D. - Quinn, Ms V.
	PH5-3	McKechnie, Ms F.
	PH5-4	Rankin, Mr H.D.
	PH5-5	Carter, Dr C.
	PH5-6	Winterflood, Dr G.
	PH5-7	Life is for Everyone Inc. - Sassone, Dr R.
	PH5-8	Hampel, Pastor M.
	PH5-9	Palliative Care, Alice Springs

		- Clyne, Ms S.
	PH5-10	French, Ms A.
3 April 1995 Alice Springs	PH5-11	Parish of Our Lady of the Sacred Heart - Duffy, Mr W. - Reilly, Mrs L. - Brown, Mrs D.
4 April 1995 Tennant Creek	PH6-1	Tate, Mr T.C.
	PH6-2	Moore, Ms W.F.
	PH6-3	Full Gospel Business Men's Fellowship Int. - Cherry, Mr R. - Geri, Mr R.
5 April 1995 Katherine	PH7-1	Hillock, Mr I.
	PH7-2	O'Shane, Mrs M.
	PH7-3	Gough, Mr T.
	PH7-4	Reading, Mr M.
	PH7-5	Maynard, Mr K.
	PH7-6	Havnen, Ms G.
	PH7-7	Uniting Church - Winslade, Rev J. *and* Anglican Church - Hodgkinson, Rev G.
	PH7-8	Donnellan, Mr J.R.
	PH7-9	Brunner, Ms L.

Roberts, Mr I.D.
Pounder, Ms P.A.
Goodie, Ms C.A.
Parker, Mr N.R.

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6 April 1995 Yirrkala	PH8-1	Marika, Mr W. Marika, Mr D. Marika, Mr W. Yunupingu, Mr Y. Wunungmurra, Mr W. Marawili, Ms G. Marika, Ms D. Marika, Ms R. Philp, Ms B.
6 April 1995 Nhulunbuy	PH9-1	Aboriginal Resource and Development Service Inc. - Amery, Mr H.
	PH9-2	Alexander, Mr I.
7 April 1995 Milingimbi	PH10-1	Djapundawuy, Mr A. Barakal. Mr J. Mathew, Mr Djerringal, Mr H. Watjun, Mr J. Ganygulpa, Ms E. Maydjarri, Mr C. Nulundurruwuy-Manwundjil, Mr J. Thurlow, Ms K. Gaykamanu, Mr J.
7 April 1995 Nguiu	PH11-1	Puruntatameri, Mr B. Tungutalum, Mr H. Tipiloura, Mr O. Gordon, Ms V. Puruntatameri, Mr E. Puruntatameri, Ms J. Babui, Ms E. Purantatameri, Ms T. Mayer, Dr J.

10 April 1995 Darwin	PH12-1	Sebastian-Pillai, Dr B.
	PH12-2	Berecry, Ms Y.
	PH12-3	Ashby, Prof M.
	PH12-4	Hunt, Dr R.
	PH12-5	Australian Medical Association, NT Branch - Wake, Dr C. - Howard, Dr D. - Carson, Dr P. - Kilburn, Dr C. - Lickiss, A/Prof N.
	PH12-6	Campton, Ms P. (*In Camera*)
	PH12-7	Syme, Mr R.
	PH12-8	Wood, Mr W. and Mrs R.
	PH12-9	Zalcberg, Dr J.

APPENDIX D

Alphabetical Listing of All Evidence Submitted to the Committee, by name and/or organisation and including attitude to the issue

Alphabetical Listing of All Evidence Submitted to the Committee

Notes:

1. The following alphabetical listing of evidence incorporates, for ease of reference, written submissions and oral evidence.
2. The evidence is indexed by organisation, where appropriate, or by surname.
3. Where it was provided the "***Origin***" of the submission (the address of the witness) is given. This is classified as overseas, appropriate State/Territory or local area in the Northern Territory. It should be noted that in most cases "mailing" rather than "residential" addresses were given.
4. The great majority of submissions indicated the witness was very definitely for or against either euthanasia in general or the Bill in particular. Where this is the case, their position is given under "***Interpreted Attitude***".
   In some cases witnesses may be in favour of euthanasia (the right of choice) but are ambivalent about the Bill. Care should therefore be taken in interpreting the basic for or against data and researchers are referred to the full record of evidence in Volumes Two and Three.
5. "***Reference No.***" is the submission registration number (refer to Volume 3) or oral transcript number as shown in Appendix B, where appropriate. All evidence is included in the index to facilitate cross-referencing where witnesses submitted a number of papers and/or also appeared at a hearing.

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Abbott, P.K.	NSW	for	422
Aboriginal Resource and Development Services Inc.	Darwin	-	670
Aboriginal Resource and Development Services Inc. Nhulunbuy Inc.	Nhulunbuy	-	PH9-1
Adam, M.	NSW	for	656
Adams, A.K.	NSW	for	744
Adams, M.	VIC	againt	985
Adamson, P.	Casuarina	against	1121
Adderley, B.J.	WA	for	224
Agnew, L.	NSW	for	228
Ahern, E.	VIC	against	707
Aids Council of Central Australia	Alice Springs	for	PH5-2
Aird, J.	NSW	for	843
Alberty, R. and S.	Howard Springs	for	170
Alcock, W.G.	NSW	for	795
Alexander, I.	Nhulunbuy	-	PH9-2
Alice Springs Christian Community Centre	Alice Springs	against	354
Alldis, B.K.	QLD	for	743
Allen, H.H.	NSW	for	221
Amery, H.	Nhulunbuy	-	PH9-1
Anderson, G.	NSW	for	769
Anderson, L.	VIC	against	048

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Anderson, M.L.	Humpty Doo	against	703

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Andrew, M.	WA	for	922
Anglican Church	Katherine	against	PH7-7
Anonymous	NSW	for	463
Anstis, D.	NSW	for	357
Appleby, Y.	WA	for	958
Archdale, B.	NSW	for	613
Armstrong, S.E.	ACT	for	473
Arora, O.P.	Brinkin	for	920
Asbridge, D.	Darwin	against	PH3-9
Ashbridge, D.	Darwin	against	PH3-9
Ashby, M.	VIC	against	PH12-3
Ashley, P.	NSW	for	433
Ashton-Martin, E.	NSW	for	552
Austen, L.	NSW	for	201
Australian Family Association QLD (The)	QLD	against	001
Australian Federation of Right to Life Associations	Darwin	against	PH3-1
Australian Federation of Right to Life Associations	NSW	against	PH3-1
Australian Federation of Right to Life Associations	NSW	against	091
Australian Federation of Right to Life Associations	NSW	against	1089
Australian Federation of Right to Life Associations (NSW Branch)	NSW	against	094
Australian Medical Association, NT Branch	Darwin	against	PH12-5
Australian Medical Association, NT Branch	Darwin	against	673
Australian Medical Association, NT Branch	Darwin	against	1105
Ayliffe Saba, R.A.	Alice Springs	for	1072
Badby, J.	NSW	for	006
Baggen, E.	NSW	for	188
Bailey, H.	NSW	for	523
Bailey-Cooke, H.	NSW	for	526
Bain, I.	NSW	for	363
Bainbridge, M.	Alice Springs	against	412
Bains, T.	NSW	for	421
Baird, A. and K.	WA	for	936
Bairstow, D.	NSW	for	972
Baker, C.	WA	for	1008
Baker, S.E.	NSW	for	304
Balke, N.J.	Casuarina	for	809
Bamford, M.E.	WA	for	1037
Bamford, P.	NSW	for	328
Banks, R.	NSW	for	147
Bannister, E.	NSW	for	841
Bannister, P.R.	Alice Springs	against	839
Bannister, R.J.	Alice Springs	against	840
Barber, K.	NSW	for	376
Barnes, B.	WA	for	1013
Barnes, G.E.	WA	for	1044
Barnes, J.E. and J.F.	NSW	for	225
Barnes, M.	NSW	against	835
Barnham, D.	NSW	for	270

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Barrow, L.	NSW	for	489
Bartlett, G.	NSW	for	508
Bates, I.	NSW	for	003
Bates, J.W.	NSW	for	004
Batten, M.W. and M.	NSW	for	385
Bearman, S.	NSW	for	551
Bearn, E.	NSW	for	219
Beaumond, C.	NSW	for	760
Beaumont, G.	NSW	for	277
Beaumont, V.	Darwin	against	PH3-9
Beeching, J.	NSW	for	766
Beer, A.	NSW	for	242
Beeren, R.	NSW	for	966
Bell, A.	NSW	for	153
Bell, L.	Tiwi	against	499
Bemelmans, W.A.	Alice Springs	against	1049
Bennett, B.	NSW	for	585
Bennett, G.B. and P.J.	NSw	for	122
Bennett, I.	NSW	for	480
Bens, J. J.	Alice Springs	for	118
Berecry, Y.	Darwin	against	PH12-2
Berecry, Y.	Darwin	against	797
Beriman, M.A.	VIC	against	852
Beriman, P.E.	VIC	for	009
Berlin, R.	Alice Springs	for	436
Bernard, D.	VIC	against	918
Bernhoft, R.	USA	against	PH3-2
Bernhoft, R.	USA	against	676
Bernhoft, R.	VIC	against	1092
Berry, J. and V.	SA	against	014
Best, H.E.	NSW	for	112
Bird, P.	Alice Springs	against	817
Bird, V.	NSW	for	175
Birmay, D.B.	NSW	for	513
Bishop of the Northern Territory	Darwin	against	689
Bishop of the Northern Territory	Darwin	against	1117
Black, A.	Darwin	against	PH3-8
Blandy, F.R.	Darwin	for	668
Bliem, P.R.	NSW	for	807
Bloomfield, A. and D.	NSW	for	627
Boger, B.	NSW	for	100
Bolen, I.	NSW	for	250
Bond, P.	NSW	for	448
Bonser, T.F. and C.M.	NSW	for	416
Bonyhady, A.	ACT	for	257
Bookham, V.M.	VIC	against	975
Bore, P.A.	NSW	for	759
Bort, R.V.	WA	for	1026

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Boubela, S.	NSW	for	867
Bound, J.	Parap	for	715
Bourke, J.	VIC	against	1109
Bowden, R.	VIC	against	1030
Bowen, B. and J.	NSW	for	511
Bowman, M.	Alice Springs	against	927
Boxall, M.E.	WA	for	1000
Bozic, M.	ACT	for	466
Bracken, K.	WA	for	989
Bradley, H. and S.	Darwin	for	690
Bradshaw, A.	WA	for	1017
Bradshaw, I.	NSW	for	789
Brady, B.	Nightcliff	against	569
Brady, J.	Santa Teresa	against	503
Brandman, E.M.	NSW	for	226
Breakspear, H.	NSW	for	405
Breen, F. and A.	QLD	for	554
Breen, J.L.	NSW	for	527
Bremner, J.	Stuart Park	for	603
Brennan, P.	VIC	against	074
Brewster, H.	NSW	for	187
Brinck, K.	NSW	for	479
Bristow, D.	NSW	for	399
Bristowe, B.	NSW	for	359
Bromilow, E.	WA	for	1025
Bromwich	Darwin	against	PH3-9
Brooker, C.A.	WA	for	948
Brooks, J.	NSW	for	265
Brookway, J.M.	VIC	against	1082
Brown, C.	Alice Springs	against	1038
Brown, D.	Alice Springs	against	PH5-11
Brown, D.	Alice Springs	against	1039
Brown, H.	ACT	for	459
Brown, J.	NSW	for	790
Brown, M.	NSW	for	248
Brown, W.D.	NSW	for	486
Browne, F.E.	NSW	for	158
Brownjohn, T.	Darwin	for	165
Brunner, L.	Katherine	for	PH7-9
Bryson de Buisonje, M.E.	NSW	for	437
Buchanan, B.	Palmerston	for	042
Buckley, M.	Darwin	for	705
Bunbidge, P.	WA	for	945
Bunett, C.J. and L.J.	Stuart Park	against	274
Burgin, E.	NSW	for	866
Burke, R.	NSW	for	212
Burkhart, M.	NSW	for	296
Burnett, C.	Casuarina	for	738

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Burns, J.	NSW	for	195
Burrow, J.	Darwin	against	PH3-7
Burrow, J.	Darwin	against	031
Burtten, J. *and* 14 signatures	NSW	for	535
Butcher, E.	WA	for	890
Butler, B.	Ludmilla	against	1062
Button, A.	NSW	for	898
Buxton, L.J.R.	NSW	for	178
C.C.	VIC	against	1081
Calder, S.	WA	for	1054
Campton, P. *(Confidential)*	Darwin	-	717
Campton, P. (*In Camera*)	Darwin	-	PH12-6
Carey, J.	NSW	for	369
Carlton, L.M.	ACT	for	622
Carney, D.	VIC	against	800
Carpenter, G. B.	Tennant Creek	for	064
Carter, C.	Alice Springs	for	PH5-5
Carter, C.R.	Alice Springs	for	692
Carter, S.	Darwin	for	709
Carter, S.J.	Nightcliff	for	355
Carter, W.F.	NSW	for	544
Cartmill, M.	NSW	for	343
Caruana, G.	VIC	against	1061
Casey, P.S.	NSW	for	529
Cash, M.	NSW	for	366
Caton, H.	QLD	against	624
Catt, D. and C.	Alice Springs	against	891
Chambers, A. and G.J.	Tennant Creek	for	502
Chapman, A.	Darwin	for	PH3-5
Chapman, A.L.	Darwin	for	040
Chapman, E.F.	Port Keats	against	602
Chappell, M. *(Confidential)*	WA	-	935
Charles, E.	QLD	for	494
Charlesworth, M.	VIC	for	033
Chasney, B.	NSW	for	642
Chater, G.	QLD	for	345
Chaunavel, R.	NSW	for	146
Cheeseman, M.	NSW	for	608
Chelton, J. and W.J.	NSW	for	426
Cheong, J.	NSW	for	431
Cherry, R.	Tennant Creek	against	PH6-3
Chin, K.	Darwin	for	836
Chisholm, D.I.	NSW	for	832
Chisholm, J. and I.	NSW	for	107
Chisolm, F.	NSW	for	446
Christensen, L.	NSW	for	837
Christian Medical Fellowship	UK	against	1075
Christiansen, K.	NSW	for	143

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Christiansen, R.	NSW	for	456
Christie, R.M.	Humpty Doo	for	046
Chula, M.	Port Keats	against	600
Cini, R.L.	NSW	for	588
Clark, D.	Alice Springs	for	056
Clark, K. S.M.	VIC	against	495
Clarke, J.	NSW	for	619
Clarke, J.	VIC	against	774
Clay, R.W.	NSW	for	144
Climpson, L.	NSW	for	097
Clyne, S.	Alice Springs	for	PH5-9
Coburn, P. and D.	Rapid Creek	against	205
Coburn, W.	Fannie Bay	against	065
Colgan, M.J.	VIC	against	833
Collings, E.	NSW	for	462
Collins, B.	VIC	against	799
Coman, J.A.	NSW	for	318
Commadeur, A. and J.	VIC	against	861
Conley, C.	WA	for	996
Constable, D. and J.	NSW	for	021
Constantine, E.	NSW	for	247
Cook, D.	NSW	for	626
Cook, M.	WA	for	1126
Cope, M.	WA	for	460
Cordell, D.	WA	against	1058
Core, J. and J.	Wulagi	for	888
Corry, A.	Alice Springs	against	826
Cottle, G.	Casuarina	for	713
Cotton, B.	NSW	for	126
Couch, J.	NSW	against	965
Coward, L.A.	NSW	for	217
Coy, N.J.	NSW	for	553
Coyle, R.	WA	for	954
Coyle, T.	QLD	against	105
Coyle, V.	WA	for	953
Cracknell, L.	Darwin	for	PH3-5
Cracknell, L. and A.	Karama	for	706
Crafoord, M. and C.	NSW	for	514
Crago, C. D.	Alice Springs	against	028
Craig, D.C.	VIC	against	073
Craig, D.H.	NSW	for	231
Craig, S.A.	NSW	for	333
Cram, P.	Alice Springs	for	PH5-2
Crane, L.R.F.	NSW	for	198
Crock, J.	WA	for	469
Croft, I.	WA	for	1024
Crowe, N.E.	NSW	for	234
Culell, F.J.	NSW	for	485

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Cummings, M.F.	WA	for	1005
Cunich, W.B. Mr and Mrs	NSW	for	683
Cuparso, T.	Alice Springs	against	671
Curnow, J.	NSW	for	420
Currie, B.	Nightcliff	against	808
Cypher, J.I.	WA	for	977
Daly, C.	NSW	for	913
Daly, I.B.	NSW	for	378
Dalziel, E.R	NSW	for	647
Darlow-Ng, D.	NSW	for	682
Darwin Palliative Care Nursing	Darwin	against	PH3-8
Darwin Urban Palliative Care Nurses	Darwin	against	1090
Davidson, P.	QLD	against	072
Davies, J.E.	NSW	for	211
Davies, Y.B.	NSW	for	430
Davis, B.	NSW	for	921
Davis, C. A.	Alice Springs	for	1118
Davis, N.	Katherine	against	220
Davis, N. M.	Katherine	against	905
Day, P.	WA	for	1053
de Kuszaba-Dabrowski, N.	NSW	for	696
de Munitiz, A.L.	NSW	for	844
de Pover, M.	WA	for	978
De Ruyter, P.	NSW	for	326
de Vries, B.E.	NSW	for	631
Deacon, F.M.	WA	for	1016
Deadman, M.D.	NSW	for	321
Delgorge, J.H.	NSW	for	249
Dengate, S.	Parap	for	168
Denniss, S.	NSW	for	236
Devitt, A.J.	NSW	for	203
Di Suvero, J.	NSW	for	609
Dick, M. B.	NSW	for	654
Dicker, K.	NSW	for	776
Diggins, P.	WA	for	974
Dittons, P.	Alice Springs	for	1074
Djakala, B.	Milingimbi	against	1104
Doctors' Reform Society	NSW	for	077
Doctors Concerned About Euthanasia	Darwin	against	PH3-9
Doctors Concerned About Euthanasia	Darwin	against	483
Dodd, J.L.	WA	for	886
Doherty, J.	Alice Springs	against	507
Doherty, J.	Alice Springs	against	838
Donald, M.	Darwin	against	Ph3-8
Donelan, S.	NSW	for	278
Donnell, F.	NSW	for	202
Donnellan, J.R.	Katherine	-	PH7-8
Dornbusch, P.and N. *and* L.	Winnellie	for	772

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Dowling, I. L.	WA	for	947
Doyle, J.A. and J.	NSW	for	137
Drum, A.J. and C.F.M.	NSW	against	566
Drum, D. and R.	NSW	against	565
Drum, L. and K.	NSW	against	564
Drummond, C.	VIC	against	348
Drummond, I.	Sanderson	against	720
Drysdale, M.	NSW	for	222
Duffield, U.	WA	for	1033
Duffy, W.	Alice Springs	against	PH5-11
Dulieu, I.G.	NSW	for	455
Duncan, A.D.	NSW	for	283
Dwyer, P.	VIC	against	1119
Dyer, B.	Darwin	against	801
Earnshaw, R.	Coconut Grove	for	083
Eddington, L. and J. and H.	WA	for	988
Edwards, E.M. and J.D.	Ludmilla	against	849
Ellis, J.	Humpty Doo	for	678
Ellis, J. and C.	NSW	for	580
Ellis, R.	Alice Springs	for	013
Elrington, G.	NSW	for	484
Emmett, L.	NSW	for	822
Endicott, D.	NSW	for	865
English, T.	Humpty Doo	against	095
Esplin, D.	NSW	for	314
Etherington, S.	Oenpelli	against	029
Etherington, S.	Oenpelli	against	611
Eugene, L.	NSW	for	471
Evans, J.	VIC	against	142
Evans, J. and G.	NSW	for	534
Ezzy, J.	Millner	against	414
Fabian, J.	NSW	for	200
Fairbank, G.D. and P.G.	NSW	for	584
Fancis, F.M.	NSW	for	451
Fant, C.M.	NSW	for	574
Faraday, A.	NSW	for	230
Faulkner-Camden, R.	NSW	for	316
Fawcett, J. *and* Josling, B.	Karama	for	026
Fay, R.J.	NSW	against	442
Feain, F. and L.	WA	against	824
Fearnley, J.	QLD	for	764
Fearon, M.	VIC	against	923
Federico, R.	-	against	020
Fellows, E.	VIC	against	723
Felt, C.	NSW	for	570
Fenn, N.	VIC	against	881
Ferguson, M.	NSW	for	851
Ferwerda, P.	VIC	against	860

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Finch, M.	WA	for	1028
Fincham, E.	NSW	for	612
Finnegan, C.	VIC	against	039
Fisher, A.E.	ACT	for	621
Fisher-White, M.J.	VIC	against	556
Fittock, M.	Darwin	for	587
Fitzpatrick, E.	NSW	for	346
Flanagan, K.D.	VIC	against	967
Flannery, R.	Darwin	for	693
Fleming, J.	SA	against	PH1-1
Fleming, J.	SA	against	049
Fleming, J.	SA	against	050
Fleming, J.	SA	against	051
Fleming, J.	SA	against	052
Fleming, J.	SA	against	053
Fleming, J.	SA	against	054
Fleming, J.	SA	against	1124
Florin, T.	NSW	for	275
Flower, D.	Alawa	for	714
Flowers, J.	NSW	for	536
Flynn, E.	NSW	for	874
Fogarty, J. M.	Groote Eylandt	against	015
Forrest Flinn, S.	NSW	for	855
Forster, D. and M.	VIC	against	1031
Foundation Genesis	NSW	against	1073
Francis, K.	Casuarina	against	1123
Frankland, C. and J.	WA	for	1012
Franks, E.	NSW	for	317
Fraser, C.	NSW	for	783
Freeman, Sue	Coconut Grove	for	664
Freer, B.	Winnellie	for	926
Fremlin, J.	NSW	for	387
French, A.	Alice Springs	for	PH5-10
Friend, M.	NSW	for	384
Fritzpatrick, Y. and L. *and* 3 signatures	Alice Springs	for	666
Frizzell, M.F.	WA	for	1027
Frizzell, P.	VIC	against	082
Frolich, J.M.	NSW	for	103
Fryer, B. and P.	Darwin	for	625
Full Gospel Business Men’s Fellowship International	Tennant Creek	against	669
Full Gospel Business Men’s Fellowship International	Tennant Creek	against	PH6-3
Fuller, T. and A.T.	Howard Springs	for	169
Fyfe, H.A.	ACT	against	540
Fyfe, S.	NSW	for	452
Gamble, J.	NSW	for	196
Gameson, G.A.	Winnellie	for	090
Gardiner, A.C.	NSW	for	758
Gardner, J.J.	Alice Springs	against	1071

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Garling, E.A.	Wanguri	for	872
Garton, G.	Humpty Doo	for	737
Garvey, M.	NSW	for	311
Gaspar, C.	NSW	for	784
Gawler, D.	VIC	against	1035
Geake, J.	NSW	for	493
Gear, S.	QLD	against	657
Geehman, M.	VIC	against	768
Gelfillan, A.	NSW	for	199
Geri, R.	Tennant Creek	against	PH6-3
Geyl, V. and B.	NSW	for	478
Giblin, E.	Darwin	against	PH3-9
Gibson, J.H.	NSW	for	848
Gibson, M.C.E.	NSW	for	773
Gifford, J.L. and M.E.	Woodleigh Gardens	for	389
Gilbert, C.P.	NSW	for	362
Gilbert, T.M.	Rapid Creek	for	928
Gill, J.A.	VIC	against	227
Gilmour, M.	NSW	for	109
Goddard, M.	NSW	for	238
Goiny-Grabowski, G.	QLD	for	650
Goldstein, G.	NSW	for	194
Gonzalez, M.J.	Darwin	for	879
Good Shepherd Fellowship Group (10 signatures)	Alice Springs	against	1096
Goodall, A. Mr and Mrs	VIC	against	089
Goodie, C.A.	Katherine	for	PH7-9
Gordon, B.F.	NSW	for	648
Goss, M.	VIC	against	084
Gough, T.	Katherine	against	PH7-3
Gould, T.	NSW	for	173
Grainer, K.M.	VIC	against	063
Grass, R.	WA	for	968
Gray, A.M.	Palmerston	for	008
Gray, J.	Alice Springs	for	PH2-2
Gray, J.	NSW	for	342
Gray, J.	Alice Springs	for	410
Green, B.	VIC	against	068
Green, I.G.	WA	for	970
Green, P.J.	WA	for	949
Greening, D.G.	NSW	for	413
Greening, J F.	NSW	for	476
Greenwell, J.	NSW	for	878
Greenwell, J.	NSW	for	938
Gregory, G.	NSW	for	099
Grice, R.U.	WA	for	946
Grieve, J.	ACT	for	256
Griffin, M.	VIC	against	788
Griffith, P.	NSW	for	332

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Griffiths, J.	NSW	for	207
Gunaratnam, L.	Brinkin	for	1097
Guppy, C.	WA	for	981
Hageman, J.	Noonamah	for	441
Hair, R.	Wagaman	against	1056
Halligan, P.	WA	for	1018
Halling, J.	NSW	for	151
Halpin, E.E.	NSW	for	443
Hamblin, W.K.	WA	for	1046
Hamon, B.V.	NSW	for	401
Hampel, M.A.	Alice Springs	against	PH5-8
Hampel, M.A. *and* 17 signatures	Alice Springs	against	882
Handley, B.	VIC	against	472
Handley, M.J.	VIC	against	757
Handman, M.	NSW	for	653
Hardie, I.	WA	for	969
Hardwick, G.	NSW	for	206
Hardy, B.	NSW	for	023
Hardy, J.	Darwin	-	PH3-10
Hargrove, S.M.	NSW	for	229
Harkin, M.	VIC	against	1032
Harris, B.	VIC	against	271
Harris, E.	WA	for	854
Harris, G.	NSW	for	550
Harrison, P.	NSW	for	403
Harrower, E.	NSW	for	517
Harry, J.R.	NSW	for	634
Hart, C.	VIC	against	034
Hart, J. and G.	NSW	for	655
Hart, W.	VIC	against	871
Hartig, M.G.	Daly Waters	for	893
Hartley, N.	WA	for	892
Hartwig, A.W.	QLD	against	007
Harvey, D.C.	Darwin	for	172
Harvey, J.	NSW	for	174
Havnen, G.	Katherine	for	PH7-6
Hawkes, B.	NSW	for	739
Hawkins, Z.E.	NSW	for	341
Hayden, G.G.	ACT	for	299
Haydon, P.	NSW	for	239
Heagney, J. B.	NSW	against	017
Heagney, M.	NSW	against	018
Heath, A.G.	QLD	for	649
Heberlein, C.	NSW	for	785
Heile, J.	NSW	for	607
Henderson, L.	NSW	for	402
Hengoed, M.	NSW	for	209
Hense, P.	NSW	for	834

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Hill, D.	QLD	for	530
Hill, H. V.	VIC	against	929
Hill, P.	QLD	against	1047
Hill, Y.	NSW	for	445
Hillock, I.	Katherine	against	PH7-1
Hillock, I. M.	Katherine	against	066
Hillock, I.M.	Katherine	against	1100
Hindmarsh, L.	NSW	for	780
Hirshman, J.H.	NSW	for	179
Hobden, J.	NSW	for	770
Hodge, A.F.	NSW	for	287
Hodge, A.K.	NSW	for	262
Hodgkinson, G.	Katherine	against	PH7-7
Hoffman, G.	NSW	for	216
Hogan, G. and H.	NSW	for	586
Hohoyde, M.	NSW	for	525
Hollingworth, R. and S.	Alice Springs	against	505
Hollingworth, S.	Alice Springs	against	907
Holloway, J.	NSW	for	538
Holmes, A.	NSW	for	134
Holmes, M.J.	NSW	for	130
Holt, P.	NSW	for	461
Homles a Court, E.C. *and* Crichley, C.R.	WA	for	992
Hoskins, S.	NSW	for	474
Houliston, J.H.	Fannie Bay	for	291
Howard, G.	NSW	for	730
Howard, P.	Darwin	against	PH12-5
Howard, P.	WA	for	1106
Hubbard, P.	Darwin	for	793
Huber, B.	NSW	for	432
Hudson, C.	NSW	for	765
Hugall, C.B.	WA	for	1006
Hughes, C.	WA	for	fo939
Hul, O.	WA	for	1125
Hull, M.E.	QLD	for	573
Hulscher, F.R.	NSW	for	182
Human Life International Aust. Inc.	NSW	against	488
Humanist Society of WA (Inc)	WA	for	632
Hunt, R.	SA	for	PH7-1
Hunt, R.	SA	for	498
Hunter, M.	Alice Springs	against	1023
Hurst, R.	NSW	for	406
Hurst, S.M.	NSW	for	152
Hurt, R.	ACT	for	545
Hutchison, I.	WA	for	994
Ingamells, R.	Alice Springs	against	059
Isaacs, B.	QLD	against	862
Ison, R.J.	NSW	for	491

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Jackson, E.	NSW	for	1077
Jackson, P.K.	WA	for	510
Jackson, P.K.	WA	for	1084
Jackson, R. and F.	The Narrows	for	167
Jacob, R.	Millner	for	215
Jacobs, W.R.	NSW	for	439
Jagst, B.D.	Palmerston	against	419
Jarrett, J.	QLD	for	425
Jauncey, L.	NSW	for	320
Jay, Y.W.	NSW	for	617
Jeffares, A.M.	NSW	for	185
Jeffries, P.	VIC	against	986
Jeffriess, M.J.	NSW	for	782
Jenkins, L.	NSW	for	562
Jenkins, P.	WA	for	943
Jentsch, A.	NSW	for	944
John Plunkett Centre for Ethics in Health Care	NSW	against	1113
Johnson, C.E.	WA	for	924
Johnson, S. A.	NSW	for	149
Johnston, B.	NSW	for	162
Jones, E. J.	VIC	against	078
Jones, E.H.	QLD	for	853
Jones, L.H.	NSW	for	620
Jones, L.M.	VIC	against	113
Jones, M.	NSW	for	098
Jones, M.	NSW	for	475
Jones, S.	NSW	for	722
Jones, Y.N.	NSW	for	407
Jurkijevic, P.	Palmerston	for	060
Kaff, K.	WA	for	950
Kane, D.	Nightcliff	for	895
Kavanagh, P.	QLD	for	568
Kave , L.	QLD	for	726
Keane, D.L.	Alice Springs	against	816
Kelly, D.	VIC	for	1085
Kemp, N.	NSW	for	365
Kennedy, M.	NSW	for	139
Khoudair, A.	NSW	against	576
Kiely, T.	Darwin	against	PH3-1
Kiely, T. A.	Anula	against	012
Kilburn, C.	Darwin	against	PH12-5
Killar Family	NSW	against	1051
King, K.E.	Rapid Creek	against	798
King, R.	NSW	for	394
Kingman, J.	VIC	against	079
Kirby, E.J.	NSW	for	549
Kirkby, D.E. and K.L.L.	WA	for	940
Kirkman, R.	Alice Springs	for	263

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Knights of the Southern Cross (Australia) Inc.	ACT	against	828
Knowles, J.	NSW	for	542
Kuhse, H.	VIC	for	PH2-1
Kuhse, H.	VIC	for	032
Kushe, H.	VIC	for	1086
Kuster, L.	Casuarina	for	672
Kvasnicka, M.	Leanyer	against	1076
Kvasnicka, M.K.	Leanyer	against	663
La'Porte, A.	Sanderson	against	643
Lamb, J.	WA	for	942
Lamb, M.	NSW	for	821
Lancaster, N.E.	QLD	for	742
Landos, B.	NSW	for	524
Lane, P.R.	NSW	for	110
Lang, E.M.	WA	for	1108
Langley, R. and S.	NSW	for	232
Lantjin, D.	Port Keats	against	601
Larkins, P.L.	NSW	against	806
LaSette, G.	Darwin	for	919
LaSette, P.	Darwin	for	684
Lassan, L.J.	NSW	for	382
Laurie, L.	NSW	for	129
Lawrence, F.	NSW	for	512
Lawrence, P.	NSW	for	575
Lawrence, R.	NSW	for	639
Lawrence, W.B.	NSW	for	641
Lawrie, D.	Darwin	for	PH3-4
Lazzaro, J.	VIC	against	037
Le Surf, T.	-	for	1036
Lea, G.	NSW	for	276
Lee, A.	NSW	for	159
Lee, R.	QLD	against	971
Lee, S.	Darwin	for	708
Leedham, G.	Alice Springs	for	506
Lesley, R. *(Confidential)*	Darwin	-	044
Levison, C.M.	WA	for	941
Levy, K.	NSW	for	847
Lewis, M.	NSW	for	741
Lickiss, J. N.	NSW	against	1103
Lickiss, J.N.	NSW	against	487
Lickiss, N.	NSW	against	PH12-5
Life Is For Everyone Incorporated	Winnellie	against	694
Lillecrapp, M.	Alice Springs	against	819
Lillecrapp, Mr J.	Alice Springs	against	813
Lillicrap, H. and C.	Alice Springs	against	041
Linden, G.	NSW	for	347
Little, E.	Port Keats	against	415
Littlejohn, L. H.	NSW	for	186

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Livermore, M.H	NSW	for	645
Lloyd, P.	QLD	for	610
Loneragan, J. and O.	WA	for	1010
Loney, S.	WA	for	1050
Long, M.L.	NSW	for	327
Long, V.M.	NSW	for	748
Longley, N.	NSW	for	141
Louden, A.A. and C.E.	WA	for	1034
Lovegrove, T.C.	Howard Springs	for	180
Lovell, R.G.	Casuarina	for	297
Lovibond, D.J.	NSW	for	397
Lowe, H.J.	Darwin	for	PH3-5
Lowe, H.J.	Nightcliff	for	501
Lowe, H.J.	Darwin	for	695
Lowndes, E.	NSW	for	310
Ludwig, L.	NSW	for	571
Lukas, M.	NSW	for	309
Lupton, D.	NSW	for	636
Lusk, J.	NSW	for	191
Lusk, R.	NSW	for	190
Lutheran Church of Australia	SA	against	1093
Lynch, N.	VIC	against	778
Macdonald, E.	NSW	for	984
MacGregor, M.A.	NSW	for	842
Macindoe, I.	NSW	for	337
MacKenzie, N.	NSW	for	102
Macleod. K.J.	VIC	against	592
MacQueen, M.	NSW	for	528
Macqueen, S.	NSW	for	393
Maertin, E.	NSW	for	106
Magetti, J.F. and M.P.	VIC	against	323
Makinson, K.R.	NSW	for	423
Manchee, J.R.	NSW	for	223
Manella, O.G.	NSW	for	351
Manner, L.	Humpty Doo	for	273
Manning, B.	NSW	for	340
Mansfield, C. *and* Shanahan, M. *and* 18 signatures	Darwin	for	691
Mansfield, J.D.	NSW	for	177
Marbury, F.B.	WA	for	1001
Margadant, R.	WA	for	982
Markey, P.	Casuarina	against	096
Marks, I.J.	NSW	for	358
Marshall, C.J. and R.J.	Batchelor	for	875
Marshall, J.	WA	for	531
Marshall, R.A.	NSW	for	438
Martin, D.	NSW	for	285
Martin, D.R.	NSW	for	266
Martin, E.	NSW	for	204

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Martin, E.	NSW	for	453
Maskell, B.	Alice Springs	for	909
Mason, E.A.	Darwin	for	PH3-6
Mason, G.	NSW	for	629
Mason, J.	NSW	for	435
Mason, S.	NSW	for	754
Master, J.	NSW	for	319
Mastrippulito, A.	VIC	against	899
Matarazzo, G. and G.	Darwin	for	1057
Mathers, E.	NSW	for	408
Mathews, H.V.	NSW	for	210
Matlak, D.	NSW	for	781
Matthews, J.	NSW	for	651
Maude, H.E.	ACT	for	496
Maxey, R.J.	NSW	for	123
Maxwel, F.	Howard Springs	for	604
Mayers, L.A.	VIC	against	964
Maynard, K.	Katherine	against	PH7-5
McArthur, G. D.	VIC	against	019
McCallum, M.	NSW	for	644
McCawley, D.	NSW	for	740
McClenaghan, W.	Darwin	against	889
McCormack, K.	VIC	against	787
McCorry, D.	WA	for	1014
McGargill, K.	Alice Springs	against	667
McGauran, J.	VIC	against	1060
McGibbon, C.	QLD	for	725
McGill, L. *and* Humphries, J.	Palmerston	for	579
McHugh, B.	VIC	against	863
McInerney, J.	VIC	against	081
McInery, J.	NSW	for	917
McKay, B.	Darwin	against	686
McKechnie, F.	Alice Springs	against	PH5-3
McKechnie, F.	Alice Springs	against	1115
McKee, L.	Howard Springs	against	897
Mckeen, P.	Sanderson	for	292
McKell, B.	NSW	for	388
McKenna, P.	VIC	against	931
McKerrow, S.M.	Stuart Park	for	1083
McLachlan, D. and L.	Darwin	against	591
McNabb, A. *and* Hop, J.	WA	for	1007
McNamara, C.	VIC	against	057
McNamara, T.M.	Leanyer	against	1098
McNeil, K.	VIC	against	598
Meakins, D.	Rapid Creek	against	811
Medlen, M.	WA	for	963
Megson, J.	NSW	for	344
Meharg, R.	NSW	for	303

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Melman, B.	NSW	for	111
Mendes, D.	VIC	against	823
Miguel, L.	WA	against	775
Milingimbi Community Inc.	Milingimbi	against	PH10-1
Miller, M.	Alice Springs	against	908
Millicen, J.	NSW	for	803
Mills, B. and D.	NSW	for	120
Mills, G.	NSW	for	577
Mills, M.	Alice Springs	against	674
Mills, N.	VIC	against	440
Mills, N.	VIC	against	467
Milthorpe, A.	NSW	for	124
Mitter, A.	WA	against	482
Moore, M.	ACT	for	876
Moore, W.F.	Tennant Creek	against	PH6-2
Moran, J.M.	Wanguri	for	558
Morgadinho, B.	NSW	for	367
Morgan, D.J. and A.L.	NSW	for	640
Morris, P. and M.	VIC	against	934
Morrison, T.	NSW	for	492
Mortimer, M.	ACT	for	076
Morton, I.	NSW	for	395
Morton, N.	NSW	for	424
Muirden, N.M.	VIC	against	831
Mulholland, D.	NSW	for	114
Mummery, B.M.	NSW	for	324
Murphy, B.	Katherine	against	1059
Murphy, J.S.	VIC	against	727
Murrell, C.	Winnellie	for	597
Myers, R.	NSW	for	237
Name withheld by request	Palmerston	for	449
Name withheld by request	Fannie Bay	for	497
Name withheld by request	WA	for	987
Neale, E. and A.	NSW	for	288
Nelson, J.	WA	for	999
Nelson, J.M.	NSW	for	532
Newboult, R.	NSW	for	846
Newman, S.	NSW	for	628
Newmeyer, H.	WA	for	465
Newmeyer, J.H.A.	WA	for	786
Newton, P J.	VIC	against	1068
Newton, P.A.	NSW	for	745
Nguiu Community Government Council	Bathurst Island	against	PH11-1
Nicholas, S.	NSW	for	868
Nicholson, M.S.	VIC	against	010
Nicoli, C.E.	NSW	for	1048
Nielsen, H. and P.	NSW	for	295
Nightingale, L.	QLD	against	071

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Noone, M.	NSW	for	518
North Australia Aboriginal Legal Aid Service	Darwin	-	1088
North Australia Aboriginal Legal Aid Service	Darwin	-	PH3-10
North Australia Aboriginal Legal Aid Service	Darwin	-	680
North-Coombes, N.	VIC	against	011
Northern Territory Council of Churches	Darwin	against	901
Northern Territory Hospice and Palliative Care Association Inc.	Casuarina	-	829
Nowak, C.	NSW	for	444
NT Aids Council Inc.	Darwin	for	1045
NT Anti Cancer Foundation Inc.	Casuarina	-	810
NT Christian Outreach Centre	Darwin	against	687
Ntaria Council (Hermannsburg) Inc.	Hermannsburg	against	PH4-1
Num, R.G.	SA	against	1122
Nunn, P.	Nightcliff	for	1110
O'Brian, D.	NSW	for	280
O'Brien, A.	VIC	against	035
O'Brien, M.	VIC	against	873
O'Connor, C.	VIC	against	164
O'Dwyer, P.	Alice Springs	against	1041
O'Halloran, D.	VIC	against	181
O'Keeffe, D.J.	VIC	against	880
O'Shane, M.	Katherine	for	PH7-2
O'Shea, P.J.	VIC	against	546
O'Shea, P.J.	VIC	against	796
Oldham, Mr and Mrs W.H.	ACT	for	197
Oliver, N. and P.	Daly River	against	734
Orr, L.P.	NSW	for	509
Osborne, V.	NSW	for	282
Osmond, S.	NSW	for	213
Osmotherly, M.	NSW	for	240
Our Lady of the Sacred Heart Parish, Alice Springs	Alice Springs	against	719
Ovedoff, R.	NSW	for	108
Overton, V.	NSW	for	724
Oxley, S.R.	NSW	for	386
Oxnam, G.A.	WA	for	991
Packer, K.	VIC	against	1040
Padgham-Purich, N.	Howard Springs	for	659
Palmer, M.	NSW	for	121
Pansini, H.	QLD	for	761
Parish of Our Lady of the Sacred Heart	Alice Springs	against	PH5-11
Parish, A.	WA	for	983
Park, M.	Alice Springs	against	904
Parker, N.R.	Katherine	for	PH7-9
Parry, J.D.	NSW	for	260
Pascall, L.J.	VIC	against	145
Paterson, J.	NSW	for	269
Patrick, R.	NSW	for	379
Patteson, C.	Nightcliff	against	792

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Patton, P.	VIC	against	623
Payne, A.	NSW	for	616
Peer, E.	NSW	for	243
Perrett, R.	NSW	for	583
Perrin, E.	WA	for	887
Perrin, P.	NSW	for	856
Pert, A.	NSW	for	331
Petition (14 signatures) *and* Opinion Poll (42 signatures)	-	for	718
Petition (6 signatures)	NSW	for	930
Petition (9 signatures)	Darwin	against	805
Petition, Tennant Creek Residents (59 signatures)	Tennant Creek	for	301
Pfanner, M.R.	ACT	for	254
Phillips, L.	WA	for	1067
Phillips, P.B.	NSW	for	302
Pike, B.	NSW	for	791
Pinchbeck, J.	NSW	for	567
Pollard, B.	NSW	against	093
Poole, N.A.	WA	for	1029
Popper, E. M.	NSW	for	092
Poulton, M.	NSW	for	543
Pounder, P.A.	Katherine	for	PH7-9
Poynter, D.M. *and* Blackett, D.B.	QLD	for	557
Priebe, W.	QLD	against	360
Prince, J.F.	NSW	for	746
Prince, M.	VIC	against	767
Pring, J.	NSW	for	259
Prokhovnik, R.	NSW	for	398
Pullen, C.	Darwin	against	PH3-8
Purcell, D.M.	QLD	against	353
Purdy, B.H.	NSW	for	763
Pybus, D.B.	NSW	for	253
Pyle, J.B.	NSW	for	374
Pyle, L. M.	NSW	for	117
QLD Right to Life	QLD	against	067
Queensland Right to Life Ingham Branch	QLD	against	896
Quinn, N.	NSW	for	350
Quinn, T.	NSW	for	519
Quinn, V.	Alice Springs	for	PH5-2
Ragnanese, J.	VIC	against	080
Rakusan, E.	NSW	for	329
Ralfe, I.	NSW	for	820
Ramming, A. Mr and Mrs	NSW	for	660
Ramsay, R.A.	NSW	for	184
Ramsey, I.	-	for	711
Ramsey, K.	Darwin	for	699
Rankin, H.D.	Alice Springs	against	PH5-4
Rationalist Association of NSW	NSW	for	500
Rationalist Association of NSW	NSW	for	753

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Ravenscroft, P.J.	NSW	against	688
Ray, L.M.	WA	for	960
Reading, M.	Katherine	-	PH7-4
Redman, D.	NSW	for	325
Reece, A.S.	QLD	against	070
Reid, T.E.	Casuarina	for	818
Reilly, L.	Alice Springs	against	PH5-11
Reilly, L. and D.	Alice Springs	against	606
Remie, G.	Palmerston	against	976
Rennie, N.	WA	for	979
Rice, R.J.	WA	for	955
Richards, A.H.	NSW	for	539
Right to Life Australia	VIC	against	PH3-2
Right to Life Australia	WA	against	825
Right to Life Australia	USA	against	1091
Rivett, K,	NSW	for	589
Roan, H.	NSW	for	370
Robarts, M.E.	VIC	against	208
Roberts, C.	NSW	for	218
Roberts, ID.	Katherine	for	PH7-9
Robertson, S.	VIC	against	732
Robertson, W.	Yulara	for	716
Robey, I.	NSW	for	869
Robins, A.	NSW	for	338
Robinson, C.	NSW	for	618
Robinson, J.	NSW	for	293
Robson, M.	Wanguri	for	085
Robson, P.	NSW	for	858
Rodriquez, M.	VIC	against	116
Roennfeldt, D.	Hermannsburg	against	605
Roman, I.L.	NSW	for	515
Rose, D.	QLD	for	864
Rose, S.A. and G.A.	Darwin	for	555
Rosenfeldt, F.L.	VIC	against	870
Ross, B. and B.	WA	for	956
Ross, M.A.	QLD	against	794
Ross, M.A.	QLD	against	857
Rubin, L.	NSW	for	630
Rural Churches Association	Humpty Doo	against	685
Russell, M.	ACT	for	255
Rust, D.	Alice Springs	against	910
Rutnam, R.	ACT	for	454
Ryan, J.B.	VIC	against	1070
Ryan, K.M.	VIC	against	281
Ryan, M.	NSW	against	383
Ryan, M.	NSW	for	802
Sainsbury, M.	NSW	for	171
Sak, E.	VIC	against	1080

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Sale, P.J.M.	NSw	for	161
Salter, H.	NSW	for	339
Samarasingh, A.M.	NSW	for	030
Samek, J.	NSW	for	101
Sanders, E. P.	NSW	for	330
Sands, W.A.	NSW	for	593
Sassone, R.	USA	against	PH5-7
Sault, D.K.	NSW	for	447
Savage, L.	NSW	for	457
Sawyer, E.	NSW	for	428
Scales, J.	WA	for	925
Scanlan, M. A.	NSW	for	135
Schaut, O.	NSW	for	267
Scheinberg, A.	NSW	for	104
Schimmel, D.	NSW	for	747
Schmidt, W.G.	NSW	for	251
Schubert, K.	Alice Springs	for	043
Schumann, G.	VIC	against	075
Schurmann, C.	NSW	for	434
Scott Findlay, E.	NSW	for	154
Scott, E.	VIC	against	045
Sebastian-Pillai, B.	Darwin	for	PH12-1
Sebastian-Pillai, B.	Darwin	for	1120
Sedgwick, D.	WA	for	1019
Segner, A.	NSW	for	315
Seidler, E.	NSW	for	136
Selvanayagam, S.	Darwin	against	PH3-9
Selvey, G.	Darwin	for	700
Selvey, J.	-	for	721
Sephton, D.	NSW	for	233
Shank, J.	NSW	for	176
Shank, L.	NSW	for	156
Shannon, Y.	WA	for	1009
Sharp, O.M. and L.G.	NSW	for	138
Shaw, C.	NSW	for	537
Shea, P.N.	QLD	for	312
Shelley, J.G.	NSW	for	163
Shepherd, A.	Katherine	for	679
Shield, B.	ACT	for	830
Shillingford, E.A	NSW	for	477
Shorter, E.	NSW	for	614
Shotton, S.	Winnellie	against	894
Siano, N.	NSW	for	729
Silberman, L.	NSW	for	160
Silverword, H.	NSW	for	361
Simons, D.	NSW	for	235
Simpson, P.P.T.	NSW	for	658
Simpson, P.T.	NSW	for	916

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Sisters of Charity of St Anne (3 signatures)	Palmerston	against	812
Sivell, G.	Nightcliff	for	914
Skevington, C.	NSW	for	148
Slezak, V.	NSW	for	368
Sloan, B.P.	NSW	for	937
Sloggett, R.	NSW	for	352
Smith, A.M.	NSW	for	264
Smith, C.	Ludmilla	against	933
Smith, D.	Ludmilla	against	932
Smith, D. and M.	NSW	for	520
Smith, E.	NSW	for	464
Smith, E.	Wa	for	1042
Smith, G.	NSW	against	PH3-1
Smith, I.	WA	for	997
Smith, I.	WA	for	1022
Smith, I.J.	NSW	for	335
Smith, L.	ACT	for	541
Smith, M.A.	NSW	for	521
Smith, M.C.	NSW	for	522
Smith, P. and M.	WA	for	1020
Smith, P.A.	NSW	for	128
Smith, R.	Casuarina	for	088
Smith, R.	NSW	for	396
Smith, S.	Alice Springs	for	1011
Smith, S.V.	WA	for	952
Smith, T.	Alice Springs	for	PH5-1
Smith, T.	Alice Springs	for	681
Smith, T.	Alice Springs	for	1114
Smitheringale, L.M.	WA	for	998
Smulders, A.J.	Alice Springs	against	411
Soane, B.	NSW	for	115
Solley, M.B.	WA	for	951
Souter, A.	NSW	for	900
Southgate, C.W.	NSW	for	336
Spark, D.	WA	for	1043
Speed, M.	NSW	for	594
Spencer, B.	Darwin	for	704
Squire, R.W.	NSW	for	516
St Francis Xavier's Parish (80 signatures)	Daly River	against	733
St Mary's Cathedral Parish	Darwin	against	915
Stackpole, M.	VIC	against	850
Standish, P.	Darwin	for	PH3-5
Standish, P.	Alawa	for	756
Standish, R.	Alawa	for	755
Stanton, J.	WA	for	884
Steane, E.	NSW	for	390
Steel, G.A.M. and P.	WA	for	980
Steele, J.	NSW	for	132

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Stephens, J.	NSW	for	305
Stevens, F.H.	NSW	for	308
Stevenson, N.M.	WA	for	1066
Stirling, K.D.	NSW	for	294
Storm Willadsen, D.	NSW	for	286
Story, R.	ACT	for	728
Story, S.F.	ACT	for	750
Stowell, G. B.	NSW	for	024
Stowers, J.	VIC	against	804
Straw, H.H.	NSW	for	140
Streber, M.B.	NSW	for	155
Street, P.E.	NSW	for	193
Stricker, E.T.	NSW	for	578
Struik, R. and B.	NSW	for	272
Styant, D.	Darwin	for	662
Suffold, D.	NSW	for	547
Sullivan, A.	VIC	against	047
Sullivan, J.	NSW	for	166
Sultana, J.	QLD	against	771
Sutherland, B.P.T.	Stuart Park	against	1087
Sutton, D.	NSW	for	372
Svendson, R.	QLD	against	859
Sydney-Smith, D.B. and S.E.	Nightcliff	against	885
Sykes, M.C.	VIC	against	058
Syme, R.	VIC	for	PH12-7
Syme, R.	VIC	for	1094
Syme, R.R.A.	VIC	for	298
Symes, K.J. and J.E.	QLD	for	022
Talbot, A.C.	NSW	for	563
Tapp, J.	Katherine	for	712
Tate, M. C.	Tennant Creek	for	036
Tate, T.C.	Tennant Creek	for	PH6-1
Taus, H.	NSW	for	252
Taylor, A. J.	Wagaman	against	025
Taylor, G.	WA	for	1003
Taylor, R.	NSW	for	751
Taylor-Cannon, B.G. and L.G.	NSW	for	560
Tenison-Woods, L.	Darwin	for	702
Tento, W. and S.	QLD	against	652
Terry, D.	NSW	for	392
Theakstone, L.	Parap	for	1065
Thomas, M.	VIC	against	458
Thomson, P.	NSW	for	307
Thomson, T.	Alice Springs	against	1095
Thorpe, J.K.	WA	for	1002
Thurston, O.A.	WA	for	959
TIAP (Terminally Ill Act Petition)	Darwin	for	PH3-5
Tierney, J. *and* 3 signatures	Alice Springs	against	815

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Tighe, M.	VIC	against	PH3-2
Tiller, L.N. *(Confidential)*	WA	-	961
Tiwi Land Council	Bathurst/Melville	against	002
Todd, E.M.	NSW	for	157
Tomalin, A.W.	NSW	for	381
Tomalin, M.	NSW	for	468
Tonti-Pilippini, N.	VIC	against	1112
Torley, V. *and* Oderberg, D. S.	UK	against	016
Toseland, D.	NSW	for	638
Toseland, D. and R.	NSW	for	637
Tragarz, M.	VIC	against	183
Trengove, B.	NSW	for	615
Trengove, D.	NSW	for	429
Trevleaven, J.	NSW	for	133
Trollope, S.	Darwin	-	PH3-3
Truman, B.	NSW	for	582
Tully, M.	NSW	for	380
Tweedie, A.D.	ACT	for	481
Tyzack, C.	Bees Creek	for	677
Uniting Church	Katherine	against	PH7-7
Unting Church in Australia (The), Northern Synod	Darwin	against	912
Upton, M.J.	NSW	for	490
van der Molen, J.A.	Palmerston	for	698
Van Dok, R.	Alice Springs	for	086
Van Eck, N.	Fannie Bay	for	911
Van Galen, L.	NSW	for	258
Van Holland, P.J.A.	NSW	for	127
Vandeleur, P.	Katherine	against	038
Vandermoran, D.	Alice Springs	for	PH5-2
Veitch, L.	WA	for	1064
Vines, L.	NSW	for	375
Virgo, P.	NSW	for	418
Vlach, V.	NSW	for	313
Voluntary Euthanasia Society of NSW	NSW	for	300
Voluntary Euthanasia Society of NSW	NSW	for	777
Voluntary Euthanasia Society of NSW, Canberra Branch	ACT	for	061
Voluntary Euthanasia Society of SA Inc.	SA	for	827
Voluntary Euthanasia Society of SA Inc.	SA	for	1116
Voluntary Euthanasia Society of VIC Inc.	VIC	for	877
Voluntary Euthanasia Society of VIC Inc.	VIC	for	1099
Voluntary Euthanasia Society of WA	WA	for	814
Waddington, V.	NSW	for	391
Wainwright, N.	WA	for	633
Wake, C.	Darwin	against	PH12-5
Walker, E.	NSW	for	189
Walker, J.	NSW	for	590
Walker, M.	Darwin	against	PH3-10
Walker, M. O.H.	NSW	for	005

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Wall, J.	NSW	for	417
Waller, N.W.	NSW	for	131
Walles, J.B.	VIC	against	1069
Wallner, G.M.	WA	for	957
Walsh, B.C.	NSW	for	581
Walsh, J.	NSW	for	373
Walsh, J.S.	NSW	for	400
Ward, G.	WA	for	990
Ward, J.D.	VIC	against	450
Ward, M.	Palmerston	for	069
Wardle, P.	Alice Springs	against	675
Warren, J.	NSW	for	245
Warruwi Community Inc.	Goulburn Island	against	962
Waterman, H.B.	NSW	for	279
Watkins, F.	NSW	for	635
Watkins, R.	ACT	for	371
Watson, Charlotte	Rapid Creek	for	665
Watson, J.	NSW	for	595
Watson, P.A.	NSW	for	596
Watson, P.E.	NSW	for	409
Watts, E.	NSW	for	548
Watts, J.H. and R.M.	WA	for	993
Wearne, E.R.	NSW	for	731
Webb, G.	Winnellie	for	701
Weeks, D.E.	NSW	for	533
Weermanthri, T.	Darwin	against	PH3-9
Weissenfeld, P.E.	VIC	against	322
Weldon, P.	WA	for	1063
Wells, E.M.	VIC	against	735
Wereford Roberts, M.	WA	for	1021
Wesleyan Methodist Church	QLD	against	646
Wetherop, V.	WA	for	973
Weymouth, M.	WA	for	995
Whitaker, E.	NSW	for	561
Whitbourn, J.	Palmerston	against	599
White, B.	VIC	against	062
White, B.	VIC	against	1052
White, L.	ACT	for	268
Whiteford, J.	NSW	for	364
Whitelegg, J.W.	WA	for	470
Whiteman, P.	NSW	for	192
Wilde, E.K.	WA	for	1004
Wilkinson, H.J.	NSW	for	241
Williams, C.	Alice Springs	against	1055
Williams, E.	Alice Springs	against	906
Williams, K.	-	for	762
Williams, P.	Alice Springs	against	504
Wilson, A. and B.	NSW	for	736

Witness	*Origin*	*Interpreted Attitude*	*Reference No.*
Wilson, E.	NSW	for	377
Wilson, E.	The Narrows	for	559
Wilson, I.	Alice Springs	for	087
Wilson, J. Jnr	Darwin	against	PH3-10
Wilson, P.	Darwin	for	710
Wilson, P.A. *(Confidential)*	Winnellie	-	289
Wilson, R.	NSW	for	284
Wilson, W.	NSW	for	752
Wilson, W.R. *(Confidential)*	Winnellie	-	290
Winslade, J.	Katherine	against	PH7-7
Winterflood, G. *(Confidential)*	Alice Springs	-	246
Winterflood, G. (*In Camera*)	Alice Springs	-	PH5-6
Wiseman, V.C.	NSW	for	427
Women's Advisory Council	Darwin	for	697
Wood, G.	Howard Springs	against	661
Wood, W. and R.	Darwin	for	PH12-8
Wood, W. and R.	Darwin	for	1101
Woods, D.	NSW	for	150
Woods, M.	NSW	for	845
Woodthorpe, S.	WA	for	1015
Woodthorpe, S.	-	for	1107
Wootten, R.	NSW	for	404
World Federation of Doctors who Respect Human Life, VIC Division	VIC	against	902
World Federation of Doctors who Respect Human Life, VIC Division	VIC	against	903
Wren-Lewis, J.	NSW	for	214
Wright, L.A.J. and P.M.	NSW	for	334
Wurst, N.W and J.D.	Papunya	against	883
Wyatt, P.	NSW	against	1078
Wyndham, M.	NSW	for	349
Wynhausen, M.	NSW	for	125
Yapakurlangu Regional Council	Tennant Creek	against	1111
Yates, K.	Alice Springs	for	356
Yirrkala Dhanbul Community Association Inc.	Nhulunbuy	against	PH8-1
Yirrkala Dhanbul Community Association Inc. *and* Lanyhapuy Homeland Association	Yirrkala	against	1102
Young, D.	NSW	for	749
Young, M.	NSW	for	306
Youssef, M.	NSW	against	027
Zabaneh, A.	NSW	for	261
Zala, G.	NSW	for	572
Zalcberg, J.	VIC	against	PH12-9
Zavadish, C.	VIC	against	779
Zevel, O.	NSW	for	119
Zimmermann, J. and A.	Nightcliff	against	1079
Zukerman, V.	NSW	for	244
Zweck, L. and S.	Alice Springs	against	055