LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

REPORT OF THE INQUIRY BY THE SELECT COMMITTEE ON EUTHANASIA

VOLUME THREE - WRITTEN SUBMISSIONS

PART C: 665 TO 915

MAY 1995

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SUBMISSION 665 1

Charlotte Watson

22 Ternau St,

Rapid Creek NT 0810

23 March 1995

Dear Marshall Perron,

I wish to express qualified support for the proposed euthanasia bill.

I feel it is essential that the person who is dying is clear of mind and it is their express wish to die by either intervening (eg drugs) methods or non intervening methods (eg: drugs with held)!

The right of the individual on how to die, when to die and where to die (eg: at home or hospital surrounded by relatives/friends) must be clearly defined in legislation.

Yours sincerely

Charlotte Watson

SUBMISSION 666 1

Mr. Eric Poole, MLA

Member for Araluen,

1A Bath Street,

Alice Springs. N T

24th March, 1995.

Dear Mr Poole,

We the undersigned are fully in support of euthanasia becoming legal in the Northern Territory.

We wish to relate to you the story of a very. special woman whom everybody calls "Grandma" who has changed from an energetic lively lady to, sad to say, a woman in unbearable pain from which the only release is her demise.

Grandma in her younger days was a keen fisherwoman in Port Pirie entering many competitions and winning against all her male opponents which was no mean feat for a lass in that era 60 years ago. She was also the centre of some lively conversations and enjoyed the odd ale at the local. Her life apart from these entertainments revolved

around bringing up a very lively youngster. working hard in the crop picking season (at which she was the champion pea picker) to later looking after a dying husband day and night for fifteen years.

About 18 years ago most of her family had moved to Alice Springs, but Grandma being her natural self was never lonely for all in Port Pirie including, the local police would always stop for a lively conversation a beer or just some support of a loving hand or advice. All who came in contact with Grandma came to love her.

Sixteen years ago Grandma moved to Alice Springs to be with and cared for by her daughter as she had had a stroke and was not expected to live for much longer, it was thought she may die on the plane up here. But being Grandma her favourite motto "I wouldn't be dead for quids, there is always too much going on to die", she survived the stroke we believe through her own will and stubbornness. Grandma whether it be watching the football with her barracking for opposing sides and have a friendly argument over it or watching her give out her love to all the little ones she loves so dearly we feel she deserves more than we are able to give her now.

From the Grandma we know to the Grandma we now visit in the hospital words can't describe our feelings. but enough to say that an animal in so much pain and discomfort would be allowed the dignity to die. Grandma has had enough, but she is not allowed to have her wish to go peacefully and now, this was not our choice but hers and we are helpless to grant her her last wish.

We hope this will help all the other Grandma's and terminally ill people who also want to be released from their pain and suffering. After all it is their pain and they are the ones who need to have the choice not us who are healthy and debating this issues. Please pass the bill for euthanasia.

Written by: Y Fitzpatrick & L. Walter.

Signatures:

K. Masters, Brenda Masters, Chris Masters.

SUBMISSION 667 1

PO Box 3383

Alice Springs NT 0871

24th March 1995.

Chairman

Select Committee on Euthanasia

FAX 089 816158

Dear Sir,

As a resident of the Northern Territory I hereby lodge my objection to the proposed Euthanasia Bill.

I strongly believe that the of abuse of Euthanasia is a grave possibility and is also a risk to the lives of other sick, vulnerable citizens and could permit unnecessary but preventable deaths.

I wish to see the Government investigate further the need for palliative care as I believe it is the most life respecting answer to the needs of the dying. I honestly believe that the only people a Euthanasia Bill would take care of is those distressed at seeing a loved one sick.

As a voter of the Northern Territory I do not wish to see this Bill approved.

Yours faithfully,

(Mrs) Kathlyn McGargill

SUBMISSION 668 1

"Granada Court"

18/40 The Esplanade

Darwin 0800 NT

18.3.95

Sue Carter

Convenor

W.A.C. N.T. House

Dear Sue,

I am fully in favour of the Chief Minister, Marshall Perron's "The Rights of the Terminally Ill" Bill with the following provisos.

1. That adequate Palliative Care and Pain management is first made available to the Patient wherever possible.

2. The Patient receives appropriate counselling and information prior to signing the "Request for Assistance to End My Life" form, including free legal assistance if necessary.

Also appropriate counselling to be available to Medical Assistants and any other concerned party after the action has taken place.

A Register of Drs and the history of the unnamed patient to be kept by the Registrar General for statistical purposes, and to prevent abuses to the system.

Yours faithfully

F. R. Blandy.

SUBMISSION 669 1

FULL GOSPEL BUSINESS MEN'S

FELLOWSHIP INTERNATIONAL

TENNANT CREEK CHAPTER NO. 12017

UNDER THE AUSPICES OF THE ALICE SPRINGS CHARTERED CHAPTER NO.7752

PO Box 1029

TENNANT CREEK

N.T. 0861

23 March 1995

The Chairman

Select Committee on Euthanasia

P 0 BOX 3721

DARWIN NT 0801.

Dear Chairman,

Please receive this submission from the Full Gospel Business Men's Fellowship International, Tennant Creek chapter.

The proposed Bill that the Select committee is considering is an intention to legalise the option of assisted suicide as a right of a sane adult person suffering from a terminal painful illness who has been diagnosed as having a life expectancy of twelve months or less. Underpinning this Bill are ethical and moral views which, though related to religious thinking, are also related to a number of human rights in general.

Prior to outlining five such notions we wish to affirm that as Christians euthanasia is incompatible with our understanding of the Gospel of our Lord Jesus Christ, and the sanctity of life as revealed throughout the Bible which we accept as the word of God.

The 1991 Census clearly indicates that a clear majority of Territorians claim a Christian heritage which will vary amongst people as illustrated by the different denominations. However, all Christians hold that there will be a resurrection and that all people will be

accountable for their own decisions and all their own actions.

However, we also contend that in terms of the moral and ethical traditions of our society, the proposed terminating of human life by medical practitioners creates serious problems in terms of human rights. These problems are outlined in the following five statements.

In the proposed Bill:

1. It claims that the value of life and the quality of life are the same thing. That is, anybody having a serious disability is seriously diminished in value. Such a rationale is contrary to our society's current rejection of suicide as a human right, for those dissatisfied with their earthly existence.

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2. It assumes suffering devalues life and in so doing denies the moral tradition of triumphing over, though not necessarily surviving, adversity.

3. It contends true compassion is to alleviate suffering of a dying person by hastening death, not by providing loving and caring support. It denies the worth of the historical tradition of Australian soldiers injured throughout this century, where we have responded to them with repatriation and hospitalisation. As a consequence of this Bill the importance of palliative care is diminished for the civilian population.

4. Mankind is equated with other animals which when suffering seriously are frequently put down. In so doing the bill denies the metaphysical personhood of humans. Metaphysical personhood is recognised in many modern culture throughout world which are not rounded on atheism.

5. In presuming that euthanasia can be tidily controlled the Bill is in error, as delineated by the Right to Life News (incorporating Life Letter) Special Euthanasia Supplement, March 1995. This supplement documents the range of international citations of abuses of euthanasia. In so doing it draws our attention to problems in maintaining moral integrity which so frequently befall mankind.

In conclusion. we urge the Select Committee to note the serious deficiencies in palliative care in the Northern Territory; and urge that positive recommendations are made to address this deficiency in medical care.

May God's providence lead you to the right recommendations.

Yours sincerely,

Jim Phillips Rod Geri

Richard Cherry Ian Field

HIS BANNER OVER US IS LOVE

Song of Solomon 2:4

SUBMISSION 670 1

NORTHERN REGIONAL COUNCIL OF CONGRESS

of The Uniting Church in Australia

Incorporatlng

ABORIGINAL RESOURCE & DEVELOPMENT SERVICES INC.

The Secretary

Select Committee on Euthanasia

G.P.O. Box 3721

DARWIN N.T. 0801.

Aboriginal Resource & Development Services is an Aboriginal organisation which has a long history of involvement with many of the coastal Arnhemland communities in helping to facilitate their development and in assisting the people to achieve their aspirations towards self-management and self-reliance. Within the North-East Arnhem region in particular, our staff have accumulated extensive experiential knowledge of the extent to which Aboriginal people feel marginalised when it comes to the many decisions that are made for them and on their behalf, about which they have had little or no say.

While we are aware that the time-frame given to the Select Committee is very short and the opportunity for people in remote communities to have their say across cultural and linguistic boundaries, at this stage in proceedings, is very limited; we nevertheless welcome this opportunity that the Legislative Assembly has provided. We believe it is imperative that Aboriginal people be involved in the debate, because as the most marginalised and vulnerable portion of the N.T. population, the provisions within the current Bill will impact on them to a far greater degree than it will on people of the dominant culture.

ARDS would like to request an opportunity for its staff to speak to the Select Committee when it visits Gove on Thursday 6 April. We believe that we can contribute some significant insights into the way traditional Aboriginal people may be thinking on a critical issue such as this, and feel sure that this will be of benefit to the Select Committee in their deliberations.

Firstly, the Select Committee should be aware that ' **voluntary euthanasia** ' already exists in Aboriginal society (i.e. old people who are ready to die will stop eating and drinking of their own volition). However this decision is not taken by the individual in isolation from the rest of the family or clan, as family members would also begin some of the preparatory mortuary rites in conjunction with this decision being taken. Dying is seen as something

that should occur naturally, even for people who are terminally ill, and any intervention by an outside person or agent should not happen, as it will immediately be seen as an act of murder or sorcery (i.e. an illegal act).

Rev. Dr. DJiniyini Gondarra GPO Box 717, Darwin, NT 0801 Rev. Wali FeJo

Executive Officer Telephone: (089) 81 8444. Associate Executtve Officer
N.R.C.C./A.R.D.S. Facsimile: (089) 81 3285 N.R.C.C./A.R.D.S.

U.A.I.C.C., U.C.A. U.A.I.C.C., U.C.A.

As English is for many Aboriginal people in the N.T. a fourth or fifth language, we need to take the issue of **cross-cultural communication difficulties** seriously. Our communication with people needs to consult the intellect (i.e. it needs to engage people in the language they are processing information in). Facility to converse in everyday English is also no guarantee that any real communication is occuring at a conceptual level as their word picture and yours, as a native language speaker, are likely to be very different. [Recently we had the experience of a man who was in Nhulunbuy hospital suffering from a stroke and whose son was asked to interpret for him. Although it was assumed that satisfactory communication had taken place it was later discovered (by dialogue conducted in his own language) that he had absolutely no idea of what his sickness was.] Also many (i.e. the majority of) Aboriginal people are not literate in the language which they converse in.

Language, and adequate interpreting provisions, is therefore an issue that needs to be considered during the consultation process and also within the content of the Bill itself.

Some of the specific concerns that we have about the proposed legislation in its current form are listed below:

1. The risk of **misdiagnosis** by both doctors and psychiatrists is very high because of language barriers and their lack of understanding about Aboriginal cultural beliefs.

2. Because of cross-cultural communication difficulties, many Aboriginal patients may **not understand what they are requesting or signing** .There should be an obligation on the part of medical practitioners to make sure that, where English is not the first language of the person concerned, there is both **an interpreter and a translation in that language** present.

3. Section 7 which allows for 'others to sign for those who are unable' makes Aboriginal people extremely vulnerable and the potential for abuse is high. It needs to be **deleted** from the Bill.

4. The fear that Aboriginal people have of the hospitalisation process, which is already high, is likely to increase as they begin to hear about the legislation and become aware that doctors are able to inject substances that can kill (i.e. have the power of a sorcerer). Bad news travels fast !

5. In section 9 the **penalty** for what could amount to 'murder' seems inconsistent with other parts of the criminal code.

6. In section 11.2 there needs to be **provision for the family to request** a **Coroner's Inquiry** if they have concerns about how the decision to terminate the person's life was made.

In conclusion we believe that this Bill will lead to further marginalisation and victimisation of Aboriginal people.

I trust that this provides you with a sufficient expression of our interest to be involved in the general debate, but in particular to assist in having Aboriginal opinion heard.

Thanking you,

Howard Amery for :

Rev. Dr. Djiniyini Gondarra

Executive Officer

SUBMISSION 671 1

Tony Cuparso

PO Box 8161

Alice Springs

NT 0871

23-3-95

The Chairman

Select Committee on Euthanasia

GPO Box 3721

Darwin NT 0801

Dear Chairman,

I would like to express my concern of the proposed private members bill on euthanasia.

I clearly understand the motive of euthanasia is to allow person who is suffering extreme pain due to a terminal illness to die peacefully and in dignity. Unfortunately I feel that the implications of euthanasia will effect far more than the autonomy of the individual.

Firstly, it is condoning killing. Our culture, law and society in general are based against the idea of killing. It is an offence to commit suicide, it is illegal to execute a condemned prisoner. By making euthanasia legal is giving our society the green light that to kill someone under certain situations is all right.

Secondly, I find it impossible to believe that it would be done honestly. If we believe this, we are a very naive society. There is an extensive legal system that deals with the dishonesty of people. It is a fact that life insurance can not be taken out on a child that is under then years old. The reason being that parents have been successfully prosecuted because they have killed their child to receive the insurance money.

These are two important issues that I wish you to consider to stop the proposed bill. Furthermore instead of going down this path of euthanasia much thought should be made in trying to develop palliative care programmes. I understand that at the moment in Alice Springs there is only one bed set up for this in the hospital. It is a serious alternative and a definite solution to allow someone to die in peace with their family and friends, or someone who clearly cares and understands. Let us develop policies that builds a society that cares for each other.

Yours sincerely

Tony Cuparos

SUBMISSION 672 1

PO Box 42952

CASUARINA NT 0811

The Chairman

Select Committee on Euthanasia

GPO Box

DARWIN NT 0801

Dear Sir/Madam

THE RIGHTS OF THE TERMINALLY ILL BILL

I would like to express my support of the above bill.

I have had personal experience of a very close relative who wanted to die four months before her death and to watch the frustration, pain and loss of dignity was a depressing and heart-rending experience.

Australians have the right of choice with everything pertaining to their body, eg medication, lifestyle, life, birth control, etc and I think it befitting that they should have the right to die with dignity, without frustration and the choice to end their life knowing that all their "affairs" are in order.

Yours sincerely

Lucille Kuster

SUBMISSION 673 1

AUSTRALIAN MEDICAL ASSOCIATION

NT BRANCH

VOLUNTARY EUTHANASIA AND THE RIGHTS OF THE

TERMINALLY ILL BILL

THREE DECADES OF CHANGE

There is no doubt that Western communities including Australia have become increasingly interested in Euthanasia as an option for the dying person over the last thirty years.

This time period has ostensibly seen a decline in the authority of the Christian Church within our community. This decline in authority is not uniform, it is more marked within the Protestant Churches than in the Catholic or Fundamentalist Churches; it is more marked within certain cultural groups such as those of British and Western European extraction than it is in those of Mediterranean or Eastern European extraction; it is more marked in out cities than it is in our rural communities.

The Christian Church has become increasingly irrelevant to certain community groups appearing out of touch in matters as diverse as abortion, gay and lesbian rights and genetic engineering.

It is generally true to say that those Churches which have maintained a strong sense of their identity in teaching and dogma have been those which have suffered the lease from loss of patronage.

At the last Australian Census 82% of the population of the Northern Territory held that they had religious affiliations. The Church remains a pervasive force in our culture with weddings, christenings and funerals being an integral part of our cultural expectation from our religious representatives.

The cultural and religious diversity of Australia has altered markedly with the end of the White Australia police and the coming of multiculturalism. Testaments to this are seen in the racial mix within our shopping malls and the Mosques, Temples and other places of worship which are common in our towns and cities. These new religions have not been part of the foundation of our legal system as Christianity has and neither do they readily recognise other Australian institutions such as the British Monarchy yet we pride ourselves upon the way that they have been integrated into our society.

The 'boom' in information technology has meant that individual access to knowledge is dramatically increased and thus there has been an attendant increase in questioning of our institutions and their leaders bot at community level and in the individual mind. The media is ever watchful, they keep up a never ending torrent of investigation, suggestion, commentary and innuendo aimed at our public figures and their organisations. The modern leader must be able to interact with the media successfully both to get his message to the people and to succeed in the goals of the organisation represented.

It is a high risk policy and the price of this leader-media interaction is the political casualty injured by impropriety or inferred impropriety of an amazing array of complexity, sexual, financial etc. Negative presentation of this information produces a view that there is no honesty within our political and other representative institutions.

The nuclear family has come under pressure. Gay and Lesbian people seek recognition of their relationships on an equal footing with the traditional family. They require that this recognition should be equal in everyway including for instance equal property law rights, access to in-vitro fertilisation programs, child adoption and legal recognition of their marriages.

The housewife has been discriminated against by Government in taxation policy and encouraged to go out to work and put the children into daycare.

Single mothers have become a normalcy within society. Our elderly people have a reduced role within the family. Improved communications technology and transport modes means that it is not unusual for young people to set up homes isolated from the town's of their birth and isolated from the support of their extended family.

The social security net has been cast ever wider during this period of nuclear family value destruction.

The consumer revolution has spawned the cult of the 'beautiful individual' we see this everyday in the newspapers, in magazines, on television and at the cinema. The entertainment media sell life, beauty and youth they despise and denigrate death, ugliness in all it's diversity and age. Our shops offer us an extraordinary array of designer goods so that we too can become one of the beautiful people one of the Martini set!

Consumerism has come to medicine with the aid of the Federal Labour Government and the Australian Consumer Health Forum. These groups have worked on the premise that the health of Australians cannot in the final analysis be improved by doctors and nurses treating ill health. They believe that prevention and social engineering are the way to improve individual health. As part of the strategy to demedicalise medicine, consumerism has been actively encouraged. Many aspects of this consumerism have had beneficial effects such as better doctor patient communication and better general information about medicine within the population. The downside to consumerism is seen in the manipulation of medicine by lobby groups such as the Women's health lobby and the Gay and Lesbian lobby whilst other groups are ignored for instance the aged and aborigines. Health decision making has been none to subtly removed from the medical professional and placed in the hand of bureaucrats and consumers! The net result is maldistribution of health dollars to the politically strong and away from the weak.

Medical Technology has seen a huge growth since 1970 and an attendant increase in costs, thus the reality of health economics and rationing are an everyday part of life for the clinician.

Civil rights in America, Red Indian rights in Canada and Aboriginal rights in Australia are all phenomena of the last thirty years that have focused our attention on human rights. The information boom brings abuses of human rights into our living rooms everyday be they executions in China, atrocities in Rwanda or Aboriginal health standards in Australia. People

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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.

Taken as a sum these changes within our society have focused the individual attention away from the immediate community, that is to say away from the Church, the family, cultural and ethnic groupings and away from the traditions of the rural townships. These changes have allowed us to focus upon ourselves as autonomous individuals who are a part of the Society of Australia and a part of the greater world society.

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.

THE PRO-EUTHANASIA

The techniques used by the Pro-Euthanasia Lobby in Holland are the same as those which have been used in Australia.

Initially it has been necessary to start a debate within the community at a relatively simple level asserting that it is each individual's right to determine the manner of their death. The arguments are couched in comfortable rhetoric such as dying with dignity and the right to die. The Church, doctors groups and other opposition is marginalised as 'traditionalist' and as not having the right to interfere with individual rights since they are not representative of majority opinion. Opinion polls form a large part of the rationale for the Pro-Euthanasia Lobby. Studies purport to demonstrate that doctors and nurses already perform euthanasia and that a majority would do so if it were not illegal. Palliative care is described as inadequate for many situations. Legislation to enable euthanasia is described as being simple and able to be circumscribed to the consenting, competent adult without flow on abuse effects. Those who invoke the 'slippery slope' argument are labelled as hysterical or ill-informed or mal-intentioned or emotive or all of these.

Each of these aspects of the Pro-Euthanasia Lobby might be grouped under the heading of autonomy arguments and they clearly warrant individual examination. This is as far as the majority of euthanasia supporters would go but their leaders go much further!

It needs to be recognised that voluntary Euthanasia is only an initial goal of the Pro-Euthanasia Lobby leaders Kuhse and Singer, they have a clearly documented agenda to introduce involuntary euthanasia and their current writings clearly state as much. This means that they support the killing by euthanasia of deformed children, mental defectives, severely disabled people and the frail aged especially if they are senile. Voluntary euthanasia is the first step *in* their plan, it establishes the principle that life can be taken under certain circumstances.

Is there a right to die?

Australian and International Law holds that there is an inalienable right to life, witness the following:

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Article 6 of the International Covenant on Civil and Political Rights states: 'Every human being has the inherent right to life. **This right shall be protected by law. No one shall be arbitrarily deprived of his life.'**

This means that life cannot be taken away from someone and it also means that they cannot forfeit their life. This is clear to us all when we consider our dismay at the rates of youth suicide in Australia, it is clear in the law which makes assistance to suicide a criminal offence!

The community views as abhorrent the crime of murder and demands the strongest penalties and indeed this is what the law provides. If you kill a person whilst driving because culpable behaviour you will be convicted of manslaughter again the community says that this gross behaviour is to viewed seriously and that a deterrent gaol sentence is appropriate.

The collective consciousness takes these views and the law the land reflects them because life is sacrosanct and this attitude reflects in turn the religious origins of our law.

In more recent times the question of whether life is always sacrosanct has been raised at law and there has been a tendency for things to become less clear. We have wrestled with the abortion debate and more recently with the questions that arise from the handling of genetic material. The recurring theme of the precious nature of life versus the rights of the individual is seen nowhere in clearer counterpoint than requests for amniocentesis in order that female children can be aborted!

The Pro-Euthanasia Lobby argue that one has no true right to life unless one can dispose of

The International Right to Life legislation was developed in 1948 when the extent of human rights abuses during the Second World War became known, the legislation was developed to protect life from premature end at the hands of despotic governments and other agencies, it is a distortion of fact to argue that it is meant to apply to the natural death or peri-death situation, it is a distortion of fact to argue that the right to life implies a right to dispose of one's own life.

The fact of the matter is that when the Pro-Euthanasia Lobby speak of the right to die they really mean the right to be killed. Such a right as that to be killed does not exist within Australian or International law. The State cannot allow such a right to be considered unless it can be certain that allowing such a right to a small group [in this case the terminally ill] will not have adverse effects upon the weaker members of our community and will not impinge upon the civil rights of others such as the doctors who are called upon to perform this action of killing.

The Director of the Hastings Centre an esteemed American ethics institute concluded that **'to describe euthanasia as a valid expression of autonomy is self-determination run amok.'** [Hastings Centre Report Mar-April 1992:52-55]

The Christian Church and Other Religions.

The Pro-Euthanasia Lobby argues that the Christian Church has lost sway and now represents a minority of Australians. This is not borne out by the last Census of Australians when the following results were obtained in the Northern Territory.

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Of a total of 169,000 people in the NT on the night of the census the following were their listed religious affiliations:

Anglican 30005
Roman Catholic 40530
Assemblies of God 485
Muslim 623
Baptist 5184
Buddhism 1381
Church of Christ 416

Greek Orthodox 3009
Jehovah's Witness 475
Judaism
Mormon's 468
Lutheran's 7137
Presbyterian 4445

Seventh day Adventists 347

Uniting Church 15745
Salvation Army 644

Traditional Aboriginal 2907

No Religious affiliation 31572. Thus 82% of the population hold religious affiliations. [Source: Australian Bureau of Statistics.]

The Christian Church remains an integral part of the fabric of Australian society permeating our Law, Culture and Ethics as a community. It is quite wrong to argue that the Church is so marginalised that it is now irrelevant to such a basic cultural argument as the way in which we will treat death and dying. It is incorrect to argue that an individual can make decisions about themselves in isolation from those opinions which continue to form the basis of law. The High Court of Australia has ruled on a number of occasions through the 1980's to support the rationale behind a law rather than it's strict wording. In just this fashion there can be no argument that the intention of our law in regard the inalienability of life is that it is sacrosanct!

It is worthy of mention here that the two other monotheistic religions Judaism and Islam both hold that life is sacrosanct. The Hindu Society in the Northern Territory finds Euthanasia offensive. Buddhists may or may not be opposed to Euthanasia.

Doctors and Nurses Organisations.

The Pro-Euthanasia Lobby argues that doctors in fact support Euthanasia and thus their representative organisations such as the Australian Medical Association should not take a position but in effect allow a conscience or individual vote. This argument is both flawed and simplistic. The argument is flawed in that doctors and nurses as will be shown later are confused about their responsibilities, they do not have a uniform understanding of what Euthanasia is, they do not understand their legal obligations. This situation arises because of the low priority given to the dying patient, we are trained to treat the living! This situation arises because ethics and medicolegal issues are not taught in medical school. The argument is flawed in that the Australian studies into Euthanasia are unreliable. The argument is simplistic in that it implies that medical ethics are a matter for a democratic vote this is not of course the case. Ethics change only slowly and often are at odds with day to day practice.

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Other Opposition.

Aside from the Church and Doctor's organisations the Pro-Euthanasia Lobby lists one other group of opponents who are listed as non-religious slippery slopers ie those who have legal and moral objections to euthanasia. It is recommended that these individuals be dealt with as before by reminding them that they have no need to interface with the legislation if they find it difficult.

Opinion Polls.

The fact that 80% of the general population support Euthanasia in Morgan and Newspoll opinion polls are an

important part of Pro-Euthanasia Lobby propaganda. The Lobby does not outline the reasons that the House of Lords Inquiry in the UK dismissed the polls {at 79% in favour} although the reasons are well known. Is opinion polling a valid way to test an ethical question? Is it possible to put ethical questions so that pollsters can be sure that each respondent has understood them in the same way? Can a moral and ethical question be decided on the basis of an opinion poll as occurs in certain states in America viz Washington State and Oregon.

Morgan Poll asks the following 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?**'

This question contains the assertion that the patient will be in great pain and has not been changed for twenty years. During this time we have seen the advent of palliative care as a specialty. Morgan-Gallop has been asked to change the question on multiple occasions in the light of advances in Palliative Care but refuses to do so. The poll is flawed.

The Newspoll published in the Australian newspaper of 23\24 August 1994 asked: '**Thinking about Euthanasia where a doctor complies with the wishes of a dying patient to have his or her life ended. Are you personally in favour or against changing the law to allow doctors to comply with the wishes of a dying patient to end his or her life.**

The Newspoll expects people to have a uniform understanding of the word Euthanasia- Since medical professionals do not understand the details of the concept, and since there is no established workable definition of Euthanasia the poll is flawed. Witness the 'youth-in-Asia' reply to a recent street questionnaire! [Bushranger Sunday Territorian Feb. l2th 1995.] This particular question was asked after a question about whether or not Mr Kerry Packer should be allowed to expand his holding in Fairfax! I invite you to ask yourself what would be the answer to a poll question that asked whether a severely deformed child with no prospect of a long life should have euthanasia?; what would be the answer if the individual was mentally deranged with no prospect of a life as we appreciate it?; what would be the answer if the individual was severe physically disabled and unable to communicate in anyway but probably mentally normal?; I submit that the answers to al these questions would subtend to 80%, the community is not favour of suffering! Does this mean we should legislate to euthanasia these groups within our community also on the ba that a majority of the population think these people's lives are not worth living? The question only has to be asked to be to be ridiculous.

The only place that such an opinion poll could be conducted would be at the deathbed- The British Medical Journal of 29th October 1994 carried a report of a study published in the Journal of Social Science and Medicine- This major study investigated 2200 families-

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Euthanasia was requested by less than 4% of patients and the commonest motive for the request was fear of being a nuisance to the family, that is fear of real or perceived dependency not fear of pain and suffering. Requests for early death were more likely to come from *non*-spouse relatives 28%, spouses were least likely to request that an early death should be procured- The authors state:

'It does provide some evidence for those who oppose euthanasia because they fear that elderly and vulnerable people can be abused. It shows that there are old people being looked after by people who don't have a large emotional investment in their lives continuing and are able to see the positive side of their dying earlier.'

Governments cannot afford to adopt a populist approach to matters of such community import as Euthanasia, the job of Government is to make sure that the community understands the complete nature of active Euthanasia in this case.

These are not episodes of euthanasia they are quite compatible with good medical practice and they must bring into question Kuhse and Singer's assertion since 1988 that euthanasia is a commonplace in our homes and hospitals.

In regard the second criticism of sampling I will quote Kuhse talking about such criticism herself:

The Kuhse\Singer mail survey had a response rate of 46%, the Baume\O'Malley survey one of 76.1%. The earlier survey had been criticised on the grounds that - like most mail surveys - it would have attracted responses from only those who are particularly interested in the issue. This observation may well be correct: it is entirely possible that the response rate from doctors who are either strongly in favour of voluntary euthanasia or strongly opposed to it was higher than the response rate from doctors who occupy the middle ground.

While the much improved response rate of the Baume\O'Malley survey may have helped to counter this possible skewed response, a different survey approach would be necessary to entirely eliminate it.

The study of Stevens and Hassan achieved 60% useable returns and again the mail-out self administered questionnaire format was used. 19% of doctors answered yes to the question:

'**Have you ever taken active steps which have brought about the death of a patient**'. This question was juxtaposed to one about 'withdrawal of treatment' and the authors opine thus: **No definition of the term 'active steps' was given in the questionnaire as it was considered the meaning was implicit in the Juxtaposition of the term with the phrase 'withdrawal of treatment', and that no confusion should therefore exist between passive and active euthanasia in this context.**

That this is in fact not the case is demonstrated in the earlier discussion in this section.

Nurses attitudes have also been surveyed by Kuhse and Singer in: **Euthanasia: a survey of nurses attitudes and practices. Australian Nurses Journal March 1992:21-22.**

This study purported to show that 85% of nurses had assisted in voluntary euthanasia and that 80% had done so on more than one occasion.

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Voluntary euthanasia and the nurse: an Australian Survey, 1993: Int. J.Nurs.Stud, 30[4],311-22.

This mailout survey had a 49% response rate and purported to show that 65% of nurses would be willing to help in voluntary euthanasia and that 78% thought the law should be changed to enable that to occur. Again these studies provide no definition of euthanasia active or passive and do not seek to understand what nurses mean when they talk about euthanasia thus there is no way of knowing whether any of the reported acts were euthanasia of any description or not!

The Pro-Euthanasia Lobby has drummed up an argument with the publication of these studies, studies which are manifestly inadequate. They have steadfastly maintained the accuracy of their results despite informed argument from many neutral sources.

Kuhse stated recently in the AMA forum Ethics and Law - The Dying Patient

- a large majority of the Australian population [nearly four out of five] would like doctors to be able to lawfully practise direct voluntary euthanasia,

- a considerable number of Australian doctors [nearly one out of three] already practise direct voluntary euthanasia,

- a majority [nearly two out of three doctors] want the law changed so that direct voluntary euthanasia

and/or medically assisted suicide will be lawful.

- an even larger number of nurses [more than three out of four] would like the law changed to allow direct voluntary euthanasia by doctors, and a large majority would be willing to assist doctors in this task.

There is my opinion no entitlement to draw these conclusions from the published work in Australia.

These studies are not reliable and should certainly not form part of a pseudo-scientific basis for Governments to legislate Euthanasia.

The Slippery Slope.

The Pro-Euthanasia Lobby argues that voluntary euthanasia can be quarantined. This is essential to their debate as only by legislating voluntary euthanasia can the non-voluntary aspects of their agenda be discussed and legislated.

That voluntary euthanasia can be quarantined is fallacious. The following examples will be discussed at length. The Nazi experience. The Dutch experience. The Australian experience.

I personally do not ascribe to the slippery slope theory I think that it is so certain that voluntary euthanasia is accompanied by abuse that it is as certain as night follows day. So in my view to invoke the idea of a progression from voluntary to other forms of euthanasia is wrong. I ascribe to a view which says that if we accept a law on voluntary euthanasia alone we deliude both ourselves and the community, this is in fact a package deal!

It is essential to recognise that the facilitation of voluntary euthanasia is, in substance, the facilitation of all these following together'. non-voluntary euthanasia, even involuntary euthanasia, physician assisted suicide, and all in only so-called terminal illness, but also [as recently demonstrated in Holland] in circumstances of mental anguish. It is not a question of a slippery slope: it is a question of the logical inclusion of all these elements into one group, or one package. [Norelle Lickless, Director Palliative Care, Royal Prince Alfred Hospital NSW in the AMA forum Ethics and Law- The Dying Patient Aug.1994.]

The Alternate Agenda.

The leaders of the Pro-Euthanasia Lobby in Australia have a broader agenda than voluntary euthanasia. The following quotes will demonstrate their alternate agenda.

When the death of a defective infant will lead to the birth of another infant with better prospects of a happy life, the amount of happiness will be greater if the defective infant is killed. The loss of a happy life for the first infant is outweighed by the gain of a happier life for the second. Therefore, if killing the haemophiliac infant has no adverse effect on others, it would, according to the total view, be right to kill him. [Singer. Practical Ethics 1989. Pg134.]

..there is a limit to the burden of dependence which any community can carry. If we attempt to keep all handicapped infants alive, irrespective of their future prospects, we will have to give up other things which we may well regard as at least as important. Kuhse and Singer 1985, Should the Baby live?

The duty to suicide occurs when through my continued living lack of autonomy, misery, isolation uniformity, unfruitfulness, incurability, lameness, pain, insensitivity, disgrace, madness, sin threaten to become the norm for humanity and my suicide is the only means available to me to prevent this. Mynen. Deutsche Gesellschaft fur humanes Sterben 1982.

"The New South Wales Humanist Society has suggested that 'converting some forms of non-voluntary euthanasia to voluntary euthanasia is very desirable'. It suggested the possibility of a 'senile degenerate' having signed prior consent to being killed 'while still in possession of his faculties'. They further suggest

that the law could be changed allow 'the mentally ill, the right of consent to euthanasia'. As for babies 'born with severe mental or physical disabilities, such as are sure to make it a misery to itself or to those who have to look after it, its life should be terminable by legal process before any person becomes emotionally attached to it.' This could be done by 'passing a law granting to parents a right to assign certain discretion to a doctor'.

The New South Wales Humanist Society refers specifically to 'Babies grossly mentally or physically handicapped. Children grossly mentally or physically handicapped. The severely mentally afflicted. Senile degenerates. It does seem undesirable to keep these unfortunates alive. Their continued existence burdens relatives, friends and the community, and often, though not always themselves.' [J.Fleming .Euthanasia, the Netherlands and Slippery Slopes.]

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Surely it is correct to flag the existence of an agenda beyond voluntary euthanasia when the leaders of the push for that legal reform in Australia express views as detailed above.

One must also question the level of commitment of the Pro-Euthanasia Lobby to true human autonomy and to the rights of individuals in the light of the above. It is manifestly the case that in the eyes of the lobby some individuals are more equal than others!

SOME SPECIFIC TOPICS FOR DISCUSSION.

The Nazi experience.

Those who promote voluntary euthanasia as a suitable option for the dying Australian cry foul when the historical perspective of euthanasia in Nazi Germany is raised. The facts of the matter are that the Holocaust occurred within living memory in a 'civilised' Western European country and that much contemporary German opinion holds that the practice of voluntary euthanasia in the 1930's had a direct and facilitating effect on the genocide conducted by Germany in the Second World War.

The beginnings of euthanasia in Germany were confined to high ranking Germans and euthanasia was promoted by German medical figures as being the correct and honourable thing to do, this was so much the case that it is interesting to note that Jews were excluded from the right to death by euthanasia initially. After Hitler's rise to power in 1933 euthanasia was increasingly used as a tool to eradicate the aged the weak and the infirm before being turned to the task of ethnic cleansing.

The way for this evolution had been prepared by doctors, and clerics who had espoused the practice earlier, in contravention of their professional obligations and undertakings to protect human life. It is a matter for serious reflection, with current parallels, that this was the path of progression, and that the doctors who later participated in genocide were all volunteers. What had started as the disposability of the unwanted, incurable sick because their lives were thought to have lost value, quickly grew into something more sinister. [Pollard *in* The Challenge of Euthanasia 1994 page 58.]

Before the postwar trials in Germany it had been generally assumed that the mass killings were exclusively the work of a relatively few fanatical SS leaders. But the records of the courts leave no doubt of the complicity of a number of German businessmen, not only the Krupps and the directors of the I.G.Farben chemical trust but smaller entrepreneurs who outwardly must have seemed to be the most prosaic and decent of men, pillars- like good businessmen everywhere - of their communities. William L Schirer The Rise and Fall of the Third Reich Page 1157.

Modern communities should ask themselves how it can be that a modern nation became involved in such atrocity! It is not correct to say that the population did not know. It is correct to say that they had been gradually

desensitised by the devaluation of life which they had witnessed in the years 1930-1945.

The Holland experience.

Holland is the only country in the world with an established euthanasia practice since 1973. In that year a woman doctor was given a one week suspended prison sentence for killing her sick

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elderly mother. Evidence was given that the doctor had only done what was common but unofficial practise amongst doctors. The court outlined a number of medical conditions which in its view could justify the killing of a patient. The Court in Rotterdam upheld the earlier conclusions in 1981 and 1983 stating a **doctor who terminates the life of** a **patient at the latter's expressed and serious desire no longer should be punishable, providing that a number of conditions have been met.** The practice of euthanasia in Holland is not legal witness the statute book Article 293 of the Dutch Penal Code:

Taking the life of another person even at that person's express and serious request, is a serious offence against human life, punishable by up to 12 years in Gaol.

But the Courts allow an indemnity to doctors who practice it. The condition under which euthanasia is allowed is very similar to the voluntary euthanasia Bill proposed for the NT. The Royal Dutch Medical Association [KNMG] published guidelines for voluntary euthanasia in 1984 and 1987. The guidelines include that there be unacceptable suffering, the request be voluntary, well considered and durable and that a second doctor be consulted.

Since 1984 the Courts no longer require that a person be terminally ill the doctor can plead 'force majeur' that is that the doctor faced with the choice of leaving the patient suffering or to give relief by killing will be not prosecuted at law if he or she takes the 'compassionate, avenue.

Details of the Remmelink report were translated to English and reported in the Lancet 338:8768 14th September 1991.

The Government of Holland [Remmelink was Attorney General] commissioned Dr Van der Maas to report on the first years of euthanasia in 1990. It is important to understand three things about the Remmelink report.

- The report was written by supporters of the euthanasia legislation and reported that all was going well and that the people of Holland should not have any concerns.

- The report was exhaustive in it's inquiry and exact in it's reporting and on the strength of the report the Dutch Government decided not to legalise euthanasia.

- The figures in the Remmelink report show widespread abuse by Dutch doctors of the strict voluntary euthanasia guidelines!

The techniques employed by Dr Van der Maas and his commissioners to gather information included firstly interviews with 400 doctors involved in Euthanasia- a retrospective study, secondly examination of death certificates with questioning of the attending physician's and thirdly a six month prospective study of euthanasia practice.

There were 25000 medically assisted deaths in 1990. The deaths were described in the following categories.

Total Medically Assisted Deaths 25306

- Euthanasia upon request 2300

- Assisted Suicide 400

- Life ending treatment without request 1000

- Non-treatment or cessation of treatment 4756

upon request.

- Non-treatment or cessation of treatment 8750

without request.

- Morphine overdose to terminate life. 8100

of these decisions were without consent.

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25306

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14691 deaths occurred without consent.

The major areas of concern are that although the commissioners only reported 2300 case of euthanasia they clearly record 1000 cases of involuntary euthanasia.

Sometimes the death of a patient was hastened without his or her explicit and persistent request. These patients were close to death and were suffering grievously. In more than half such cases the decision had been discussed with the patient or the patient had previously stated that he would want such a way of proceeding under certain circumstances. Also, when the decision was not discussed with patients, almost all of them were incompetent.

There were 4941 cases listed under 'pain control' who are described as receiving overdoses of morphine without their knowledge with the express intent of killing the patient. This means that there have been 5941 cases of euthanasia which have occurred against the wishes of the patient or without their knowledge in addition to the 2300 'recognised' cases. In addition 6450 cases where medicines were used to relieve suffering in large does without the knowledge or against the wishes of the patient. A total of 14691 cases where end of life decisions were taken by doctors without consent.

The Australian experience.

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

When medicines administered to a patient with an honest design, to produce alleviation of his pain, or cure of his disease, occasion death, this is misadventure, in the view of the law: and the physician or surgeon, who directed them, is not liable to punishment criminally. [Sir Thomas Percival in Medical Ethics 1803]

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 that 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.

Our local Australian Medical Association Executive has 220 doctor years of accumulated practice all around the world and not only have none of us been involved in euthanasia we do not know anyone who has. Does this mean that we are unrepresentative of the profession in regard death practice? I think not. I believe that as highly motivated doctors who are leaders within the medical community we have a clearer understanding of the issues, in this case a clearer understanding of what euthanasia is.

In early February 1995 I asked the Federal President of the Australian Medical Association Dr Brendan Nelson to write to the Chief Minister expressing the Federal Executives views. That letter was sent on 6th March 1995 and I will quote from it at length.

· ...the view that doctors and their patients should remember is that they have an obligation to uphold the value of human life and to ensure that death occurs without pain in a dignified manner.

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.

In this day and age people should not die undignified and needlessly painful deaths. Doctors should be educated about modern palliative care techniques, pharmacological and other treatments should be available to the patient and his or her and Government's have an obligation to see care services are well funded and resourced. Doctors should deliver whatever level of treatment is provided ensure a pain free death, even if such treatment in itself death.

. . . .Your legislation does not secure and protect patients rights but in the view of the AMA diminishes them...

There is no more complex nor emotional area of human endeavour the care of dying people. Not all things in life can be regulated and it is an issue that is neither black nor white. As doctors we will continue to treat individual as just that. Every death, like every birth is the one that came before and these matters are best left to ethics, morality, commonsense and the mutual regard that a patient and doctor should have for one another. It is far better that doctors go to work believing that they have an obligation to maintain the value of human life and treat exceptional circumstances according to their conscience.

. . . .you do not enjoy the support of the majority of the medical profession in this matter although I respect the views of our members who would disagree.

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Studies involving the nursing profession produce results in the hands of Kuhse which purport to show overwhelming support for euthanasia but again the flaw of no definition of euthanasia causes the same mistakes in information process that have occurred amongst doctors. Other studies of nurses attitudes show quite different results *in* nurses opinion!

This exploratory study examines the ethical justification that cancer care and dementia care nurses gave for active voluntary euthanasia. A convenient sample of 319 nurses in seven countries was interviewed using a structured interview guide. The great majority of the nurses could not ethically justify active voluntary euthanasia. Even if the law changed, only 9 of the total sample viewed active voluntary euthanasia as ethical.

For those 9 nurses who could ethically justify euthanasia the majority did so because of patient suffering. [An international perspective of active euthanasia: attitudes of nurses in seven countries, Davis et al. Int. J. Nurs. Stud. Aug 1993:30{4}:301-310.

Naturally most doctors, should your legislation be successful, would be acting out of compassion. However I am concerned about a very small number, whose intentions may not be of the best and who could bow to pressure from less well motivated members of the immediate family.

You were correct to say that if there is 'evil intent' among a small number of doctors that this will exist no matter what the law may say. Unfortunately however, the legislation you propose is likely to offer more protection to them than the current situation. [Brendan Nelson to the Chief Minister March 6th 1995.]

It is difficult to anticipate the effect on doctor patient relationships in Australia however we can draw upon the deterioration in those relationships in Holland.

The Dutch Patients Association stated in 1985 that: **The fear of euthanasia among people has considerably increased.**

A group of severely handicapped adults wrote to the Parliamentary Committee for Health Care and Justice thus:

We feel our lives threatened...We realize that we cost the community a lot... Many people think we are useless... often we notice that we are being talked into desiring death... We will find it extremely dangerous and frightening if the new medical legislation includes euthanasia.

In the Northern Territory the Chief Minister has expressed concern that Aboriginal groups will be afraid to attend hospital. In a personal communication dated 6th March 1995 he quotes the issue of euthanasia being raised in the following fashion by Aboriginal leaders:

We have been talking about that law which Marshall Perron is making next week. We are all really frightened.

Another said:

Yes. We heard about it too. They reckon the government is going to round up all the real sick people and those with V.D. and things like that and finish them off. That's not the Aboriginal way. People are frightened to go to hospital now.

Doctors, nurses and hospitals are people and places for healing not for killing. It is my view that there will inevitably be groups within the community who will not trust medical practitioners if they have the power of death over patients.

Morals.

Morals are what is considered virtuous by the community according to civilised standards of right and wrong. The study and application of morals is based on right conduct rather than on principles of law or of custom. Thus a doctor can say 'It is not what the law tells me I can do but what my heart and sense of justice tell me I should do!'

There is little need for [amendment or additional] legislation in respect of the terminally ill patient, the great majority of life and death decisions can be based on good medical practice which is contained by relatively clear legal and moral guidelines. [Mason and McCall, Law and Medical Ethics. Butterworths.l987.pp245-246.

Ethics.

Because of their specialised knowledge and expertise, doctors have a professional responsibility to maintain and improve the health of their patients who, either in a vulnerable state of illness or for the maintenance of their health, entrust themselves to medical care.

Over the centuries, doctors have held to a body of ethical principles developed primarily to guide their behaviour towards patients, their professional peers and society. The Hippocratic Oath was an initial expression of such a code. These codes of ethics guide doctors to promote the health and well being of their patients and prohibit doctors from behaving, if opportunities arise, in their own self interest. The Australian Medical Association Code of Ethics represents the core of fundamental principles which should guide doctors in their professional conduct.

The code say this of the dying patient:

Always bear in and 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 be futile.

The World Medical Association Declaration on Euthanasia adopted by the 39th World Medical Assembly, Madrid, Spain, October 1987 states:

Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow it's course in the terminal phase of sickness.

The World Medical Association Statement on Physician-Assisted Suicide adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992 states:

Instances of physician-assisted suicide have recently become the focus of public attention. These instances involve the use of a machine, invented by the physician who instructs the individual in it's use. The individual thereby is assisted in committing suicide. In other instances the physician has provided medication to the individual with information as to the amount of dosage that would be lethal. The individual is thereby provided with the means for committing suicide. To be sure, the individuals involved

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were seriously ill, perhaps even terminally ill, and were racked with pain. Furthermore, the individuals were apparently competent and made their own decision to commit suicide. Patients contemplating suicide are frequently expressing the depression that accompanies terminal illness.

Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient.

Here are the summary conclusions of the British House of Lords Report of the Select Committee on Medical Ethics 31st January 1994.

278 - we recommend that there should be no change in the law to permit euthanasia.

279 - We strongly endorse the right of the competent patient to refuse consent to any medical treatment.

280 - If an individual refusal of treatment by a competent patient is overruled by the Court, full reasons should be given.

281 - We strongly commend the growth of palliative care services in hospices, in hospitals and in the community.

282 - Double effect is not in our view a reason for withholding treatment that would give relief, as long as the doctor acts in accordance with responsible medical practice with the objective of relieving pain or distress, and without the intention to kill.

283 - Treatment limiting decisions should be made jointly by all involved in the care of a patient, on the basis that treatment may be judged inappropriate if it will add nothing to the patient's well being as a person.

284 - We recommend that a definition of pvs [PERSISTENT VEGETATIVE STATE] and a code of practice relating to its management should be developed.

285 - Development and acceptance of the idea that, in certain circumstances, some treatments may be inappropriate and need not be given, should make it unnecessary in future to consider the withdrawal of nutrition and hydration, except where its administration is in itself evidently burdensome to the patient.

286 - Treatment-limiting decisions should not be determined by considerations of resource availability.

287 - Rejection of euthanasia as an option for the individual entails a compelling social responsibility to care adequately for those who are elderly, dying or disabled.

288 - Palliative care should be make more widely available.

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289 - Research into pain relief and symptom control should be adequately supported.

290 - Training of health care professionals should prepare them for ethical responsibilities.

291 - Longterm care of dependant people should have special regard to maintenance of individual dignity.

292 - We support proposals for a new judicial forum with power to make decisions about medical treatment for incompetent patients.

293 - We do not recommend the creation of a new offence of 'mercy killing'.

294 - We strongly endorse the recommendation of the previous select committee that the mandatory life sentence for murder be abolished.

295 - We recommend no change to the law on assisted suicide.

296 - We commend the development of advance directives, but conclude that legislation for advance directives generally is unnecessary.

297 - We recommend that a code of practice on advance directives should be developed.

298 - We do not favour the widespread development of a system of proxy decision making.

The Law.

It is often muted by legal minds that the progression in medical technology over the last thirty years leaves doctors exposed legally when they make end of life decisions for patients. When doctors are told this by legal people they are usually not in a position to argue however it is important to note that there is a great body of legal expertise that says it is inappropriate to legislate for every change in medical fashion. These experts hold that the common law interpreted in the light of ethics and good principles of medical practise are a strong basis for end of life decision problem solving.

The strength of the common law principles governing this area lie in their flexibility in the rapidly changing world of medical technology, their regard for the opinion of the profession and their careful balancing of the responsibilities of health professionals and the rights of patients to be given reasonable medical care. [Clark KSM. A Commentary on the NSW Health Department Discussion paper. January 1991]

There are a number of levels of law that guarantee certain rights, the first are United Nations declarations to which Australia is a signatory and they include specifically declarations on the rights of children, the mentally ill and the disabled person.

Under Australian Law Euthanasia is always murder. Pro-Euthanasia Lobbyists try to obfuscate the issue by saying that there is no difference between allowing to die and killing and then go

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on to argue that the change in law is only small and relatively simple. Whilst it is true that the change in law may be technically simple it represents a huge change in the basic position of the common law needing to protect all innocent life. The withdrawal of medical support or allowing to die is a well established medical principle accepted by law, religious, medical, ethical and moral bodies. To legalise euthanasia is to try and legalise murder. It is hard to imagine a more complete reversal of a fundamentally important legal principle.

When the fundamental justification of killing is that patients would be better of dead because of a lack of value in their continued existence, such reasoning already contains the justification also for non-voluntary euthanasia. As clear headed advocates of euthanasia recognise, if euthanasia is at all justified, there can be no good reason for denying it to a patient because he is unable to consent. [Pollard.The Challenge of Euthanasia page 100]

David Kelly a former Law Reform Commissioner for Victoria says that legal voluntary euthanasia would lead to strong pressure for legal non-voluntary euthanasia:

.. would welcome this as entirely appropriate. It is perfectly consistent with the principle of respect for human freedom. Indeed, it seems to me to be required by that principle.

There are four major reasons that euthanasia has not been legislated and they are the following,

1. Difficulty in determining the motivation of the one doing the killing.

2 The possibility of wrong diagnosis.

3. How do you define distress or suffering?

4. Difficulty with ensuring freedom of consent.

Thus legislating for euthanasia not only brings it into conflict with the criminal law it will certainly be used as the basis for other 'exemptions' in the future.

The law is quite clear on the use of therapy to relieve suffering in terminal illness. Lord Devlin in the trial of Dr. Adams:

was entitled to do all that was proper and necessary to relieve pain and suffering, even if the measures he took might incidentally shorten life by hours or even longer. The doctor who decided whether or not to administer the drug could not do his job if he were thinking in terms of hours or months of life.

Lord Donaldson in another case:

the use of drugs to relieve pain will often be fully justified, notwithstanding that this will hasten the moment

of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so.

Palliative Care.

Palliative care is a relatively new specialty in medicine being just twenty years old. During its

short history it has made a great difference to the care of the dying person. The level of comfort possible is so good that there is no place for the word euthanasia in the lexicon of most palliative care specialists. Most palliative care specialists would maintain that it is indefensible for them to be in anyway a party to the purposeful taking of life.

There are a few palliative care doctors who consider that euthanasia should be accepted [and legalised] but this view is strongly opposed by the vast majority, and leaders in the UK, Europe, Canada and the USA. [Norells Lickless. Ethics and Law- The Dying Patient.]

It is quite possible to relieve the majority of patients symptoms completely. It is not possible to relieve all suffering because suffering is a complex and individual issue and is far more complex than just pain.

...sedation is occasionally necessary to reduce suffering associated with intractable symptoms, normally after careful discussion with the patient...but morphine is not appropriately used in sedating doses and should not be increased close to death: other drugs are far more appropriate to assist patients sleep gently in their last days, and the knowledge concerning the most appropriate medical care of patients who are actually dying needs rapid dissemination. [Norelle Lickless. Ethics and Law - The Dying Patient.]

So it is true that whilst palliative care is not a panacea it is a very excellent beginning and as Prof. Lickless states above can in fact respond in an ethical fashion to all end of life situations.

I have outlined earlier in this document the confusion in the professional mind about how far it is reasonable to go in the dying situation and that is why we need specialist palliative care services in the Northern Territory.

It is an unfortunate truth that palliative care services in the Northern Territory in 1995 are essentially inadequate. There is no specialist in the NT and every doctor in fact functions as his or her own specialist. Some do it very well others poorly. The number of inter doctor referrals for palliative care assistance are minimal in my experience. Darwin has two day time palliative care nurses with various ancillary support. After hours patients often take their chances with other patients at the A&E departments of our hospitals. We have no community based hospice system in the NT so that greater than 50% of our people die in acute hospitals which is generally recognised as inappropriate. Katherine and Alice Springs have no dedicated palliative care service.

The Bill.

Part 2 Clause 3.

The definition of terminal illness is problematical. It becomes a more difficult concept still when it is linked with a prognostic period of 12 months.

Whilst most of us are able to recognise the terminal nature of a malignant disease or perhaps of HIV disease as having a terminal phase there are other more subtle illnesses confronting doctors on a daily basis.

Physicians are often confronted with people who are aged, isolated and in chronically poor health. These people sometimes request shortening of their life for various reasons. It is quite

possible to prognosticate for such people who have diseases of involutive and degenerative type to advise for instance that the airways disease or heart disease is terminal and likely to be so within twelve months. Is this the intention of the Bill? If so then the ramifications are far wider than the general public has been led to believe. If it is not the intention of the Bill then the term 'terminal illness' needs accurate definition lest doctors discretion be left as the sole arbitration point for access to the Bill.

Part 2 Clause 4.

Many doctors in the Northern Territory are in isolated situations and are thus the only medical advice and help available. It needs to be recognised that the pressure to fulfil a patients wishes once those wishes are legal may become very great indeed. The situation of isolation has great potential to imbalance the doctor patient relationship in these areas of the Northern Territory.

Part 2 Clause 5.

This clause potentially appears to outlaw protest against those practitioners who may be involved in euthanasia. Is this part of the intention of the clause given recent experience with protests outside Abortion Clinics?

Part 2 Clause 6.

a, That the patient shall have attained the age of 18 years is discriminatory against those of younger years who have equal suffering pain and distress. Since these latter qualities are along with those *in* Clause 3 above the 'arbitration' points for euthanasia practice logic demands that the rights should be extended to minors. As I have said not to do so will be seen as arbitrary, discriminatory and unjustified!

b, This section is open to the criticism that doctors do occasionally make diagnostic errors but very frequently make prognostic errors.

c, This section involving examination by two doctors is the system used for the abortion act and the cremations act. In both these cases the system does not operate in the manner it was envisaged to operate. It is likely that familiarity with the euthanasia Bill should it ever become law will result in a degree of informality around the two doctor provision leading to dangerous shortcomings in control of abuse.

d, Severe pain or suffering or distress is much too broad a category to describe the status of the patient's discomfort. Is it the intention of the legislation that the doctor should entirely exercise his judgement in this area, or are there legislative guidelines that should be considered? Legislators need to be cognisant of the simple truth that pain, suffering and distress are all subjective phenomena and doctors can only make educated guesses about the quality of suffering endured by another individual human being.

h, Studies in HIV infected people show 80% of patients will have psychiatric disease at sometime in the course of their HIV infection. This is perhaps reflected in the USA finding that the suicide rate is 66 times that of the general population.

Similarly multiple studies demonstrate a greater than 50% incidence of major depressive illness in the terminally ill. Treating this has been shown to improve mood and pain tolerance as it does in the non-terminally ill. Judgement of competence should not be a matter left to junior doctors as the tell tall signs of incompetence are often subtle. I believe that a specialist psychiatrist is needed to judge the relativities of competence in these situations especially where a patient's life will depend upon it.

m, This section seems to imply a projection of competence and consent in time, that is that the patient was competent at an earlier time but may conceivably be assisted to die at a time when the competence and consent may have lapsed perhaps due to disease progression. Having once established competence the only reason for the

doctor to reassure him or herself is should the patient have changed their mind or become incompetent. If the time of induced death is remote from the judgement of competence and consent then it needs to be repeated and renoted at the time of death that the patient remains competent and consenting.

Experience from abroad shows that the performance of euthanasia occurs within the hour of request in 13% of cases and on the day of request in 35% of cases. There should be a 'cooling off' period of seven days between request and deed as being a mandatory requirement of the act.

Whither to from here?

The Australian Medical Association is not a 'Right to life' organisation and is pluralist in many of its views including euthanasia- This of course does not mean that the AMA does not have a policy stating that euthanasia is unethical, it does mean that we recognise the concerns *and* difficulties that many people have with the current status of dying.

I think had we been consulted in this matter we would have been able to go a long way to producing sensible compromise however that was not to be. At this point in time the legislation proposed is premature. We need to consider whether or not the multiple questions raised in this discussion in the Northern Territory have points which are of longterm significance to our growing community and if so how should we go about instituting them. In this regard the conclusions from the British House of Lords Committee are worth reading again.

The AMA in the Northern Territory is agreed to the following:

1. We endorse the summary report of the British House of Lords Committee report into euthanasia published in January 1994.

2. We call for an urgent inquiry into the state of palliative care services throughout the Northern Territory-

3. We believe that we must begin to educate our members and junior doctors once again in matters of ethics and law as well as medicine. Specifically doctors and nurses should know about the legal and ethical obligations that they have to the dying patient.

4. That we initiate discussions with Government, other political groups, health carets and community groups into the so called 'grey area' of deaths which includes discussion of euthanasia because of doctor or patient views, the patient in a persistent vegetative state plus investigation of what is and what is not euthanasia in modern medical practice.

CJW23 March, 1995

SUBMISSION 674 1

P.O. Box 218

Alice Springs. 0871. N.T.

22/3/95

Hon Eric Poole

The Chairman

Select Committee on Euthanasia

G.P.O. Box 3721

Darwin

N.T. 0801

Dear Mr Poole

As an experienced general registered nurse I want. to appeal to the Select. Committee on Euthanasia to reject the Bill of Rights of The Terminally Ill.

I have lived in Alice Springs for the past 24. years and have worked as a nurse over this period in the Alice Springs Hospital, in the Community and for the past 11 years. My 11 years in Aged Care in Alice Springs has given me a good insight into issues related to this Bill. This is a personal opinion as a concerned aged care nurse, with grave concerns as to the "watering down" or "slippery slide" of such a Bill and its impact on the dependent, frail aged and the nursing profession. My concerns are:

1. The clause that a person be mentally competent. As a nurse I have experienced society's and the medical professions dilemma and the 'slippery slide' in interpreting mental competence. I am experienced in the area of applications for Adult Guardianship. and the cumbersome procedures to apply for and receive guardianship. I have witness the medical and legal professions dilemma when faced with determining mental Competence. I urge the committee to research and discuss the broad interpretation of mental competence. Put simply how well must informed consent be understood before it can be said that the person has been appropriately informed. Secondly is the issue that is associated with valid consent. How can one know that a persons decision or choice is intellectually unimpaired and voluntary, free of both intrinsic (stress or grief) and extrinsic (eg. money or threat) pressures. (Ref. Mitchell and Lovat, See attached documentation on informed and valid consent.)

2. The Bill states that the patient must be offered medical treatment, including palliative care. The committee must recognise that currently in the Alice Springs, there is little or no palliative medical or nurse expertise There is no oncologist there, there is no Palliative Care Consultant. the A.S. Hospital has 1 palliative care room, furnished by the A.S. community. As I am frequently requested to provide palliative care at the aged care facility which I manage, I am quite aware of the shortfalls in the delivery of this specialised area of care. I have been advised by one family last year whose parent was terminally ill that they were being pressured to move out of the palliative care room as the hospital was experiencing financial difficulties providing nursing staff. There is no palliative care service consisting of a community facility, expert and trained nursing staff, physiotherapist, councillors and equipment. The community health Service in A.S. does have pain control equipment, donated by the community. The community's support and contribution of equipment surely is an indication of a community

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commitment to improved palliative care and a demonstration or an identified need. Health Systems have limited means and the introduction of a new service could cause the reallocation of funds and I suggest that a service for palliative care will ender into competition with other services or departments, particularly with those specialised and involved in the cure. The establishment of a palliative care service appears not to be driven by the medical professions in this community but rather by Public opinion movements The aim of palliative care is to make the patient's body a comfortable enough place to live in so he is free, if he wishes to prepare for death. To me this means that when troublesome symptoms occur such as nausea and vomiting are removed, the person can appreciate the experiences of love and feelings that life, no matter how short, has been meaningful. Everyone appreciate the experiences of love and feelings that 'life, no matter how short, has been meaningful. Everyone, seeks love without condition. Then there is the question of palliative care and various attitudes towards what consists of good palliative care. In my experience as a nurse in an aged care facility, we have had to borrow syringe drives to administer medications, coopt volunteers to sit with the dying person and deliver care that in 1995 I consider could be more expert and effective. Some doctors in this community are very supportive and have good intentions, however the expert Palliative care delivery is often delivered by staff not experienced in this field who simply do the best they can under what circumstances they as in at the time. If Marshall Perron is so concerned for the care and support of the dying why has he been so inactive in the area of palliative care education and services

in the N.T. A wider section of the population would benefit, and a greater quality of life and death could be delivered. In nursing homes palliative care deserves a greater significance in our society as a place where death occurs and where death is or should be managed with skill and dignity. Unfortunately this is not always the case because of conflicting attitudes of individuals. I have experienced a doctor in this community resisting sending acutely ill Alzheimer's resident to the Alice Springs hospital for investigation and diagnosis with the argument that a woman of 84 years of age would be expected to die, and that it would take up an acute care bed in the hospital. I have been consulted by a peer seeking advice on policy to administer Flu Vaccine to end stage Dementia patients because a doctor had felt it was not necessary despite it being recognised by health professionals that the frail aged are high risk and should be vaccinated annually. I have witnessed many times relatives of Alzheimer's affected residents, resisting the medical professions need to investigate a problem in order to make an informed diagnosis, in turn to deliver competent care and treatment. On several occasions this results in the lodgement of Guardianship application in order to arrive at a moral and just decision for the aged person. Be aware these dilemmas face nurses and doctors daily.

3. The Bill states that a person must be terminally ill, and I have concerns as there is no guidance as to its application. I have never in 25 years as a nurse witnessed a member of the medical profession being able to predict accurately when death will occur. The clause is left open for perhaps application to the socially inconvenient and vulnerable members of the community, that is of course if a doctor is happy to state they are mentally incompetent to fir the Bill. I fear greatly as a gerontic that the vulnerable aged could be made to feel burdensome and resort to choosing death as an out when they feel a threat of inconvenience. sensibilities and the resources of a family or community.

In the Medical Journal of Australia (June 1988) doctors were asked to state what illness they felt were terminal, they named cancer together with depression, old age, chronic pain and
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paralysis. It was felt that it was not the medical condition, but psychological despair which lead to the request. Would this imply that the less empowered members of the community would have to search for doctors whose ethical codes permit euthanasia. Ethics has to do with values. It is a privilege to be involved with a patient who faces death, but to be comfortable with the situation we need to be comfortable without own feelings and attitudes to life so that we are free to be good carers. I have cared for many patients while dying, I consider it the ultimate privilege to be involved in the care of the dying. As a nurse I consider the prospect of being associated with the act of euthanasia a fundamental erosion of all that is good and right in my profession. For the information of this committee I have enclosed a report from the aged care industry in South Australia on the major concern of inadequate deliver of palliative care in nursing homes. These stated concerns are contentious issues and reveal the inadequacy of funding to nursing homes nationally. With early discharge policy, I see nursing homes becoming more involved in the care of the terminally ill, and currently the national funding instrument does not allow for the special needs of terminally ill in nursing homes.

4. Finally this Bill has a fearful attitude that society can develop a consumerism of death, at a time when we are moving towards a strained health dollar. The Rights of the Terminally Ill Bill is I feel a quick fix and not the solution to the needs of the care of the dying. It is often advanced that people are helped to an early death, this has not been my experience. One needs to distinguish between the consequences of the Natural Death Act which does not prolong life, and euthanasia which actively takes a life.

I am happy to speak to the committee should the committee require information in regard to the above information from the perspective of an aged care nurse and provider.

Yours sincerely,

Mary Mills

Enclosed with submission:

1. Article from Biothics for Medical and Heathl Professionals pp34-4.

2. Articles entitled "Dying in a Nursing Home" - A Historic Forum -

3. Newpaper Clipping, extract from "The Advertiser" 28th January 1995.

SUBMISSION 675 1

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23 March, 1995

Mrs. Pauline Wardle,

2 Avro Court,

ALICE SPRINGS N.T. 087.0

The Chairman,

Select Committee on Euthanasia,

G.P.O.Box 3721,

DARWIN N.T. 0801

Dear Sir/Madam,

I am writing to express my deep concern regarding the Euthanasia Bill to be introduced in the N.T. Legislative Assembly in May.

Sadly life is too short already without taking someone's life before they are ready to die

a natural death. I believe the Bill should be overturned in favour of a better Palliative Care system being introduced into the Northern Territory. These specialised professionals who take care of the terminally ill believe that there is no-one that can't be helped in Palliative Care and preserving life is very important.

No one has the right to make a decision to take someone's life, I don't believe anyone can rationally make a decision to terminate a life. With Palliative Care life can be prolonged in a humane and dignified manner.

I do not support this Bill and trust that the Select Committee finds against its introduction.

Yours faithfully,

PAULINE WARDLE

SUBMISSION 676 1

Robin Bernhoft~ MD, FACS

1030 North Park Drive

Everett, WA 98203-1827

206 252-1940 FAX 258-6791

March 23, 1995

Chairman

Select Committee on Euthanasia

Legislative Assembly

Darwin, NT 0801

Sir:

Attached you will find a copy of the testimony I hope to deliver in Darwin next week. l look forward to discussion this issue with you and your colleagues.

Thank you for the opportunity.

Sincerely

Robin Bernhoft, MD, FACS

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TESTIMONY 'FOR NORTHERN TERRITORY

SELECT COMMITTEE ON EUTHANASIA'

by

Robin Bernhoft, MD, FACS

Everett (Seattle), Washington, USA

The Supreme Court of Canada, in 1993, ruled In *Rodriguez v. British Columbia* that there is no constitutional right to assisted suicide in Canada. The Court ruled that the government's responsibility to protect the vulnerable against abuse outweighs any privacy right to be killed by the doctor of one's choice.

In the United States, three senior courts, including the Supreme Court of Michigan, the United States Federal 'District Court in New York, and the United States Court of Appeals for the Ninth Federal Judicial Circuit in San Francisco have all concurred with the opinion of the Canadian Supreme Court. All agree that legalization of physician-assisted suicide would be bad public policy.

I think it is very significant that even American 'courts agree that the public interest outweighs the private as regards euthanasia and assisted suicide, as we Americans have a much weaker tradition of considering the public good than other English-speaking countries. We are, for example, considerably more keen about the death penalty for various crimes, and have been considerably less enthusiastic about public welfare policies than have the Commonwealth countries.

What exactly are these Courts talking about? Who are the vulnerable people the Courts are concerned to protect, how would they be abused by legal assisted suicide, and why would meaningful safeguards be so hard to create?

Bill Mahoney is one of these people. Bill lives in Yaklma, Washington. Seven years ago, back in 1988, he came down with lung cancer. Bill was 80 then. He was in a lot of pain, he lost 40 pounds. He could not eat. He was told by not one but two respected doctors that he only had a few weeks to live, and that it was a shame they could not put him out of his misery, because the demerol and codeine pills would not make his pain go away, and there were 'no stronger pills on the market that they knew of.

But they were afraid to "put him out of his misery" because assisted death was illegal.

So Bill went home, and after a while -- since the pills didn't work -- he decided to kill himself. His daughter caught

him loading up his deer rifle and took him to a friend of mine, a cancer specialist named Tom Boyd. Tom put Bill on morphine pills, and the pain went away. Bill started eating, gained his weight back, the cancer went into remission, and Bill is now 87, doing fine, fishing a lot, and I heard he had a new girl friend a couple years ago. I tall(ed to Tom Boyd recently, and Bill is still doing fine. Healthy as a horse.

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But Bill would have died and missed all those years of quality life if assisted suicide had been legal back in 1988.

Bill helped us campaign against Initiative 119 in. Washington state (which would have legalized euthanasia and assisted suicide), because he knew that a lot of other people would be killed before their time If 119 had passed.

How many people would be killed prematurely? The average cancer specialist in the US sees around 2 people every month like Bill Mahoney -- people who have been told by well-meaning, respected doctors that nothing else can be done and that it's a shame we can't just put them out of their misery. But just about every one of these people, when they get good care, does very well and lives months or years of high quality life, comfortable and alert.

If you multiply 2 people a month times 12 months in a year, times the thousands of cancer specialists, you get a lot of tragically premature death -- thousands of people robbed of years of high quality life. Because under treated pain is the most common reason terminally ill people want to die, according to the World Health Organization. Several studies show most American doctors don't know how to treat pain like Bill Mahoney's -- or my brother's, who died of cancer in his bones. But In good hands, there's almost never any reason for pain. Nor for being in a drugged stupor. My brother, for example, was taken care of at the Mayo Clinic; he was comfortable and alert, despite his broken bones. because his doctors knew how to care for his pain. But most people aren't as lucky as Larry was. Most community doctors don't know how to treat people like Bill Mahoney or Larry Bernhoft. We need to protect people from well-intentioned but under-trained doctors who don't know how to take care of pain. If we do not, well-intentioned doctors will put people to death months or even years prematurely -- like would have happened to Bill Mahoney.

Killing somebody to relieve their pain isn't mercy; it's malpractice. And completely unnecessary malpractice. 'According to the World Health Organization (and my experience at Hammersmith Hospital in London, 1983-4) outside the U.K., maltreatment of terminally ill people is commonplace in most countries.

Depression is another problem that can make terminal people want to die. Anne Sires was a patient of mine, and became a friend of my wife and mine before she died two years ago at age 44. I first operated on her at age 35 -- took out a chunk of her liver, where cancer had spread from her colon. For a while, it looked like we had cured her, but then the cancer came back. She saw a number of different primary care doctors in the next seven years, and was told five times in those seven years that she only had a few weeks to live,

Each time she was told that, she got deeply depressed. She gave away her personal belongings, arranged custody for her young son, but then she got better. Anne told me that if physician assisted suicide had been legal, she'd have asked for it each of ;the five times she got depressed. (Not because of the cancer, but because of the depression.) But it wasn't legal, and she didn't ask for it, and her son got to live with his mom until he was 15 years old. People like Anne aren't rare, either.

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Practically everyone who is told he's going to die gets badly depressed. In the US, over 20% of the population suffer from what psychiatrists call "low self-esteem;" these are people 'who are psychiatrically predisposed to choose the most negative suggestion offered by an authority figure. If a doctor says "we can operate, or we can kill you" they only hear "the doctor thinks I should be killed." They aren't free to "choose" anything other than the

most damaging suggestion.

According to the New England Journal of Medicine (October 10, 1991) most terminally ill people with treatable, curable depression aren't treated for their depression. Their doctors either don't notice the depression, or ignore it. That issue of the journal ,concluded that many, many times more people would die from untreated depression If assisted suicide were legalized than would legitimately want to die from any cause related to their disease.

For pain and depression, legal assisted suicide is malpractice, not mercy killing. If we care about the terminally iii, we have to train our doctors to recognize and treat pain and depression long before we talk seriously about giving them the power to kill their patients. We also need to make Hospice care available to everyone, as is generally the case in the U.K. Again, according to the World Health Organization, most of the world (including the US) has not done a good job getting Hospice care to its people.

The third reason people want to die *is* because they have been abandoned, by families, by caregivers, and increasingly -- in America, at least -- by their insurance companies. 'three years ago in Seattle, a 22 year old black man with AIDS from IV drug use had a mild pneumonia. He could have been cured with about $100 worth of antibiotics. But his doctors said "What kind of quality of life could he have? He has to endure poverty, racism, drug abuse, and now AIDS. Surely it would be better not to treat him."

They didn't ask him if he wanted to be treated; God knows they didn't ask hie mother. They just decided "compassion" said no antibiotics, so they let him die. He'd have lived another five or ten years probably, might even have gotten over his drug problems and straightened out his life. But he never got the chance. The doctors "knew best." Guys like him aren't rare, either. His case tells you a lot about why assisted suicide should be illegal.

As a profession, we doctors have not earned the right to kill our patients. According to the National Institutes of Health, a black man with insurance in the US is only 1/3 as likely to be offered needed heart surgery as a white man with insurance. I have no idea if such would be the case with racial minorities in Australia, but it is likely that in any country the disparity between the quality of care given the influential and that given the poor is great. That is certainly the case in Canada, despite the National Health system. It seems likely, if physician-assisted suicide were made .legal that the poor would "choose" it a lot more often than the well-to-do, simply because the poor would be less likely to have their medical needs adequately met. That is a double standard no one wants.

There is a lot of pressure on doctors now, in the States at least, from insurance companies to cut costs and get patients home and out of the medical system, as soon as possible. That can produce some very nasty results. A friend of mine in San Diego: who runs

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Hospice there tells me she frequently gets referrals of people with treatable cancer who have never been told they have treatable cancer, because it's cheaper for the insurance company to send them to Hospice for terminal care than to treat the cancer, so the insurance company pressures doctors into making those referrals. They do something called "economic credentialing" in Which the amount of money spent by the doctor on patient care counts against the doctor, and could cost his or her job.

Elderly folks in the polls we did in Washington and California already feel a lot of pressure to get out of the way. Legal assisted suicide would only increase the pressure. 1 don't think any of us wants to live in a society that pushes its oldsters out of way so brutally. That's something the Courts take very seriously in the opinions mentioned.

The Dutch semi-legal euthanasia system has produced thousands of involuntary deaths, according to official Dutch government statistics (in the 1991 Remmelink Report),: despite very tight safeguards. The doctors increasingly just ignore the safeguards, decide when the patient is going to die and give the poison, whether asked for or not, even

though the system was designed to give patients control. On paper, patients call the shots, but in reality, the doctors decide when it's time to die for perhaps one death in nine.

Given the fact that Dutch doctors 25 years ago had a reputation for being humble and democratic, it would seem that the power to kill has corrupted the majority. According to the government survey, 59% do not consider themselves bound by the safeguards created to protect the public against abuse, and 27% admit having done involuntary euthanasia. Absolute power corrupts absolutely, just like Lord Acton said it would.

Doctors call the shots in every country, no matter how much rhetoric you might have heard about "choice," because we supply the information and advice upon which the patient relies to make his or her decision. If we don't know how to treat pain or depression, any advice we give will be incomplete, and the patient will 'make a tragically unnecessary decision based on bad advice.

Also, the effect on teen suicides from legal assisted suicide would be disastrous. Anytime you make something legal, a lot of people conclude it must be moral. Legal assisted suicide would make teens just that much more likely to consider self-destruction.

It would appear that meaningful safeguards on assisted suicide are impossible to create. The doctor-patient relationship is so private, and we doctors have such complete control over not only what the patient knows but also on what the documents show, that there is no way to keep euthanasia under control once it is legalized.

Proponents often argue "that is precisely why we need legalization -- to bring it into the open" but a moment's reflection reveals the fallacy of that argument. Consider if I were to give a patient a massive overdose of muscle relaxant and barbiturate; the entire hospital (and the police) would be quite curious what exactly I was about. But if such overdoses were routine, they would receive little scrutiny. Familiarity is the loophole that allows Dutch doctors to ignore the legal safeguards.

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Proponents also argue that public opinion demands legalization. I am something of an expert on public opinion, having conducted two successful campaigns against legalization, in California and in Washington State. In both states, support was at first around 80%, just like it is in Australia, until people (at the behest of our campaigns) began thinking practical thoughts: how would you implement the idea? How would you enforce safeguards? Can meaningful safeguards ever even exist, let alone be enforced? What about pressuring the medically, socially or psychologically vulnerable into choosing to die when they really don't want to? What would the effects be on public attitudes towards the gravely ill and the disabled? What about depressed teenagers?

Even in Oregon, where a more limited measure passed by 50.3% (largely due to an incompetent NO campaign), initial support was actually 10% weaker than it was in Washington or California. (The Oregon measure, by the way, seems doomed in Federal 'Court for reasons perhaps peculiar to our Constitution.)

When people begin asking such practical questions, support plummets drastically, until by the time you are through polling, you find only about 20% hard-core support. These are what l call the "Hell's Angels" vote, moral cowboys who don't care what happens to anyone else, as long as they have their right to do whatever they want.

I suspect that if you did detailed polls in Australia you'd find the same thing. Your population seems 10 be a lot like our West Coast population: unchurched, outdoorsy, essentially pagan in outlook. But you have a much better reputation for looking out for the underdog than we have. You have a tradition of taking into account the public good, the general welfare. We aren't very good at taking those things into account, and yet we and our courts have been rejecting legalized euthanasia for exactly that reason. Our people are not bothered about moral arguments, but they do care about injustice and abuse. I think that if you give Australians the chance to think about this issue a bit, they will have even less stomach for it than West Coast Americans.

I urge you to follow the lead of the Supreme Court of Canada, and the three Senior courts in the United States who have so far ruled on this issue, and vote against legalization of physician-assisted suicide or euthanasia.

Thank you very much for allowing me to testify.

SUBMISSION 677 1

Chairman

Select Committee on Euthanasia

GPO BOX 3721

Darwin NT 0801

Re: Rights of the Terminally Ill Bill

I have had opportunity to read the Bill and wish to place on the official record of the committee my view in support of the process of this legislation through the Legislative Assembly of the NT.

I am a competent individual and believe as an adult I should be able to exercise choice with respect to terminating my life when I so choose.

My only criticism. of the bill is minor but one that should be taken up and further advice sought in relation to the clause with respect to destruction of records, clause 8(2). I would suggest the record should not be destroyed but rather kept with it noted or stamped in some way and if possible countersigned by the individual that he/she wished to rescind the request.

Yours Sincerely

Chris Tyzack

580 Bees Creek Rd Bees Creek

PO Box 860 Humpty Doo NT 0836 Ph:089 881.587, Fax: 089 881149

SUBMISSION 678 1

March 23, 1995

PO Box 860,

Humpty Doo

NT 0836

Chairman

Select Committee on Euthanasia

GPO BOX 3721

Darwin NT 0801

Re: Rights of the Terminally Ill Bill

I have read the proposed Bill very carefully and support the passing of this legislation. In doing so, I believe the arguments that this legislation could lead to involuntary euthanasia are unfounded. However, should any of the

provisions of Part 2, Section 6 of the proposed. legislation be found to be flawed, I would support any moves that would close possible loop-holes that do not lessen the effectiveness of the legislation or the right of individual choice.

I do have a concern that this debate will/be hijacked by a vocal minority of right to life supporters, ethics experts and vested interests in the medical profession. While these people have a right to express their views, I strongly object to them enforcing their views on my future well-being.

I look forward to the outcome of the committee's deliberations with considerable interest.

Yours sincerely,

Jack Ellis

SUBMISSION 679 1

The Chairman

Select Committee on Euthanasia

G.P.O. Box 3721

Darwin N.T. 0801

Firstly my apologies for this hand written submission.

Having talked to many people in Katherine on the proposed legislation I estimate that there is a 5 to 1 ratio of those in favour to those against. Naturally, like all minority groups those that oppose will be more vocal.

I totally repudiate the "Right to Lifers" and their ilk's comparisons to The Netherlands situation. The proposed legislation deals with the individuals right to choose, and if I am terminally ill, I believe that I should have that right.

With a background of years practising as a registered nurse I would defy anyone who says that no person need die in pain to-day. None of us can judge another's pain or mental anguish or a terminally ill road to death!! Loss of dignity and control over one's life adds incredibly to this anguish.

My background is also Catholic, although, I may now be facing excommunication.

I agree that all life is sacred, however, there must also be quality of life, dignity and self respect, and I can not believe that if there is a loving God He would want us to prolong that suffering.

Those that oppose the legislation need not make use of it. However, I object strongly should this influence carry enough weight to prevent it becoming law, and therefore deprive me of my right of access.

Yours sincerely

Anne Shepherd

PO Box 460

Katherine N.T. 0851

Phone: 721338

24 March '95

SUBMISSION 680 1

NORTH AUSTRALIAN ABORIGINAL LEGAL AID SERVICE

1 Gardiner Street Darwin NT 0800

PO Box 1064 Darwin NT 0801

Ph: (89) 815266 Fax: (089) 812393

22 March 1995

The Chairman,

Select Committee on Euthanasia,

GPO Box 3721,

DARWIN NT 0801

FACSIMILE: 816158

This Service, through its regional members of the NAALAS Council, has consulted Aboriginal people in several communities in the Top End about the proposed Rights of the Terminally Ill Bill. It should be stressed that the consultation has been limited, due to the time constraints placed upon submissions to be made. to the Committee. As such, this submission should not be seen as representing the views of all Aboriginal communities and organisations in the

Our limited consultation has shown that Aboriginal people in rural areas are generally worried about the Bill and what it means. While some people are supportive, many people are concerned and more time is needed to explain the terms of the Bill, particularly who it applies to and what the process will be if the situation envisaged by the Bill arises. Several communities have requested more time for discussion and to have an opportunity to call community meetings.

While this Service welcomes the Committee's plans to travel to several communities, the limited time the Committee will spend in those communities will probably still not give people the time to discuss this Bill properly.

This Service therefore recommends more widespread consultation with Aboriginal communities and a further delay to any proposed passage of the legislation to allow this consultation to take place and to alleviate concerns about the Bill.

Culturally, the Bill appears to deal with a concept which is not familiar to Aboriginal people. Most of the comments received during the consultation indicate that a person who is sick should die naturally and intervening in any way in that process is not something which should happen. When suicide occurs in Aboriginal communities, it is often attributed to spiritual causes rather than to a conscious decision of the person who has died. The concept of choosing to end your own life does not appear to be a concept which is generally accepted in Aboriginal communities.

Interestingly, "suicide" is not a word which appears to translate easily into Aboriginal languages.

Also, an important decision in an individuals life is usually not taken by that individual alone, but by the person's family as well. The person's family will usually include extended members of the family as well as the immediate family. Therefore, an individuals decision to end their own life would culturally require consultation with many

other people before a decision was made. We also received the comment that this consultation is necessary because other members of the family may also decide that if the individual is going to end their life, they will end their own lives as well.

The Bill, as drafted, does not contemplate such a process, instead leaving the decision to the individual in each case. One possible way of solving the problem may be to include a mandatory "cooling off" period between when a person indicates to a doctor that they want to die and when the treatment to terminate that person's life is administered. such a cooling off period would at least allow some of the necessary consultation between family members to take place. When Aboriginal patients are involved, this cooling off period may need to be extended to allow all of the necessary extended family members to be contacted and consulted properly. It is difficult to know what an appropriate cooling off period would be but perhaps a mandatory period of 7 days could be imposed, but that this could be extended for a further 7 days if Aboriginal family members requested it to be extended..

Another concern that has been expressed to this Service is that many Aboriginal patients may not understand exactly what they are requesting and consenting to because of language and cultural difficulties. This Service frequently receives complaints from Aboriginal people who have consented to medical procedures without fully understanding what the procedure will involve and what the consequences will be. In these cases, they have signed consent forms in similar terms to the consent form attached as a Schedule to the Bill, however, after the event, it is clear that they have not understood what it is they are consenting to.

This Service also sees the difficulties experienced by the courts and the police in murder cases when they are speaking to Aboriginal suspects about whether the suspect intended to "kill" the victim or not, for example, when a person is asked "did you mean to kill that person?", the response will often be "yes, I meant to kill that person a little bit". If this is further explored the response may continue "but I didn't mean to kill the person dead." The Bill may have disastrous consequences if a person requests to be "killed" but believing that they will be "killed a little bit" and go to sleep for a while rather than being "killed dead".

The lack of trained interpreters in the many Aboriginal languages which exist in the Northern Territory means that there is no easy solution to this problem. A suggestion from Michael Cook, Lecturer in Aboriginal Languages and Linguistics, at Batchelor College may solve this problem and should be seriously considered. The suggestion is that the procedures and consequences of using the option provided by the Bill and the consent form could be translated into Aboriginal languages which could be recorded on audio tapes which could be played to Aboriginal people who do not understand the procedures and consequences to ensure that the consent is truly informed consent. The reason for the need to tape the translation rather than present the translation in brochure form is that many Aboriginal people, while speaking a particular Aboriginal language, do not understand the language in written form.

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There should be a positive obligation on medical practitioners and health care providers included in the Bill that where an Aboriginal person "requests" the procedures provided by the Bill, and that person speaks an Aboriginal language as well as English, that a translation in that language should be provided which explains the procedures and consequences of the Bill and the consent form which needs to be signed. The reason for including the reference to "an Aboriginal language as well as English" is to avoid problems arising where an Aboriginal person understands English but may in fact not clearly understand, because of cultural or technical language difficulties, the consequences of requesting and consenting to the procedure.

There is also no definition of "terminal illness" included in the Bill. While the term may be clear to medical practitioners, it is not clear whether the phrase applies to terminal injuries, for example, injuries which have been sustained in an accident which will cause the death of the patient within the time frame contemplated by the Bill. This Service does not wish to suggest an amendment to the Bill but believes that a definition should be included after consultation with members of the medical profession, so that it is clear in which situations the Bill applies.

We are also concerned about how a general practitioner is going to make an assessment about whether a person is competent or not, .as is required by section 6(h) of the Bill, particularly when the person may be physically and emotionally distraught when they are faced with death and may be in a great deal of pain. Many difficulties of misdiagnosis currently arise when psychiatrists who are not familiar with Aboriginal cultural beliefs and mores are assessing whether Aboriginal people suffer from a mental illness or not, for e.g. when an Aboriginal person avoids eye contact with a psychiatrist during an assessment. These problems have been recognised by the NT Government and are being considered by the Mental Health Review Committee in considering a draft Mental Health Bill. The same problems are likely to arise when medical practitioners are making decisions about whether a person is competent for the purposes of this Bill.

This Service is unable to suggest a solution to this problem, however, passage of the Bill could be delayed until the same issue has been considered and dealt with by the Mental Health Review Committee. I understand that the Committee is considering a legislative provision which requires assessment of an Aboriginal person's mental health a manner appropriate to and consistent with their cultural beliefs and practices. A similar provision could be considered for this Bill.

This Service sees enormous potential for abuse in Section 7 of the Bill, in light of the above comments about language and cultural differences, which allows "any person who has attained the age of 18 years" to sign the consent certificate if the patient has orally requested the medical practitioner to end his or her life but is physically unable to sign. This Service is of the view that Section 7 should be deleted from the Bill. If it is to be included, consideration should be given to including a mechanism to video record the patient's consent rather than have another person sign on their behalf. A video may then be available to alleviate family member's concerns that the patient did, in fact, freely consent to the procedure.

While the Bill provides that the procedures set out in section 6 of the Bill must be followed, ie., "only if all or the following conditions are met", the Bill does not provide for the consequences

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of failing to follow all of the conditions. Section 13 does provide that "an action taken in accordance with this Act" does not constitute an offence under the Criminal Code, however this Service is of the view that there should 'be a stronger statement of the consequences of failing to follow the procedures set out in Section 6 to ensure strict compliance. A possible amendment may be to include the words "failure to comply with the conditions provided by Section shall be an offence against Part VI of the Criminal Code etc." in either section 13 or at the end of Section 6.

Also Section 11(2) provides that a death which occurs as a result of assistance given under this Act shall not be the subject of a Coroner's inquiry under the Coroner's Act. There is no mechanism for a family to request an inquiry where there are concerns about whether the correct procedures have been followed or whether a person has requested and freely consented, or was competent to make the request to be given assistance under the Bill. The Bill should be amended to provide that a Coroner's inquiry can be requested by the family of a person who has died in these circumstances, particularly in light of the previous comments in this submission about the importance of Aboriginal family members participating in the decision making process.

If further comments are received, we will include a further submission.

Yours sincerely,

Jenny Hardy

Solicitor,

Policy and Research Unit

SUBMISSION 681 1

SUBMISSION FOR THE SELECT COMMITTEE ON VOLUNTARY **EUTHANASiA**

TRICIA SMITH

MASTER OF EDUCATIONAL STUDIES MONASH UNIVERSITY

2

PART 1. A Philosophical Paper

"Death Education - A Professional and Personal Perspective."

PART 2.

Case Studies of Death and Care Giving Experiences with Terminally HI Patients.

PART 3.

Rationale.

3

PART. 1.

A PHILOSOPHICAL PAPER.
"DEATH EDUCATION- A PROFESSIONAL AND PERSONAL PERSPECTIVE"

As members of a humane society, people have basic human rights. People have the right to quality of life during their passage from birth to death. People are constantly making decisions as they acquire knowledge through adaptation to their physical, social and spiritual environments. Decision making and adaptations continue from birth to death.

Within Western Societies, death and dying are seen as "taboo" subjects or experiences. The stigma that has been created around the death process perpetuates the continuation of a death defying Western culture.

Western societies have devised their own evasive language when referring to death experiences. People use terms like "passed away', "departed", "at rest", "gone", and are reluctant to face reality and say a person has died.

People, as human beings, do not focus on their very essence of humanity and mortality. Instead, they adopt social behaviours that ignore their very human nature. They tend to live life as supernatural or superhuman beings rather than accept the fact that they are primary human beings.

Human nature is associated with pain and suffering in the physical world. Rather than address the real issues which surround pain and suffering, two of the most natural components associated with our humanness, people tend to adopt superhuman and supernatural qualities to cope with "real" situations.

As a result, society continues to move away from the acceptance of its very being.

The greatest example of this "non- acceptance "of our humanness and social expectations that we operate as supernatural beings can be seen when we look at dying patients.

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I have personally cared for many terminally ill patients. These have included children I have taught, parents of the children I have taught, close friends and my mum and dad.

These death experiences drove home the absolute truth about social realities. Never before were these human beings expected to adopt such superhuman and supernatural behaviours as we have seen in the face of death and on their death beds.

When members of a society live a death denying life and reject their very humanness, the final death picture is quite understandable. Any mechanism that has been devised to "blot out" pain and suffering in life becomes totally useless in the face of death.

So we let people suffer excruciating agony, dementia and watch them degenerate into distorted physical and mental human frames and become totally dysfunctional.

We watch them become powerless victims to a Capitalist society.

We allow the flourishing development of a "death industry".

We watch doctors, hospitals, pharmacists, paramedics, engineers of life support machines, funeral parlours, florists, etc improve their financial businesses at the expense of the terminally ill.

The power and control have been taken away from the terminally ill patient, whose life is being determined and controlled by all of these other agents.

Practices of repetitive surgery, increased drug dosages, medical experimentation all prolong life and delay a natural death. They also fragment the physical and emotional "being" of the terminally ill patient.

Death is the ultimate physical loss. Throughout life, everyone experiences losses of some kind. These include the loss of physical health, the loss of employment, loss of a partner through separation and divorce, loss of material goods, loss of precious memorabilia, loss of friendship, etc.

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Yet people are not educated to deal with grief and loss. Most people are not aware of the mourning processes, which one must go through in order to readjust to the loss and readapt to life in the physical world.

As a result, personal and social instability is entrenched in the very foundation of our social structure because of all the "unfinished business" in life.

* Let's examine our attitudes towards life.

* Let's support the right of the individual to make choices in life.

* Let's accept death as an integral part or natural component of life.

* Let's promote the "right of quality of life" with all members of society.

* Let's work towards becoming a death accepting society.

* Let's deinstitutionalise and demystify the death process.

* Let's introduce "Death Education" and "Grief and Loss" Programs into our schools.

* Let's put a stop to the practice of profiteers making financial gains at the expense of the dying patient.

* Let's oppose the imposition of values and beliefs upon others, who do not share the same plausibility structures.

* Let's provide the legal structure and systemic mechanisms so that people can make the ultimate choice in life and that is to retain the power and control over their own life process, which includes death with dignity and the alleviation of inhumane and unnecessary suffering when terminally ill, if the adult patient so chooses.

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PART 2

CASE STUDIES OF DEATH AND CARE GIVING EXPERIENCES WITH TERMINALLY ILL PATIENTS.

CASE STUDY 1.

My mother died from terminal cancer at the age of 63 years. For the last 2 months of her physical life, I assumed the major responsibility as Care Giver. My mother suffered excruciating pain for the last six months of her life. During this course of time I saw Doctors deny her the right of truth about her condition. They repeatedly told her that she had an arthritic spine etc. They continued to send her for X-Rays knowing at this stage that she was terminally ill. I drove her to the hospital, some 36 kilometres away, for her last lot of X-rays. She could not walk without assistance, vomited non-stop throughout the journey and ordeal and cried in agonising pain. I realised at this stage that my mother was dying at a rapid rate. The doctors denial continued so I undertook it upon myself to contact all immediate family members to prepare them for mum's impending death.

Horror surrounded the whole situation with family members refusing to accept the fact that mum was dying.

As the only death accepting person within the immediate family, I nursed my mother and openly discussed her death process, according to her determinants. My mother did not die peacefully as so many people claim is characteristic of the death process.

My mother did not die with the support of a death accepting family.

My mother was deceived the right to share her final life's experiences with family and friends as a result of professional dishonesty with doctors and family inability to accept death as an integral part of life.

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My mother was denied the right to die at home. She pleaded to stay in the home environment and I offered to take extended leave from work to enable the fulfilment of this dying need. Other family members took control of my mother's decision making process and confined her to a sterile hospital ward where she remained until she died.

My mother suffered unnecessarily as a result of the professional dishonesty of medical practitioners. Instead of leaving her to rest in comfort in the family home, they continued to put her through rigorous tests and X-rays when they knew that she was near death.

Given this death experience over again, I would refuse to cooperate with Doctors who put dying patients through unnecessary and useless trauma.

My mother eventually died from terminal cancer. In the end, the doctors allowed her the right to death with some form of dignity as euthanasia took place under the shroud of a secret silence.

(I say "some form of dignity" because I believe the unnecessary suffering destroyed most of her personal dignity

and the "real" medical assistance of practitioners came much too late).

CASE STUDY 2.

As a trained Care Team member, I provided intensive support to my closest friend of 15 years when he was dying from the A.I.D.'s virus.

I watched him waste away to the size of a child's body, become incontinent, confined to a wheelchair and suffer from dementia.

His death and dying debilitated him to a point of non-recognition.

He became totally dysfunctional. I will describe this man in the printed words attached to a poem that I wrote about him. "This has been dedicated to the most important person in my life. His intellectual knowledge, political prowess, social justice ideals, empathy, understanding, teaching expertise and total acceptance of the individual epitomise the qualities which he so freely shared.

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During my prolonged illness, Ken provided the necessary support and stimulus to keep me focussed on my strengths. He knew pain and suffering too well as a result of his 18 month imprisonment because of Draft Resistance to the Vietnam War.

Ken was instrumental in the establishment of the North support Group, through the Victorian A.I.D.S. Council, in 1984. This was in the days when the Gay Community was ostracised by society as a result of sensationalised media reporting which placed full responsibility for the A.I.D.'s virus on homosexuals.

In spite of all his positive contributions to A.I.D.'s education, Ken finally died from the A.I.D.'s virus on October 29th, 1992. As a trained member of the Care Team, I was with Ken until the end of his physical life. We now share a spiritual existence. I have Ken McClelland to thank for the person I am today."

Ken lived with a personal pride, integrity and respect for the rights and privacy of people. Until his physical and mental decline, he was always in control of his own destiny, highlighting the importance of the empowerment process and the individual's right to decision making processes and self determination.

I know that Ken would have chosen the right to die with dignity if the legal opportunity had been there. He would never have wanted the total invasion of his privacy that occurred as a result of his physical and mental degeneration.

He would never have wanted to lose that impeccable mind which allowed him to complete "the Age" and "Australian" Cryptic Crosswords within two minutes and thrash all opponents when it came to involved and complex Board Games.

He would not have wanted to lose his independence and exist merely on the support of others. He would not have wanted to lose his quality of life.

He would not have wanted to impose upon the lifestyles of others and demand the care giving time which became necessary during his last six months of his mere existence in life.

He would not have wanted to be reduced to the physical and mental nothingness which he became in the end.

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CASE STUDY 3.

My dad believed in and was an advocate of legalised euthanasia.

He died from terminal cancer in 1992.

Whilst he suffered during the last twelve months of his life, he always put on a brave front. This was a typical personality trait and no doubt influenced by his Air Force days in World War II his active Union role as a Shop Steward, his laborious hours as a shift worker in a milk and cream factory and his political activity on the frontline in a small town.

Besides suffering from terminal cancer, dad was a chronic diabetic and injected insulin three times a day.

The prolonged prescribed medication for the cancer often conflicted with his insulin treatment.

Dad often lost control of reality and went into diabetic fits. In these instances, he became very difficult to handle.

During the last few months of his life, he was forced to spend most of his time in bed. He transformed from an active social contributor into a passive non-contributor, biding his time to die.

Just before his death, his internal organs became non-functional. He lost complete control of his bowel motions and physical mobility. Added to these physical traumas, he lost the functioning of his mind.

Dad went into a diabetic coma and did not recover. The Doctors anticipated the exact time of dad's death and I believe euthanasia took place as a result of the administering of excessive doses of insulin.

CASE STUDY 4.

I was hospitalised for two and a half years following a serious car accident.

These prolonged hospital stays taught me a great deal first hand about death and dying and the treatment of dying patients.

PATIENT 1.

In a large Melbourne hospital, I shared a two bed ward with Jean. Jean was awaiting the results of her head X-rays as she said the doctors suspected a tumour.

We were about to eat breakfast when the Doctor and the Trainee Medics entered the room.

Jean asked for the prognosis. A Junior Medic replied that the X-rays confirmed the shadows on the brain to be malignant tumours. The medical team walked out and left Jean sitting there in a state of shock, staring into space.

Jean let out a piercing scream and broke down completely. I left my bed to comfort her and encouraged her to free all emotions. Jean talked and talked. She explained how her two sisters had died from brain tumours and that she didn't want to go through such an horrendous death experience.

I was absolutely disgusted by the insensitivity and lack of support of the Medical team. Jean was just another prognosis in their daily lives.

Given Jean's expressed fears, legalised euthanasia may have been her preferred choice.

PATIENT 2.

Again, I shared a two bed ward in a large Melbourne hospital.

This time a tiny, thwarted frame lay in the bed alongside me. This replica of a wasting sparrow was known as Mrs.

P.

She couldn't eat solid food so the best she could try to consume was liquid food.

Milk drinks were placed in front of her on the hospital tray. Milk drinks were taken away untouched. I realised that this woman didn't have the physical capacity to reach out for her drinks.

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The next time, I went over and cradled her in my arms. Barely sucking through the straw, I allowed her to take her time sampling the minute droplets as I held the glass.

Night time came and the screaming started.

Mrs. P was in absolute agony. Her screams and pain were indescribable.

Legislation had it that after a certain number of days, a bed had to be vacated if the occupant was not in private medical health benefits.

I watched Mrs. P's son come to take her home so that the bed occupancy regulation could be adhered to.

Two nights after her forced release, I identified the screams penetrating the air of the hospital corridors. I knew it was Mrs. P.

Unable to accept that human beings should experience the excessive pain and suffering that Mrs. P was going through, I approached the night staff and begged them to do something to relieve her agony. I was told that everything within their legal power was being done for her.

I told them that this was not good enough. "No human being should have to put up with such torture. You wouldn't let an animal suffer this way. What about quality of life? Do something for the woman".

I was virtually told to mind my own business and return to my room.

The next morning I overheard a discussion between the night staff and the Doctor who came on duty. They were talking about my complaint, which was based on concern for another human being.

The Doctor fully supported my stand and reprimanded the night staff for allowing such inhumane suffering. I heard him order unlimited quantities of morphine injections. He stated that under no circumstance was Mrs. P. to suffer any longer.

Mrs. P's screams were abated. Mrs. P. died the next day.

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PART 3. RATIONALE

The rationale behind my presentation to the Select Committee is that the proposed legislation is actually addressing a Human Rights issue.

Whilst Australia does not have a Bill of Rights, it does promote Social Justice, Equal Opportunity and Human Rights Policies, practices and ideals.

Section 116 of the Constitution dearly states:

'The Commonwealth shall not make any law for establishing any religion or for imposing any religious observance, or for prohibiting the free exercise of any religion."

Current Death legislation does exactly this. People whose epistemological bases or belief system are not in accord with established religions are being prohibited the free exercise of their religious choice.

Current Death legislation is therefore "exclusive" to those whose values and ideals fit within the parliamentary legal system.

This "exclusiveness" is forcing medical practitioners and family members to take the law into their own hands.

Besides the trauma associated with pain and suffering and grief and loss, these members of a humane society are being forced to carry unnecessary (and unqualified in many cases) responsibilities with the exercising of "appropriate" care.

The ultimate physical loss or death experience should be one that can be shared by the dying patient, immediate and extended family members and friends, if he or she so chooses, in the chosen environment of the dying patient.

The dying patient must be allowed to control his or her own death process in accord with the lifestyle to which he or she is accustomed.

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Death is an integral part of life. Life is all about making decisions and choices. People have the right to make their ultimate choice in life.

"Best practice" in the medical world is not necessarily the prolonging of life, provision of quality care, the administering of drugs, and/or the organising of a physical environment externally determined for patient comfort.

Whilst these aspects of care giving may in fact suit some terminally ill patients, they may contravene and contradict the aspirations and well being of others. As individuals within a society, we know our inner selves and as individuals are the best judges of our physical, social and metaphysical worlds.

It is not in the best interests of public health to have external agents deem what is "best medical practice" when decision making processes infringe upon the rights of the individual and impose values and beliefs from a differing plausibility structure.

Legislation is a strange ideological phenomenon and practice.

On the one hand we see support for current medical practices with the treatment of terminally ill patients. This support is of stalwart strength even though it is forcing medical practitioners and family members to perform death assistance acts illegally.

When one opposes voluntary euthanasia for moral and religious reasons, yet at the same time approves illegal death practices and overburdening responsibilities on doctors and family members, one must question the authenticity of the value and belief system.

Many opponents of the legislation actually sanction what is happening illegally. They just don't want it to become an honest and open legal practice. One would have thought that on moral and religious grounds, legal practices would be encouraged.

Another legislation which comes to mind is the availability of a commodity which has been classified as lethal to consumers and passive users - the cigarette.

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Does the legislation which allows people the freedom to slowly and surely destroy physical health reflect the consciousness of a society that values quality of life?

Or does it reflect the importance of the "almighty dollar" at the expense of quality of life?

I am a smoker yet I resent the fact that a product, which has been classified as lethal, is available on the open shelves for human consumption.

If Governments were genuine about the health risks associated with the cigarette industry, the product would be removed from the open market. This practice occurs when contaminated canned products are identified as harmful.

The reality is that the product is being sold, consumers are being warned about the dangers and programs to discourage the use of the product are costing large amounts of Government expenditure. The real issue is being side stepped and "band aid" measures are being adopted to justify the sale of the product.

I will gladly give up the habit if legislation demands the removal of the product from the market. I cannot accept that legislation sanctions the sale of a product then introduces by laws which infringe upon the rights of the consumer.

This is analogous to the current Death legislation in that it endorses illicit or anti-social practices and has not been necessarily designed in the best interests of the individual or society as a whole.

It is also analogous in that it promotes the development of a powerful business industry or a financial market at the expense of the powerless.

Huge anomalies exist between legislative Policy and implementation practices.

Whilst Policy principles may appeal to a dominant social group or look good on paper, they can often have a counterproductive effect on society through their very structural "exclusiveness".

They can also perpetuate the embedding of hypocritical practices within the walls of institutional structures. eg. education, health, legal and political systems.

Legislation must be inclusive and truly represent the voices of all members of society.

Legislation must be the culmination of people input from a bottom-up rather than a top-down structural process.

Legislation must be "inclusive" and encompass the rights of all human beings within their diverse cultural worlds. (I use the word "culture" in its broader sense and not in relation to race or ethnicity).

Legislation must truly reflect the needs of all members of society.

Rapid social changes have occurred throughout the technological

age. Too often, as with professional practices, legislation becomes

inappropriate and outlives its temporal boundaries.

What was considered appropriate at an historical point in time is

not necessarily relevant to a society at a future point in time.

The "Rights of the Terminally Ill" proposed legislation is not

radical or even progressive in this day and age.

It is actually recognising a human rights issue, which has been too

long ignored. It is also legally establishing systemic mechanisms

for the monitoring of voluntary death assistance, which are sadly

lacking with current illicit practices.

It is actually highlighting the need for social change in accord with

the aspirations and basic human rights of today's societies.

The Northern Territory can take pride in the fact that it pioneered

the way with long overdue legislation in the late 1800's. **Women**

were given voting rights.

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Arguments from the opponents of the Suffrage Movement at the time included, "desecration of the motherhood ideal, destruction of family life, immorality, blight on the fine character of women, employment displacement and the dangers of introducing biological weakness and feminism attitudes into public life."

It is interesting to note that the "voluntary euthanasia" legislation currently under debate is a piece of legislature that would impact upon the lives of more women than men. Research clearly indicates that the majority of people employed in the "helping professions" are women.

Because of sheer numbers in the "helping professions", social conditioning as "natural nurturers" and co-operative rather than competitive styles of management, women are carrying the burden in cases of "inappropriate palliative care" and are usually the gender sought to execute the illicit assisted death acts.

Compassion and understanding take priority over the possibility and probability of litigation.

Voluntary euthanasia **will** eventually be introduced as a legal process in Australia.

Let the Northern Territory lead the way and demonstrate its foresight by legislating for a positive outcome.

Let the Northern Territory become the indelible mark on the national and international front as the "pioneer of a long overdue legislation", which recognised a human rights issue too long ignored.

Let the politicians provide the opportunity to take pride in the fact that the Northern Territory was brave enough to take the initiative in the political world to legislate in the name of Social Justice and Human Rights.

I will conclude with an affirmation, which has always given me the strength to venture into the unknown, in the face of adversity, for the achievement of Social Justice and the acknowledgment of basic Human Rights.

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"You cannot discover new oceans

Until you have the courage to lose sight of the shore".

Tricia Smith.

M.ED. Studies.

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QUESTIONNAIRE.

DATA ANALYSIS

AND

CONCLUSION

OF FINDINGS

PREPARED IN CONJUNCTION

WITH THE

PHILOSOPHY OF "THE RIGHTS OF THE TERMINALLY ILL" PROPOSED LEGISLATION

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AIMS:

A cross section of the public completed this questionnaire which was designed to:-

(1) gauge the attitudes of the public towards the rights of the individual.

(2) provide a data base or framework for analytical purposes.

(3) create an awareness of the proposed "Rights of the Terminally III" proposed legislation,

(4) gather basic information through a gallup poll survey methodology.

METHODOLOGY : SURVEY PROCEDURES

100 people participated in this exercise.

The majority (67 participants) were selected at random from the crowd attending the Business Expo in Alice Springs on Friday, 24th March.

Ten participants were selected at random from patrons at the Oasis Frontier Resort Hotel, Gap Road, Alice Springs on Friday, 10th March.

A further 23 participants were selected at random from the Telephone Directory. Telephone interviews took place with this latter group between 17th-24th March.

Whilst the sample of people used in the survey is relatively small given the size of the Alice Spring's population, I do believe the questionnaire served the purpose of providing raw data to gauge basic opinions of the public.

The survey was inclusive in the sense that the target group of participants included:-

(1) adult males

(2) adult females
(3) Aboriginal adults
(4) Non-Aboriginal adults
(5) Adults from various religious denominations and non-established religious plausibility structures
(6) respondents from all age groups - approximately 19-70 years of age
(7) people from diverse socio-economic backgrounds

Given more time and people resources, l would have analysed the data to determine the specific responses of the social groups represented in the survey e.g. gender, cultural, age, professional, religious groups etc. l would have also compared and contrasted the statistical responses to each of the ten questions in relation to conclusive findings.

The 100 responses received do provide a basic framework for statistical analysis and do serve as general indicators of public opinion. As with any survey or opinion poll, participants' anonymity was respected.

As the proposed legislation directly affects the Northern Territory, I ensured that all participants were Northern Territory residents.

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THE TESTING INSTRUMENT OR KEY

DETERMINANTS USED IN THE SURVEY

A series of 10 questions were prepared which required the simple responses of "yes" or "no".

All those who completed the questionnaire were told that the exercise was to provide a raw data base and to gauge public opinion in relation to the proposed "Rights of the Terminally Ill" legislation.

Although some of the questions were leading or direct, they were designed to address the overt and covert issues surrounding Death and Dying and to specifically focus on areas pertinent to the proposed legislation.

As this was not a strict academic exercise, I believe the testing instrument provided an appropriate framework for its designed purpose.

The testing instrument may have been improved if definitive meaning of specific terminology had been more clearly illustrated. However, l wanted to allow for individual interpretation of terminology and encourage interactive discourse.

These objectives were certainly achieved.

Other questions could have been included, which related specifically to the contextual content of the Bill. The inclusion of too many questions would have made the task more time consuming for participants and more demanding with data analysis.

One participant added a Question 11. She wrote "Do you believe there are sufficient medical officers who would feel "right" in doing this -"terminating life" when they are trained to "save life"?"

The testing instrument attempted to ascertain people's attitudes towards several individual and group social issues.

The focus was on human rights issues surrounding life experiences (including death as an integral part of life).

Seven participants chose to just circle "support Mr Marshall Perron's "Rights of the Terminally III" Private Member's Bill".

They then added their signatures to the page.

I believe the testing instrument served its desired purpose, prompted much positive discussion and clarified many aspects of the proposed legislation, which some people had held in reserve.

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RESULTS OF THE FINDINGS

Question 1

Do you believe in basic human rights?

100% of participants believed in basic human rights.

Question 2

Do you believe in quality of life?

98% of respondents believed in quality of life. Two of these positive responses were based on the fact that "quality" must be self determined.

2% of respondents merely answered with question marks.

Question 3

Do you believe in mere existence in life?

65% of the respondents did not believe in "mere existence in life".

28% of the respondents believed in "mere existence in life".

6% of respondents recorded question marks.

1 respondent did not believe in "mere existence" if the individual was being kept alive by external influences.

Question 4

Do you believe that life is a decision making process and that people should have the right to make choices in life?

100% of the respondents recorded positive answers.

Question 5

Do you believe that people should suffer unnecessarily when dying from cancer and other painful terminal diseases?

95% of the respondents recorded negative responses to this question.

5% of the respondents recorded affirmative responses to this question.

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Question 6

Are you afraid of death ?

52% of the respondents were not afraid of death.

7% of the respondents were unsure of their emotional acceptance or denial of death.

41% of the respondents were afraid of death.

Question 7

Do you believe there is a "tabu" or "stigma" attached to death and dying within society?

81% of the respondents replied in the affirmative.

19% of the respondents replied in the negative.

Question 8

Do you believe people should be making excessive and unnecessary money at the expense of dying patients?

98% of respondents replied in the negative.

1 respondent was unsure and answered with a question mark.

1 respondent registered a "yes" answer.

Question 9

Do you respect and accept the dying wishes and choices of terminally ill people ?

97% of the respondents replied in the affirmative.

2% of respondents replied in the negative.

1 respondent registered a question mark.

Question 10

Do you support the practice of people imposing their value and belief systems upon others who do not share the same plausibility structure?

96% of the respondents responded in the negative.

3% of the respondents answered in the affirmative.

1 respondent registered a question mark.

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AN ANALYSIS OF THE FINDINGS

In relation to Question 1, the participants unanimously believed in basic human rights. This response clearly indicates an attitudinal thinking which supports Social Justice, Human Rights and Equal Opportunity Policy principles and implementation practices.

This response also reflects the conscious level of functioning of people rather than sub-conscious behavioural or attitudinal social patterns.

Responses to Question 2 indicate that 98% of the sample group could interpret or define "quality of life".

The 2% who responded with question marks reflect an uncertainty with interpretation or definition of "quality of life".

The responses to Question 3 demonstrate that 65% of the participants could differentiate between "mere existence in life" and life having some form of purpose.

Two of these respondents stipulated that "mere existence in life" applied only to those people who are being kept alive by life support machines or the terminally ill who are having their lives prolonged against their own wishes when they have reached the final stages of physical degeneration.

A further 28% believed in "mere existence in life" and responses appear to indicate that existential behaviour or life patterns are acceptable.

The 6% of respondents who answered with question marks appear to have some confusion with the terminology "mere existence" or have some difficulty with defining the situation according to their own frames of reference.

Responses to Question 4 clearly exemplify that the sample group unanimously believes in life being a decision making process and that people should have the right to make choices in life.

The responses to Question 5 provide evidence that 95% of those who participated in the survey, reject or disapprove of unnecessary suffering with terminally ill patients.

In essence, these people actually oppose the current palliative care practice which allows people to suffer unnecessarily. Responses indicate the right of the terminally ill patient to die without experiencing unnecessary pain and suffering.

Only 5% of the sample group accepted the practice of unnecessary pain and suffering with the death process.

It is interesting to note that all 5% of the respondents who accepted unnecessary pain and suffering with terminally ill patients also respected and accepted the dying wishes and choices of terminally ill people and rejected the practice of people imposing their value and belief systems upon others who do not share the same plausibility structure.

Anomalies appear to exist with these five responses to Q.5, Q.9 and Q.10 in that acceptance of unnecessary pain and suffering may not necessarily be a respect for and acceptance of the patient's death wishes and choices. Unnecessary pain and suffering may also result from the very imposition of value and belief systems upon others.

Responses to Question 6 reflect that a majority of the participants have developed death accepting attitudes towards death and dying.

The majority percentage is marginal in that it registers at 4% above the combined death denying responses of 41% and the unsure category of 7%.

Participants' responses to Question 7 indicate that just over four-fifths of the total number surveyed believe that there is a social "stigma" or "tabu" associated with death and dying. Marginally less than one-fifth of all respondents did not believe that there was a "tabu" or "stigma" attached to death and dying.

The making of excessive and unnecessary money at the expense of dying patients was considered to be an inappropriate practice by 98% of the respondents in their answers to Question 8.

Of the remaining 2% who completed the survey, 1 respondent was uncertain of his/her position with this issue whilst the other respondent approved of the money making practice within this specific circumstance.

In answer to Question 9, 97% of the respondents expressed a respect for and acceptance of the dying wishes and choices of terminally ill people.

These responses clearly indicate an "unconditional" respect or acceptance as only one respondent within this category made a "conditional" response. This woman stated that the patient must firmly establish his or her will to die. The request must be made continuously and a temporal boundary must be determined to allow for the demonstration of patient sincerity.

Two respondents did not acknowledge respect for or acceptance of the dying wishes and choices of the terminally ill.

Yet these same two respondents did not support the practice of people imposing their value and belief systems upon others. An ethical dilemma appears to exist with these individually recorded responses.

Responses indicated that only one person was uncertain when defining this situation.

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An overwhelming majority opposed the practice of people imposing their value and belief systems upon others who do not share the same plausibility structures. This was reflected in 96% of recorded responses to Question 10.

A minority of 3% approved of the practice of the imposition of values and beliefs upon others.

Only one person was unsure of how he or she viewed this social practice.

The inclusion of Question 11 by one female respondent demonstrates an awareness of the realities of "ethical dilemmas".

This woman was obviously thinking about the "ethical dilemmas" which arise when methodology and directional changes occur within a secure institutional arena.

I discussed the fear and insecurity of teachers when the Language Curriculum Statement was introduced in 1975.

This was the first time teachers were expected to move away from prescribed Courses of Study and to design their own "inclusive" curriculum to cater for the specific needs of their children.

The reality was that education had to become relevant to the changing needs of society. Outdated Course of Study were no longer appropriate.

Several of my close friends are Good Samaritan Sisters.

They spoke of the "ethical dilemmas" which occurred when overdue legislation was introduced in the Catholic Church.

Many of the nuns did not feel "right" changing out of their old habits into lay people's attire.

These initial anxieties are to be expected with any change, which alters the path of traditional practices. And with the passing of time and re-adaptation to social and physical worlds, previous causes for anxiety become issues non-contentious.

9

CONCLUSION OF FINDINGS

The information received clearly suggests that members of Australian society have evolved with attitudinal and behavioural patterns, which recognise and incorporate basic human rights within the structural belief system.

The data reinforces the shift in social thinking away from dominant control groups towards a human rights social ideology.

Whilst the majority of participants could determine "quality of life" according to their own frames of reference, a minority had difficulty interpreting the terminology. The difficulties arose because I had not provided a definition for an interpretation of "quality of life". In the face of uncertainty, these people opted to answer in question mark form. It was interesting to note that they did not respond negatively and would have been quite happy to have answered in the affirmative if "quality of life" were determined by the individual and not external forces.

The terminology "mere existence of life" confused many of the participants. Much discussion revolved around meaningful interpretation. The questionnaire would have been enhanced had I differentiated between factual existence which occurs in life and the practice of "mere existence" with the lifestyles of human beings according to readily identified determinants.

All participants strongly supported the right for people to make choices in life. No one disagreed with this humane decision making process.

If people were to accept that death is a natural or integral part of life, then these responses would support the right of the individual to control his or her own decision making process when determining death practices.

This concept receives substantial support from the documented evidence that the vast majority did not approve of "unnecessary" pain and suffering when terminally ill.

Whilst these responses reflect the thinking of the public at a micrographical level, they certainly complement the statistical information that 80% of Australia's population support humane death practices which include "voluntary euthanasia".

Death accepting attitudes are undoubtedly revealed through the majority responses which express lack of fear of death.

Although death accepting attitudes were only marginal, this marginality is not surprising given research findings have demonstrated that Western Societies are death denying and death defying overall.

Research shows that non-Western cultures have developed death accepting attitudes and social behavioural patterns.

These research findings are certainly substantiated by the majority of respondents' belief in a social "tabu" or "stigma" associated with death and dying.

This "tabu" or "stigma" has influenced people's understandings of death and dying and the death process. Voluntary euthanasia is just one aspect of the whole "death" picture. The significance of grief and loss, mourning processes, accurate

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terminology, appropriate death assistance practices i.e. open and honest discussions and support for dying patients and/or assisted termination, has been ignored or mystified as a result of social "tabu" or "stigma".

Yet "finished business" is so important in life for the dying patient, family members and close friends. It is also important for the maintenance of social stability.

When life is prolonged unnecessarily and against the wishes of the dying patients, society endorses the flourishing development of a solidly established "death industry".

This forces one to question the motives for the prolonging of life.

Is it really for the benefit of the patient?

Or is it to boost economic growth?

Who is the real gainer and loser in this situation?

Opponents of the "Voluntary Euthanasia" legislation express their fears of exploitation of vulnerable groups.

Is not exploitation occurring now with current "accepted" death practices?

Why have we moved away from a natural death in the home place to an institutionalised structure, which has impersonalised and bureaucratised a once accepted natural process, a process which was part and parcel of every day life in the home environment?

An overwhelming majority respected and accepted the dying wishes of terminally ill people. Given this response and the national support for "Voluntary Euthanasia" legislation, it is difficult to understand why a minority group within society feels that it has the right to determine what is best for others.

Paternalism has been recognised as one of the most sinister forms of discrimination and racism.

Whilst paternalism may find its roots in religious and ethical foundations, it nonetheless manifests the imposition of ideals and values upon others.

In the case of "Voluntary Euthanasia", the minority group is demonstrating paternalistic behaviour.

One must ask why the view of a moral minority is having such impact upon the beliefs and views of a majority?

It is because bureaucratic, hierarchical structuring has established solid, institutional bases of power and control. Associated with the vertical lineal rungs is status of position. Those who occupy points of apex are in a position to assume, expect and sometimes demand rights of privilege through power and control. This type of structural formation thus provides a base for the dominance of particular peoples over others e.g. churches, legal systems, education systems, health systems.

According to Agger (1978:p.46)"Institutional fragmentation deepens false consciousness and misplaces human effort in trying to solve false problems in an illusory or delusory manner. If the distinction between institutions were interest based, nature and structure could be mixed or changed easily as people change perspectives.

Institutions are now suprapersonal in the sense that they are difficult to change by people's shifting values. A society of institutions is more powerful than a society of individuals living in person-to-person social space. It has the double strength of values resistant to change and formal structural power."

11

FINAL PERSONAL NOTE

Throughout the past few weeks, I have discussed the proposed legislation with hundreds of people in a variety of cultural contexts and in diverse situations. These have included formal presentations at political forums, general discussions in workplaces, interviews with people on the streets and media discussions.

I can honestly report that only three members of the public were opposed to the proposed legislation. When asked the reasons for their opposition, these people responded on the grounds of established religious beliefs. They were members of the Catholic and Uniting Church of congregations.

One of these completed the questionnaire fully endorsing the rights of the individual throughout life, including death.

This woman was then alarmed to see that her ideological thinking was in accord with the philosophy of the proposed legislation.

She then wrote "I reject Perron's Bill". When asked how she could answer the questionnaire in the manner in which she did and at the same time reject the proposed legislation, she replied that her rejection was on "religious" grounds.

It appears that many people are torn between the strength of their own personal convictions and the institutional strength of the Church on this human rights issue.

I can understand this conflict, having been brought up a devout Catholic.

On the one hand, the flock is being told to love one another and to accept people for the beings they are.

On the other hand, attitudes of superiority and paternalistic behaviour are the order of the day.

The metaphysical world is divorced from the physical world within the Catholic belief system.

When the two are confronted together, unlike elements meet and "cultural confusion" occurs.

These comments are based upon first hand experience with "Catholic enculturation".

I would strongly urge all members of the Select Committee and Parliament to read as many books on Death and Death Education, view as many videos on the subject of Voluntary Euthanasia e.g. Who Owns My Life - the Sue Rodriguez Story and be prepared to listen to the majority social voice before making an informed decision.

12

Politicians should be legislating for democracy within society as the elected representatives of the people.

The democratic decision making process should not be influenced by personal, ethical, religious, cultural or professional interests.

Politicians must develop the capacity to distance themselves from their own culturally acquired ideals and values, take a view from afar and redefine situations that may be outside of their own culturally determined frames of reference.

Only in this way can interpretation of social worlds be realistically determined, can "blueprints" develop for pictorial inclusiveness and can the ideals of democracy reach meaningful fruition.

Agger, R.E. (1978) A Little White Lie.

New York: Elsevier.

SUBMISSION 682 1

Telefax to: Select Committee on Euthanasia

Parliament of the Northern Territory

PO Box 3721

DARWIN

Fax no: C/0- of 089 816158

From: Denise Darlow-Ng

4 Leemon St, Condell Park 2200

Fax no: (61-2) 223 5180

Tel no: (61-2) 223 5151

Date: 24 March 1995

No of Pages 2

Dear Committee Members,

Enclosed for your information is a copy of my communication to the Chief Minister, upon reading of his efforts to legislate in favour of voluntary euthanasia.

Even prior to my personal experience with my father's death, I held the conviction that people should be able to chose when to die when they determine life has become unbearable for them. It is not enough to say, sotto voice, "well, they can hook themselves up to the exhaust, or jump off a bridge, if they're really determined". Sick people are often too sick to sit up, let alone take action - that's assuming they know how to finish their lives. In the case of my father, it was impossible for him to swallow - so how could he take piles to end his life, even if he had known what pills to take and how many. And as for the view that people can will themselves to die, just a visit to the terminal wards and hospices will confirm that this is not the case.

As a community concerned about alleviating suffering, and safeguarding individual rights, we should at least give human beings the same consideration we give our domestic pets. That is the right to not have to endure further, that which is unendurable.

I am sure others will put to you personal experiences and convictions. I wanted to put mine on one page, so there have not expanded with details of my person experience with my Dad's death, or on all of the other reasons I believe in voluntary euthanasia.

I urge you to look forward. Remember it is not "compulsory" but voluntary euthanasia. People who don't agree with it, need not avail themselves of it.

Yours sincerely,

Denise Darlow-Ng

Enclosed with submission copy of Confidential letter to The Hon Marshall Perron MLA.

SUBMISSION 683 1

PO Box 387

Cootamundra

24th March ;95

To Fax No. 089 412661

To The Select Committee of Euthanasia

Parliament of Northern Territory

Darwin

We wish to support the case for legalising Voluntary Euthanasia because we feel ever individual should have the right to terminate one's life.

When the quality of Life due to poor health has deteriorated to stage where life support machines have to be used.

Where Brain damage gas caused the correct Body functions not to occur.

Yours faithfully

Mr & Mrs W.B. Cunich.

SUBMISSION 684 1

P.O. Box 2651,

DARWIN. N.T. 0801

24 March, 1995.

The Select Committee,

'Rights of the Terminally Ill',

Parliament House,

DARWIN. N.T. 0800.

Dear Sir,

I refer to the Member for Fannie Bay's Private Member's Bill, "The Rights of the Terminally Ill'.

I wish to advise that I fully support the Bill.

I understand the Bill to be about personal choice - my choice, not the medical industry, not the churches, not the host of vocal minority groups, not even my family.

Having undergone surgery for breast cancer and possible lung cancer I still like to think I may be lucky and die in my sleep but if my previous health problems re-occur I would like to know that I have the option of not having to suffer to the bitter end.

I have also written to my local Member (Port Darwin) advising him of my support for the Bill.

Yours faithfully,

PENNY LA SETTE.

SUBMISSION 685 1

Submission to the Select Committee on Euthanasia.

Rights of the terminally ill.

Prepared on behalf of the Rural Churches Association,

PO. Box 346, Humpty Doo, NT. 0836

by the Rev. Wilfrid John Pinson, President.

The committee has been charged with a difficult and emotive task; to comment on appropriate and humane provision for the terminally ill - those deemed "likely to die within 12 months as a result of illness"1 The Rural Churches Association has been formed by the Anglican, Catholic and Uniting Churches working together around

Humpty Doo, to co-ordinate shared activities and to promote a common witness in the Rural areas. The following submission is the result of careful discussion and is offered to share a constructive viewpoint with the committee members.

The term **Euthanasia** is used to cover a wide variety of legal and medical circumstances, So called "passive euthanasia", or the decision not to continue aggressive medical treatment (let nature take its course) is distinguished from "active euthanasia" or "in relation to the death or proposed death of a patient ... prescribing of a substance for the patient to administer ...the preparation of the substance for administration,.. also, the administration of the substance"2 The *Natural Death* legislation covers "passive euthanasia", and the committee is primarily considering whether terminally ill patients should have, as an option, the right to voluntarily request "active euthanasia".

The Honourable Marshall Perron has clearly stated "Society has, through the laws in place today, made an assessment for all of us -- that our quality of life, no matter how wretched, miserable or painful is never so bad that any of us will be allowed to put an end to it. I am not prepared to allow society to make that decision for me, or those I love.3" There is an assertion of a right built into this argument. Put simply, in other contexts society does not agree that a person should have something, simply because they want it. There is always an element of individual moral responsibility for a request.

Further, these remarks imply three elements in the definition of active euthanasia:

a) It is the intention of the person doing the killing which determines the nature of what is done

b) It is done at the request of a person who is mentally competent and fully informed, and when that request does not override the rights of another person, or of society and

c) The morality is the same whether killing is be a direct action, or whether death results from omitting to do something which should have been done.4

Bishop R. Appleby stated "If the relief of pain results in some shortening of life, then there would be no objection ... "let nature take its course" provided everything possible is done

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to relieve pain"5 ie., there is general agreement to avoid inflicting any suffering that can reasonably be avoided. Pain and suffering are subjective experiences. Ultimately, the individual is the only arbiter of acceptable pain. An observer cannot be sure of the level of pain, or its "bearability"- which can fluctuate with circumstances.

The point is that pain imposes its own conditions on the sufferer. What may be unbearable today can become bearable tomorrow - and vice versa. A decision to "Request assistance to voluntarily terminate life" may be made; and once that has been executed, the request - despite the provisos of clause 8 "Right to rescind request" and clause 10 "that the patients decision to end his or her life was made freely, voluntarily and after due consideration" will take on a life of its own, which may well result in failing to give adequate time for consideration and recension.

Active euthanasia suffers from the same fatal flaw as capital punishment - if a mistake is made, nothing can undo it. All persons go through periods of depression, especially those for whom the horizon of life has been abruptly foreshortened. My concern is that the terminally ill are encouraged rather to make the most of the time left to them; actively involve themselves in the effective management of the illness and make the fullest contribution to society that they are capable of - rather than being encouraged to "request assistance to voluntarily terminate life." Society's best interest is served when people are encouraged to deal constructively with these matters.

It is interesting that the Hon. Marshall Perron does not draw out the important distinction between active and passive euthanasia. He simply remarks "when deemed appropriate, some doctors actively and humanely terminate life". He implies that this is done with tacit consent, both medically and from the community.. There is a further

implied argument here - that if a distressing death serves no apparent good purpose, and the person asks to be killed, then killing my be seen as a good action because it produces relief of distress - a good outcome.

Chris Wake points out that he "helps people to die" and explains "What doctors do is to titrate increasing doses of opiates and other drugs against a patients symptoms of emotional and physical pain. In unusual circumstances it may be necessary to render a patient to unconsciousness at the very end, and then nurse them until death takes its course - usually within 48 hours or so. This is good medical practice ..."6 Dr Wake assures us that this is the only course of treatment accepted by the medical profession. This description is very far from the emotive word "torture" which Mr Perron applies to it. As a reasonably regular hospital visitor, my experience agrees with Chris Wakes description rather than Marshall Perrons.

The existence of active euthanasia methods within our medical system goes well beyond the "rights and choices" of patients. Patients already have the right to choose or refuse treatment - and most medical people would advise against treatment which unnecessarily prolonged life and suffering. The right to refuse treatment is an important safeguard against the extension of life, without regard to its quality. Despite the safeguards built into the Bill, the existence of active euthanasia in our medical services alters the relationship between patient and practitioner, and within relatives. It is wrong to kill, and to plant the possibility of being killed. This would be a far greater burden for the community to carry because, despite

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assurances, there can be no guarantees that the killing can be limited. A voluntary agreement to be killed threatens my right to life as well.

The Christian faith places a unique value on human life - it is given by God and therefore irreplaceable. The differentiation of Life into nations,. groups, sexes and individuals adds a particular and unique feature - nobody is "just" a human being. Life's meaning therefore does not just derive from what we make of our faculties, but rather from the purpose God has for life. Our common purpose in caring for the terminally ill should be to ensure that the distress is taken out of their condition, by providing the most appropriate care - hospice or palliative care.

The committee will best serve the needs of the Northern Territory community by recommending the setting up and extension of simple palliative care units staffed by appropriately trained carers, to provide a cost-effective option for those who truly wish the blessing of "euthanasia", a good death. No medical science or technology can completely eliminate the anticipation of death, but well managed death does not become a torture.

I would be pleased to further support this submission by appearing in person as a witness.

Revd. W. L Pinson.

1 Rights of the terminally ill Bill. Interpretation (b)

2 ibid 2. (1)assist.

3 Perron M. 1995. *Rights of the terminally ill - reforming the* law, *Background paper.*

4 Pollard, B. 1991 Euthanasia *Annals Australia* October/November 1991 p. 22.

5 Appleby, R. 1995. *An open letter to the* members *of the Legislative Assembly of the Northern Territory'.*

6 Wake C. 1995Address *to Rotary on the subject of Marshall Perron's proposed euthanasia legislation.* leaf. 5.

SUBMISSION 686 1

COMMENTS : EUTHANASIA

23 March, 1995

Smallness of community

We live our lives within a small and close community in Darwin and those of us called upon to make professional health care decisions often find friendships make providing objective care difficult. This would certainly be the case regarding a request for euthanasia. I say this as a trained nurse with post graduate geriatric nursing experience and also as a psychologist and family therapist working with families at Resolve/Anglicare N.T.

Dual relationships are common here and often interfere with objective decision making regarding clients. Difficulties arise for medical practitioners who have friendships that are long term and significant, with members of the community. There are people they have formed business relationships with, and consulted with, professionally. They have worked with them in Rotary and the Lions clubs or in their local church or drunk with them at the pub or met regularly with them at the sailing club, on the footie field, at the races, in the neighbourhood, the local CLP or Labor party meetings. They see them socially at fund raising activities and dinners and work along side them. They meet at school council meetings. They meet at cultural meetings and share common goals. They have shared the stresses and difficulties of their jobs. They have shared as friends their experience of their relatives' lives.

It would be strange if these medical people in our small community were not to rationalise and feel sympathy for their friends' pain as carets, and want for them to be quickly released from it. To have their judgment seriously swayed in the direction of being more attuned to the carers anxiety and distress more than to the patient's desire to live till the end even if that process is difficult for others.

Our Darwin agency is constantly amazed at the length to which family members go in sacrificing themselves and their own needs for their family and their families' displays of pain. The elderly or the seriously ill are especially sensitive to the distress of relatives. This feeling of upset commonly leads to emotional distance between them and that relative - a "fate worse than death" for those already facing death.

Family dynamics shape decision making at all stages of family life (and death). We see in counselling that often young people become homeless rather than disclose family secrets of abuse against them. Family loyalty is continually displayed by even children in an effort to help the entire family to survive. A child will "act out" to stop a couple (who have themselves huge relationship problems), separating or fighting openly. I have noticed that suffering people sacrifice themselves in order to please and make life easier for others in the family.

Elderly abuse is fairly - much hidden and undisclosed -little research has been done in this area but this abuse is thought to be significant in our society. If "push" can come to "shove" physically with the elderly it will take very little effort to co-erce those in our society who are politically weak and socially isolated from the outside world from deciding as the group has decided for their own good regarding giving up their life.

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Along with Dr. Chris Wake, I wonder who will set themselves up to make judgments on when a life is worth ending. This will differ hugely across medicos and nurses. All human beings differ greatly in what they value in a life.

Institutionalised suicide may look humane at one level but certainly could be opportunistic at another. Many dying parents would trade the brief period of closeness they achieve over a few days of negotiation for their death for the distance and remoteness they have experienced in their extended families. Often also they have experienced lack of empathy and caring on the part of relatives who are in turn finding it difficult to cope with their own distress and anxiety.

People who cope least-well or decide for premature death will be those who are in a relationship with someone

who has low personal tolerance to frustration currently in interpersonal relationships. When the partner is accustomed to "making" others by using both overt and covert strategies rather than negotiating so the matter under discussion will be OK for both. Those who are weak; in pain; feeling they are a burden to others will be easily coerced into making a "grand" gesture as a solution to the family's problem.

Thoughts on the local Darwin euthanasia presentation on T.V.

Both the doctor and the wife seemed to provide little to affirm or validate the value of the patient's life - the focus of we saw was on the death and the lack of value of him as he was or had been.

The final letter showed little of real closeness between the couple - little sense that the time of death was a good choice for the patient. The analogy of their lives as bookends didn't to me, give a sense of "a great love story".

This man's whole existence and directed dialogue was centred on living the time that remained by getting the system (wife and doctor) to be willing for a few more days. Atone level the doctor suggested deferral (e.g. at the end "for a day or so") but the overriding message was "let's get rid of this useless life".

The main focus was on the relatives' difficulty of living life rather than the patient's problems - the information from the patient about pain was almost exclusively distilled by the relative. She spoke of his view of dying rather than allow him to speak of this himself.

How much was the doctor on T.V. paid for his services to evaluate the right hour of death? Was it by the hour? All doctors know they will have to deal with pain and death. It's a normal process. If they have a close relationship with the client it will always be ambiguous - pain on the one hand and release on the other. That's what being a doctor involves. This doctor made himself a victim. If it was so difficult for him personally as he stated in the program, he was the last person who should be euthanasing people. He took on a counselling role with no skills for the job - he showed he knew nothing about celebrating the nature of the man's life and validating his day by day struggle in an appropriate way. There was no emphasis, on the doctor's role of responsibility for easing or eliminating pain. There was no emphasis on contact by the patient with an extended supportive community of relatives or a caring community of respite or palliative care workers for the wife to help her deal with the pressure and stress of

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these circumstances. Would she have let him live longer if she'd had more support? Would he have volunteered to go if he hadn't been so affected by what he called her 'sacrifices'?

Was it moral to tape this record because it presumed the outcome and made it more difficult for the man to back out if he changed his mind?

My experience last year with my own mother when she was in such great pain that she spoke of death being a release showed me the depth of despair that poor pain management by the medical system can bring.

She, now with a new regime, has limited bearable pain and has what she and her family and friends consider at 88 to be a full, worthwhile life both in the home and outside it.

I have nursed in aged homes and listened to stories from patients who talk of dying to relieve relatives. I've seen the despair and lack of desire of old people to live any longer. I've heard their stories and seen the tears. I've seen those ideas radically change after visits of family members and a quite different attitude be shown when they are valued and visited by friends and relatives.

There are issues of legacies and divided properties. There is the extreme sadness of failed relationships and making up for these by being as little trouble as possible. Ideas about sacrificing oneself for the family are pervasive for some dying people.

It's a very different setting for this legislation that we have here in the N.T. compared with other areas where this policy has been introduced. It's a small community. Dual relationships, professionally are common. Medical practitioners are often here briefly and are frequently relatively inexperienced in comparison with larger Australian centres of population.

No diagnosis of death within twelve months is certain. Sometimes a markedly different treatment regime can unexpectedly and against medical predictions, add ten years of quality life. My mother is an example.

Radio broadcast: 13/1/95

On 13 January 1995, a senior interstate A.M.A. "medico" said that pain management was the key issue and most people did value their lives and only asked to be euthanased when in severe pain - if this is treated the picture alters and they again desire life.

For us in Darwin the key issues are that we need as a community to provide universally accessible and culturally appropriate palliative care medically and socially, for the dying and their families and or carers.

SUBMISSION 687 1

Christian Outreach Centre

DARWIN

GPO Box 4708,

DARWIN NT 0801

23 March, 1995

Select Committee On Euthanasia

Legislative Assembly Of The Northern Territory

GPO Box 3721

DARWIN NT 0801

Dear Mrs Braham, Dr Lim, Mr Poole, Mr Rioli, Mr Stirling,

I would like to briefly present to you on behalf of the membership of Christian Outreach Centre in the Northern Territory, represented in Darwin, Katherine, Alice Springs and many Aboriginal communities, our thoughts on the current private members bill on Euthanasia.

We do not wish to laden you with information which we have gathered, as we are sure that you will have had much submitted already, but it is our intention to give you our stand on the issue based purely on a Biblical understanding. We appreciate that this is not necessarily the view of the majority but we are sure that you will also be aware that the majority are not always right.

Our Creator made man and saw that what He had created was good. He is the life giver-. He made man for a purpose, a destiny. No-one would be so naive as to think that mankind is perfect and without faults but God's love is extended to all mankind. God said that murder is unacceptable and if it should take place there must be punishment. "An eye for an eye." Life is precious and must be valued.

The Scripture tells us that God holds the keys of death and hell. He is the One that appoints the time to die. God also informs us that *it* is the thief (devil) that comes to steal, to rob and to kill. The thief certainly seems to have many agents working for him in today's society.

In many countries where there are multiple millions, life is so cheap and often dispensed with so carelessly , but, please do not allow that to happen in our country. Life is precious, to be valued and needs every opportunity to be lived to the fullest.

We certainly are not in favour of the legalisation of this bill or any other that impowers man to take on God's role.

Please support moves to improve palliative care services in the Territory.

Yours faithfully,

PASTOR MERV WESTBROOK

On behalf of the entire membership

of Christian Outreach Centre in the Northern Territory.

Enclosed with submission article entitled Euthanasia, Can we kill to be kind?, published by the Thomas More Centre, 582 Queensberry Street, North Melbourne, Written by Bishop George Pell (1994), Imprimi potest: Rev. Dr. G Diamond, Imprimatur, Mons. G. Cudmore, Vicar General Melbourne.

SUBMISSION 688 1

Peter J. Ravenscroft 9 Whiley Close

MD, FRACP Merewether NSW 2291

Professor of Palliative Care Phone 049 631720

Fax 049 636537

10 April 1995

The Chairman

Select Committee on Euthanasia

GPO Box 3721

DARWIN 0801

Dear Sir

I write from the perspective of a doctor who has worked in the Speciality of Palliative Care for a number of years. I am Professor of Palliative Care at Newcastle University and Director of the Department of Palliative Care at the Newcastle Mater Hospital. I am also President of the Australian and New Zealand Society of Palliative Medicine.

My work is with a team of doctors, nurses, allied health professionals, including a pastoral care associate which provides inpatient care at a hospice, outreach care to patients in their homes and advice for patients in hospital. Our service looks after about 900 patients each year including children, of whom about 600 die, the majority of cancer, but some of neurological disease, AIDS, cardiac and renal disease. Most of us on the team have had personal experience of deaths in our own families. We are involved in teaching health professionals, both undergraduates and postgraduates about palliative care.

I would like to make the following general comments about the Northern Territory Bill:

The clinical picture portrayed by a palliative care specialist as quoted in the Honourable Minister's speech in the second reading of the Bill is a composite description of a variety of distressing symptoms which may be suffered in

the terminal stage of disease. These symptoms taken individually and considered by the staff of a palliative care team can be relieved, if not controlled.

Nowhere in the Minister's speech does he acknowledge the lack of Palliative Care staff and facilities to cope with such problems in the Northern Territory. The average General Practitioner in Australia would see about 3-6 patients a year with terminal illness needing palliative care. This means he or she is usually not sufficiently experienced or aware of the medications or procedures which can be used to alleviate pain and other symptoms. Reasonable standards of practice would require that there are Palliative Care Specialists and a training programme established for GP's. It would be desirable that in the legislation provision of sufficient funds be made available to establish palliative care services in the Northern Territory. I would recommend that a palliative care service would consist of palliative care specialists and nurses and allied health staff providing inpatient services and providing home care. There are ways that this service could be made relevant to the Northern Territory situation.

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When considering the small proportion of patients in whom symptom control is very difficult people in favour of euthanasia may use the argument of compassion, but it has been an aphorism in law for a long time that "hard cases make bad law." Many of the cases quoted have not had adequate palliative care and there is much that can be done for them. The cases that this legislation is drawn up to cover is only a small proportion of the total palliative care cases. The community at large, and the Government in particular, has a role to see that these people are not left on their own to cope with their difficulties. Loneliness is an important factor leading to despair and despair leads to thoughts of suicide. My reading of the Bill suggests that one could request euthanasia, and with good organisation, have it carried out the same day. I believe that there should be a period of two weeks to allow the patient to reflect on the decision and its implications before it is carried out.

The medical profession has principles on which practice is based. The first is enshrined in the Hippocratic Oath,"above all, do no harm." The idea is that patients could trust doctors to offer the treatment that is best for them under all circumstances. A decision for euthanasia would require full disclosure to the patient of the pros and cons of all treatments available before a choice is made. Full disclosure requires a knowledge of palliative care treatment. The legislation seems to assume that any doctor will have the knowledge relevant to this decision. I do not agree. Would you accept a GP's decision that you had an incurable heart condition, without going to a cardiologist in this modern day?

Another principle is the right of patients to make decisions for themselves. The practical implication of a patient's autonomy means that doctors can examine and treat only with the patient's consent. The supporters of euthanasia would say that people should have the sole right of making decisions about their health; not anyone else, not the government. One of the aspects of living in a community is that we do not have absolute autonomy, if we did we would have anarchy. This limitation of autonomy applies particularly when we want to change the law for a whole community as the supporters of euthanasia wish to do. It must be acknowledged that doctors, nurses, pharmacists and other community members have autonomy too, so that what is done must be best for the whole community. Much thought, effort and persistence goes into symptom control by a palliative care team. If there was legally acceptable the option of euthanasia, it might be tempting for some staff to take the easier alternative and opt for death of the patient rather than persistence to find effective treatment. I have had patients that it took weeks to get their symptoms under control. I have had patients whose symptoms have settled spontaneously. Some of these patients have lived much longer than I would have anticipated. Death by this Bill would have denied them valuable opportunities to live. As Clint Eastwood said in one of his films, "Its a hell of a thing that you do when you kill a man - you take away everything he's got and everything he's ever likely to get".

This Bill seems to only consider the doctor and the patient. If the patient is in hospital or being looked after by a team, what does this legislation consider of the nurse's opinion? What of the pharmacist's opinion? What of the physiotherapist's or social worker's opinion? There seems to be nothing in the legislation to deal with these issues.

Contrary to widely held belief, morphine even in large doses will not kill when it is being given regularly, in fact the reverse applies. Studies have shown that doses of morphine, sufficient to relieve pain will extend life, not shorten it. Death may come expectedly sometimes, at others quite unexpectedly. Doctors who are giving increasing doses of morphine and other drugs may think they have contributed to the death, but in our experience it is more probable that other processes have led to death occurring unexpectedly. Drugs such as curare, barbiturates, potassium chloride and others will have to be readily available. How will these drugs be regulated and distributed?

This Bill is introducing the factor of choice into the lives of the dying. Choice is a good thing, but is the choice to end your life too much to ask? Initially only a small proportion may choose euthanasia, but it is likely in my view that more and more people will be asked to make that choice. This is because of economic factors and social factors. It is relatively easy to say why you might want euthanasia, but the reasons you might have for wanting to remain alive are much more difficult to verbalise. This Bill may lead to the inadvertent steam-rollering of the dignity and propriety of life.

It is not easy for those who are suffering and their carers to see the issue of the risks of legalising euthanasia, no matter to what the degree, from the public perspective. Those in government and in the health professions must assure them of our commitment to their welfare and see that there are funds and staffing for all the services that they need to keep them pain and symptom free as well as assist them to have their psychological and spiritual needs met. The care of the dying is the responsibility of the whole community, not just the health professional and those with a special interest.

I have some comments on the detail of the Bill itself:

In the Bill under Clause 6 :

(b) We define a patient who uses the palliative care service as having 3-6 months to live. This is a rough guide. Twelve months seems too long a period.

(c) The examination by the second medical practitioner should be conducted independently and preferably by a palliative care specialist. Unless one of these doctors is a palliative care specialist the issues of pain relief will not be addressed by a specialist. I have personal experience of GP's who have thought that they have done everything that could be done to relieve pain, but there have been other options that have been available and were successful. What happens if the two practitioners disagree? Who will determine which of the practitioners is right? Will it be left to the first to find a like-minded colleague? Where is justice and fair mindedness in all of this?

(f) The assumption in this section that "medical treatment" is the only treatment which is available and effective is simply wrong in fact and emphasis. This whole legislation is constructed around a medical model of care which is not appropriate for a palliative care patient. Palliative Care Units recognise that medical, nursing, allied health professional and pastoral care all play different but additive roles in the care of someone who is dying.

(h) The doctor should be required to record the "grounds" on how the decision was made in the patient's notes.

To decide if a patient is "competent" can be a very difficult decision. It is a well known fact that patients with a debilitating disease or cancer can become confused and depressed. This can be very difficult to assess even for experienced practitioners. I would like to see a requirement for this aspect to be documented in the notes. I have experienced such patients who after the appropriate treatment have had a completely different outlook on living and dying.

What is "due consideration?" This legislation allows no "cooling off" period - is life less important than a second

hand car? I would suggest that there be a period of two weeks to allow the person to reflect on their decision.

(j) Can any person sign on behalf of the patient? I think it would be safer if the Bill stated that it should be a family member or carer.

Clause 7

In the case where a person is unable to sign a will, usually the person makes a mark, for example "x". This is a serious decision. Surely the patient should state orally and make a mark on the document if possible. This would appear to offer a lot more protection to the patient than a third person signing the document.

Clause 8 states, " Notwithstanding anything in this Act, a patient may rescind a request for assistance under this Act at any time and in any manner." There should be a "cooling off" period as outlined previously.

I have had the experience of patients requesting death, and 24 hours or a short time later when I have raised the issue with them they have looked at me completely puzzled and have not had any memory of the incident.

Clause 9

I would have thought that a more appropriate penalty would be a more substantial sum of money and imprisonment for life. The result of such deception is murder. There seems to be no penalty for attempt to procure, nor is there any consequence for breach of the separate conditions of Clause 6.

Clause 10 (e) and 11

Who is the patient's medical practitioner? Could a locum be called in one night and decide that the patient needed euthanasia? I do not think that would be satisfactory and would like to see that situation guarded against in the legislation.

Clause 12

(1) "As soon as practicable" is too nebulous and should read "Within 14 days" to ensure that the notifications are made.

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The statement by Lord Walton in the Journal of the Royal College of Physicians (May/June 1994) summarises the situation in the United Kingdom:

"We recommended that the law should not be changed to permit active euthanasia. We did so because:

** while we have every sympathy with those in suffering close to the end of life who would wish to see an end to their misery (something which many of us have experienced in our own families), we did not believe that it would be proper to prefer the interests of the individual to those of society as a whole;*

** we did not believe that it would be possible to set secure limits if euthanasia were to be legalised; and we were in no sense reassured by the evidence we obtained during our visit to Holland despite the obvious sincerity of the Dutch doctors and lawyers whom we met".*

I believe that this same problem besets the Northern Territory Bill and that the Committee should recommend that the proposed Bill is flawed and should not be passed into legislation.

Yours sincerely,

Peter J. Ravenscroft

SUBMISSION 689 1

THE BISHOP OF THE NORTHERN TERRITORY

BISHOP RICHARD APPLEBY

PO Box 6

Nightcliff NT 0814

Telephone: (089) 85 2044 (Diocesan Office)

(089) 85 3099 (Bishop's Lodge)

A SUBMISSION TO THE SELECT COMMITTEE ON EUTHANASIA OF THE LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY FROM BISHOP RICHARD APPLEBY. THE ANGLICAN BISHOP OF THE NORTHERN TERRITORY

1. In an Open Letter to the Members of the Legislative Assembly of the 7th February 1995, 1 have outlined the fundamental reasons for my opposition to the Bill and its purposes as set out in the Preamble. This Open Letter is attached to this submission (Appendix 1).

In addition, I submit the following matters to the Select Committee as further reasons why this Bill should not proceed.

2. The Bill requires the medical practitioner to be satisfied on reasonable grounds, that the patient is competent (Clause 6 (h)). This poses three major difficulties:

i) The difficulty of deciding competence in such circumstances;

ii) The difficulty of the patient making and adhering to a rational decision of this kind, in circumstances of severe illness;

iii) Related to (ii) the inevitable difficulty of the person's mood fluctuating as their condition deteriorates and under such circumstances making it increasingly hazardous to determine whether they still understood what they decided earlier and wished to abide by it,

And further, the Bill makes provision for the cancellation of a request (Clause 8 (1)) but does not specify whether the patient also needs to be competent when rescinding. This simply underlines the difficulty.

3. Whilst the Bill seeks to avoid bribery and other such influence on medical practitioners (Clause 5), there is no way in which such a Bill can legislate to avoid social and other pressure on patients with terminal illnesses. It is contended, that in the event of this Bill being passed, there would be a real danger of resultant pressure on patients with terminal illnesses. There would inevitably be the painful questioning in the minds of the patients as to whether they should prolong "the burden" upon their families and others who cared for them. It would require more than ordinary serenity and faith, not to wonder whether there were some who wanted them out of the way. It is submitted, that the passing of this legislation would make those with terminal illnesses vulnerable to fear, confusion and to social pressures which they may not fully comprehend.

And further, the risks of pressure from those who stand to gain from the death of the patient are all too real.

4. It is submitted that this legislation if passed, would result in a serious change in the relationship between doctor and patient. Today there is a large measure of confidence in the medical profession on the part of patients and their

relatives. It is generally, and tightly, thought that doctors do not kill. Even so it is not unknown for patients and their relatives to be suspicious of injections. This Bill, if enacted, would allow doctors to kill, even if under limited circumstances. This would result, for many, in a disastrous blow to the confidence which they have in their medical practitioners.

The Chief Minister, in a letter to me of the 6th March 1995, told me that the had become aware that Aboriginal people in eight different communities in the Territory were, as a result of the Euthanasia proposal, now fearful of going to hospital. The Chief Minister alleged that this was the result of a campaign of lies and misinformation. Whether this fear resulted from such a campaign or not, I do not know. But I do submit that such fear of hospitals and doctors would be a disastrous and inevitable consequence of this Legislation being enacted.

5. The Bill makes no recognition of the very significant Aboriginal population in the Northern Territory and further, the timetable which has been adopted for the Select Committee, is such that there is virtually no chance of having a considered Aboriginal input to this important debate.

6. The Bill, and the resulting debate, has done us a service by highlighting the grossly inadequate state of palliative care in the Northern Territory. It is my considered submission that the energy of the Parliament would be much better directed to the resourcing and improvement of palliative care.

CONCLUSION

For the reasons outlined above, and for those contained in my earlier Open Letter (Appendix 1), I submit that the rights of the Terminally III Bill 1995 must be rejected. Rather, a proper concern for those with terminal illnesses must result in improved palliative care facilities and services in the Northern Territory.

BISHOP OF THE NORTHERN TERRITORY

24 March 1995

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APPENDIX 1

AN OPEN LETTER TO THE MEMBERS OF THE LEGISLATIVE ASSEMBLY OF

THE NORTHERN TERRITORY

7th February, 1995

Dear Members of the Legislative Assembly,

RIGHTS OF THE TERMINALLY ILL

As you consider your response to the Chief Minister's controversial Bill I urge you to take into account the considered views of the Christian Churches.

In particular, as the leader of the Anglican Church in the Northern Territory, I have endeavoured in this letter to list some of the crucial issues from an Anglican point of view.

1. The alleviation of the pain and suffering of those with terminal illnesses must be given the highest priority. I am aware that current approaches to palliative care can keep pain under control I also know that there is an urgent need to develop and extend the provision of palliative care in the Northern Territory.

2. If the relief of pain results in some shortening of life, then there would be no objection from an Anglican point of view.

3. Further, we do not object to what is often referred to as "passive euthanasia" by which is meant the withholding of medical treatment intended to prolong the lives of the incurably sick. In other words, "to let nature take its course", provided everything possible is done to relieve pain.

4. 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 human being, either with or without their consent.

5. Even if you do not share our belief that life is sacred, I would ask you to accept that the Chief Minister's Bill is asking you to cross an exceedingly dangerous threshold. For, should we ever permit life to be terminated (even in limited and strictly controlled circumstances) this will result, in due course, in a change of attitude in society towards the value of human life. Human life will be seen to be expendable.

SUBMISSION 690 1

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5 Melville Street

The Gardens

Darwin NT 0820

22 March 1995

The Chairman

Select Committee on Euthanasia
GPO Box 372l
Darwin NT 0801

Dear Sir,

We wish to register our support for the principle of active voluntary euthanasia which underlies the Rights of the Terminally Ill Bill.

We particularly applaud that aspect of the Bill which allows active intervention by a cooperating doctor within the prescribed guidelines, rather than merely the prescription of drugs as in the Oregon Act.

Our support for the decriminalisation of active voluntary euthanasia is based on:

- respect for personal autonomy and our right to make decisions in matters which are primarily our own concern.

- compassion for those who are suffering with no prospect of relief and the belief that a quick and peaceful death is preferable to a prolonged agonising one.

- concern for the dignity of the person and the importance of the quality of life.

- the belief that guidelines developed in the process will ensure safeguards which are not now available to protect the rights of the individuals involved.

We are aware that there are objections to the principle of active voluntary euthanasia:

- "Right to life" and religious arguments.

We respect the views put forward and we do not ask the proponents to avail themselves of the choices being proposed in the Bill. We do ask that they respect our views and our right to choose.

- Arguments by medical associations.

The Australian Medical Association adheres to a traditional code of ethics which places the preservation of life above the interests of the patient who wishes to discontinue suffering. The Association does not support those doctors who disagree with that code of ethics.

Often the material being presented by such organisations takes no note of the number of members being represented.

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For example, in the Netherlands with 40,000 registered medical practitioners 25,000 are members of the Royal Dutch Medical Association which supports euthanasia. The vocal opposition is from 650 members of the Dutch Physicians League.

Australian surveys suggest that around 60% of doctors support active voluntary euthanasia within clear guidelines. The Australian Doctors Reform Society supports voluntary euthanasia under safeguards similar to those in this Bill.

- The palliative care argument.

We welcome any advances in palliative care services. However, there are acknowledged limits to palliative care no matter how sophisticated. There are still cases where pain cannot be satisfactorily controlled. There is also the distress of loss of faculties and total dependence on others as a prelude to an inevitable death.

- "The thin edge of the wedge" argument.

We do not believe it is logically possible to base a case for non-voluntary euthanasia on the practice of voluntary euthanasia.

One of the great strengths of Democracy is the ability to change the law to reflect changing views of society. Equal rights for women has had legislative consequences unforeseen last century!

There may well be attempts to extend the provisions of this Bill in the future. One foreseeable extension may be the right of people fearing future mental incompetence (eg. dementia) to make a living will expressing his or her personal wishes concerning treatment during a terminal illness. If that future society feels this is desirable it may well become law. That is as it should be.

The real danger which underlies this argument becomes evident when proper democratic processes are not applied; when a vocal or powerful minority override the wishes of the majority. If this is coupled with political reluctance to legislate for controversial social reforms in the face of vociferous or powerful minority opposition, then there is danger indeed.

Some issues which concern us about the Bill in its present form are:

1) Re S: Patient who is unable to sign certificate of request.

Even though S9 makes provision for improper conduct, it may be leaving relatives or likely beneficiaries of a person's death open to question if they are asked to sign the certificate of request. You may consider suggesting that only impartial parties act as agents for the purpose of this section.

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2) Re S4 and S6.

There appears to be a need for some process to cater for the situation where a medical practitioner who has received a proper request for assistance to terminate his patients life is unable or unwilling to give that assistance.

Otherwise the process outlined in S6 may be commenced with no prospect of a result.

Perhaps this issue may appropriately be addressed in S4 by adding words to the effect that:

"A doctor who is unwilling or unable to assist a patient to terminate his or her life following a request for assistance shall be required to advise the patient of his or her right to seek alternative medical attention and shall transfer the patients medical records to any alternate medical practitioner named by the patient."

The Bill may need to specify the rights of patients in the public health care system to alternate medical practitioners in this case.

3) There is no specific "cooling off" period envisaged in the Bill even though S8 allows for rescinding of a request. It appears that requests may be acted on immediately. It seems in the interests of all parties to allow some period, perhaps 48 hours as in the Oregon Act, so that decisions made perhaps in anger, have some capacity for review.

We would be happy to discuss any aspects of the above with your Committee.

Yours faithfully,

Hugh and Sue Bradley

SUBMISSION 691 1

The Chairman

Select Committee on Euthanasia

G.P.O. Box 3721

DARWIN N.T. 0801

22-3-95

Dear Sir,

We the undersigned are employee's of the Northern Territory Health Department and wish to support the principle of assisted voluntary euthanasia with the controls outlined in the Rights of the Terminal Ill Bill.

Yours sincerely,

Carole Mansfield

4 Green Street

Fannie Bay 0820

Marienne Shanahan

50 Kestrel Circuit,

Wulagi 0812

Attached with submissions 19 signatories

SUBMISSION 692 1

Dr C R Carter B.Sc. Ph D

22 Chewings Street

Alice Springs N.T. 0870

Ph. & Fax (089) 532933

22/3/95

FAX TO 816158

Chairman

Select Committee on Euthanasia

I enclose a submission to the Select Committee, also a copy of a paper dealing with palliative care.

I also seek leave to appear before the committee when it sits in Alice Springs on April 3rd.

Yours sincerely

Charles Carter

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SUBMISSION TO:

SELECT COMMITTEE ON EUTHANASIA,

RE; RIGHTS OF THE TERMINALLY ILL BILL

The Bill is very accurately named. it is a matter of rights. However. many of the Participants in the debate are not addressing the issue of voluntary euthanasia as proposed in the "RIGHTS OF THE TERMINALLY ILL BILL" at all. Some obviously have not read the bill. Some are clearly trying to misrepresent the bill to argue for their own Positions.

Some opponents of the bill seem to be starting from the premise that it offends their personal religious belief, and they proceed from there to try to find any argument to oppose it. Normally l would regard the religious beliefs of people in public debate or public life to be their own business. In this Instance it appears that participants in the debate are allowing their own convictions to override the rights of others.

It may be useful for contributors to acknowledge their religious beliefs and affiliations at the outset, including all of the members of the NT Assembly. I was brought up in a family of Anglican and Methodist belief, but as a rationalist and a scientist l can find no convincing evidence for the existence of a god, and no reason to postulate the existence of one.

Non-religious people may have ethical and moral values that are deeply held and soundly based. Many people in the debate seem to be suggesting that a Christian ethic forbidding voluntary euthanasia is the only one, and furthermore that it should be imposed on everybody. This is not the case.

Australia does not have a bill of rights, but the only section of the constitution that deals with rights does in fact deal with religious freedom, and I quote it.

"116. The Commonwealth shall not make any law for establishing any religion, or for imposing any religious observance. or for prohibiting the free exercise of any religion .... ".

I am not a constitutional lawyer and I doubt that section **116** applies directly in a legal sense to this issue, but it does express clearly what I believe to be the fundamental issue, the right of individuals not to have other peoples

religious convictions applied to them.

The right of individuals to regard voluntary euthanasia as personally unacceptable is freely acknowledged. However, the principled position for such people to take is to acknowledge the rights of others to hasten their. own death under the rigorous conditions set out in the bill. I commend this position especially to Members of the Assembly.

If I am suffering from a terminal illness, and I want to hasten my own death to avoid intolerable suffering, that should be my decision. I have not heard any of the opponents of the bill tackle this issue. They seem to concentrate on issues which are not directly relevant. Yes. there should be stringent safeguards to prevent abuse. and I think these are in the bill.

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Yes, there should be better palliative care, but that does not negate the principle. However, tile assumption that palliative care takes away. the desire for a hastened death may not be well founded. A recent paper in the British journal Social Science and Medicine1 this issue. They report "the view that requests for euthanasia are uncommon in hospices is not supported by the findings". The authors suggest "Expert understanding of the psychology of dying...is one of the hallmarks of hospice care, and this is associated with placing a high premium on allowing patient choice. Requests for euthanasia may indicate not the patients are giving up in the face of suffering, but that they are positively -asserting their desire to control events".

Yes, some medical practitioners will find that assisting a competent terminally ill person to hasten their own death offends their beliefs. Fine. they don't have to help. and this is also clearly covered in the bill. However, it is also clear from the debate so far that some medical practitioners already do assist, and they deserve the protection of the law.

The allegation that it is the duty of doctors to prolong life is incorrect, it is their duty to act in the interest of the patient. and the competent patient never relinquishes the right to have the final say as to what is their best interest.

It is difficult to keep an emotional and controversial issue such as this rational and relevant. Many people just read (or listen to) the headlines. Every headline that uses the phrases "death bill", "mercy killing". or "euthanasia" without the "voluntary" in front of it. is misleading the headline readers, We need to be very precise about what we are discussing. I suggest that if we address the issue of the freedom of the competent, adult., terminally ill individual to ask for assistance to hasten their own death in a dignified manner, there is only one reasonable conclusion. I support the bill.

Charlie Carter,

20/3/95.

Dr. Charlie Carter, BSc. PhD.

22 Chewings St

Alice Springs, NT, 0870.

1 EUTHANASIA: THE ROLE OF GOOD CARE, Seale, C. and J. Addington-Hall. Social Science and Medicine, Vol. 40, No. 5, 551 - 587.

(copy enclosed)

SUBMISSION 693 1

GPO Box 33 17

DARWIN NT 0801

17 March 1995

The Chairman

Select Committee on Euthanasia

GPO Box 372 1

DARWIN NT 0801

Dear Sir,

Please accept this submission as my total support for the Rights of the Terminally Ill Bill 1995.

I do so on the basis of personal experience - My Mother and Mother-in-Law committed suicide when unable to cope with deteriorating health prior to inevitable death. Both my father and father-in-law asked medical practitioners in my presence to end their long and debilitating suffering prior to death. One doctor's response was that only a patient can end a life. Both refused medication to hasten their ultimate demise. This personal experience overrides any moral attitude in my mind that could have persuaded me to oppose euthanasia.

In providing this support I have read the Bill, the Notes on the Clauses, the Executive Summary and Second Reading Speech by the Member for Fannie Bay.

Instead of writing at length, I enclose a copy of a paper delivered in August 1994 by Dr Helga Kuhse, Director for Human Bioethics, Monash University and commend it to the Committee. The conclusions drawn by Dr Kuhse coincide with my own attitude and underpin the basis of my support for the Bill under consideration by the Legislative Assembly.

Yours sincerely

ROBIN FLANNERY

Enclosed with Submission article from Australian Medical Association One Day National Forum Ethics and Law - The Dying Patient, Morality, Public Policy and Medically Assisted Dying for Now-Competent Patients, Canberra, August 11, 1994, Dr. Helga Kuhse, Director, Centre for Human Bioethics, Monash University.

SUBMISSION 694 1

Life Is For Everyone Incorporated

P.O. Box 36853

WINNELLIE N.T. 0821

March 22, 1995

Select Committee on Euthanasia

GPO Box 3721

DARWIN NT 0801

Dear Mr Poole,

L.I.F.E. INCORPORATED SUBMISSION TO SELECT COMMITTEE ON EUTHANASIA.

Our Constitution states that "Each human being possesses an intrinsic and inalienable right to life", "The right to life of each and every human being is paramount to all other rights - other rights being meaningless without this basic right", and "The right to life of each and every human being must be protected and preserved regardless of age, stage of development or degree of dependency on others."

We therefore submit to the Select Committee on Euthanasia the following statements:

1. Euthanasia is morally wrong. Both voluntary and involuntary euthanasia involve the intentional killing of another human being. This is generally accepted to be wrong by all civilized groups and societies, because the right to life is so basic and intrinsic to human beings.

Each person possesses a deep instinct to protect his/her life from attack and death. This instinct for self-preservation is respected to such an extent that laws are created which attempt to guarantee that Others accept this instinct as the right of every person, and imposes on them a duty to refrain from infringing it.

Universal ethics state that no-one has the right to take another's life, nor to take his/her own. Our laws state clearly, therefore, that it is wrong to ca. nit both murder and suicide. Euthanasia kills just as surely as these do.

In addition to the universal moral Principles against which euthanasia acts, euthanasia opposes religious moral Principles. Persons of religious persuasion regard all human life as given by God, and thus as sacred. They further believe that all human beings are made in the image of God. God, as the author of life has given us life, and only He has the authority to remove it.

It is not enough to say that religious people need not choose euthanasia if it contradicts their moral principles, because in at least some cases it may be chosen for them; that ism without their consent.

2. It is not possible to adequately or safely legislate for euthanasia. There are four key reasons for this:

(i) Once any killing is legalised, the principle that all persons have a right to life is jeopardized. Respect for the right to life of any one person must necessarily be extended to the right to life of every person. The persons most in need of protection are the weak and vulnerable of society, and where laws protect the common good, these persons are also protected. Once we remove some protection, even a little, we in fact remove all protection, because the strongest chain is only ever as strong as its weakest link.

(ii) Euthanasia, legislation, no matter how stringently worded, is no guarantee against misuse. Two examples of this can be seen in; A. the abortion situation, where not only is abortion on demand practised in contravention of existing "strict" laws, but is practised where abortion is actually illegal, and B. the Netherlands experience of euthanasia, where involuntary euthanasia accounts for more than half of the total euthanasia deaths.

Hard cases always make bed law, and this is what the "Rights of the Terminally Ill Bill" is trying to legislate for - hard cases.

(iii) Where attempts have been made to legalise euthanasia, (eg. House of Lords, U.K. and Victoria, Aust.) a thorough study of the issue has led to the conviction that it is too risky to do so. Even pro-euthanasia persons have accepted this premise. There is simply too much at stake to allow killing to be legalised.

(iv) If doctors are already flouting existing laws regaling dying patients, why should they become law-abiding once new laws come into existence? It is nonsense to reverse a law which is being disobeyed, simply to protect the wrong-doers. It is obvious that those who now disobey the law will continue to do so, involving greater risk to patients.

3. The 1988 Natural Death Act permits doctors discretionary rights to allow patients to die without unwanted or unwarranted medical intervention to prolong life, where the dying process is irreversible. This is a common law right which has been enshrined in legislation, and doctors are protected from prosecution should they put this Act into practice.

4. Palliative Care funding in the Northern Territory is already minimal, with only two palliative care nurses and one part-time doctor currently working in this area. If euthanasia were to become legalised, the current funding would stagnate at the very least, and possibly be dropped altogether. It is obviously much cheaper to provide euthanasia than palliative care. Killing, and not caring, could easily become the norm. Furthermore, legal euthanasia provides no impetus to explore, improve, and develop palliative care methods.

Another long-tenn effect of the lack of funding for palliative care, will be that those who do wish to avail themselves of this type of care, in order to live as long as possible, as comfortably as possible, may find themselves unable to do so. For these people, life and their last moments are very important, perhaps precious, to be deprived of the opportunity of pain-free, quality time with families, would be a supreme injustice. Four options may evolve for the terminally ill:

(i) to pay a high price to obtain "private" palliative care,

(ii) to die with limited or no pain-relief,

(iii) to opt for euthanasia, or

(iv) to have someone else decide on involuntary or non-voluntary euthanasia

for them.

Whilst this bill has the title, "Rights of the Terminally Ill Bill", there seems to have been scant attention paid to eliciting, from the terminally ill, exactly what their needs are. Where palliative care measures are adequate, there seems little doubt that only a very small percentage of dying patients ever request euthanasia. Even amongst these, there may be cases where perceptions of the sufferings of their families play a more significant role in their requests, than that of their own suffering.

5. Euthanasia legislation is in the realm of public policy. Laws are designed to apply to all. In civilised society, laws protect the weak and defenceless, who are most vulnerable to exploitation and capricious abuse of their rights, specifically the rights to be heard and to life itself. Public policy must protect the "least" of the citizens, and put none at risk.

Euthanasia legislation, whilst purportedly giving rights to a few, removes a more basic right from all. This is very dangerous.

6. The "right to choose", a self-centred argument, revolves around the assumption that making one's own decisions, even over life itself, is more important than the right to life. This argument, in the context of euthanasia, falls down for several reasons:

(i) euthanasia always involves others, either as killer or accomplice,

(ii) death itself is difficult enough to cope with, for those around the dying person, without the extra grief associated with suicide, assisted or otherwise,

(iii) all major law systems protect persons from being killed by themselves or

others,

(iv) just as we have no right to determine the moment of our birth, we have no right to determine the moment of our death.

Laws are not only about rights, but also about responsibilities. We must not only he protected from wrong-doers, but also from wrong-doing. We don't have the right to choose to do anything at all, because we may choose to do something wrong. Good laws reflect this principle.

7. Religious considerations should not be disregarded on this issue. It is a moral issue, and at the very least, a large number of the population have religious beliefs. Moral truths are fundamental, and must be considered when evaluating a life or death matter. Most secular laws are based on moral principles, especially the ones which are held in common by the major religions. Moral laws are for the good and the protection of all.

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8. The cost to the Territory, if there should be an influx of terminally ill patients from elsewhere in Australia, should be seriously considered. Patients waiting to avail themselves of N.T. euthanasia services will not require immediate death, but medical care for an indefinite period. The cost of this may be considerable, since: (i) care towards the end of life can be quite expensive, and (ii) the numbers of terminal patients, as a percentage of the large populations outside the Territory, would dwarf the number of terminally ill Territorians catered for in our hospitals.

SUMMARY

* Euthanasia is morally wrong. It infringes the most basic human right, the right to life. The instinct for self-preservation is enshrined in the universal laws, which uphold the principle that no-one may take his/her or another's life.

* It is impossible to safely legislate for euthanasia. This is because (a) removing protection from the weakest in our society removes protection from us all,(b) misuse of legislation is inevitable, (c) the recognition of the risks involved in legalising euthanasia has led highly reputable commissions to reject it, and (d) doctors who already flout existing laws are unlikely to adhere to new ones.

* The current Natural Death Act sufficiently covers the needs of the terminally ill, in regard to the removal of unwanted or unwarranted medical treatment.

* Palliative care funding, already low in the N.T., may be stemmed, and ultimately stopped altogether. Future development of palliative care may be stalled, as the cheapness of euthanasia renders it a preferred option. Palliative care may then become too expensive or too burdensome to consider.

* The legalisation of euthanasia is dangerous public policy, and puts the most vulnerable at risk.

* The "right to choose" principle cannot be used to justify any other wrong-doing in society. Therefore it has no legitimate place in the euthanasia debate.

* Religious considerations should not be ignored, since a large proportion of Territorians hold basic religious principles. Most secular laws have a sound religious/moral foundation.

* An influx of terminally ill patients from other states may put a huge cost burden on the Northern Territory.

CONCLUSION

An acceptance of legalised euthanasia will lower the current value put on human life, which we take for granted as members of a civilised society. Any euthanasia legislation, no matter how carefully worded, will be open to exploitation and misuse from the moment it is enacted. As a public policy, it will be impossible to contain, and will put those most in need of protection dangerously at risk. Killing of human beings should never be presented as a

solution to their sufferings.

* * * * * * * * *

PREPARED ON BEHALF OF THE L.I.F.E. ASSOCIATION INCORPORATED, by; Mrs I. Jones, Dr M.A. Aralar, Mr G. Phillips, and Mrs C.V. Phillips. - SUBMITTED BY: Mrs Carol V. Phillips (PRESIDENT) Mr Graham Phillips (SECRETARY/TREASURER

SUBMISSION 695 1

A PERSONAL SUBMISSION from

Hinton J Lowe

to the Select Committee on Euthanasia, Legislative Assembly of the Northern Territory of Australia

The Chief Minister deserves public expressions of support from those who agree with his politically courageous initiative to decriminalise euthanasia. He was no doubt aware of the implacable and vocal antagonism from some sections (apparently a minority) of the electorate which his proposal would attract.

It is disappointing that attention is being diverted from this important issue of public policy and ethics, to questions about the political risk he has taken in his leadership of the government. For many in the electorate, it is to his credit that he has been willing to take the risk.

There is widespread perception that his qualities of leadership have been enhanced by his demonstration of political courage..

The opponents of Mr Perron's Private Member's Bill are entitled to opportunities, both in the media and elsewhere, to voice their contrary views and arguments. However they are not entitled to demand the enforcement of their own moral opinions by legal prohibitions, with attendant punitive sanctions, to be applied to every-one irrespective of their contrary views. It seems that theirs is a minority view. While not wanting to suggest that majority views are always right, whether in terms of justice or truth (that is patently false), in this case there is no prospect of the majority imposing euthanasia on the minority under the proposed legislation.

Opponents have already attempted to skew the discussion of the issue by defining it in terms of the unilateral termination of a suffering life by an agent other than the patient. A particularly perverse form of this distortion has been perpetrated by an unconscionable opponent of the Bill, who has compared the implementation of euthanasia to the practice of veterinarians putting down dogs. He might have some difficulty in finding a member of this profession who can recall any Bonzo or Fido expressing his wish to die, and requesting that his vet assist his departure from this world! Yet in this case also, the motive is respect for the life of the canine companion, and the compassion to reduce the time of intractable suffering.

The opponents of euthanasia have no monopoly on the claim to respect a life.

Framing the proposal made by the Bill in terms of 'murder', or less emotively, 'killing', is also an abuse of language. Both terms suggest, essentially, and tendentiously, that the action to be taken is contrary to the will, if not the expressed intention, of a patient. Such conditions would evidently be absent from any situation in which the provisions of the Bill would be applied. The use of such terms in this context is therefore rhetorical and propagandist.

This form of argument and some other similar, less obviously crass versions, commit the *straw man* fallacy: that is, they set up a proposition which no-one asserts, least of all proponents of a position in the debate; and then advance arguments against it. The strategy attempts to take

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advantage of the possibility that readers or hearers of the argument will not notice the misrepresentation of the alternate view; against which, of course, it has no logical force.

The way in which the issue is framed by proponents of decriminalisation is: protecting people from the punitive sanctions of the law when they choose, and enact, the moment of their own death; and also protecting those who assist them from criminal penalties: i.e., decriminalising the actions of those who make the choice, and of those who then help them to take the necessary action.

It is a crucial consideration in this context that no-one is proposing that such an action would be permitted (i.e., free from criminal sanctions) unless it were the choice and decision of the patient; nor that assistance in implementing the person's decision would be compelled upon any health professional; who could, in any event, decline to participate.

Decriminalising behaviour is not the same as making it compulsory!

At the risk of over-simplifying the positions, there appear to be several different categories of argument which are advanced against the justice of removing criminal sanctions against patients and their doctors who, together and respectively, make such personal and professional decisions.

The first of these positions rests on claims by some members of society, (sometimes representing, in positions they gain by the operation of patently mundane institutional procedures, the interests of various religious organisations, mostly governed by patriarchal hierarchies) to have privileged, and direct, access to the mind of a god: whose intention, it is affirmed, is to prohibit any such actions. Variants of this argument include: appeals to ancient texts, evidently written by human beings, which are claimed to authoritatively reveal a god's intentions; metaphysical arguments which claim to deduce those intentions; or those which appeal to 'nature' as if it operated intentionally ("Let nature take its course."). The premises of such arguments are rarely more than dogmatic statements resting on claims by some people to insights or authority that are presumed to be superior to those of others. They are, at best, contentious.

The second category consists of the pragmatic arguments. These are mostly of the form that the decriminalisation could be abused by unconscionable or careless health professionals, or greedy and impatient relatives, sometimes in collusion. The present local AMA afficionado of the medical profession apparently believes that a significant number of these unsavoury characters is practising in the Territory: an allegation which one would think would be a matter of even more concern to the profession itself than to the community at large; albeit also to all of us too, since life and death decisions, quite apart from euthanasia, are no doubt taken daily about patients by almost all of his members.

At a National level, Brendan Nelson, the President of the AMA, has been quoted to say: "... laws could conceal medical ineptitude, lack of knowledge of patient rights or evil intent." (NT News, 27/2/95) Some action to put the profession's house in order is urgently needed, if such persons are presently practising medicine!

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The problem is exacerbated if there is no explicit definition in law at present of the rights of patients to end their own lives, and of the rights and duties of health professionals who may be willing to participate, including safeguards against abuses. A clear definition of the circumstances and conditions under which actions may be taken to assist in the termination of patients' lives would surely afford greater protection than exists at present, and reduce the risk of immoral terminations and malpractice.

Fortunately, I have a high level of confidence in my own general practitioner, which has not been dented by these statements. I can only wish my fellow patients the best of luck, in view of the public expression of lack of confidence in some of their colleagues by these representatives of some of the medical profession!

A variant of this argument is that decriminalisation of the acts of doctors to assist patients to shorten their lives would increase their stress in treating patients who have terminal illnesses.

In rebuttal of this assertion, it should be pointed out that no doctor will be obliged under the proposed Bill to agree to participate in a patient's wish to shorten her/his life. Furthermore, the present position of the criminality of any such action, with the consequent fear of detection and punishment, presumably creates greater pressures than would arise from taking explicitly legal action under the Bill.

Another pragmatic argument is that the patient might lose his/her entitlements under some insurance policies; or that the beneficiaries of a will would suffer the loss. Some people would accept this result, and take it into account when making their decision: i.e., weighing the costs and benefits. Perhaps the government could mitigate the consequence by agreements with insurers or other measures. Since the period of life expectancy of a patient at the time of taking such a decision is intended to be less than one year, this should not be a great additional burden to insurance companies; and would save them the cost of litigation and investigations into suspect cases.

The fourth type of argument can be characterised loosely as political. For example, it is said that the legislature has a duty to concentrate its attention on other more important issues, including negotiations with the Commonwealth Government on NT funding: for policing, education and hospital resources. (e.g., Alcorta, Sunday Territorian, 26/2/95)

Against this, it must be said that a government that can't keep more than a couple of balls in the air at the same time would be incompetent; and that the Ministers and departmental officers who brief and advise them in their specific portfolios should be replaced if they cannot perform their duties. Irrespective of one's assessment of their abilities and performance, it would be a poor excuse against incompetence that another political issue had hijacked their attention. In any case, such concerns are not a sound reason to oppose the legislation: they are instances of the proverbial *red herring.*

A further example of the use of the *red herring* is a complaint that influences outside the Territory are intruding into the local debate to build support for the proposed legislation. Local conditions are said to differ from those in the States, and the views of our fellow Australians are demonised in terms of the dominance of 'Southern' interests. (A familiar political ploy!)

But there can be little doubt that the way in which the issue is settled in the Territory will have ripple effects throughout the Nation; and that our communities are deluded if they suppose that the views of Territorians can be insulated from the rest of the country. In any case, one is entitled to ask whether the same principle is to b~ applied to opponents of the legislation, such as the Presidents of the AMA and the Right to Life lobby, or interstate religious leaders. Whence, and from whom, the arguments come, is not relevant to whether they justify the legislation. *Non sequitur!*

Against the first category of argument, i.e., the 'religious', it is perhaps enough here, without indulging in an embarrassment of ridicule and satire, to state that there are many people, apparently a majority in our society, who repudiate ecclesiastical claims to a moral authority based upon such pretences. Unfortunately, those texts which were written by the Hand of God Himself, for the benefit of Moses and Nebuchadnezzar in particular, have not survived. Anyway, as every-one should know, the Greek god Hermes was the creator of writing: "which is the art of evasion and dissimulation". In case some-one has forgotten this fact, it can be read, and verified, in *FoucauIt's Pendulum,* by Umberto Eco. After all, I am even more inclined than previously to agree with Gore Vidal, that patriarchal monotheism is the worst catastrophe to have befallen humanity - and self inflicted at that. Before its invention, at least there was some prospect of personal choice of affiliation amongst a variety of deities, and of negotiation between their contending interests!

We would contest the power which those self-proclaimed monopolists of moral insight claim and strive to perpetuate. We do not consent! We also have a few arguments of our own, and not so easily refuted, even by the cunning sophistries and casuistry of authoritarian, and most often patriarchal, clerics and evangelists.

An alternative, humanist, moral view is that avoidable suffering, whether physical pain or indignity (efficient palliative care is eventually not enough, *pace* the local branch of the AMA - what can that do about the loss of dignity which some people experience in late stages of their deterioration?) is an evil; and that the deliberate, and preventable protraction of that suffering against the will of a patient, is a form of wickedness. It is comparable, in its moral quality, to compulsory clitoral circumcision, or sterilisation.

The right of a patient to decide her/his own limit of suffering, and of health professionals who have the expertise and means to assist the implementation with a minimum of additional suffering to do so, should be protected by decriminalising such actions. Those people who choose not to do so for religious or personal moral reasons. would remain free not to participate.

The second category of argument is rebutted by the observation that no legislation can guarantee that no offences, or abuses, or anomalies will occur; nor can it absolutely close all loopholes against possible future adverse consequences. That has to do with the indeterminacy of language, and of its literary forms in particular. Some people will also probably break the law. This case does not differ in these respects from other legislation: yet parallel arguments are not advanced to repudiate legislative mechanisms of social control in general, nor should they be.

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Of course, legislatures have a duty of care to do the-best they can to foreclose predictable abuses and-anomalies; and to take corrective action by mending legislation to respond to those which were not envisioned when it was drafted and promulgated. There is also a duty to detect and punish abuses which would remain criminal offences. It is to be hoped that the Committee of the Legislative Assembly will focus on these issues.

I have no doubt that the proponents and supporters of decriminalisation in our legislature are willing to respect the right of people not to engage in euthanasia (both patients and health professionals) should they wish to decline the opportunity; nor do I doubt their concern to take care to prevent predictable abuses, and to amend the legislation in future if unanticipated abuses or anomalies eventuate.

Offences against the law would remain the responsibility of the Coroner, the Police and the Courts. The proposed law would at least define those responsibilities, in contrast with the vagueness of the present *de facto, ad hoc and laissez faire* situation, admitted by many medical practitioners.

A repertoire of misrepresentation and fallatious arguments is now being deployed in a propaganda campaign which has little respect for rationality and truth. Undergraduates in any tertiary course in philosophy or logic would recognise their speciousness.

'The end justifies the means' is apparently the governing principle.

A particularly pernicious example of the fallacies is the suggestion by two of the prominent entrants into the debate, that the intimate experience of the suffering of a dying relative might cloud moral judgement. This argument has been directed personally against the Chief Minister. Quite apart from the speciousness of the *ad hominem* argument, and its cruelty, (both reason and compassion apparently suspended in the interests of maintaining a pseudo-moral authority); what could be a better basis of moral understanding than empathy with the suffering of a beloved member of one's family, friend, or life partner; and his/her disempowerment under current law?

I will always recall vividly the suffering of my mother in her last hours. In spite of the relief from pain achieved by

excellent palliative medical care at home, she reached a moment when she evidently wanted her life to finish. The time after that, when no-one, including her doctor, would help her to go, was the worst.

This experience, far from disqualifying me from making a moral judgement in this context, is part of its legitimate and rational foundation.

I want the right to make a decision to end my own life, and to engage professional assistance in carrying it out painlessly and efficiently.

Many others share this desire.

As for those who don't want the freedom to choose the time of their death, or to assist those who do:

they should mind their own business.

Hinton J Lowe

23 March 1995

SUBMISSION 696 1

3/12 Dawson Avenue,

Armidale 2350

N.S.W..

Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

Darwin N.T. 0801.

Dear Sir,

I am writing in support of Voluntary Euthanasia. I am doing this for reasons both personal and impersonal. In 1986 I had to watch my husband die slowly and painfully for nearly six months. I have cancer of the colon.

Apart from this personal experience, I regard the right to die with dignity at the time of one's choosing as the right, of every human being - not the right of some religious group to decide. Certainly they have no right to dictate to the Government what laws should be passed. Doubtless these groups might be insulted if I called them sadists, but the word sadism came from the doings of the Marquis of Sade, who got his pleasure from inflicting pain on others.

I also find the present law extremely hard on doctors who might wish to accede to their patients pleas to end their suffering, but who would risk their careers if they did so.

I trust that these views may be of some use to you, and will end by offering you my most sincere congratulations, and every good wish for the success in the work you are doing.

Yours sincerely

(Countess N de Kuszaba-Dabrowski)

SUBMISSION 697 1

NORTHERN TERRITORY

WOMEN'S

ADVISORY

COUNCIL

24th March 1995

The Chairman

Select Committee on Euthanasia

PO Box 3721

DARWIN NT 0801

Dear Sir,

The members of the Women's Advisory Council have considered the provisions of the Rights of the Terminally Ill Bill and submitted herewith for your consideration is a summary of their deliberations.

Yours sincerely

Sue Carter

CONVENOR

Darwin NT 0801

GPO Box 4396

Telephone: (089) 89 6107

Facsimile: (089) 89 6253

SUBMISSION TO THE SELECT COMMITTEE ON EUTHANASIA FROM

THE NT WOMEN'S ADVISORY COUNCIL

The greater majority of the 16 members of the NT Women's Advisory Council supported the Bill as a whole but some members were hesitant to endorse the document.

All members supporting the Bill had comments on the contents and these are summarised below. The greater majority expressed the opinion that it was only humane to permit a person to evade pain and distress when facing death in the circumstances described in the Bill and all agreed that the informed public concern over the Bill stemmed from one of two concepts:-

1. That the Bill offended the objector's religious or philosophical convictions or,

2. That the unscrupulous elements of society would misuse the legislation to force untimely death for monetary gain or to rid themselves of an unwanted burden of care.

It follows therefore that if the invoking or operation of the legislation remains purely optional and if the parameters are carefully enough defined, then the public should be satisfied.

The comments on the contents are as follows:-

(Please note: These are in order of discussion and therefore reflect an order of importance to a certain degree.)

1. Section 15

This is not clear, particularly ssl. The intention obviously is that no will or contract may in any way relate to a death under the Act but the drafting is poor. Any reasonably intelligent member of the community should be able to read a piece of legislation and understand it. Wording should be as simple and direct as possible. Furthermore, the heading refers to statutes but there is no reference to statutes in the body of the section.

2. Section 9

The penalties subscribed are inadequate. A breach of the provisions of this section would be tantamount to murder. The penalty should be in the vicinity of "$100,000 or 20 years in jail or both".

3. Section 5

The penalty provided for pursuant to this section is similarly inadequate and should be the same as that suggested for Section 9.

4. A person invoking the provisions of the Act by very definition could well be in a state of mental distress. There should be provision for a period of time to elapse between the making of the request and the effecting of it. Certainly there must be an examination and report from a second practitioner and this would invariably take time, but a specific period to allow the patient to consider his or her action should be prescribed. A period of 3 days is suggested.

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5. Section 3.

"Illness" is not defined but it was felt that it tended to mean "disease". It is suggested that this word be replaced with "medical condition" to cover persons for example severely injured in accidents.

6. Section 12.

Ss 2 requires the Coroner to advise the Attorney-General each year of the number of persons who have died as a result of assistance given under the Act. Whilst there was a strong reaction towards ensuring that the details of the patient and the doctor remain absolutely confidential in all areas, it was felt that, for statistical and research purposes, particulars of the illness should also be recorded. Confidentiality was felt to be needed to protect against possible discrimination against families where one of their number had received assistance to die from a disease such as AIDS, which still carries with it a sense of stigma.

7. Section 16.

Much concern was expressed regarding life insurance companies endeavouring to escape the provisions of the legislation. No reference is made in the section to the payment of the policy proceeds being affected by a death under the Act. This should surely be specifically provided for and the clause should be expanded further to state the legal position with greater emphasis and clarity.

8. Section 7.

It is too loose to permit any person over the age of 18 years to sign the request where the patient is unable to write. It is suggested that if the request is made orally, then a competent person should be present and act on behalf of the patient.

A "competent person" should be defined, as in other acts, as being a J.P., Solicitor, Bank Manager, Public Servant of 5 years standing etc.

9. Section 8.

This clause should be expanded to refer to a written, oral, or other indication of withdrawal of consent even though the patient may be considered to be mentally incompetent when the indication is given.

10. Section 3.

Some members queried how any doctor could determine death as being likely within 12 months and why 12 months. Other members thought that some period had to be prescribed and 12 months was reasonable in the circumstances. It was impossible to be more specific.

Some members felt that any doctor referred to in the Act should have had a minimum of 5 years practice before being permitted to assist under the legislation and others felt that expertise within that particular area of medicine should be a pre-requisite.

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11. There was some support for a provision in the Bill requiring a medical practitioner who declines to carry out a request for assistance under the Act on grounds of conscience or otherwise, to refer the patient to a suitable community resource. Similarly, for the provision that a hospice or other institution caring for the sick may refuse to permit euthanasia but must inform all patients entering that institution of their policy prior to the entry of that patient.

Apart from the provisions of the Bill the Council members felt that the following issues were worthy of further consideration:

1. Because of the distress aspects, appropriate counselling should be available not only for the patient but for any other persons associated with the proposed death. The next of kin are properly not mentioned in the Bill, but their possible anxiety and distress should be catered for.

2. Competent and comfortable palliative care should be available in the NT. and would go a long way to assisting persons facing terminal disease. This is not yet available and little priority has been given by the Government to its establishment.

3. Whilst on the one hand acknowledging the difficulties of including terminally ill children under the Act, many members expressed concern at society allowing children to suffer the same or maybe even a greater degree of pain and distress as adults, but being unable to invoke the termination provisions of the Act. Some members stated that the inclusion of children was a total impossibility.

4. Consideration needs to be given to the unborn child of a terminally ill mother.

SUBMISSION 698 1

23/3/95

THE CHAIRMAN

SELECT COMMITTEE ON EUTHANASIA

GPO BOX 3721

DARWIN NT 0801

Dear Sir,

Please find enclosed my submission on The Rights of the Terminally Ill Bill.

I have limited my information to the relevant points, but my experiences over all the past years of being involved with terminally ill people, hospitals, nursing homes etc. leaves me fearful of the end of my life,

I am now retired from the workforce and can be reached by phone or postal address shown below, if needed.

I wish the Committee well and thank you for the opportunity to express my opinions to you in regard to this important Bill, that gives us the Right to choose how we conduct our life.

(Mrs.) Janice A. van der Molen

P.O. Box 1478

PALMERSTON NT 0831

Tel: 325646

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LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

SELECT COMMITTEE ON EUTHANASIA

I, Janice Ann van der Molen have read all the literature on the Euthanasia issue that was sent to me by Mr Perron. I do not feel that there is a need to make any changes to the Bill other than to Part 3, Clause 3, and Clause 6(b) and (c) referring to 12 months to live or where the quality of life is unbearable.

As I feel very strongly about this issue having personal experience with terminally ill people, I submit my experiences in the hope that this may help in some way to support the Bill. This legislation is needed, if not now, then at some stage in the future with factors such as, world population growth, the many disease that cause terminal illness and the lack of funding for medical care, to be considered. It may not be a right in future but rather a necessity.

In support of my argument, I will briefly outline my personal experiences with terminally ill cases.

My mother and a close uncle both died of cancer; drugs didn't ease the terrible pain. My uncle had to be caged in the bed as he would spasm with pain and the effect on his wife and my sister and myself was traumatic. Fortunately, my uncle had no children.

Mother signed herself out of hospital to die at home. She said they would not give her enough pain killers. My sister who is a registered Nurse had to get extended leave from her job and move her husband and two young sons into the parental home to take care of her. The effect of my mother's screams and the tension and the stress in the home on the two children was tremendous. My sister had to see a number of doctors in order to get sufficient painkillers to provide some relief, especially at night. This in the end had a detrimental effect on my sister as she felt in the end she had killed out mother. It was against all she had been taught in her profession. The morphine did not ease the pain altogether and often her legs would often have to be tied down in order to prevent further damage to her body from the spasming.

In early February of 1983, my husband suffered a severe stroke paralysing the right side of his body and throat. The throat paralysis was not detected early enough to prevent the fluid ingested from going to his chest causing infection and consequently he was moved to the Intensive Care Unit (ICU). I, and my family were told he was not expected to live. After the time allocated for assisted life support was due to expire, the doctor in charge called a

family meeting and explained that his life expectancy was short and should he survive, there would be no quality of life. But with the insistence of myself and the head Sister, he was given a further two days on life support. After this time he was removed from ICU to a private room in order "to die". Due to my personal nursing of my husband he recovered from the chest infection and was started on rehabilitation with the aim of returning home which he did in October of 1983. He came home seven months after the stroke and he would ask "to what and what for" as he could only walk within a frame for limited distances and times eg to the bathroom. The rest of the time he was committed to a wheelchair which was still limited as his right side was unusable. He tried many times to commit suicide and knives, tablets etc had to be hidden. He constantly begged to be given the right to die.

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In the last year he developed arthritis from being mostly bedridden. he also had a huge Aneurism which was pressing on the spine causing further extreme pain. He was constantly in and out of hospital and for the last 6 years he continued to beg me to help him to die. In the last sixth months I had access to morphine but not the experience or the knowledge to help him die and not way of accessing this help as it was against the law.

My husband said he felt he was less than an animal - at least they are allowed to die with dignity. It is ironic that if he had remained a Dutch citizen he could have had the right to die by Euthanasia.

I believe it is an individual's right to control his or her earthly body and their soul's final destination is in the hands of whatever god they believe in.

(Mrs) J.A. van der Molen

P.O. Box 1478

PALMERSTON NT 0831

Tel. 325646

SUBMISSION 699 1

TO THE SELECT COMMITTEE

ON EUTHANASIA

I applaud the introduction of the Rights of the Terminally Ill Bill and support its introduction by the Northern Territory Government.

I believe that every human being has the right to choose in matters relating to their own life and health.

Those who do not agree with Euthanasia will maintain a right to choose not to end their life by this means, however I do not wish to have my options determined by the religious of moral beliefs of others.

Yours sincerely

Kaye Ramsey

SUBMISSION 700 1

TO THE SELECT COMMITTEE EUTHANASIA

I strongly support the introduction of the Rights of the Terminally Ill Bill by the Chief Minister. I believe that the right to determine my own life or death under the provisions of the Act is a basic right of the individual according to our democratic conventions. Hence, I object to this right being denied me due to other people's religious or

philosophical beliefs.

I also encourage the Government not to lose sight of the importance of adequate hospice and palliative care being provided for Territorians.

Yours sincerely

Geoff Selvey

SUBMISSION 701 1

Wildlife Management International Pty. Limited

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From: Dr. Grahame Webb

To: Select Committee on Euthanasia
No: 816158
Date: 23 March, 1995

Dear Sir,

Having read the "Rights of the Terminally Ill Bill 1995" and followed the debate in the media, I would like to make the following points that your Committee may wish to consider.

My personal position is that I support the Bill because I believe that despite obvious controversy, it offers the chance of social advancement. However, I hasten to add that if the evidence against the Bill was objective and sound, I would be prepared to oppose it.

1. Risk of Abuse

Giving anyone the power of "life and death" over other people in society always has and will remain a controversial and risky business. Such power needs to be exerted with extreme wisdom and compassion if society as a whole is to benefit from it. History is full of examples where this has not happened where such powers have been abused.

Thus I can understand why some people in society may oppose the Bill on the grounds of "risk of abuse".

But I strongly believe that opposition based on this reason alone reflects ignorance of the facts. For example;

1.1. Every day doctors and nurses around Australia exercise the power of life and death over terminally ill people. They do so quietly and discretely, with compassion and pragmatism. Society may not be party to the details, but it happens continually. Rarely, if ever, have serious problems emerged. Really, the power of life and death has been in the hands of the medical profession for centuries. Rather than bestowing a new power, the Bill attempts to legitimise an existing one.

1.2. Opportunities for abuse are very minor when the full text of the Bill is considered.

1.3. Although we live in a society where Government increasingly takes over the role of solving people's problems for them, I would argue that this is having disastrous consequences socially, culturally and economically. In the

case of terminally ill people, in pain, society can no longer help - it can no longer solve their problem. Surely at this stage the individuals have the right to do so themselves, with dignity.

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2. Religious and Philosophical Dogma

Clearly, some people in society are opposed to the Bill on the basis of philosophical and religious dogma. I use the word dogma without any disrespect, but merely to emphasise that their opposition cannot be changed. No amount of reason, science. evidence. compassion. argument or persuasion can cause some opposition to change.

I think it is very important that your Committee establish whether opponents to or supporters of the Bill hold such fundamental dogma's, or are indeed prepared to evaluate evidence honestly and objectively. That is, supporters and opponents should be asked a question like; "if the overriding weight of evidence indicated that there were very sound reasons, that you may not have considered, to reject (or accept) the Bill, would you be prepared to adopt an opposite position to that you have taken?"

The significance of this has a sound scientific base. People who support or oppose controversial issues on the basis of a dogma, realise that the public at large are not swayed by fixed, rigid positions that no amount of evidence can change. (It is also highly wasteful of resources). And so a great deal of effort may be put into developing all sorts of secondary arguments which seem more "reasonable" than blatant opposition. But in reality, they are contrived reasons being used to mask fundamentalist support or opposition. What is needed in this case is reasoned arguments.

3. Should religious dogmas be imposed on NT Society

Tolerance, respect and understanding of all people's, cultures and religions should be the underlying philosophy of the NT I would suggest we achieve it now to a higher degree than other Australian cities. This means we must all be prepared to accept the view of majority agree to disagree where necessary, with humility and understanding recognition that the imposition of one religious philosophy on all people is a totally unacceptable goal.

4. Monitoring

There is no doubt that the Bill is a controversial issue, not just in the NT but throughout Australia. However, regardless of the arguments put forward or against, no one can predict accurately what will happen. There may not be any serious problems (despite concerns), or problems may develop that no one anticipated.

In advancing the Bill, the NT is making a bold move for Australia. Should the Bill be accepted there should be objective monitoring of the results so that this evidence can be used by other States, who may be faced with similar proposals at some later stage.

5. 10:80:10

Within the US, the 10:80:1.0 approach to controversial issues is increasingly being used in a proactive way. That is, the vocal 10% that are greatly in support or opposition do not reflect the majority view. Assessing the majority view throws a totally different light on many of these issues, and has led to proactive actions directed at the majority.

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In this case, it is clearly appropriate, notwithstanding the opposition from some parliamentarians, to determine "what the people want". On this specific point, I am still totally confused by the ramifications (political correctness, democratic rationalisation; implications) of a decision made by some parliamentarians not to determine the views of the people in this matter!

This was such a profound decision that the Committee should consider acquiring a detailed assessment of the ramifications by appropriate experts.

7. Biased Submissions

One of the difficulties with advertised "submissions", in the absence of an assessment of public attitudes, is that the Committee is likely to receive far more submissions from opposition than support factions. This is because there is an existing religious dogma in some sections of society in opposition, but by comparison, no equivalent dogma in support, and thus the "driving force" to make a submission may not exist.

For example, 100 submissions in opposition may really only tell the Committee with more confidence what the 10% opposed believe; 10 submissions in support may tell the Committee what that 10% believes, but with less confidence. That there is 100 to 10 may be largely irrelevant.

8. Conclusion

Whether the Bill is finally supported or rejected, Government should ensure that a full and objective written record of the events surrounding it becomes available. It is a bold NT initiative, and one deserving of a permanent record,

Regards,

Grahame Webb

SUBMISSION 702 1

P 0 Box 368

DARWIN NT 0801

Phone: 277279 h

816636 w

22nd March 1995

The Chairman

Sessional Committee on Euthanasia

GPO Box 3721

DARWIN NT 0801

FAX: 816158

Dear Sir

RIGHTS ON THE TERMINALLY ILL BILL

I have agonised about the form my "submission" to your committee should take. I had meticulously laid out many pages containing all of the arguments and I had put carefully structured responses to them. As individuals I am sure you have heard them all and now as a committee you will hear them over and over again.

It was my early aim to debate this on paper for you, as unemotionally as possible but it became clearer as I progressed that nearly all of the arguments for and against this proposed legislation have a probable counter.

I had also planned to relate in detail my own dose personal experience as a means of illustrating my points but

what became clear through this exercise was that there is ultimately only ONE simple question:

SHOULD WE NOT GIVE AN OPTION TO THE TINY PERCENTAGE OF TERMINALLY ILL FOR WHOM THERE IS NO RELIEF FROM UNSPEAKABLE PAIN, FEAR AND INDIGNITY?

If this option is open to the sufferers, whether they choose to access it or not, it can mean security for them. for with this level of pain there often comes terror and despair.

These people already have all of the other traumatic emotional burdens of being very close to death.

All of the other arguments are shallow and academic when one is faced with this tragedy. A person in this circumstance who requests that the end of their life be brought forward slightly, is not interested in philosophy - they have done their reconciling. The opinions and moralising of "interest groups", including doctors. do not much interest a person who is dying in such a way. Those who are currently the victims and are presently facing death this way do not

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usually have the energy or ability to speak for themselves in this important forum, and nor can the dead. The argument must be carried by those of us who have suffered with them and who still have the strength to put their case for them.

In the way that those who oppose abortion choose not to access abortions, those who oppose choice in the matter of death for themselves may elect net to exercise their right to a choice. They will allow nature to take it's course.

Doctors who try to justify to themselves and the rest of us, that the act of administering lethal doses of pain killing drugs by saying that they honestly give them to kill the pain, even though they are aware that the side effect is respiratory failure and death, are having themselves on if they do not call this action euthanasia. Under today's law it is murder. This is absurd.

I suggest that it must be very difficult for many doctors to face up to these facts and this is why there is a reluctance on the part of many of these practitioners to come forward and declare their support for the Bill. Many do believe in the need for this legislation. It is a much easier option for those without courage to find reasons to oppose it or to make no declaration at all. There is an immediate suspicion cast by some on any health professional who comes forward and supports this Bill. The fear that some others will immediately wonder whether they have been quietly killing people is real.

It is a courageous doctor or nurse who declares themselves solidly for this proposal. It could certainly affect financially, the practices of some.

There is one argument against this Bill which I find particularly offensive and it is the one which says that palliative care offers control for all sufferers of pain. This is a grotesque lie. There are conditions which cause unspeakable pain that cannot be relieved other than by rendering the patient **unconscious.** I repeat it is a cruel and atrocious lie to say that all pain can be controlled. (his is not to say that palliative care is of no value - that is another issue.)

My position and my family's position. must be dear?. We stand solidly in support of the RIGHTS OF THE TERMINALLY ILL BILL. If we had not had the recent experience of a family member who slowly died with no legal choice to end his suffering as an option, and with him begging and weeping endlessly to be released from the unendurable pain which could not be controlled, we might be just like the silent majority who are choosing not to make formal representations to you.

I thank you for you time and hope you will relay this message to your colleagues on both sides of the House.

My family and I will be watching very carefully how our local members. (who are in a number of electorates,) respond and plan to vote. The issue for us is a very important one and will unquestionably translate on election day to votes or not.

LORNA TENISON-WOODS

SUBMISSION 703 1

Box 45,
Humpty Doo,
N.T. 0836

24th March, 1995

The Chairman,

The Select Committee on Euthanasia,

Darwin, N.T.

Dear Members of the Select Committee on Euthanasia,

I wish to submit the following information to your Committee and inform you of my willingness to give further evidence or information if deemed useful to the Committee.

l have several areas of concern and comment l wish to bring to your attention. Not many have specific answers or action to be taken, so I simply list each item by number. (if anything is unclear and you wish further enlightenment, please contact me.)

1. The Bill in question is entitled "Rights of the Terminally III" and does not appear to mention euthanasia once, yet :your Committee is called the Select Committee on Euthanasia**.**

A. I believe this needs clarifying. Can a Select Committee on Euthanasia give any feed back to the Bill on the "The Rights of The Terminally III"?

B. Euthanasia is not the right of the terminally ill, yet. Even if it becomes a law. it still may not be a *right*, but just a law.

C. The rights of the terminally ill are far larger than covered in this Bill. I therefore request that the Government Committee investigate and provide for the terminally ill appropriate and adequate laws, services and facilities, to improve the life of all the terminally ill, not just those who are over 18 years and of sound mind.

2. I am concerned that much of the debate is based around personal experience and thus is subjective in nature rather than objective.

3. As l read the paper and view or listen to the reports on this subject, I am distressed by the ignorance on both sides which has caused the debate to degenerate into name calling. Most people, including the Chief Minister, have based much of their input on a limited human experience and then concluded that their point of view is correct and valid, thus making the views and opinions based on alternative experiences, invalid or beyond consideration.

4. The 'personal opinion' approach to this important subject will bring about an important decision being made without the most relevant issues having been understood and acted upon.

5. In my experience I have found that many terminally ill folk often desire to terminate their life to prevent further suffering of others. I have had many people say to me,

"Isn't, there some way can bring all of this to an end. You must know of how others have done it. If it was just for me I wouldn't want to, but can't bear to see my family suffer." This has come from all ages and is the experience of others I know, who are involved in caring for the terminally ill. When there has been opportunity to provide continuing care and counselling to the terminally ill and all involved, the one 'who made the original request. will, in most cases, say. "I'm glad I didn't do it. I can put up with the pain".

6. The main issue at stake concerning this Bill and debate seem to be *suffering.* Often the observer's approach to suffering seems to be the motivating force. Suffering is a part of life and is not always able to be avoided and can benefit to us when confronted and worked through.

I would now submit some comments on various parts of the Bill,

If this Bill became Law:

(Part 2: 3.) How many of those people who have been given months to live (in the past) have not only live longer, but in some cases, continued to live a full life? I alone, personally know of a good few. This Bill would open up the very real possibility of wrongful and premature termination of life.

(Part 2:4 (2)) Regardless of how many doctors support euthanasia, if only a few doctor's decide to be actively involved, I believe severe pressure will be put on them leading to overwork and stress, will impact on their decision making.

(Part 2: 5) Who pays the fine if an offence has been committed by the one whose life has been terminated if the intent of the Bill is not to involve the family'?

(Part 2:6 (c)) also in (Part 2: 3) and in Section 6. The words, "likely to die within 12 months" are used. This seems open to misuse. There is a need to be far more precise and careful with 'legal' word usage when life is at stake.

(Part 2:6 (h))

(a) Allowing the terminally ill to have the personal right over their death will destroy some families. It will create, rather than solve problems. It is said that 'when the family structure and fabric is broken, so is the community'.

(b) Is there a presumption in this passage, and in all of Part 2:6 that the

terminally ill, their immediate family and close friends will take all of this in their stride? I do not believe they will. My experience of being present with people when death comes. is that most people benefit from counselling. In the case of sudden, tragic death and suicide, all involved, including doctors and staff are helped by counselling.

(Part 4:17 (2)) None the less, people's opinions can be expressed in such a way that much harm can be caused. The recent court case of a person claiming wrongful diagnosis of breast cancer demonstrates my concern here. One of the doctors accused, even though 'round not guilty, said upon leaving court, "My reputation is tarnished". ('Ruined' is not too strong a word for me.) I do not believe that the Bill can prevent some of what is listed in 17 (2) from happening.

To conclude, as a community, we find suicide very difficult to deal with. and will become more so if people are assisted to take their own lives. This Bill raises more problems than it solves and will be divisive.

I know there is great. pain and suffering in our world that appears purposeless. But we are not God. Neither should we place others in a position to play God, whether they want to or not.

May God grant :you His wisdom in .your endeavours to discover the best way ahead for us all.

Yours respectfully and sincerely,

(Reverend Mervyn L- Anderson)

SUBMISSION 704 1

Barbara Spencer

GPO Box 4145

Darwin NT 0801

24 March 1995

The Chairman

Select Committee on Euthanasia

Legislative Assembly of the Northern Territory

GPO Box 3721

Darwin NT 0801

Facsimile: 81 6158

Dear Sir,

Rights of the Terminally Ill Bill, 1995

1. I strongly support the Bill, and urge the Select Committee to support its passage. I feel the legislation as drafted contains adequate statutory safeguards against wrongful use.

2. My feeling is that the ultimate human right of a responsible individual is the right to cause the termination of his/her own life - if uncontrollable pain has ultimately rendered it unbearable. If this course is chosen by even one patient for whom the best palliative care has proved inadequate, the passage of the Bill will be justified.

3. There can be little doubt that most members of the medical profession are deeply committed and caring individuals who would not countenance misuse or abuse of the legislation.

Further, it is evident that a medical practitioner is not compelled by this legislation to comply with a patient's request for assistance in terminating his life. The practitioner's own values will dictate his/her response in the matter.

4. I do not accept the suggestion voiced by a prominent Darwin member of the medical profession that passage of this Bill may possibly cause a gradual shift in society's values toward a greater acceptance of what might be called 'widespread institutionalised euthanasia'. (I believe the holocaust parallel which was invoked constitutes an insult to the Jewish people.)

5. I have faith that the population of the Northern Territory of today is sufficiently mature and sophisticated to enable the judicious implementation of the provisions of the Act. Let us lead the States of Australia, through the implementation of this enlightened legislation.

I applaud Marshall Perron's actions in having provoked thorough examination of these issues in our community,

It is to be regretted that not everyone who comments publicly seems to have carefully read the Bill.

Yours sincerely,

Barbara Spencer

SUBMISSION 705 1

ATTENTION: The Chairman,

Select Committee on Euthanasia

GPO Box 3721

Darwin NT 0801

FACSIMILE: 089 816 158 .

Dear Chairman. & Members of the Committee,

Please find attached a copy of my letter to the :Editor of the Northern Territory News (which was published) and a copy of a short note to the Right Honourable Shane Stone, my local member, which he has not yet acknowledged. Please be advised that I have no desire to keep the information here submitted confidential.

In addition to my letters which, I believe, quite clearly outline my feelings on the issue of euthanasia, I wish to submit the following information for your consideration.

I nursed for a period of approximately ten years at Ashfield Masonic Hospital, Prince of Wales, Lidcombe State Hospital, and Blacktown General Hospital all in New South Wales, and more recently *at* Chan Park in Palmerston. My areas of specialisation were Geriatrics, and Intensive Care,

As a nursing sister it was common to be involved in the practice of voluntary and involuntary euthanasia. By 'voluntary euthanasia' I refer to a request by a patient for help to die. By 'involuntary' I mean that the decision was' made by hospital staff, not necessarily by the attending physician, and / or in consultation with relatives,

The method used for both was normally an overdose of narcotics (usually morphine) prescribed by the Ward Doctor or the patients specialist, to be given for pain P.R.N. (as required). The determination as to how regularly the dose needed to be effected to bring about death, was at the discretion of the Ward Sister or senior charge nurse for the shift. The dose was drawn up and signed for by the 'drug sister' and administered by any allocated staff nurse. There was awareness by all parties as to the probable consequence of administering the drugs.

In two specific instances that I can recall, both patients were entirely lucid and both were aware that the injection would kill them. In one instance, where a special bond had been formed between nurse and patient, there was a request for the nurse to stay and hold the patient's hand until death. In the second instance the patient requested that the nurse leave as she wished to be alone in the final moments.

In all cases of 'voluntary' euthanasia the drugs were administered by the nursing staff at the request of the patient, and with the full approval of the medical practitioners. Neither the patient nor the staff members could know exactly when death would occur. However, if the patient was deemed to be terminally ill, and suffering from excruciating pain and where the possibility of a quality of life was believed to be entirely absent. death would be arranged and would usually occur within 48 hours of the request. The estimation of the patient's condition was made by attendant nursing and medical staff who then requested the doctor in charge to prescribe the appropriate drugs. In my experience, no request by nurses for such a prescription was ever denied by a doctor.

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The drugs were prescribed and given with empathy and compassion. Often it was possible to arrange final visits from distant relatives, because staff were able to any with confidence that the end was near. This proved to be extremely benefit for the patient and for relatives as it allowed the proper grieving cycle to commence. In the case of 'involuntary' euthanasia the procedure of assessment was the same.

There were some variations to the means through which the desired end could be achieved, IV therapy could be suspended, Nursing care could be diminished to bodily comfort only. If staff were unable to justify the use of powerful narcotics, the patient literally starved to death. Coma was inevitable, and made the process bearable for all concerned. Relatives were usually informed that only basic nursing care would be provided as there was no point in intensive intervention.

Thinking back on those choices, although a comatose state was usually achieved, it was slower and not as elegant as morphine.

If the situation arose in Intensive Care, respirators would be turned off, cardiac arrest and haemorrhage would be ignored, various intervention techniques such as IV therapy, blood cooling, or heating would be suspended resulting usually in instantaneous death (to the very vocal relief of relatives who were forced to see a loved one transformed into a robot like apparition in a star trek setting).

Similar situations will probably be well known to you, or at least will become so during the course of your inquiry. During my years of nursing I was familiar with the case histories of a minimum of 40 deaths due to euthanasia. Not one of these deaths were arranged for any other reason than to provide relief for the patient. The only considerations were humanitarian.

The points I wish the Committee to consider are as follows:

1 Slow death, be it by 48 hours of overdose or starvation and coma, is uncivilized. Upon considered request, death should be immediately forthcoming using a substance deemed to provide the most peaceful and expedient exit.

2 Hospital staff and relatives should be protected. The practice of 'medically correct' euthanasia will not cease if this Bill is not passed, nor should it. However the ability to provide total care for a patient or a terminally ill person with the backing of legislation is the ideal situation for all involved.

I hope you find enough evidence, anecdotal and otherwise to support this Bill, a most positive response to an important human issue.

Yours faithfully,

Mrs Moya Buckley

4/11 Geranium Street, The Gardens

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Dear Editor

I feel compelled to put pen to paper regarding the Euthanasia issue after reading some of the 'right to suffer' letters recently published.

I was a triple certificated nursing sister and specialised in geriatrics and during the course of my career I saw many people die.

In the beginning I thought I could be of some comfort to these people, giving sips of water, puffing pillows, changing linen and stroking hands. At the end of my nursing career I knew that comfort for the painfully terminally ill came only in the shape of an overdose of morphine.

It is impossible to believe the pain, the suffering, the sheer torment that the human body may sustain until it takes its last gasp. It is impossible to comprehend the grief, anguish and impotence of the relatives who have to observe their loved one dying (wasting and vomiting and begging for the end), or attached to the end of countless tubes and heartless machinery designed to prolong life where there is really none,

Do you really think that there is a calm and gracious exit for the terminally ill in Hospital? Where stressed and sweaty brows are cased by cool handed soft voiced nurses akin to angels in their white starched dresses. Think again my friends!

The reality is the noise and pandemonium of an ugly hospital ward, generally understaffed and under-equipped. It is about a pan round (not your timetable but theirs), and about catheters to drain your bladder, It is about a nurses care and responsibility divided among 30 patients in the same ward (and we worry about our children's class sizes!). There is no sunshine, peace, or grace in a public ward. There are no home comforts, no privacy, and definitely no quality of life.

This Bill, put forward courageously by Marshall Perron, aims to give back to the terminally ill patient, their dignity and peace when all other medical intervention has failed. We are not talking about "putting people down like dogs". Most of us who have had to help a loved pet to escape pain, would admit that while it was an agonising8 decision, it was handled professionally, and that our pet was at peace. No violence, no blood, no nothing. The ultimate 'passing over'.

Don't we deserve the same peaceful exit, the choice of time, the last drink with friends? Shouldn't doctors be able to assist the terminally ill in this way at the patients own request with the backing of legislation?

Thank you Mr Perron for attempting to put right that which is so wrong. I hope you succeed and that some of the more pusillanimous members of your Cabinet do not conspire, through ignorance, superstition or faintheartedness, to deny the right of choice in a matter as personal as the manner of one's death.

Moya Buckley

4/11 Geranium St, The Gardens

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Dear Shane,

It has come to my attention that it has been difficult for you to back your Chief Minister, and represent your constituents, on the Euthanasia Bill because of your religious beliefs.

I understand how hard it is to put aside personal feelings in the pursuit of party unity, but hope that you understand that some of your constituents. who admire and support you, and who hold strong religious beliefs of their own, still expect you to support the Party and represent them too.

My own feeling is that God moves in many and varied ways. It is possible that He has seen the suffering that people go through, and has guided Marshall Perron to draft a Bill that may ease this suffering in certain controlled circumstances,

If we accept that God guided the doctors hand, and medical research, so that we can now prolong the life of the terminally ill (and life generally), then we should also accept that God has guided us to the current position, where we find it is kinder to end our loved ones suffering at theft request through the use of drugs, or through

nonintervention.

I have enclosed a copy of my 'letter to the editor' on this issue.

Yours faithfully,

Moya Buckley

SUBMISSION 706 1

Lynda & Alan Cracknell

20 Wearing Crescent, ... KARAMA NT 0812 ..

Ph 454-718

The Chairman,

Select Committee on Euthanasia,

Box 3721

DARWIN NT 0801

Dear Sir,

We wish to register our full support for the Rights of the Terminally Ill Bill.

It is our view that

. introduction of the legislation will hurt no-one; whereas

. failure to introduce the legislation will continue to hurt many.

Each of us has made a pledge to the other that should we ever be in a position where death through terminal illness is imminent, and the terminal partner considers that palliative care has ceased to be effective, that the other will - if the law does not permit a better way - actively assist in ending our partners life - and the law and consequences be damned!

Our relationship is strong enough to contemplate this awful eventually - but we beg you to allow us a more humane solution, through the law which is in your power, (along with other members of the Assembly), to enact.

Yours sincerely,

L CRACKNELL

LYNDA F CRACKNELL ALAN C CRACKNELL

SUBMISSION 707 1

A Secular Case

A Submission

to the

Select committee

on

Euthanasia

of the

Northern Territory

Legislative Assembly

Submitted by

Fr. Eugene Ahern

290 Childs Road,

Mill Park. 3082

Tel 03-4043865. Fax 03-4043052

2

A Secular Case Rejecting Euthanasia And The Arguments Put For It

The Rights of the Terminally Ill Bill has occasioned a major debate on euthanasia in the Northern Territory and throughout Australia.

Because human life is at issue it is proper that all should be concerned about this proposed legislation which would radically change our age old prohibitions against direct killing in our society.

It is a step which must never be taken without long and full deliberation.

This submission is made in the spirit of honest and open dialogue.

Given the nature of The Northern Territory society the author has made a very deliberate decision to make a secular case against euthanasia and likewise subject the arguments advanced for euthanasia to a secular analysis.

This is not to say that other compelling cases cannot be made against euthanasia. They certainly can and must be made.

An Overview

Taking two steps back from the terms of the present bill before the Legislative Council will enable us to see the fatally flawed nature of any project to legalize euthanasia in whatever terms the legislation may be couched.

From the relatively emotion free atmosphere distanced from so called "mercy killing", let us examine a request, a special kind of request.

A doctor receives a call from a patient. The call is quite simple: "Doctor, will you please come over and kill me." The voice is quite calm and deliberate.

The patient insists with the request. "Doctor will you please come over to my house and kill me."

The doctor is stunned. He must make some response. His years of training lead him to ask some questions.

"Do you really want me to come and kill you?" he asks. The patient responds quite adamantly. Of course that is what I want. Don't you believe in patient autonomy? Don't you respect my fight to choose?

He has never encountered a request like this before. He does not like being challenged on the sacred turf of the

freedom of choice, so he retorts: "You have no right to expect me to come and kill you. You are being quite absurd." By this time the patient is becoming a little aggravated. "But doctor you don't seem to understand that I have decided I would be better off dead because Collingwood have just lost another Grand Final. My life is ruined for the next year. There is no way I can live another year.

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By this time the doctor has grasped that he has been set up by the patient! Nevertheless he is not to be outdone or made a fool of. He will be party to the charade!

"I understand your situation. I agree entirely with you. Of course you cannot live another year without Collingwood being premiers. I will be right over to end it all for you."

But in simple English, it is being argued that the fact that a request to be killed is made in an entirely, totally and absolutely voluntary way, in some respect makes it legitimate for a doctor to comply with that request.

For a doctor to kill any patient and claim as a defence against the charge of murder that the patient had requested to be killed has up until now been totally unacceptable to a court.

One might argue that it is some consolation for the family to know that the patient requested to be killed, that it was no arbitrary killing on the part of the doctor. Nevertheless the reality remains that the doctor has murdered the patient or at least been a party to assisted suicide.

In reality a doctor would not act on a request to be killed by a patient solely on the basis that it is made voluntarily. Something more is required. We will shortly examine what that something more is.

The proponents of the bill will then object that the redeeming element in the bill is that the patient must be terminally ill and be expected to die within twelve months.

Now that bleak prognosis is no ground on which to justify the plea to be killed, even if the patient might genuinely believe that he would be better off dead. In the doctor's mind, the nail has been struck in the coffin by his own judgement that one would be better off dead.

THE TRUE NATURE OF WHAT IS BEING LEGISLATED FOR

This euthanasia legislation is presented as being sanitised and acceptable because of two features of the bill:

a) it is legalizing only patient killing which is requested by the patient - i.e. it is only voluntary euthanasia.

b) it is restricted to those who are terminally ill i.e. those expected to die within twelve months.

From the fable recounted above, the failure of both these features of the legislation to support the validity of legislating to allow a medical doctor to accede to a request by a patient to be killed should be obvious.

In reality doctors do not simply act on the free, voluntary request of a patient to be killed even if the patient considers he is dying and would be better off dead.

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The emphasis given in the case for euthanasia to the voluntary nature of the request is at best a smokescreen. This presented as a safeguard is no safeguard at all. More importantly it hides the real issue which I shall address shortly.

The supposed safeguard that access to patient killing is limited to those expected to die within twelve months is equally spurious.

The fable I have recounted serves to show that the patient's perception of his or her condition will not serve to persuade the doctor to agree to the patient's request however it is expressed. What is vital to the persuasion of the doctor is the decision in the doctor s own judgement that the patient would be better **off dead.**

Once the doctor has made that quality of life judgement regarding the patient then he will be willing to help kill the patient.

Until such time that he is convinced that the patient is better off dead he will never seriously entertain the request for assistance in the killing.

This leads into the core issue of the euthanasia debate.

The Core Justification For Euthanasia: ***"Better Off Dead"***

While almost all justifications for euthanasia represent it as a benefit to the patient there is the essential element in the judgement that a particular person would be better off dead even if that requires actually killing the patient by act or omission.

Put very simply a justification of euthanasia which is based on the assumption (and I would say false assumption) that human life does not possess an inherent value denies the basic dignity and equality of every human being.

When one decides that a particular person would be better off dead one is concluding that the person no longer has a worthwhile life. It is that judgement which really strikes at the core of an estimation of the worth and dignity of every human life without exception.

This country along with almost every country in the world has and continues to have a long and painful struggle to recognize the true dignity and worth of every human person without exception. One immediately thinks of the failures of our country on the basis of colour and race. It was not only a denial for so long of true equality but a denial of the true dignity of those being discriminated against. The absurdity of the situation was that it was often justified in the most high sounding terms of taking "proper care" of aboriginal people which was only a cloak for very negative judgement as to their true dignity. However much the same can also be said of our treatment of disabled persons. I almost hesitate to even refer to the terrible way m' which people with Down's Syndrome were labelled as "Mongols." The true dignity of that patient was being almost totally denied.

Purported justifications for euthanasia such as those offered by Mr. Perron rely on the apparent benefit to the patient.

In fact most justifications of voluntary euthanasia in so far as they are presented as a benefit to the patient being killed are based on a view of the human person which is inconsistent with the acceptance of true dignity and worth of every human being.

One very common justification of voluntary euthanasia concedes that human life has value but then argues this value is eliminated by the realities of suffering. This has been put by among others James Rachels in an essay "Euthanasia" in the collection "Matters of Life and Death" NY, 1980. In this view the ending of suffering even by killing becomes a higher value than the basic dignity of the person. This view treats the value of our humanity as eliminable by counter values. The result is that the basic dignity of the person irrespective of his or her condition is undermined.

Commonly we hear those who say that they recognize the dignity of the person to be killed while they argue that the person is better off dead. This line of reasoning is truly inconsistent. It is arguing that the continued life of the person is a negative value and that death itself is thought of as a positive value. When thoughtfully scrutinised this argumentation is not only fallacious but dangerous. It is fallacious because it is based on an assessment that

non-existence can have a higher value existence. It is dangerous because it can be invoked to justify the elimination of many in society starting with those whose demise is justified on the grounds that they request it but if its logic was accepted it would be a mercy to grant the same fate to other judged *"better off dead."*

Though some advocates of euthanasia may be daunted by having their logic challenged and the basic attack of euthanasia on human dignity exposed they will want to persist.

They will press a claim for the *"right to die".* Many quite illusory rights are claimed in our world. Surely the right to die must be the most spurious of alleged fights.

Leonard Butt, a feature writer for the London Times affectively demolished this supposed "right" twenty years ago in the article entitled "A Right to Life and a Duty to Life". The basis of his argument is that contrary to case in true rights, death has a claim on us. We have no claim on death. We will all inevitably die. Further whereas in the case of a true right, such as the fight to life, a person may make a claim for the object of one's right to be respected against those who would impinge on the object, *namely one's life,* in the case of death one is impinging on the inevitability of another' s death. No one can impinge upon or take away the reality of another's death.

Having been thwarted as to the *"right to die"* the euthanasia advocate may then turn around and claim a *"right to be killed".* This is an altogether different matter. Given what has been argued above about existence as a good to be respected above non-existence, it would seem that there is no human value or good to claimed in a bogus *"right to be killed".*

Finally there may be a case made for personal autonomy or the autonomy of the patient's decision making - a so-called right to privacy or fight to free choice as the basis for the justification of euthanasia.

SUBMISSION 708 1

PERSONAL COMMENT:

I hope the future of this bill is determined on the rights of the terminally ill and not on the moral nor religious grounds that have largely controlled the present community debate on this issue.

The Rights of the Terminally Ill Bill provided the individual with the right to choose to end their life legally and in a dignified manner.

Voluntary Euthanasia has been and will continue to be practised by medical practitioners to meet the needs of certain patients, forcing sympathetic doctors to act contrary to the law. It is unacceptable for this to occur without any regulations and guidelines in place to protect the health care provided or the patient. I, there fore welcome the Bill and hope it proceeds to full legislation.

SUZANNE LEE

Women's Advisory Council Member.

SUBMISSION 709 1

Euthanasia: a personal view

I applaud the development of this courageous bill, and sincerely hope that it is introduced by the Northern Territory Government.

I have worked as a nurse in many settings. I have nursed people who were in desperate situations, and for whom current nursing and medical practice was insufficient.

The proposed euthanasia service outlined by Mr Perron's bill is designed as an option. I hope that if one day I

desire this option, that it will be available to me.

I have examined the proposed bill, and support it, with the amendments suggested by the Northern Territory Women's Advisory Council.

Sue Carter

15.3.95

C/- WAC

GPO Box 4396

Darwin

SUBMISSION 710 1

My Personal Response to the Bill

I believe in the need and right of every person to have choice over their own life where this choice does not conflict with the lives of others. Currently there is no choice in the way people face their death. To choose to end your life when your physical pain can no longer be sufficiently alleviated is not a choice available to you if you require assistance. This Bill gives people that choice.

Personally, I do not think that I could face a slow and agonising death in a situation where pain relief is not sufficient. To know that if this situation should ever arise, I could choose my own time to end it is comforting. Helplessness on top of pain must be totally devastating.

Even in such a situation I may never choose euthanasia. The will to live is very strong, I do not know how I would react, but I do need to know that I could have a way out of the pain if nothing else worked. I also want this choice for the people I love. Choice allows human dignity.

If this Bill, when law, is assiduously followed with all its safeguards, and constantly monitored to ensure its principles are not degraded. then it has my full support.

Peta Wilson

C/- Women's Advisory Council

GPO Box 4396

Darwin 0801

SUBMISSION 711 1

TO THE SELECT COMMITTEE

ON EUTHANASIA

I applaud the introduction of the Rights of the Terminally Ill Bill and support its introduction by the Northern Territory Government.

I believe that every human being has the right to choose in matters relating to their own life and health.

Those who do not agree with Euthanasia will maintain a fight to choose not to end their life by this means, however I do not wish to have my options determined by the religious of moral beliefs of others.

Yours sincerely

Ian Ramsey

23/3/95

SUBMISSION 712 1

24th March '95

Eric Poole

Chairman

Select Committee on Euthanasia

I would like for there to be some system in place if and when I made a decision to die because of a terminal illness which I felt was no longer bearable.

June Tapp

ph. 722 369

Fax. 722 395

P.O. Box 1979

Katherine N.T.

SUBMISSION 713 1

The Honourable Peter Adamson, MLA

9th February, 1995

Dear Peter,

May I convey to you, as our elected representative, our opinions on Marshall Perron's "Rights of the Terminally Ill" Bill.

As practising Anglicans, and fully respecting your religious beliefs, we both strongly support the Bill, obviously subject to its final composition.

I must also comment that I considered the comments by the Honourable C N Padgham-Purich relative to a Plebiscite should be given serious thought, given the modern political interpretation (1860) : A direct vote of ...electors... to decide a question of public importance; also ..., a public expression, ..., of the wishes ... of a community.

I should also support strongly Mr. Perron's statement that, given the size of our electorates, each Member should be able, in the available time frame for the readings, to ascertain the views of their electors.

Yours Faithfully

(Gordon Cottle)

SUBMISSION 714 1

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24 March 1995

The Chairman

Select Committee On Euthanasia

GPO Box 3721

DARWIN NT 0801

Dear Sir

I am writing to register my support for the introduction of the 'Rights of the Terminally III Bill'.

I have read the Bill and understand very clearly what is being proposed and believe that each person should have the right to make a decision to terminate their life, when they are suffering from a terminal illness and have no quality of life.

Yours sincerely

DIANE FLOWER

8 Stobo Crescent

ALAWA NT 0810

SUBMISSION 715 1

The Chairman

Select Committee On Euthanasia

G P 0 Box 3721

DARWIN NT 0801

Dear Sir

I wish to register my support for the introduction of the 'Rights of the Terminally Ill Bill'.

I believe that individuals should have the right to make the choice of voluntarily terminating or being assisted by a consenting medical practitioner to terminate their life, when they no longer have quality of life and are suffering unbearable pain from an incurable illness, and have the knowledge that death is inevitable.

I have read the Bill and understand very clearly what it being proposed.

Yours sincerely

JILL BOUND

2 Jensen Street

PARAP NT 0820

SUBMISSION 716 1

WENDY ROBERTSON
PO BOX 42

YULARA NT 0872
Telephone:
(Home) 562 636
(Work) 562 702

FACSIMILE TRANSMISSION TO:

SELECT COMMITTEE

INVESTIGATING M PERRON PRIVATE MEMBERS BILL ON EUTHANASIA

FACSIMILE NUMBER: 816 158

I wish to add my name to the list of persons advocating the acceptance and legislation of this proposal.

To not do so is to discriminate against those people desiring a choice in the way they live, and die.

There are persons who will choose this way to pass on, and those to whom it will not appeal no matter what their medical state.

Those who do choose yes should have that right when, having considered their short term quality of life, or lack of it, causes them serious anguish in the way their dignity will be removed, or when they consider the affect it will have on their carers, either through a medically controlled palliative care resource or by family members. One hears more and more stories of patients being returned to their homes for finally caring, because medical science can no longer assist.

I personally find it strange that doctors with strong views against this proposed legislation are advocating that they would be "playing God" by assisting a patient in actively terminating their life. And yet these same doctors are "playing God" by increasingly utilising the latest technological treatments, equipment and drugs to prolong a life.

In cases of severe emergency trauma, for instance car accidents and drownings, first aid and medical staff are committed to saving that life, or go to great lengths to resuscitate a victim. thereby bringing some "back from the dead". Sometimes they are totally effective, sometimes it ends in a further tragedy with mental and physical disabilities. Is that not "playing God"? Please understand that this example is to underline the medical treatment angle only, and I am not saying that mental and physical disabilities are bad or wrong. Many trauma victims accept or overcome their handicaps, some excel in different areas, one being in sports, and some others cannot come to terms with their difficulties for the remainder of their lives.

I affirm that -

. I have no religious affiliation. I have no political affiliation.

. I have never lost a close relative or friend to a serious prolonged disease.

. I do not condone suicide.

. This is a totally personal view.

. I am a well and healthy person.

. I make my own choices in my daily life.

And I believe that I should have the right to CHOOSE what happens to me should I be faced with a prolonged death sentence, such as advanced cancer. I do not know whether I would or could decide to take up this very

serious and very courageous option. But I should have the CHOICE. That is nobody's else right but mine. And if I could convince the proposed two doctors to allow me to die with dignity, to say goodbye to my family and friends, to put my house in order, then obviously I would have put my case intelligently and with conviction.

I am advocating this belief only for myself. Should my spouse, my parents, siblings or any of my close friends ever be confronted with a serious debilitating and lethal disease, and desired care in an institute or at home to their natural Dr drug induced end, I would try to be a main carer for them,

But should any of them arrive at a point in their thinking that they can intellectually analyse and decide on a better passing on, then to deny them that would be a crime. Discrimination, in fact.

I cannot imagine that my life would have any quality should I realise that in the short term I may need any of the following -

. drugs to control excessive pain.

. a carer to tend to my bodily functions

. a carer to tend to my hygiene needs

. other carers to tend to my laundry, my financial affairs and a whole host of other issues that exist in normal everyday life.

I applaud the Chief Minister for having the sensitivity (yes!) in bringing this issue into the open for debate. It's about time someone had the guts to do so.

It is nearly the year 2000, and with technology changing every day, I do not like to consider what could be further developed tomorrow to prevent me from exercising my rights and options in living my life. This should include how my life ends should I be faced with a shortened version.

For all the people crying "no" to this proposal, I find them selfish and lacking in consideration of other people's feelings and rights to choices in their lives.

I realise that the Committee will have in difficult time in deciding recommendations on this very emotional issue, and thank you for allowing my opinion. My belief in this issue is so strong, that I would like you to know that this is the first time I have ever written on a subject in this way.

I would be happy to discuss my personal opinion further, should you require.

Yours faithfully,

WENDY A. ROBERTSON

24 March 1995

SUBMISSION 717 1

IN CAMERA

SUBMISSION 718 1

To:

Chairman

Select Committee on Euthanasia

From:

Cheryl Laizans

Parap Bookshop

Dear Sir,

Please find attached. 1 page of petitions and 2 pages of an Opinion Poll on the Euthanasia debate.

With thanks,

C. Laizans

Enclosed with submission 1 page of petitions singed by 14 citizens of Darwin and 2 from South Australia.

2 pages of Opinion Poll signed by 42 residents from varying places in Australia.

SUBMISSION 719 1

SUBMISSION TO THE SELECT

COMMITTEE

ON EUTHANASIA

"THE RIGHTS OF THE TERMINALLY ILL BILL" 1995

A SUBMISSION ON BEHALF OF THE OUR LADY OF THE SACRED HEART

PARISH ALICE SPRINGS

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SUBMISSION TO THE SELECT COMMITTEE ON EUTHANASIA "THE RIGHTS OF THE TERMINALLY ILL BILL" 1995

A submission on behalf of the Our Lady of the Sacred Heart Parish Alice Springs. **AUTHORITY:**

On Thursday, 2 March, 1995 the Our Lady of the Sacred Heart Parish Pastoral Council passed a motion to empower a sub-committee to

a) Co-ordinate the Our Lady of the Sacred Heart Parish response to the proposed Euthanasia Bill

b) To prepare a submission on behalf of the Our Lady of the Sacred Heart Parish to the Select Committee on Euthanasia

c) To assist Our Lady of the Sacred Heart Parishioners to respond to public debate.

This submission is prepared and authorised by that sub-committee, endorsed by the Parish Council and assented to by the Parish Community.

The Parish of Alice Springs has in excess of 6,300 persons and operates 3 schools within the town.

The sub-committee has received active support by other congregations within Alice Springs. **FOCUS:**

In this submission we have not dissected the Bill and commented on it Clause by Clause. To do so would give some sort of recognition to the Principles behind the Bill. This committee is totally opposed to the concept of

legalised killing, whatever the motive. We have therefore concentrated our intention on the idea of the Bill and to fundamental principles relating to the taking of life and to possible alternative options.

DEFINITION

Euthanasia literally means "easy death".

Today one no longer thinks of this original meaning of the word, but rather of some intervention of medicine, whereby the sufferings or sickness or of the final agony are reduced, sometimes also with the danger of suppressing life prematurely.

Ultimately, the word euthanasia is used in a more particular sense to mean "mercy killing", for the purpose of putting an end to extreme suffering, or saving abnormal babies, the mentally ill or the incurably sick from the prolongation, perhaps for many years of a miserable life, which could impose too heavy a burden on their families or on society.

It is therefore necessary to state clearly in what sense the word is used in the present document.

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By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used. The term euthanasia should be reserved for the compassion-motivated, deliberate, rapid and painless termination of the life of someone afflicted with an incurable and progressive disease.

A suffering and terminally ill person is not allowed to die - his or her life is terminated.

If euthanasia is performed at the dying person's request or with that person's consent, euthanasia is voluntary; otherwise it is non-voluntary.

The terms 'active' and 'passive' euthanasia are ambiguous and misleading, so should be avoided.

MORAL CONSIDERATIONS:

"Good care is not cheap; it is much cheaper to kill people."

The following remarks will be confined to two areas: basic premises of the debate and lessons from history.

There is sufficient evidence provided by surveys of current practice that show the overwhelming majority of cases of euthanasia, voluntary or involuntary, whatever the jurisdiction, are falsely certified as death by natural causes and are never reported and investigated.

Investigators into euthanasia practises report

"A doctor who has acted in breach of the law is no more likely to admit having done so in his report than a tax evader is likely to reveal his dishonesty on his tax return."

"Vast majority of deaths from euthanasia are illegally and incorrectly reported as natural deaths itself casts doubt on the lawfulness of much of the euthanasia which is being carried out."

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.

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When medical killing is allowed in some circumstances, the number of circumstances in which such killing occur quickly increases. Since some doctors and nurses in Australia are already prepared to break the law and kill some patients, one wonders why they imagine that those same doctors and nurses would be any more law abiding if the law were changed.

Doctors have a professional and moral mandate to use every reasonable means available to free patients from the pain and other symptoms that cause them to suffer. The relief of pain and other symptoms, such as dyspnoea, has nothing to do with euthanasia. The purpose of such treatment is to free patients from the pain and intense discomfort that dominates consciousness and leaves no psychic space available for the personally important things people want to think about, say and do before they die. The aim of such treatment is to liberate life, not to terminate it.

The pro euthanasia lobby does not distinguish between a right, a liberty and a permission to do something, nor do they recognise that a liberty does not become a right simply by asserting it to be one. Nor is any distinction made between having a right and right conduct.

The "right to death/die", claim continues the confusion which surrounds the many meanings of the term: the fight to refuse treatment even if, or so that, death may occur; the right to be killed or to become dead; the right to control one's own dying; the right to die with dignity; the right to assistance in death.

The Bill advocates only one solution to all of them - death.

It is extraordinary and unacceptable that this is the ultimate solution offered by the Bill.

It seems that this "final solution" embraces one or more of the following premises:

- that it is better to die than to suffer
- that it is better to be killed than to suffer
- that I have a right to die
- that I have a right to be killed
- that it is a greater good to die or to be killed than to live
- that I am no longer of any use to myself
- that I am no longer of any use to my family or friends
- that I am no longer of any use to society
- that I am an unendurable burden to myself
- that I am an unendurable burden to my family and friends
- that I am an unendurable burden to society.

The Bill fosters and proceeds implicitly on the basis of pre-eminently utilitarian premises of the kind just listed.

It is unacceptable to use them as criteria to determine whether someone lives or dies.

A person's use to himself or herself, or to society, is but one factor which reflects their more

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intrinsic value as human beings capable of being the object of another's care and attention. One's value or worth ought not be dependent merely or exclusively on one's "productivity"; on what one does.

The Bill reflects a world-wide tendency to try to move the issue of euthanasia from the debatable to the justifiable, so that, ultimately, it becomes the unexceptionable.

And this "progress" is all in the language of reason and compassion.

The fact is, modern liberal societies view human life as "the presence or absence of certain capacities..... We tend to think and speak not of being a person but of having personhood, which becomes a quality added to being."

The arguments advanced in support of the Bill such as patient autonomy or the need to avoid patronising care do not require legislative control. Better treatment and care of those with terminal conditions would alleviate the problems.

No philosophically sustainable argument has been adduced to support the Bill.

Pain and suffering, although inevitable, are able to be controlled by the prudent administration of pain-relieving medication and by appropriate, palliative care. Futile and unduly burdensome treatment should not be advocated. Respect and dignity should be accorded every person at every stage of his or her life.

Lessons from history concerning the fragile balance between care of people who are stricken with illness and legislative intervention to legitimise killing should caution against the Bill.

A patient with a problem for which there are two management options, conservative and surgical, cannot "choose" and, therefore, give consent, if information regarding conservative management has not been disclosed and understood. The degree of information disclosed by the doctor and the level of comprehension achieved by the patient together shape patient choice. The doctor directly affects freedom of choice.

Coercion, which refers to intentional use of a threat or actual harm or force to influence another, can describe the controlling influence a doctor or other health professional can exercise over patient choice. If looked at as a continuum, strong forms of coercion, such as threats and force are at one end, and move through milder forms such as "rational persuasion", to weaker forms of control or coercion such as emotion-laden appeals to family who may be dependent on the patient at the other end can inevitably be applied by those "in charge".

Care must be taken to ensure that the patient is not subjected to deceit, force or manipulation. Medical problems often leave patients physically weak and psychologically vulnerable, prone to "controlling influences" that might otherwise be resisted.

In the course of illness, the time arrives when it is no longer possible to restore health, function or consciousness, and no longer possible to reverse the dying process. The most that even the

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aggressive use of sophisticated technology can achieve is to prolong that dying process. It is in these situations that we speak correctly of withholding or withdrawing interventions that are not stabilising a person's life, but only prolonging a person's dying. It is in these situations that we speak correctly of allowing a person to die.

It is at this low point the Bill would allow interference in the natural process thereby denying the person natural participation in the last acts of life.

We acknowledge that prolonging life at all costs, especially at the cost of unbearable suffering, is not the right thing to do. We are not arguing that. That is the point of the evolving ethic of allowing the dying to die, and in doing everything possible and justifiable to help them die in peace and without pain. That is the point of palliative medicine and palliative care.

The concept of person is the starting point and the constant reference point for clinical ethics in all its dimensions. It emphasises that each patient is unique and, in critically important respects, different from all other patients. Humanity means seeing and respecting patients as unique human beings, physiologically and psychologically. Such an approach is essential if we are to maintain the highest clinical ethics.

Legalised killing as advocated in this Bill will erode these ethics.

Saving lives has always been and must always be a central goal of clinical practice.

We firmly and without qualification oppose the legalisation of euthanasia as both unnecessary and dangerous. We believe that the N.T. Government should promote programs of education in palliative medicine and palliative care rather than jumping on the bandwagon of hysterical pleas for the decriminalisation of euthanasia.

The binary logic of the alternative, dying with pain or euthanasia, may have held true in earlier periods, before the development of modern methods of palliative medicine and palliative care. It does not hold true today, anywhere in the world. The civilised solution rests with a rapid implementation of programs of palliative medicine and palliative care, not with resignation to pressures for euthanasia.

LEGAL:

"If you stand by and don't help a patient who therefore dies - or if you are standing by and you help that patient to die - there is no real difference."

The Bill requires doctors to kill patients and, in certain circumstances, either penalises those who do not do so or absolves those who do.

The essential elements of the proponent's case are:

a) The doctors and nurses are doing it anyway, it is better it is legal so that patients can have access to the services that "would put them in control of the last phase of their lives."

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b) The Netherlands system means that a second opinion will be required and strict conditions met.

c) It will put the minds of doctors and nurses at ease that they will not be charged with murder.

d) As in The Netherlands "voluntary euthanasia can be offered openly, in specified circumstances, and reported as the cause of death on the death certificate, without any fear of prosecution, as long as correct procedures were followed."

e) In The Netherlands about 2300 deaths each year result from voluntary euthanasia carried out by doctors.

The evidence from The Netherlands, provides conclusive evidence of abuse. Reports contain abundant evidence that doctors kill more patients without their explicit request than with their explicit request, and that euthanasia is not restricted to the so-called "strict medical guidelines" provided by the Dutch courts.

The Lancet Dutch Report, acknowledges that "in cases of euthanasia the physician often declares that the patient died a natural death". This amounts to a tacit admission that Dutch doctors are prepared to make false statements even when they kill patients according to the strict medical guidelines laid down by the judiciary. 38.0% of all deaths involving MDEL were "life-terminating acts without explicit and persistent request". The deaths of about 1,000 Dutch citizens in a single year which were the result of the doctor hastening the death of the patient, without the patient's explicit request and consent have been reported.

The real number of physician assisted deaths, estimated by the Remmelink Committee Report in reality, 25,306 which is made up of:

2,300 euthanasia on request

400 assisted suicide

1,000 life-ending treatment without explicit request

4,756 patients died after request for non-treatment or the cessation of treatment with the intention to accelerate the end of life

8,750 cases in which life-prolonging treatment was withdrawn or withheld without the request of the patient either with the implicit intention (4,750) or with the explicit intention (4,000) to terminate life

8,100 cases of morphine overdose with the implicit intention (6,750) or with the explicit intention (1,350) to terminate life. Of these 61% were carried out without consultation with the patient, ie non-voluntary euthanasia.

This total of 25,306 physician-assisted deaths amounted to 19.61 per cent of total deaths (129,000) in The Netherlands in 1990.

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To suggest that the Northern Territory medical profession would act any differently than their Dutch counterparts is ludicrous.

The "dying" industry would embark down the "slippery slope" of legal, moral and medical modification of the law. One only has to look at the "progress" of the abortion laws to demonstrate the fact.

There are already responsible groups arguing for an extension for the catchment for Euthanasia.

The New South Wales Humanist Society has suggested that" converting some forms of N.V.E. (non-voluntary euthanasia) to V.E. (voluntary euthanasia) is very desirable." It suggested the possibility of a "senile degenerate" having signed prior consent to being killed "while still in full possession of his faculties".

They further suggest that the law could be changed to allow "the mentally ill, the right of consent to E. (euthanasia)." As for babies "born with severe mental or physical disabilities, such as are sure to make it a misery to itself or to those who have to look after it, its life should be terminable by legal process before any person becomes emotionally attached to it."

"Babies grossly mentally or physically handicapped. Children grossly mentally or physically handicapped. The severe mentally afflicted. Senile degenerates. It does seem undesirable to keep these unfortunates alive. Their continued existence burdens relatives, friends and the community, and often, though not always, themselves."

It appears, then, that many of the key proponents of voluntary euthanasia are committed, as well, to the non-voluntary killings of other classes of humans, some of whom they are disposed to define as non-persons to make the killings seem more "reasonable". That being the case, there is every reason to question the claim that voluntary euthanasia can be quarantined from the non-voluntary killings of different groups of vulnerable human beings.

In Holland many physicians who had practised euthanasia mentioned that they would be most reluctant to do so again.

This begs the question as to why such physicians "would be most reluctant" to practise euthanasia again. Is it that they feel they have done something very wrong? Was it an unpleasant experience, and, if so, in what way?

To voluntarily agree to be killed threatens the right to life of other members of the community as well.

In most of the heartrending end-of-life situations, it is hard enough for practical wisdom to try to figure out what is morally right and humanly good. There is no such thing as right to die, the notion is groundless and perhaps even logically incoherent. Even its proponents usually put "right to die" in quotation marks, acknowledging that it is at best a misnomer.

Most of the literature discussing voluntary euthanasia has concerned the 'merciful release' of

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those who are painfully diseased. Yet this is only part of the wider problem of casing the passage of all those who are burdened with the ills associated with age.

There are instances where the taking of human life can be justified such as self defence, capital punishment and just war.

Current legal decisions query the extent of the right to protect ones property and person. Recent decisions on "level of force" have undermined the concept. Similarly capital punishment is outlawed right throughout Australia and when reported as happening overseas is greeted with abhorrence. There are many in society who will argue that there is no such thing as just war. If this is so where the so called "defence paradigm" is being rejected by our law makers how can the Northern Territory legislators introduce a law that legalises killing that has no component of credible threat to society or individual person?

Even where legalised killing in any of these forms is practised a substantial burden of justification, of giving valid reasons for actions, before diverse audiences is required of the person or institution that takes life.

The only "threat" which could be posed by a person with a terminal illness, as it is defined by the Bill, is that he or she is a threat to the convenience, sensibilities and resources of one's family or the local community.

Further, it seems that supporters of the Bill do not pay sufficient attention to a number of distinguishable matters which are perceived to have mutually inconsistent goals.

Those matters are, the desire for certainty of diagnosis, the desire to respect and further the autonomy of the "sick" person, and the desire to spare the patient pain.

The perceived inconsistency between these matters is quite illusory.

For example, if priority is given to relief of pain and care of the dying, rather than focussing on when and how someone might be killed and relieving the parties to that action of legal responsibility for it, the goals identified can be made to be perfectly consistent and achievable. Control of pain - physical, emotional and psychological - is used as a means to justify the need for patient autonomy and to advocate death as the primary, or only, alternative for all three goals.

It is too dangerous and macabre a situation to allow one person to substitute his or her judgement for another on the strength of which that "other" will be killed. The skill of the physician, historically directed by the ancient oath of Hippocrates to preserve life, is now enjoined by this law to conspire to terminate it.

In the course of his speech, Mr. Perron discounted the "slippery slope" argument.

In response to the suggestion that the Dutch Government's "Remmelink Report" has been misrepresented in community discussion, Professor Destro, from the Columbus School of Law

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in Washington DC, notes sections of the British Medical Association's report on the situation in the Netherlands, France, Denmark, the Federal Republic of Germany and Sweden which gives a more thorough-going account of the situation. With respect to the Dutch, the BMA Report concludes that:

"...it...seems that, although certain members of Dutch society are against active termination of life for cogent reasons, there is a widespread use of the active termination of life..."

Commenting on this summary, the British Medical Association's position on euthanasia is clear:

The active intervention by anybody to terminate another person's life should remain illegal.

Neither doctors nor any other occupational group should be placed in a category which lessens their responsibility for their actions."

Justice Andersen of the Washington Supreme Court has summarised the medico-legal position in the United States. It should be a salutary warning for Australia.

"As recently, as five years ago, or perhaps three, the idea that fluids and nutriment might be withdrawn, with moral and perhaps legal impunity, from dying patients, was a notion that would have been repudiated, if not condemned, by most health professionals. They would have regarded such an idea morally and psychologically objectionable, legally problematic, and medically wrong. The notion would have gone "against the stream" of medical standards of care. (However,) .... this practice is receiving increased support from both physicians and bioethicists. This new stream of emerging opinion is typically couched in the language of caution and compassion. But the underlying analysis, once laid bare, suggests what is truly at stake: That for an increasing number of patients, the benefits of continues life are perceived as insufficient to justify the burden and cost of care; that death is the desired outcome, and - critically - that the role of the physician is to participate in bringing this about."

Professor Destro notes succinctly:

" .... The difficulty lies not in allowing nature to take its course whenever continuation of treatment would be medically contraindicated, counter-productive, or otherwise inhumane, but in the assumption that policy makers of any sort are competent to judge the quality of another person's life."

Death, as the ultimate solution, is an unacceptable philosophical or jurisprudential base for legislation which attempts to deal with human beings who are suffering in the community. Such people are deserving of care at every stage of their lives. In our view, killing is not care.

The Bill requires the person requesting termination of his/her life to be competent.

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Competence may be thought of as a necessary and existing state pre-dating the apprehension of disclosed information and the making of a voluntary act of consent." .... a precondition of being able to authorise autonomously." It is, in fact, a set of capacities which, pre-existing and residing in the person, enables that person to perform a specific task. Those capacities include:

(i) The capacity to receive, comprehend, retain and recall information provided by the doctors and others;

(ii) The capacity to perceive the relationship of the information received to one's current medical problem;

(iii) The capacity to integrate and order the information received and to relate it to a realistic perception of the need for making a choice in such a way that the patient can weigh benefits and risks against some set of personal values;

(iv) The capacity to select an option, to give cogent reasons for the choice, and to persevere in that choice, at least until the decision is acted upon; and, finally,

(v) The capacity to communicate one's choice to others in an unequivocal manner.

There is ready agreement that a person or patient possessing these capacities should, other things being equal, be competent. However, a person lacking one or another capacity is not necessarily rendered incompetent. The important question is whether a person is sufficiently competent to make a reasoned, conscious, free and autonomous choice, and not whether he or she makes the absolute best decision possible.

Generally, judgements made about the competence of a particular person always require a setting or a context in which the competence of that person is to be assessed.

For example, a person may be a competent teacher but an incompetent gardener and when, in a few cases, we refer to someone as generally incompetent (e.g. severely retarded person), we are usually assuming that incompetence is manifested across the ordinary affairs of life.

Thus, our judgements regarding another's competence or incompetence more often apply to a limited range of decision-making contexts and not to all contexts in which a person may make decisions.

Whilst informed consent implies both competence and autonomy, yet adequate information and autonomy do not assure competence. There must be a capacity to process information and to use freedom in a reasoned fashion. Hams (1985) identified four different "defects" which serve to diminish autonomy which, in turn, reduce the level of a person's competence.

These are listed as:

(i) Defects in the patient's ability to control either desires, actions or both. Mental illness and drug addiction are examples where you might expect this defect to affect decision-making;

(ii) Defects in the patient's reasoning. Here, the defects may be related to difficulties associated with the reception of information (e.g. deafness or unconscious); comprehension (e.g. low mental ability); retention (e.g. neurological damage); recollection (e.g. severe anxiety); or, acceptance (e.g. prejudice);

(iii) Defects in the information available to the patient, upon which he or she bases the choice or decision; and,

(iv) Defects in the stability of the patient's own choice. Failure to persevere with a decision, at least until the decision is acted upon, suggests that the patient may lack good an cogent reasons for making that choice or that he is subject to some form of "controlling influence", (e.g. grief, stress, neurosis).

If a patient makes a decision and expresses his or her choice, health care professionals usually do not raise questions about incompetence unless the patient's decision differs from their own, that is, from what they think is best for the patient. Childress (1982) argues that there should be a moral presumption of an adult's competence to make decisions in health and medical matters. In other words, the burden of proof should fall on those who believe that a particular patient is incompetent to demonstrate that the patient is incompetent. Because of the legal presumption of competency, a patient must be found incompetent before the doctor chooses to accept or not accept the patient's decision as either a valid consent to authorise or refuse treatment.

The proponents of euthanasia are very sensitive to the word "kill". However, that is exactly what we are talking about - to have in place a law whereby one person (and one who has taken the Hippocratic oath) is given the right to kill another person, or to assist that person to kill themselves. Euphemisms don't disguise fact.

For the N.T. to take the step of legalising the act of killing another human being is a deadly one, open to abuse, as historical precedent has already shown.

The above mentioned philosophy behind the Bill is in contravention of the United Nations Declarations, of which

Australia is a signatory. Article 6 of the International Covenant on Civil and Political Rights: "Every human being has the inherent right to life. This right shall be protected by law."

The Declarations on the Rights of the Child, the Rights of Mentally Retarded Persons, and the Rights of Disabled Persons all recognise that these persons, (children, the mentally retarded, the disabled) have the same rights as other human beings.

The purpose of law is to provide justice for all in our community, and protection for the weakest.

On this premise, a Report (published in 1994) from the Select Committee of the English House of Lords inquiring into euthanasia, firmly rejected the legalisation of voluntary euthanasia.

This Report described the prohibition of intentional killing as

"the cornerstone of law and of social relationships which protects each one of us impartially."

The Committee was conscious of the difficulties facing some individuals, but stated

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" ..... the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole."

SOCIAL:

The use of the term voluntary euthanasia to specify a policy, shifts the emphasis from the objective nature of the act of killing to the intent or choice of the persons involved, be they doctor or patient. This pro-choice emphasis is similar to that used in the abortion debate.

The supporters of the Bill believe that voluntary euthanasia can be kept separate from other acts of euthanasia which involve the killings of patients without their explicit request. Changes to the law to permit voluntary euthanasia represent "a clearly defined and unambiguous boundary", and that such evidence as SAVES *(South Australia Voluntary Euthanasia Society)* claims it has "does not support this escalation fear."

They contend that voluntary euthanasia can be domesticated, that it will not lead to other forms of medical killing which violate the patient's autonomy or right to choose.

There are already arguments being mounted that go like this:

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

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

3. If we can get people to accept the removal of all treatment and care - especially the removal of food and fluids - they will see what a painful way this is to die. and then, in the patient's best interests, they will accept the lethal injection.

4. Daniel Myen proposes suicide not just as a right but, in some circumstances, a duty. "The duty to suicide occurs when through my continued living lack of autonomy, misery, isolation, uniformity, unfruitfulness, incurability, lameness, pain, insensitivity, disgrace, madness, sin threaten to become the norm for humanity and my suicide is

the only means available to me to prevent this"

5. If you stand by and don't help a patient who therefore dies - or if you are standing by and you help that patient to die - there is no real difference.

With this type of argument being mounted those sections of society that are least able to rebut are threatened.

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Mr. Perron in his speech denigrates the idea that human life is sacred. Many in today's world share his attitude. There is a great lack of respect for other human beings and for the worth of the individual person. Poverty and violence are manifestations of this. In fact, it can already be witnessed in the legal system where an offender is likely to receive a much greater sentence for a crime against property than for that of violence to another person.

Quality of life is an expression that means different things to different people. It does not only apply in terms of our state of health. A person may be wretched and miserable because he/she lacks adequate housing, access to essential services, medical, transport, etc - to meet their needs.

Those deprived of the dignity of work, the ability to be self-supporting, for themselves and their families, frequently suffer great anguish. These factors, and others, are what can be described as contributing to a poor "quality of life" for many indigenous of our country. And for many others, - street children, the chronically unemployed, ethnic people isolated because of language and cultural differences, etc. How do you quantify this suffering?

Mr. Perron's remarks imply that anyone whose life is "wretched, miserable or painful" should be able to put an end to it. It will not be long before the amendments to the Bill will reinforce this attitude in the Community.

Mr. Perron asks

"The question for those who oppose this Bill is why should that choice be denied?"

How can you give an absolute guarantee that it will never be used in a non-voluntary situation, despite the present narrowly defined provisions? You can't.

Abortion was originally legalised to be approved only in very limited circumstances: In cases of rape, and where a woman's mental health was considered to be endangered. Now, as virtually any member of the medical profession can testify, it is available on demand, frequently as just another form of contraception, with the motivation simply of convenience.

Euthanasia movements in both the United States and Great Britain, have, in the past, proposed non-voluntary killing, particularly in the case of handicapped infants. This line of thought has also appeared in the euthanasia advocacy movement in Australia. ("Should the Baby Live?" H. Kuhse, P. Singer) The philosophy of Professor Singer and Dr. Kuhse proposes a range of values of life: "no infant, defective or not, has as strong a claim to life as beings capable of seeing themselves as distinct entities, existing over time" and "killing a defective infant is not morally equivalent to killing a person". In other words, what is proposed is that the value of life of an adult is greater than that of a newborn infant, and that killing an infant is a lesser evil than killing an adult. Further, "this conclusion is not limited to infants who... will never be rational, self conscious beings" ..... "everything I say about them would apply to older children or adults whose mental age remains that of an infant."

If voluntary euthanasia is a human right, as Marshall Perron proposes, then what of the equivalent rights of others whose quality of life is not considered the full 100%?

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Territory, are proposing legislation which would authorise one person to legally take the life of another, innocent person. You can't get any State in Australia to legalise the death sentence for convicted murderers, no matter how horrendous their crime. Yet this Bill sanctions terminating innocent human life.

Euthanasia, even when motivated by compassion, is not a socially acceptable substitute for the establishment of effective programs of palliative medicine and palliative care.

The challenge of civilisation to our societies at the end of this decade is to transform our care of the suffering and the dying, not to legalise an act that would all too easily substitute for the palliative competence, compassion and community that human beings need during the most difficult moments of their lives.

Legalisation of euthanasia would be dangerous. The lobby to legalise euthanasia presupposes a world of ideal hospitals, doctors, nurses and families. But we do not live in an ideal world and, for this reason, arguments supporting the legalisation of euthanasia rest on five flawed premises:

1 Euthanasia, once legalised and socially acceptable, would remain voluntary and vulnerable and burdensome patients would not be subtly manipulated and pressured to request termination of their lives.

2. We would continue to resist the extension of euthanasia to those who are irreversibly unable to request or consent to termination of their lives.

3. The legalisation of euthanasia would protect doctors against lawsuits and would minimise the chances of doctors being brought to trial.

4. With euthanasia legalised, we would remain a caring society ready, in times of budgetary constraints, to invest money and resources to develop humanitarian programs of palliative medicine and palliative care.

5. We could never, as have civilised societies before us, slip into the intolerable abuses of legalised euthanasia.

These illusions, upon which arguments rest in favour of legalising euthanasia, need to be exposed. It is not proven and utterly unlikely that legalisation of euthanasia would not provoke a slide towards intolerable abuse. Admittedly, that slide is not certain and there is no proof that it would occur, but already arguments are being voiced to extend the catchment of the legislation. It is prudent to ask whether we should try this social experiment once again in this century and see what will happen.

The signs in our society of overt discrimination, latent racism, and utilitarian insensitivity to the vulnerable are too prominent for us to be naive about proposals to decriminalise euthanasia. We should maintain an uncompromising stand against a law that would permit the administration of death.

Death does not always come in dramatic circumstances after barely tolerable sufferings. Nor

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do we have to think only of extreme cases. Numerous testimonies which confirm one another lead one to the conclusion that nature itself has made provision to render more bearable at the moment of death separations that would be terribly painful to a person in full health. Hence it is that a prolonged illness, advanced old age, or a state of loneliness or neglect can bring about psychological conditions that facilitate the acceptance of death.

Nevertheless the fact remains that death, often preceded or accompanied by severe and prolonged suffering, is something which naturally causes people anguish. Physical suffering is certainly an unavoidable element of the human condition.

There is a tendency in today's society to resort to drugs as a remedy to a problem.

The unemployed, the homeless, the lonely, the sick, those suffering stress, basically all those disadvantaged in society all turn to drugs. This legislation would enshrine the use of yet another drug, the lethal injection as the answer to the problem of caring for the sick.

The principle is totally unacceptable.

It is only in the last 4 generations that the elderly have been placed in hospitals to die. Prior to the turn of the century people "died in their bed". There were sympathetic carets and no intervention of drugs to prolong death to the point where the agonies of dying outstripped the bodies physiological capacities to deal with it.

Should this law be promulgated it represents a further erosion of family values, a shift to State and a bureaucratic solution to a problem.

PALLIATIVE CARE:

"Good care is not cheap; it is much cheaper to kill people."

Palliative care has been brought into this discussion because there is confusion in the minds of both the lay public and many professionals about what it is.

Dr Lloyd Morgan and many others in the medical profession reject the call for active euthanasia "because it is unnecessary in most cases", and because the choices of dying in pain or being killed are not the only choices available given modern palliative care.

A forum, organised in February 1995 by the Palliative Care Council of SA inc., confirmed overwhelmingly that palliative care in nursing homes is an issue of major concern amongst caregivers.

Seen through the window of palliative care, nursing homes deserve a greater significance in our society as places where death occurs and where death is managed with skill and dignity.

The aged and ill are among the most vulnerable members of our society. We fear for those who may, if euthanasia were legalised, feel pressured to request it so as not to be a burden on their loved ones. What of those who might request it while in a temporarily depressed state?

Supporters of euthanasia do not believe that better palliative care negates the principle of euthanasia. We disagree.

Palliative care is not only about pain relief, which trained medical staff, in this day and age, should be able to deliver effectively. It covers a sphere of emotional, psychological and spiritual areas, where a skilled palliative care team could communicate with and offer support to a patient and family members.

A time comes in the course of a disease when it is wrong to continue to prolong life aggressively and when it is right to honour informed patients' refusal of treatments that only prolong suffering.

Where are the priorities of this Government?

In the Northern Territory, we have no medical oncologist, no palliative care specialists, not one hospice, limited radiotherapy services - in other words, totally inadequate funding for the needs of those with life-threatening illnesses.

The second Reading Speech gives little attention to the positive aspects of palliative care. There have been great advances in this field in recent years. Good palliative care can address the physical symptoms and emotional distress of the patient, and provide support and comfort to the dying and their families.

We believe that the challenge facing the members of this Parliament, if they are sincere in providing relief for the

terminally ill, is to set up a palliative care system which would be an example to the rest of the country. Provide medical oncologists, palliative care specialists, training for staff in this field, hospice services in major centres, and radiotherapy services. You won't need euthanasia legislation then. Of course, such care of the dying will be more costly, but it would make us examine our priorities.

We should rigorously promote programs of education in palliative medicine and care.

We should, first of all, look at euthanasia in its familiar context. People used to die at home, with their families, surrounded by objects and memories that represented a life history to them during their last days, hours and moments. Today, people usually die in hospitals and institutions - sterile and strange, and equipped with a complex range of technology capable of supporting and prolonging life, frequently only biological life, when a return to health and vitality is no longer possible. Indeed, life may be prolonged far beyond the time when patients have lost all capacity to be masters of their remaining days.

Consequently, 'dying with dignity' has become a slogan of opposition to useless and degrading prolongation of life when a patient's organs, though still minimally functional, can no longer support or permit the exercise of self-fulfilling personal control over life's events. Dying with dignity, however, means entirely different things to different people. The term is used in support of such ethically disparate approaches to the care of the terminally ill as withholding clinically useless life-prolonging treatment, and adequate control of pain on the one hand, and euthanasia and assisted suicide on the other.

In this context, it is essential to distinguish between: euthanasia; control of pain and other symptoms; and withholding or discontinuing life-prolonging treatments. One must never confuse these three different types of clinical judgements and activities.

Legislation of euthanasia should be opposed as both dangerous and unnecessary.

CATHOLIC TEACHING:

Everyone has the duty to lead his or her life in accordance with God's plan.

The Bill raises a large number of vital issues for consideration by the whole community.

The position of the Church is:

"When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted."

"(f)or the terminally ill who are incapacitated there are other factors which cause suffering such as the loss of bodily functions, the inability to do the most menial of tasks for themselves or being treated in a patronising and paternalistic way."

There are a number of matters to be noted here.

Much anguish stems not from death itself but more from the process of dying.

Our modem world looks invariably to technology to overcome all problems only to find that for all its positive worth, the same technology enables lives to be prolonged which, formerly, would have ended at an earlier time with a lot less negative impact.

Living with knowledge of one's pending death requires more than technology to deal with the attendant anxiety.

That is, if one is offended by 'patronising and paternalistic care' of the kind described by Mr. Moore, (*the proposer of a similar Bill in the SA Parliament)* the remedy is to be found, primarily, in the care-giver; it should not require the patient, the object of care, to forfeit life and be killed. To quote again from the Declaration on Euthanasia:

"today, it is very important to protect, at 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 ':

This statement of principle defines the Catholic tradition. The statements of principle used to justify the introduction of the Bill in question are diametrically opposed to it.

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In this regard, the Second Vatican Ecumenical Council solemnly reaffirmed the lofty dignity of the human person, and in a special way his or her right to life. The Council therefore condemned crimes against life

"such as any type of murder, genocide, abortion, euthanasia, or wilful suicide".

No one can make an attempt on the life of an innocent person without violating a fundamental right, and therefore without committing a crime of the utmost gravity.

Intentionally causing one's own death, or suicide, is therefore equally as wrong as murder.

All medical and surgical measures, not just extraordinary ones, have - and should always have the protection and nurturing of life in some form as their objective.

It is those who "lack stable connections with others (who) appear to be the most frequent victims of suicide." Legislation, such as this Bill, which facilitates death as a solution to the social malaise of "lack of stable connections" is alarming.

It is necessary to state firmly once more that nothing and no one can in any way permit the killing of an innocent human being, whether a foetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person; who is dying. Furthermore no one is permitted to ask for this act of killing either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly. Nor can any authority legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offence against the dignity of the human person, a crime against life, and an attach on humanity.

It may happen that, by reason of prolonged and barely tolerable pain, for deeply personal or other reasons, people may be led to believe that they can legitimately ask for death or obtain it for others. Although in these eases the guilt of the individual may be reduced or completely absent, nevertheless the error of judgment into which the conscience falls, perhaps in good faith, does not change the nature of this act of killing, which will always be in itself something to be rejected. The pleas of gravely ill people who sometimes ask for death are not to be understood as implying a true desire for euthanasia; in fact it is almost always a case of an anguished plea for help and love. What a sick person needs besides medical care is love, the human and supernatural warmth with which the sick person can and ought to be surrounded by all those close to him or her, parents and children, doctors and nurses. Death does not always come in dramatic circumstances after barely tolerable sufferings. Nor do we have to think only of extreme cases. Numerous testimonies which confirm one another lead one to the conclusion that nature itself has made provision to render more bearable at the moment of death separations that would be terribly painful to a person in full health. Hence it is that a prolonged illness, advanced old age, or a state of loneliness or neglect can bring about psychological conditions that facilitate the acceptance of death.

Nevertheless the fact remains that death, often preceded or accompanied by severe and prolonged suffering, is something which naturally causes people anguish. Physical suffering is

certainly an unavoidable element of the human condition; on the biological level, it constitutes a warning of which no one denies the usefulness; but, since it affects the human psychological make, it often exceeds its own biological usefulness and so can become so severe as to cause the desire to remove it at any cost.

"Is the suppression of pain and consciousness by the use of narcotics .... permitted by religion and morality to the doctor and the patient (even at the approach of death and if one foresees that the use of narcotics will shorten life)?", the Pope said: "if no other means exist, and if in the given circumstances, this does not prevent the carrying out of other religious and moral duties. However, pain killers that cause unconsciousness need special consideration. For a person not only has to be able to satisfy his or her moral duties and family obligations; he or she also has to prepare himself or herself with full consciousness for meeting Christ. Thus Pious XII warns: "It is not right to deprive the dying person of consciousness without reason".

Today 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.

CONCLUSION

In conclusion, we restate our total objection to the "Rights of the Terminally Ill Bill".

'Dying with dignity' is a term used to support ethically disparate approaches to care of the terminally ill.

The means are available to largely relieve the suffering of the dying, if we are prepared for the financial commitment required.

We are completely opposed to the introduction of legislation which would overturn the principles now protecting the life of each human being in our society, young or old, sick or well.

Any law allowing euthanasia affects all members of our community it recognises and authorises some lives to be devalued. The implications, morally, legally and socially, are dangerous and unacceptable.

REFERENCES

The figures and information quoted in this submission were drawn from

1. Personal experiences and quotations provided at public meetings.

2. Information folders provided by a number of research bodies.

3. A number of authors who the same quote source documents.

4. Original authors.

Should the Committee wish to sight the original written source material that can be provided.

SUBMISSION 720 1

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I DO NOT BELIEVE THE CONFIRMATION OF THE BILL BY LEGISLATION

WILL BENEFIT SOCIETY AT SMALL COST.

The loss of human life is always an unfortunate and grievous fact as the contribution to society of individuals cannot be adequately measured and must never be easily dismissed, if it is to be dismissed at all!

Confirmation of this bill by legislation is an attempt to quieten the "plea" of some of the terminally ill people. A result would be the lessening of endurance of medical practitioners and health carers to statements made by some of their patients.

Those practitioners and health carers are presumably trained to expect such negativity in patients with bed-side manner and rapport in dealing with welfare of the "whole patient".

When no more can be done for the patient, no more should be done! That is not so say "caring" is diminished nor taken away. Nor should it mean that "caring" should be diminished nor taken away from any individuals: that is also their right, whether they like it or not. However the patient should be fully informed of all options that can be made available locally and abroad to ease their discomfort, especially if local resources do not offer options satisfactorily offered by other locations and nations. In light of unavailable local options due to the Australian medical profession's failing behind current world studies and practices in the allievement of pain, expense must be made to update and qualify practitioners in the fields of pain specialists and palliative care.

Recognition should be paid to the fact that a sufferer expressing words and concepts of any kind is achieving momentary respite. Complaints are healthy! Attention seeking may be all these patients are capable of. The medical profession may not have adequate answers to deal with such situations: the challenge for it is to endure the problems it faces, not hope they will go away by legislation. This is in the frontier of scientific discovery which has in the past given us the solutions to other life threatening problems. People died in agony in the ages of mankind. This Bill will not undo agony.

Sanctioning this Bill allows us to perceive that it is alright to no longer care by physical and psychological means: it must be a devastating blow to the psyche of such patients. This Bill represents a sophisticated form of denial. Has the psychological part of the "whole person" in the terminally ill patient been sufficiently explored in today's modern world of health care, prior to writing this bill? This may be an inadequacy of this Bill!

Assistance in certain circumstances without legal impediment causes proeuthanasia believers to call on *human dignity* to defend their case.

There is nothing to suggest the patient may not ask the medical practitioner at the present time

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while this Bill has not been sanctioned. The patient does not need a law to ask the question of anybody. The only reason for this inclusion is to further the request into deliberation of an act which is technically illegal because it is planning a deliberate taking of life. Such planning has always been considered illegal as well as immoral, except in the case of a "just war". In this case the patients involvement in war is with pain not another person, and not his own person. If this clause is accepted it allows the argument to ask sanction for the practitioner and or patient to execute the plan. It is not a just reason for the destruction of the self of the patient, it is merely an excuse and should not be tolerated. This clause searches for twisted reason to justify breaking with a persons right to have life. If we acknowledge it as just reason we justify conspiracy in private and in public...for the reason must be first be socially acceptable. This wilful negation of the primal right to life by a society is a social illness for which we may not feel blame if others assist us not to accept blame. It is an insidious evil where acceptance is made no longer by

identifiable people as individuals, but by the masses which has no personality to be punished except by the Pandora's Box of eventual consequences. This social evil is called "Social Sin" or "Collective Sin" because of the ills it will bring upon society by the collective sanctions of people, (even if by some clever manipulation of due processes to achieve popularity of the 'Euthanasia Cause or Movement' and establish the numbers for popularity to sanction this Bill, resulting in a stunned unquantified number of people who rightfully oppose the opinions expressed in the Bill - these too will live in a society which will impose its view as a justified law with Pandoranian consequences.)

Such assistance through prescribed stages may weaken further the patients ability to accept any form of life. It may strengthen the patient's expression for the will to die, raising the expression of desire from the level of whim, made in transitory or prolonged depression or as a mind block to the pain itself; a trick of the psyche. This form of assistance, as defined in the Bill for the Terminally Ill 1995, may not be the positive kind of help the patient really wants nor needs. The patient cannot always be trusted to know what is in his best interests - something doctors should attest to. To legally sanction an individuals rights to opt for self-imposed death, opens the possibility of patients making a choice based on feelings: which fluctuate at times even in prolonged depression. It is highly undignified to let a patient sense the possibility it is better for them to die in a place they are not wanted nor cared for while they suffer. Caring can be sensed despite anyone's incapacity. That is what is recognised as dignity. The clearly thought stages of 'procedure' for this Bill enabling a patient to give the final decision to die may always seem logical, but life does not always work in the ways man plans. We should not attempt to assist the terminally ill to explore their feelings alone. Feelings do not make the whole person. Judgements acted upon based on feelings alone, as in depression are always dangerous ones. This is hardly a safe and simple case of identifying soundness of mind. We must consider the possibility of intermittent respites in many forms during slow death. It is unwise to allow this sanction for the option to die prematurely because it forces people into meditating on a destructive act to the individual and as a consequence on those who have a relationship to that person. This is a most serious anti-social effect. An old traditional view of the world of people, a view which as its origins from the middle east thousands of years ago and still in use, recognises nine types of character - each of which can operate from one of three levels within a person; the head, the mind and the gut. Any person bases their operations of living predominantly around one of these centres. The restoration of well being comes from one recognising where this centre is for oneself and striving to

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overcome the compulsion of the imbalancing two. Each character type has its own totem to identify it. It is a journey of discovery and mastery. If euthanasia is given the sanction some want for it and these other avenues are not explored by the patient, he or she can easily, by ignorance, be denied a source of great strength!

A thousand and one conditions for euthanasia under certain circumstances would equally flout the dignity of the terminally ill patient as the fourteen listed in the *Bill for An Act -The Rights of the Terminally Ill, 1995.* The (inadequate) list diminishes the dignity and high esteem of the Northern Territory Government, the medical practitioners and health carers of the Northern Territory and the people of the Northern Territory. The monetary disincentive described as "penalty" which is used to deter opposition is enough to draw attention to the seriousness of the Act, pitting other legal human rights of individuals below that of some one who is certain to die, but we know not when within an estimate of twelve months, and below the rights of the medical practitioners and health carers in execution of what some may see as their duty to the patient. I cannot justify the "loss of liberty" for protesters. This country lost so many lives in wars with the belief they were defending liberties and the society they lived in and its values. If this bill is sanctioned those values are certain to change from what we know today. That is not always a good thing. The threat to the fundamental right of life is not partially attacked m this Bill. It is a direct assault! In this day and age, I *could* choose to die because of the absurd living constraints and injustices that are protected that make the joys of living intolerable; all in the name of people's rights and freedom. But I will not! Some who lie are very good at not getting caught and can readily, successfully project guilt to the innocent. In this bill we see guilt dissolve with lawful sanction as supreme giver of rights! We are already over governed with

tight constraints. Our society has become Philistine in its quest for the progress of dignity rights and freedom! We have missed the mark widely. And we propose to do it again! Rights have always existed, even prior to legislation which acknowledges them. They can exist without legislation though. The law should not excuse euthanasia more than homicide!

If this set of prescribed procedures must be filled by the sanction of this Bill through the Legislature, I cannot stop it. However I remain dismayed the process has come to this. I no longer have the respect for this government I once had. I have no confidence it will be able to fulfil its mission beyond that of staying in power at any cost. This will be the belief I will always carry till the day I die! This Act is not about cleverly walking a tight rope to success. It is about retaining every piece of remnant life and energy we are put on earth to respect. Amoebas have maintained the dignity of their level of creation through their omission in any clause in this bill.

I refuse to elevate this set of clauses [section 6 (a) - (n)] for "Conditions under which medical practitioners may assist" (a patient to die according to his or her will) with sanction, proposed by the government for our community, in the belief that this Bill, born through cognitive dissonance, will give birth to further cognitive dissonance and the creation of social stupidity! See attachments.

Notes furthering positive nature of these conditions and important questions of details can be found on pages with numerically itemised paragraphs.

In reference to 6(1) and (m) medical practitioner's conditions: How gratifying! Can we be sure

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no one has nothing to gain by this condition? - until we question the integrity of the medical practitioner. Perhaps for each case we institute a Commission to investigate each practitioner in each case of life termination he or she is involved in to ensure nothing was gained. Integrity should always be questioned from now on. Gross denial of complicity! double standard. A law as a lie to protect itself and to achieve the ends which it proposes.

A reasonable ground for doubting the patient's wish is that the doctor will never know what is in the mind of his patient upon administering of any drug. That reasonable ground will always exist. A true cause may always be that the patient armed with the knowledge this bill provides may make the right claims to fulfil a swift end for reasons never divulged to the doctors, nor anyone else, especially if conditions are that someone else may do it for him or her. Complaints of pain, discussions, filling out forms are activities the patient is able to achieve. He or she may not really want to die at all! But the processes of deciding and a having reaffirmed affirmations by someone else may be a patient's mental exercise only; a purpose of creating an interaction and an alternative relationship during the course of suffering where the brink of the end is at administering the lethal dose, the mind exhausted at effort, gives in to the attitude of not bothering to care for oneself- resignation!

A Darwin barrister, John McCormac, featured in the Northern Territory News [under the header "Opinion", sub-header "Death Bill May Cause More Pain", Thursday 16 February, 1995] gives an outline of frustrating possibilities the Bill may cause if enacted. The innocent living should not be subjected to furthering consequences of suffering and hardship resulting from the enactment of this Bill.

I disagree with the destruction of the certificate of request upon a patient wanting to rescind the decision to die and rescind the consequences of having signed the document. As evidence, it must never be destroyed.

No document involved with this Bill or its enactment, or procedures on fulfilling the Act "Rights of the Terminally Ill, 1995" (should the Bill be passed as an Act) should have government sanction to be destroyed at any time unless certain other conditions are met. The document should be in triplicate. A decision to rescind should allow the original and all copies of it to be *"marred"* or crossed out with red texta colour. Should legislation of this Bill be inevitable, it should include the specific statement that a marred certificate or request or "schedule" automatically makes the request void and must not be acted upon and by acting upon a marred document of request a criminal,

punishable offence has been committed. It should be legislated that only a triplicate copy may be destroyed in front of the patient if it serves the purpose of satisfying him or her that no action will result from the document, upon the request from the patient that a burning of the paper is deemed important to him or her, that the original and second copy of the "marred" request-form be retained in the patient's file as evidence. Should a patient wish to cancel the rescindment and opt again for death procedures, all new paperwork must be introduced and also included in the patient's file. Destruction of any original paper work only creates the possibility for suspicion and creates a bad work practise in the work environment, which would make possible the mistaken destruction of official documents not otherwise due for destruction. This set of circumstances does not alleviate the medical practitioners and health carets from present responsibilities. This means they continue to be accountable for making notes on all activity involved with the patient as "duty of care"

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and responsibility for contributing notes to patient-files is not rescinded nor diminished. All accountable events in the process toward the patient's death must be retained as intact records or is an irresponsible omission of practitioners and carers who may have to defend themselves to a charge of such omission in some future time.

In response to Clauses 9.1 and 9.2: I cannot concur with these clauses on the grounds that the principles on which this bill is established are from the outset the antithesis of those upon which the present laws of society have been built; that all people will prosper by their introduction; that the needs of the few do not impinge on the needs of the many; and that the notion that the Bill is portrayed to seem as well intended, is flawed by its deceptive disassociation from the basic values which aim to respect the total make up of all social beings. [This Bill sets the precedence of social segregation by total denial of future existence for some of our people. I find this a contradiction in terms by including in the Bill a few clauses about "improper conduct", while the actions the Bill seeks to make lawful are themselves improper!]

If I have to resign to and live with the possibility that sanction is inevitable, and be forced to accept the reality of this Bill as a piece of legislation despite my beliefs of the principles of life then and only then must I live by social restrictions this Bill intends for dissenters. While exterior conformity may appear to be supportive of sanction, the interior spirit will not. From these viewpoints I wish to contribute a token recognition of positive support to society by qualifying the need of supplementary clauses in union with those as proposed in this Bill. Should I be faced with having to accept the Bill as law because of popular opposition to my beliefs, and have to resign in accepting these clauses, I assent to the keeping of medical records without reservation with the belief that these may one day be used to legally support belated retribution on those participants who freely choose to execute the conditions of this Bill and any redrafted-form of this Bill.

It is not my intent to be insulting, but with all due respect, I cannot respect what I perceive as misuse of existing law, at least in it's spirit.

Perhaps "last illness" can be defined further as misdiagnosed mental stability, if this Bill is sanctioned for further debate in the Legislative Assembly prior to legislation of this Bill for an Act.

This bill does not state positively what Government mandatorily requires to be written on the actual Death Certificate, only what it is permissible "not to write". I object to this because it appears that such omission suggests an embarrassment in final documentation on part of the executors of the Bill when enacted, as if they might have something to hide. Let it be open and public that each such death resulting from such legislation be seen to be the fulfilment of this law. Let it be a mandatory condition of the legislation that the patient's medical practitioner must write the cause of death on the death certificate as "legally euthanised" or "By legally planned euthanasia" this may be of some great interest to later generations of each Australian family doing research into their genealogy and drawing up their family trees.

I find it interesting that the Bill's clauses relating to processes for "letter of request" be sent to the coroner. Does he

inter this document with the deceased after forwarding statistical information to the Attorney-General or forward it to him? Why should this document be

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separated from the patient's medical file after he or she has died? Perhaps a duplicate or original of a triplicate must be forwarded to the Attorney-General. There must be more than a summary offered to the Attorney General so he (or she) as Attorney-General's Department is less dependent on the feeding of information from sources which can filter out information from the public reporting of case file information. The freedom of the Attorney-General to report "..in such manner...as he or she thinks appropriate ...to the Legislative Assembly" may not satisfy the Opposition Party nor the interests of the population of the Northern Territory. Is this censorship, as implied in the current wording of this drafted Bill for an Act to ensure that the public is only to see the benefit of euthanasia as a means of financial economy per capita, used to not let the population have living standards depreciate through projected medical-estimate expenditure?

I do not understand why the government wishes to protect medical practitioners and health carets if there is nothing wrong with this proposed law? This makes me suspicious of civil unrest. Could this Bill provide the incubator for civil war in the Northern Territory? If accepted as law and role model for other nations, could it be the accused model for social upheavals in other countries? Is this bill designed to safeguard those practitioners who, while competent in all other areas of their work, bear the hidden guilt of having broken the law as it currently stands, to protect them from punitive action resulting from declaration of what they already know may put them behind prison wails? If we value them for the majority of their work and override the current laws with these conditions we will protect them in future by legislation of this Bill. Will this automatically absolve them for their past actions or will that be implied in this Bill? Will this implied status to the argument be sufficient to extricate them from their 'technical guilt' and will it be enough to free them from the objective moral guilt. To say the subjectivity of the situation is to no longer allow guilt does not follow. Sincere people who commit crimes are sometimes legally classified as mad. This does not mean they are not responsible for their actions. But if by law's view they are deemed irresponsible for their actions society is protected by mandatory seclusion of these people from the situations that effect destruction or danger to both themselves and the public.

I expect the Committee on Euthanasia to study and refer to arguments and conclusions of those lawyers and doctors sent by the United Nations to Nuremburg trials when the questions of "responsibility" and defences of "just following orders" was raised to defend actions before war began and after the second world war was ended. I do not have access to these resources and expect the Government appointed Committee, with it's freedom of powers to search out the truths, should have use of them and to make references from them.

I cannot understand the wording of clauses 15 and 16. I would appreciate more definition of this section of the Bill.

I would appreciate clearer statements telling me the effect this bill has or will have on will. Again in separate statements how contracts are effected by someone choosing to take the option this bill proposes to give them should it become law. Please do the same for statutes. Does this mean all previous wills made prior to signing the request form become void or cancelled? As I am not a lawyer and have no understanding of what statutes are and obviously more than one of them is effected by or altered by enactment this bill, what exactly is being changed? Do clauses 15(I) and 15(2) mean all previous wills made prior to signing the request form become void or cancelled?

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What if the patient rescinds? Do previous wills become reinstated or do they have to be rewritten and witnessed? If they have to be rewritten, OK. I agree with this, but I still want clear details in these areas. Is this a form of revenue raising for the government in which the elderly of the Northern Territory who pioneered much of our past now

suffer under different conditions may also sign away what ever profits small or large they may have struggled to save by assenting to die earlier than expected? Is this a means by which the government of the Northern Territory ensures that what money is in the Territory stays in the Territory because someone opting to enact the conditions of this current bill when it becomes law, surrenders their life savings to the government rather than have it willed to relatives who reside interstate or who live in the Territory and who might move interstate?

Regarding clause 16: Insurance or annuity policies. Does this mean that contracts made before signing the request for assistance to terminate life prematurely remain binding when the request is signed and after the death has occurred? If it does, OK. I agree with this clause.

Clause 17: Immunities. Has good faith saved people from disciplinary action before? Perhaps, sometimes. It alone is not enough. See my further notes and comments about evidence. While I believe this is well intentioned, responsibilities must be more defined. Too bad for those who already suffer from lack of immunity in other laws, workplaces in our protective society! Will amendments be made for all of them too? See item #34 of these notes and comments.

I feel powerless to stop this process of the Bill's advancement with my firm belief that if a person has assisted in another person's death, he or she has done just that, whether he or she has a clear conscience or not about the circumstances and conditions: the person died at their hands - and that in itself is wrong. Society has abolished death by hanging for serious offences but we now are led to believe it wishes to give the same result to an innocent person. What was once punishment because society could not run the risk of the liberty for any serious criminal is now proposed as a reward; for members of society's esteemed medical profession who cannot cope with the aliments of incurable patients. This is a fact. A counter argument may easily refute this view. Nevertheless, such a statement can always be justly made, as it just has been. Prove that this is not so!

In black and white, allowing for no grey areas, assisting in the performing of taking anybody's life is a gross act of disloyalty: to the human race, to the esteem in which life is held by the majority of human beings on this planet and to the creator of all living things. In short. It is a serious sin against all we should stand for and attempt to defend. The act of defending life should not be diminished. Assenting to the legislation of this Rights of the Terminally Ill Bill is assent to diminish the reality of true witness to the defence of life. Some may argue it is OK to take life in some circumstances. Perhaps it is with the unspoken view that it is OK as long as it is not them who is losing the life.

I have watched healthy animals behaviour around another of their species in the act of death, and death while giving birth; they do not assist in their death. They are aware that a precious moment is imminent during another's suffering. They remain close as if caring. They do not assist but do look on. Only people, it seems, are willing to assist in death.

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Reason cannot justify the wrongness of the act of taking a defenceless persons life. Citing the recent horrendous attempts of genocide by tribal peoples as different from what is proposed in this Bill is to ignore the scale and technological differences contributing to the manner that people have been killed before their natural time. We do not hear of those people finishing off their own families who have been brutally wounded to the brain, ears and noses cut off by an enemy wielding machetes and left to die. With painful, hopeful and yeaning dignity they await the resourcefulness of the world of witnessing countries to assist them to live, restore to health and to their natural abodes. The tenacity these peoples show us in surviving at the most basic levels until they die, either by starvation or through malnutrition, thirst or by disease from insanitary conditions, all causses of great human suffering,... it is this tenacity to live by these people which is the strongest testament to the lack of natural instinct the proposals of the Rights of the Terminally Ill Bill offers society.

Is it that we are just lucky enough in the lucky country to not want to live and to have a good friend help us expire.

Is this proposed model for dying maintained in the ancient and current cultures of the Aborigine? I would not do it for a good friend, as I hope a good friend would not do it to me!

Places change and the world looks on just as helpless as the victims of Boznia, Israel, Jordan, the Sudan, Ireland, Moscow, America and other countries. It is all the same, no ,matter the reason. Do we wish to be included in this list with a good reason rather than a bad one? We should be able to raise ourselves above the distinction of being the species that encourages the killing of itself. If we do not attempt to stop it, it will not stop. If we do not attempt to stop it now, when will we decide to stop it. We cannot stop it by continuing to kill. We all have to just stop it.

Society has the unique distinction by its laws to enable the slowing down of this trait in man for self destruction. Only by observance of laws to control oneself is man able to stop it. It is this right of each individual's responsibility for the community that peaceful co-operation and good-will are able to exist. The fulfilment of this obligation to the community results in the benefits our society is able to provide us individually and collectively, which enables us to further share with those of other societies

Each of us owes the community an obligation of support and without it the community is lessened. We are obliged to care for our weak and protect them from harm. If we will not do it for them, who will do it for us? Our weak should not be discriminated by age or by limits of life expectancy. The era we now live in is marked by it's pronounced accent on youth with resulting disadvantage to the older generation. Confirmation of this bill to legislation will once again prove this point. The Government has not addressed the issues of Pain-Specialists and Palliative care with any detailed recognition that Australia is way behind England's and America's medical professions in recognising and providing these services to patients: details which would reveal that the greatest majority of terminally ill patients who might choose to die today can face life painlessly, lucidly and in dignity when provided these specialist services.

Choosing to die and dying are separable and as far as possible, to the best of our abilities, should remain separated for the benefit of the rest of the community. If we agree to this Bill we weaken the will to be strong. That attitude will pervade every other thing we do. We will pass on to our children this attitude and they in turn to their children.

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Listed below are some consequences and issues to be addressed arising from the Bill for an Act, Rights of the Terminally III, 1995, with my opinions

1. Patient dies sooner rather than later; due to altering of expectations - the passing increasingly less a God sent gift of respite and more a manufactured exit. (I cannot dignify it. legislation may recognise it and not necessarily dignify if, as with a going away present?) Marshall Perrons use of "Confirmation" suggests divine intervention to soothe the soul and succour the minds and hearts of the people of the Northern Territory. This does not win my respect.

2. Grief of significant others too easily lessened, is suppressed & latent which can resurface with dysfunctional behaviours in grievers.

3. Important fundamental meanings more easily not confronted nor addressed.

4. Weakening of social values for life & increases ease in possibilities of practices opposing life support.

5.(a) Unstabalising of established strengths of social groupings by allowing dissent of individuals to override the basic principles of some of those groups. This contributes more to the "melting-pot" of social pluralism, waiting to bubble over unexpectedly in the future.

5(b) Discrimination by government to criminalise some freedom of speech and to limit the freedom of speech by lawful restraint while other offensive forms of free speech remain unchallenged by law. I object to this.

6. Creating other human dilemmas for these groups. I object to this.

7. An action, caused by the government allows a person to die just as helpless as if by natural means. This action does not result from an achievement of positive work excellence contributing extra applications of human endeavour. Rather it adds denial of positive achievements. Stopping life is no contribution!

8. Government decrees there is no hope for the future of some of its citizens. This will not change because of a new law! Such proclamation must be already comforting those who feel they are sailing in this boat, especially if they do not fit in the boundaries set by the Bill.

9.(a) Government elevates and enforces hopelessness of the patient, medical practitioners and significant others with permission to extinguish life. I object to this.

9.(b) Government empowers the medical profession to challenge and override the family unit and the uniqueness of each family further eroding it. I object to this.

9.(c) In cases where resentment for this proposed law and its consequences on family members are realised and become so strong that, through grief, family members may choose to retaliate (a situation which might have been avoided if government never

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enacted this scheme): Will there be any measure of compassionate immunity from prosecution; if the damage caused be verbal disquiet, breaking the peace by any means, any degree of physical damage to property (which is not more sacred than the lowliest of created life or the highest form of diminished life); to property or people seemingly unrelated to those involved in the due process requested by a deceased person? List and solve these problems before legislation of the Bill for the Terminally III.

9.(d) Some cultural beliefs in the wider community hold that such expressions of personal grief are permissible, acceptable and are not to be censored. Can the government deal adequately with any such repercussion effectively, should it wish to counter the challenge and to what cost of the Northern Territory economy?

10. Reinforces to the patient the opinion that there is no reason for hope at all for a healthy un-pained future: thereby assisting in extinguishing hope altogether and replacing it with a lethal promise (upon consent) - a narrow option left to him or her. Hardly a positive psychological piece of counsel!

11 .(a) This Bill supports the position that government will authorise, upon enactment: limited accountability of actions through a paper trail of events; I object to this limited accountability but agree with the archival of all stated paper-work! This is good grounds for arguments on

(1) good law,

(2) justice,

(3) Nuremburg trials: outcomes on views of "responsibility"

Lawyers may come to satisfactory conclusions to the debates on the issues 11 (a)-(c). If the Bill is sanctioned I want these issues addressed and written with specific detail as possibility so I can begin to understand the governments justification of these issues.

l11.(b) This Bill supports the position that government will authorise, upon enactment: the "rightness" of legal negation of responsibility: creating new freedom from effects these actions contribute to the final act of the patient and significant others - gives access to a process that fulfils the requirements of a paper trial which would presumably lead to additional archival processes which have yet to be stated. If the Bill is sanctioned I want this addressed and written with specific details as possible. I view this legal negation of responsibility as irresponsible

12. This Bill does not state positively what Government mandatorily requires to be written on the actual Death Certificate, only what is permissible 'not to write'. I object to this. If the Bill is sanctioned I want this addressed and written in specific detail. This is not asking too much in the light of the seriousness of the proposal.

13 The bill further enables its citizens to go beyond dying naturally by opting for enhancement of self mutilation and assisted mutilation, however sterile and cleanly it is presented. I object to this on humanitarian and religious grounds! A clean death at the hands of self or others is still mutilation of what nature and God intended.

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14(a) The Bill does not address itself with consideration for the bereavers nor with declaration of due processes for counselling after a relative's fulfilment of the Bill when it becomes an Act. I want this addressed and written with the due care and consideration as would be for the patient.

14(b) Appropriate counselling should be mandatory following such a death: records of each family and its members' counselling should be made and kept by the government in archives, if the Bill becomes Law.

14(c) The services of a variety of counsellors should be made available for the bereavers to choose from and details of the services should be on record. If the Bill is sanctioned, I want this addressed and written in.

15. The Bill, if sanctioned, may lead to amendment by addition, a cause of grave concern for many in the constituency; (If the Bill is sanctioned I want this addressed and written in, stating how the government will limit such expansion of amendments to not include people of lesser incapacity than the terminally ill. see item # 34.) for example, developing the sanction of death upon request in geographic isolation, when no transport is available or is unreliable and when communications with nearest settlements and established taxes with appropriate communication to the authorities necessary for the prescribed fulfilment of the Bill (when it is an Act) are impossible to be contacted such as when a party is really lost in the bush; How are these people in this dilemma faced with agonising death even if endurance be for a few hours or days, addressed? Will they also be given immunity If responsibility under fulfilment of other conditions? If so, what are those conditions? If the Bill is sanctioned, I want this addressed and written in. (See item #35.)

16.(a) Through omission, this Bill refuses to address the issue of self-justifying and rightness! It presents itself for public scrutiny with the limiting rider which will only allow it to be opposed in its present form, allowing "little change". I object to this for reason contended throughout my papers to the Select Committee on Euthanasia.

16(b) The mission of this Bill includes: (1) an implied recognition of largely unpublicised past, and perhaps present, practices of euthanasia in our hospitals in the Northern Territory, a question of guilt for these and its dissociation from it for practitioners and health carers. Why was this not addressed in public forum, used as an authorisation and attached prefix to the Bill? Was this an unnecessary oversight, not detailing the perceived demand for the need of it in the Northern Territory? Or was this manner of presentation necessary to create the need to debate with little factual information in the wider community so the passing of this Bill could be more easily facilitated into law?

16.(b) The mission of this Bill includes: (2) a breaking with a fundamental belief in the sanctity of life upon which the Australian Constitution was created, and following it on one should presume, to its basis of the Constitution of the Northern Territory:- a contradiction of basic principles! Does the Northern Territory Constitution mention the "sanctity of life". If not why not or in what form does it refer to the sacredness of life of

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the constituents? If not, is this an over sight that needs addressing, as it is a universal trait of mankind? Will this be recognised and stated in the redrafting of the Bill if the Select committee sanctions the Bill for Debate in the

Legislative Assembly prior to enactment?

16.(c) The mission of this Bill includes: (3) a new precedence to forget the past, create an anomaly to replace the undesirable anathema and begs sanction! Surely this breaks new ground! I object to this striking out in a new direction. How about funding latest technology and understandings of the study of treatment for practitioners and health carers of the terminally ill instead?

17. This Bill is as much an abomination, if not more, than the anathema of anguish and pain suffered within some people associated with the dying, the significant others, as well as the dying person in his or her almost optional last twelve months of life.

18. This bill is unique! There are few in the world similar to it. It follows that a lot of unknowns could result as a consequence of legalising it.

19. Armed with these facts, it follows that what we are considering to be lawful is new, untested by the ages of civilisation and, in good faith experimental. Governments normally legislate against a product to be released to the public until conclusive evidence provides the certainty that the consequences of using the product or following a certain procedure or course of action in not overwhelmingly damaging to the public.

20. This Bill is not supported by such strong documentary support that society itself will not suffer strong adverse effects.

21. Human societies are resilient and eventually restore themselves, but they never recapture their past characteristics completely when catastrophe occurs.

22. I am not willing to enable our government to legislate for a social experiment, even in the name of human rights! If a social experiment fails, do we all opt to sign the Certificate of Request or the Schedule to gain respite? This is not merely a matter of "grin and bear it" for society; for that is what we are about to decide.

23. Examine the criminal Code, not just Part IV of the Criminal Code as cited in Part 4 - Miscellaneous Section 13, subsection (1) of the Bill for an Act - Rights of the Terminally III, 1995. See that this accurately validates subsection 1 of Construction of the Act, or if it is on shaky ground as proposed in the Bill. A lawyer may fight this if there are inconsistencies.

24. How can you justify that a sane person be classified as equal to one who administers a lethal prescription and remain innocent ? Please clarify. This is beyond my understanding. Nice intentions of service and warm hearted legislation cannot make me see a cold act as good or just. I cannot classify good, healthy treatment of anybody as being equal to killing them, watching them use a drug prescribed by an agent under

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medical supervision which will knowingly kill them if they administer it to themselves or have it done for them. It is not good treatment to kill anybody. We do not assist criminals plan their next operation, nor assist them in executing it. We treat them differently, when caught in the act, or after the act and sometimes before the act! This Bill is insidious because it proposes to decriminalise the act of planning a death as well as executing that death. This is not right under any circumstances! This law chooses to decriminalise an act for which some call good reason, which I call an excuse for leniency; more tolerant than the lowest form of accidental homicide - not as innocent as an accident because of the degree of predetermination by government to sanction it. Why not reintroduce hanging then, or is that next for resanctioning, so we can have a choice of method? If this Bill were proposed for Australian nationals in another country, we might find Marshall Perron and others currently in favour of euthanasia shouting the roof tops off in opposition. The possibility for "racial purification" within our own country becomes greater and this should send a shiver down our spines.

25. If Federal Government is able and willing to spare the resources to *greatly detail legislation and policies* for

the social justice of Aborigines, the minimum I expect from the Northern Territory is equal attention to detail and forethought to all the ramifications, in writing, for all its constituents.

26. I perceive the presentation of this Bill as the bold imposition of will

rather than careful consideration of consequences one from which we cannot easily escape and one we cannot easily let pass. Is it truly the will of the people? Have they been adequately informed of all the options of all it represents to them and what it proposes in the interest of the patient? Will popularity of it be soundly based, so regret or misgiving may be minimised if it turns sour on the people of the Northern Territory? Will escape from such a law be easy if at all possible and if it be perceived to be needed, because the option to individuals may not be the option to society.

27. At the moment, no one has the fight to opt on the action of euthanasia under existing laws. We do not sell the right of suicide to our youth when they find life too difficult. Society does not encourage death for them. Yet it occurs because of the sense of powerlessness. If we change the law to allow it, would we have more taking that option because of a further sense of society lacking care whether they do it or not? If we care for our youth with this regard; not encouraging the taking of their own life why should we encourage the taking of other lives? Do we aim to encourage them to take their own lives as their right? Will there be some faceless bodies in the crowd who may cause an "accident" for them short of killing them but enough for them to want to take their own lives? It is unwise to allow the negation of any level or responsibility relating to euthanasia.

28. Shall we hide behind the anonymity of the institution of Government and parliamentary privilege to allow some of our citizens to self destruct rather than to protect them? l hope not and I do not want to be a party to it.

29. If we consider to legalise this Bill with its proposals we are not only opting to sanction the local points of individual rights, euthanasia and the justness of these. We are also

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sanctioning the precedent to formulate other laws based on the model principles of this Bill.

30. The Government would have us believe, through this bill, that by having the option it successfully addresses those with scruples or doubts about the activities involved in the process of euthanasia - giving them room to remain impartial, unsoiled and unaffected by the legislation proposed in compassion and courage.

30(a) Does it allow for the projection of negative attitudes (by medical

30(b) What damage will this do the grievers and how will this be addressed in a positive manner to the benefit of grievers?

31. Workers in Health Care Industry such as insurance officers and Medi-Care officers: will it be a mandatory requirement of their duty of care to inform the public at inquiries of the nearest local practitioners who are willing to fulfil the requirements the Bill proposes when it is legislated? Will Government only employ those in favour of the Bill to man these posts to ensure the "public service" this Bill proposes will be given to the public. Will any officer have the right not to hand out promotional material if it is against his or her beliefs?

31 .(a) Will anybody be able to have access to this public information? or;

31. (b) Will it only be given to those who ask for it? or;

31.(c) Will it only be given to those who can prove they are diagnosed as terminally ill upon providing a doctor's certificate to that effect and appropriate personal identification such as a driver's licence or birth certificate? or;

31. (d) Will it be denied to the patients relatives?

32. If we want to protect those closely involved with the procedures the bill proposes, let us write further in their interests in protection from liability by stating as a necessary condition of the Bill:

(a) that medical practitioners and health carers not be allowed to mention this option to the patient at all unless the patient requests it to be discussed;

(b) the patient be advised of this right of health carers and medical practitioners, for their protection;

(c) that the initial discussion be recorded on tape to be kept as evidence.

33.(a) Some reference should also be made to the Freedom of Information Act concerning he freedom of access to the patients file should there be suspicion, or where any legitimate enquires about the patient's ease can be addressed, either before or after the patient's death. A Procedure to answer inquires should be in place in the Bill and people should be able to know what that procedure is.

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33(b) In a case where a patient is about to make his or her last act as allowable by this Bill when it is legislated and an inquiry has commenced into the validity of the procedures purported to have been taken it should be a punishable, criminal act if a medical practitioner or health caret has assisted in the final act while the inquiry is under investigation. That is to say: the patient may not take his or her own life while the matter is under inquiry and the medical staff and significant others may not effect the death. This should be a valid course of non-action for all parties concerned should there be increasing suspicion that medical fraud is apparent (because doctors have been known to commit scientific fraud.)

34. No cost should be spared in the deliberation that supporting evidence for each case of demise resulting from enactment of this Bill should be impartially saved.

34(a) to maintain proof that the processes at work are working as specified in *every* case.

34(b) to eliminate suspicion that any case has been handled incorrectly, since the bill as is suggests the need for a "rider" condition which allows for acting in good faith. good faith is not good enough when we are considering a 'life and death' situation and the well being of participants of those described in this Bill. They need better protection and guarantee than "good faith" if they have need to self defence in a court of law. (The more material evidence the better).

34(c) an outside professional camera man, with no interest in the medical profession, the family of the patient nor the patient, be employed to record all the stages of the processes involved from beginning to end;

34(d) that the cameraman be responsible for:

(1) for correct archiving procedures or;

(2) attaching information labels to recordings and sending them through official courier to a predetermined government department archive or the patient's solicitor for archival or further forwarding to the government archive.

34(e) original recordings be copied so originals can be stored safely away from their copies elsewhere in the archive collection: and both collections be clearly identified with all tape recordings being individually identified as belonging to one of the two collection on archive;

34(f) that all original recordings be classified information: only allowing a classification clearance from ministers to senior officials and solicitors or their agents

34(g) that only official "copies" of the archived material, which must be returned intact be allowed out to

researchers for their examination of it upon request;

34(h) that the archive be kept in an independent government department other than the government's Health Department;

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34(i) that official classification processes are maintained to ensure purity of information and not distort it nor hide it from public scrutiny.

3 5. Continuing possible future amendment by addition (refer back to item #15): I fear this bill will establish the necessary legal requirements to add clauses and conditions which will eventually lead to acceptance by law, whether planned or not to include terminally ill children and persons less incapacitated. I fear that any later date we will have sanctioned away the fights of other less incapacitated people I fear this may take years or decades in which time the population may have been adequately weaned from the values of life which we already hold dear to ourselves and that the population will begin to accept lower standards of life-span and other conditions of life, particular for select targeted people other than those who hold the keys to social power and dominance.

36. Do not let it be said that this move to euthanasia is the only thing that can be done. Let us focus on the issue in its repercussions on the future generation of Australia. To dismiss our care for their future by respecting their rights to decide for themselves, is not to recognise that they will be living under different conditions and starting from a different premise than we are faced with. the values we give them by an affirmative decision on this bill will also deny them the possibility of knowing what it is like to live without lawful intervention of death. A new norm will have been created for then; one in which it well be less likely they will have to attempt to come to terms with the rightness of this issue because the have the answer enshrined in law; a fact presenting itself as truth because of the law.

37. Sanction of this Bill as Law will decrease their chances of coming to terms with the issues of life and death values because a new value of life has been conditioned for the minds of future generations: one which accepts a right of choice, which may argue is not theirs to have. That argument will have been greatly weakened (not because *it* is wrong but due to the overpowering weight of legislation) by the resulting expectancy of lawful practice of euthanasia as a normal occurrence; resulting in further resignation of future generations to the law that it must therefore be right. for the terminally ill to take their lives. This practice of the law will diminish the reality of the existing awe in death.

38. the struggle for the positive values contributed by the wisdom's of ancient heritages through various religions will be even more difficult to achieve, and to be seen to exist, except in test-book references for those who wish to find them. We are not yet an extinct lifestyle. The basic tenets of our being today will never be diminished while there are people who carry within them those beliefs. but we will greatly diminish living witness to those beliefs very quickly if our values for life itself are in any way diminished and have community's sanction for this. Do not forget that our modernised life that we know has, greatly if not wholly been built upon the positive values of Christianity and church law beliefs enacted upon in parliaments. Do not forget that the institution of democracy as we know it in the Westminster tradition as we know *it* is not as old as these other contributing laws of wisdom. This tradition of democracy in the western world is our current lifestyle, the only one we know, and has a long way to go before it is three hundred years old. We will be introducing a radical change to its future development by what we decide in this Bill.

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39. Once this Bill becomes law, we will see greater numbers of people die by euthanasia than at present, even if it is being quietly practiced in our hospitals at the present time. When that option is exercised will there be anyone who will not opt for it or have it opted for them? Will this lead to the amendment of the law to disallow the option

to forego death before its natural time? This step is only one small step for man and one giant leap for mankind. We presently have a responsibility to the future of Australians still to come Do we envisage this as the beginnings of international population depletion? the "thin edge of the wedge" argument always remains possible once we give in to the "rights of others" as expressed in this Bill. It can only be accurately described as the "Slippery Slope" if the rate of change is not gradual throughout our times. But if the rate of change consequential to accepting this Bill is kept at a minimum (if this is possible), as in the evolution of the changing lands in continental daft theory, the term "slipper slope" is not valid in strict terms. However in loose terms it is corrected by the use of the term "Thin Edge of the Wedge". The results would still be the same, no matter how long it takes nor the name of the terminology; as a rose is still a rose if called by another name. Destruction of life is still destruction, whether we accept it or not, whether it legal or not. In this sense, let us be true to ourselves and to our community and to our children's' community and to their future children's' community. Let us call the acts of euthanasia for what they really are.

If we are prepared to not recognise the facts and their consequences we are deluding ourselves into innocence (if that is truly possible) by planned ignorance and wishful thinking; for the raising of this Bill does not allow is to be ignorant any Ionger We must decide. The objective wrongness of these acts can never make them objectively right. A deliberate decision requires we do more than close our eyes and hope for the best that everything will turn out fight. A deliberate decision requires we do more than close our eyes and hope for the best that everything will turn out for the best. We can only allow that to happen if we deliberate to do out best - yet this may not be enough because we are only human.

40 Dare we trust that future generations of our young practitioners will have the same degree of personal responsibility to the ethics of the medical profession?

41. We should have tighter conditions for their present activities preventing the arbitrary flouting of the life principle; not merely to censor their admissions to their past practice of euthanasia by to criminalise it, providing server penalties for those practising it and those who have practised it - even if we have to begin with anew crisis caused by a shortage of untainted medical practitioners and health carers.

42. Acceptance of this bill is acceptance of lower attitudes and expectations for our medical professionals. It is not the expression of work excellence! It should not be rewarded with payment. The cost of these practices should not be supported by government funding.

43. I fear the progressive groundwork towards solving problems of overpopulation, on child family policies of governments for population control, shortage of food

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worldwide and prospect of resulting dysfunctional selfish only child in family individuals opting to further their causes through the use of euthanasia.

Enclosed with submission:

Article entitled Euthanasia: One of my responses ..... Ivan Drummond,

Ned Kelly, by Ivan Drummond

Article entitled The Catholic Church and Euthanasia from Fundamentals of Catholicism,

Vol 1, by Fr. Kenneth Baker, S.J,

SUBMISSION 721 1

TO THE SELECT COMMITTEE

ON EUTHANASIA

I strongly support the introduction of the Rights of the Terminally Bill by the Chief Minister. I believe the concept of a democratic society springs from our placing the highest value on the rights of the individual. Passage of the Bill will ensure that each individual will have the right to determine that they either will or will not end their life.

Some people seem carried away with the notion that passage of the Bill will force them to elect Euthanasia if they become terminally ill! It simply protects doctors who elect to assist someone to end their life should the patient so **choose**.

I would also urge the Government not to allow the debate on Euthanasia to distract it from attending to the problems which exist through insufficient palliative care and hospice accommodation in **all** Northern Territory regional centres.

Yours faithfully

Joanne Selvey

SUBMISSION 722 1

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35 Asquith Ave

Wentworth Falls 2782

19.3.95

Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

Darwin N.T. 0801

Dear Committee Members,

I wish to add my voice to the plea to have your Euthanasia Bill passed. If yours is passed, then there could be hope for the other states to follow.

My personal reason for this urging is that my own brother shot himself to end his sufferings with what he apparently felt was some sort of dignity. He took his gun down the back yard to lessen the horribleness for his wife. His son had to identify what remained. Even the accompanying policeman had difficulty coping with this. After years of heart trouble he had emphysema and was rapidly deteriorating. He signed himself out of hospital and took action while he still could.

People in my brother's situation should have an easier way to carry out the choice they make. His wife and family should have been spared the horror of what he saw as his only way.

May your Bill be passed.

Sincerely

(Mrs) Shirley Jones

SUBMISSION 723 1

DR.EDWINA H.L. FELLOWS M.B.B.S. 5 Quinns Pde,

Mt. Eliza 3930

21st March 1995

The Select Committee into the

Rights of the Terminally Ill Bill

c/- Secretary, Ms Pat Hancock Legislative Assembly

GPO Box 3721

DARWIN NT 0801

Dear Committee,

As a medical practitioner who has been involved in the care of the terminally ill, I strongly oppose the Rights of the Terminally lll Bill for the following reasons:-

1. The terminally ill are one of the most vulnerable groups of society, beset with anxiety/depression about the future, the effects of their illness on their families, etc. This Bill would create a distinct pressure for those who already feel a burden to their families/society to end their lives for the good of all concerned. The potential for abuse by those who stand to benefit from the person's death must also not be minimised.

2. Medical practitioners must not be cast in the role of executioner. We must act to preserve life or when the time to die has come, facilitate a dignified death by excellence of palliative care, not a lethal injection such as one might give a "dumb" animal to put it out of its misery.

3. Such a Bill sets a dangerous precedent for involuntary euthanasia legislation to ensue. There are those within the medical/legal professions who are keen to see such legislation deal with the "problem cases" of disabled infants, the demented elderly, the comatose patient, etc. We do not want a society that in the name of compassion takes the lives of its most vulnerable members. Compassion needs a moral compass and euthanasia, whether voluntary or involuntary is a moral minefield.

I urge you therefore to reject this Bill outright.

I await your earliest reply.

Yours sincerely.

Edwina Fellows

Dr Edwina Fellows MBBS

SUBMISSION 724 1

20th March 1995 Vivienne Overton

62 Lynbara Avenue

ST IVES 2075

The Secretary

Select Committee on Euthanasia

Parliament of the Northern Territory

PO Box 3721

DARWIN N.T. 0801

Dear Sir,

I am writing to lend my strongest support to the bill to allow voluntary euthanasia in the Northern Territory. It would be a great comfort to many thousands of people (indeed, the majority of Australians, if the results of recent polls are to be believed) to know that somewhere in Australia we could die with dignity at a time of our own choosing without needing to find a doctor who is willing to break the law to assist us.

Committing suicide is only an option for people who still have the physical and mental capacity to help themselves. The decriminalising of assisted suicide would offer justice to people who clearly foresee that they would not wish to live AFTER they have lost the capacity to help themselves. At the moment even the existence of "living wills" is not enough to ensure that such a person can have confidence in the law not seeking retribution against doctors or loved ones who carry out their clearly expressed wishes with regard to their life (and death).

I and many Australians would rejoice in the courage and commitment to justice of the Northern Territory Government if they passed a bill to decriminalise voluntary euthanasia.

Yours faithfully,

Vivienne Overton

SUBMISSION 725 1

Chris McGibbon

2/7 Harris Street

Parramatta Park

Cairns, 4870

F.N.Q

Tel. (070) 511 401

Dear Sir or Madam,

I am writing in support of the Bill that was proposed by Marshal Perron. Recently my brother who was suffering from a terminal illness took his own life.

He was petrified that if he didn't do it when he did, that he would lose the capability to end his life. I feel with all my heart that Keith died too soon, that if this Bill was law then he would of been able to die with dignity in a controlled environment at some later stage of his life.

Instead he waited until I went away on holiday, mixed a lethal cocktail, placed a plastic bag over his head tied with an elastic bag and waited to die a slow & painful death. Can you imagine how I felt when I returned home to fine a horrendous smell of death that lingers to the present. I don't want to image how the person that found him felt.

Don't you see, it didn't have to be this way. I loved my brother with all my heart & I am so sad that I will never hear his voice again. Yet I am happy that he succeeded in what he wished to accomplish. Voluntary Euthanasia is precisely that - Life is precious and I do not image that people will be queuing at their doctors surgery to be put down.

Perhaps you feel I am being a little harsh -I think not, I watched two people I love die. My Dad died a slow agonising death in hospital and my brother died alone after carefully planning his exit, hardly a dignified finale. This is a democratic society and I feel that we have the right to choose, that if life becomes intolerable and the quality is less that what we expect for our selfs, then we should be able to make our own decisions in how our life should end. I have signed a living will & hope that if anything happens to me my memorandum of wishes will be upheld. Hopefully I will never need to utilise this Bill, only a few people will ever need it. These few should have the right to choose.

I have enclosed a letter that Keith wrote to many Politicians, right to the end he was fighting for what he believed in. I have now taken up his fight. Please read it and when you vote on this bill, vote with your conscience and don't let my brother down.

Yours sincerely

C McGibbon

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Copy of letter mentioned in submission.

Keith Kristi

1/352 Severin St

Cairns PH 313118

Dear Dr Clark

During the next year or so, I will die - Dying doesn't bother me at all but the way I die does - Left to take it's natural course, I will become a "rotting vegetable" with faeces, urine, blood and mucus oozing from various orifices. A small army of medical staff will have the soul destroying task of continually "cleaning me up" and prolonging a pointless existence - possible 100's of thousands of dollars - Obviously I've no intention of allowing this to happen - Because the Qld government feels I shouldn't be allowed to read it. I must sent to NSW for a copy of Derek Humphrey's "Final Exit" to get details of methods of suicide. I then have to lie to a medical practitioner to obtain appropriate medication (He knows I'm lying - I know he knows I'm lying - it's all so hypocritical) - When the times comes, I'll take the medication, put a thick plastic bag over my head, held with an elastic band (In case the medication fails - may then suffocate while unconscious) - Should anyone assist me they could face charges of murder - Doctors, families and friends frequently assist people to die - all could face prosecution for this compassion) - Hardly a dignified death and should I faith there will be a "trauma" of having to repeat the exercise - also the risks of brain damage or being left in a coma - and all because the medical trade and politicians will not face up to their responsibilities over this issue - Surely it would be much more civilised if I could have the assistance of a wiling professional who could give me the supervised means or even assist in ending a life which is no longer tolerable - Of course the first question a politician asks is "Is there a vote in it for me?" - in this case - there is - Approximately 80% of the population is in favour of voluntary or assisted euthanasia. Should you actually get to read this letter - please don't send me one of those standard cliche ridden replies full of insincere platitudes - Rather, use your efforts to see that the laws are changed to be more in keeping with this century and the next - and with the wishes of the Australian people.

Cheers Keith Kristi

SUBMISSION 726 1

21.3.95

TO WHOM IT MAY CONCERN

I support completely the Euthanasia Bill. I believe everyone should have the right to define and determine their own destiny and quality of life. When to say the suffering and degradation of a life through an incurable illness becomes unbearable.

If I were in a coma with no hope of returning to the world of really living, and if I did surface, to have severely impaired facilities, the mere thought horrifies me and frightens. It is akin to being buried alive.

The mass of the people are not going to misuse this proposed right and I am sure society will impose many checks and balances to ensure legitimate use of the practice of responsible euthanasia.

Sincerely

Loulanna Kave

2/7 Harris St

Cairns 4870

SUBMISSION 727 1

1 Kildare Street

HAWTHORN EAST, 3123

March 20, 1994

Dear Ms Hancock

I am writing to express my great concern and objection to the "euthanasia legislation" proposed for the Northern Territory.

This legislation affects all Australians.

Vulnerable, sick and elderly people are likely to be attracted to availing themselves of this "service". Those advocating this course of action say that it is 'voluntary', but where it is practised, about 40% of people are put to death without their consent. Moral standards, such as they are, are even more degraded. King George V. was put to death by his physician, who admitted what he had done.

How could any God-fearing. respectable persons allow themselves to be deluded in this way. What people need is excellent palliative hospice or home care. They deserve this and not a sentence of death. Please oppose the Bill.

Yours faithfully,

J.S. Murphy.

SUBMISSION 728 1

104 Buxton Street,

Deakin ACT 2600.

21 Mar 95

Select Committee on Euthanasia,

Parliament of the Northern Territory,

P.O. Box 3721,

DARWIN N.T. 0801.

Dear Secretary,

Permit me to put my point of view to you.

I find it totally unacceptable that a civilised society should legislate against the right of an individual to determine how and when he or she should die. And it is a sham to propagandise us at the same time that the rights of an individual are sacrosanct. I believe furthermore that the reasons for my choosing to end my own life are entirely my own business and the business of my family.

May I suggest that the Select Committee should be given the opportunity of visiting the terminally sick in a cancer ward It would be best if the members could see the patients who are dying of oral cancer. It would surprise me if the members remained unconvinced of the desirability of granting mercy to them in the shape of a speedy death.

Having seen four cases of terminal oral cancer, I assure the members that I know what I am talking about. In one particularly sad case the patient finally lost sight, speech, and ability to swallow. Understandably, I hope, I do not wish to dwell on these cases or upon others I have seen, but I assure the members of one more thing - they will need to draw on all their fortitude if they are to contemplate cases like those I have mentioned.

Yours sincerely,

Robert Story

SUBMISSION 729 1

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16 Holland Rd.,

Bellevue Hill NSW 2023

21 March 1995

Select Committee on Euthanasia

Parliament of the Northern Territory

PO Box 3721

Darwin N.T. 0801

Dear Sirs/Mesdames

I'm writing on behalf of myself, my husband and my parents. We all support the principle of voluntary euthanasia.

Both my parents are old and frail and I would hope that when I am in their position I will be afforded the dignity I deserve, that is, to die without having my life prolonged as a vegetable or suffering unnecessarily.

There is a lot of support in the community for voluntary euthanasia and I believe that it is simply unfounded fear and ignorance that prompts a minority of people to oppose the right of individuals to have control over their

deaths, as they do over their lives.

I am also concerned about voluntary euthanasia being considered a crime and believe it is a great responsibility and very daunting to have to decide whether to assist someone you love to die, or expect a doctor to defy the law, bearing in mind the costly price one would have to pay.

Consequently, we would like to see a legally controlled situation apply in the Northern territory and ultimately in the whole country, as it does in Holland and we urge you to please consider this bill in a favourable light.

Yours sincerely

(Mrs) Nizza Siano,

Arpad Green, Klara Green

and Max Siano.

SUBMISSION 730 1

Ph: 567 1542

3/30 Hercules Rd

Brighton 2216

N.S.W.

The Sec.

The Select Committee on Euthanasia

Dear Sir/Madam

I understand that he above committee are about to introduce a motion in parliament to legalise euthanasia.

Because of seeing a relative being kept alive when he wished to be put out of his misery and pain. I believe it should be persons choice how and when they should depart this life. Any bill to make this possible has my whole hearted support. I'm almost 80 yrs - and if and when I can no longer communicate with my loved ones, I would and should be able to terminate an unendurable existence.

Yours faithfully

(Mrs) G Howard

SUBMISSION 731 1

19/25 The Glen Rd

Arncliffe 2205

19/3/95

To the Committee,

I would like you to know that I fully support controlled Euthanasia 100%. I have an 83 year old sister in a Nursing Home, and it is pitiful to see the gradual decline of a once intelligent and gifted person, through the course of Alzeimer's Disease. I am very firmly of the opinion that providing the way for someone to pass on is the only way,

and should not be considered against the law. I have signed Advance Directives etc, but I suppose whether this is carried out depends largely on the Dr's views on this matter. I think it should be a person's right (in the case of pain and suffering and eventual death in any case) to have some say in the matter. I watched the television program from Holland, and I think the whole exercise was carried out very properly and calmly with no fuss and also with a quick dignity. I know that is the way that I would like to go if necessary.

I sincerely hope that we can achieve success in this very worthy and crucial matter.

I am

Yours sincerely

(Mrs) E.R. Wearne

SUBMISSION 732 1

21.3.95

Select Committee into

Rights of the Terminally Ill Bill

c/o Secretary: Ms Pat Hancock,

Legislative Assembly

GPO Box 3721

Darwin NT 0801

Dear Ms Hancock,

No state operates in isolation, and so if this Bill becomes law in the Northern Territory it will effect every Australian.

As an Australian citizen I wish to register my total opposition to the Bill, which if passed, will make your State a place for some to visit - as a place to die.

It will also lead to the eventual treatment of our most frail and vulnerable citizens as being of no value - note well the results in Holland where a large proportion of euthanasia victims are now being "put down" without their consent.

I ASK YOU TO OPPOSE THE BILL.

Yours sincerely,

Susan Robertson

SUBMISSION 733 1

ST. FRANCIS XAVIER'S PARISH

P.M.B. 28 DALY RIVER N.T. 0822

PHONE: 089 782 449

NAUIYU NAMBIYU

DALY RIVER NT 0822

Select Committee on Euthanasia

Northern Territory Legislative Assembly

GPO Box 3721

DARWIN NT 0801

TO WHOM IT MAY CONCERN

RE RIGHTS OF THE TERMINALLY ILL BILL

We the undersigned would like to make the following submission to each of the members of the Select Committee on Euthanasia.

* Mr Perron putting forward this Bill has done so, as he says, because he feels so deeply for the terminally ill, having witnessed and suffered at the deaths of his own parents. Is it his or his parents' suffering that has urged him to table this Bill? We affirm the importance of a deep and abiding compassion, especially for those who are in the final stages of life. The language of rights and self-determination frequently alters the meaning of compassion which is entering into and sharing the suffering of another, to that of pity which is evincing sadness over the suffering of another who is left to bear the pain alone.

* Killing people to relieve their pain conveys the impression that they are being regarded as we would regard animals.

* The severely sick are prone to wide fluctuations of mood and often become depressed. They may express the wish to die at one time but feel quite differently at others. It would be dreadful if medical practitioners were on hand to kill them when they were feeling "low".

* The terminally ill **DO** have rights and these include the right to good palliative care. It would serve the community better if the Government (Federal and State/Territory) were to spend more money in educating doctors and nurses in the advancing area of palliative care and even more money in the application of this care to the terminally ill. We agree with the opinion of the Select Committee on Medical Ethics of the British House of Lords:

Despite the inevitable continuing restraints on health-care resources, 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. Such a responsibility is costly to discharge but is not one we can afford to neglect.

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* We do not agree that the terminally ill doctors, or anyone else for that matter has the right to determine when or how he/she will die. However, as Doctor Brian Pollard states in his carefully researched book *"The Challenge of Euthanasia":*

In medical ethics, a genuine right to die is a right to be allowed to die, and refers to one's right to receive proper treatment when one is dying. This means that people should be allowed to die when they are dying and should be given all necessary comfort and not have their dying prolonged or impeded. When a right to die is claimed in support of euthanasia, what is meant is something different. The same words are now used to mean a right to be killed on request, and a right of another person to kill when asked. It can be seen that this is both a misuse of language and a mistaken concept of rights, since there is no right to be killed by another person nor any right to kill on request. Such claimed rights have never appeared in any code of ethics or law, and no argument is ever produced to justify them. It is therefore unreasonable to expect the law to be changed to protect rights which do

not exist.

* There is always the possibility that doctors have erred in their diagnosis. If assisted dying is to be legalised, the burden of responsibility on doctors would be enormous and unfair. There is no margin for error once the person has been "killed" - euphemistically referred to as "assisted to die".

* The practitioners are as human and as able as others to fail in their duty or to act under duress. This is made evident by the provision of penalties in the Act under discussion.

The penalty for improper conduct of $20,000 or imprisonment for 4 years seems rather inappropriate when a life is at stake and that life could have been terminated "by deception or improper influence".

SIGNATURES:

Signed by 80 residents of Daly River

SUBMISSION 734 1

N & P Oliver

Nauiyu Nambiyu

PMB 28, DALY RIVER

N.T. 0822

23rd March, 1994

Select Committee on Euthanasia

Northern Territory Legislative Assembly

GPO Box 3721

DARWIN NT 0801

TO WHOM IT MAY CONCERN

RE: RIGHTS OF THE TERMINALLY ILL BILL

COMPASSION-YES/PITY-NO. PLEASE DO NOT TREAT OUR TERMINALLY ILL AS IF THEY ARE ANIMALS TO BE PUT DOWN.

PLEASE GIVE US MORE MONEY FOR EDUCATING DOCTORS AND NURSES IN THE AREA OF PALLIATIVE CARE.

PLEASE SPEND MONEY ON HOSPICES SO THAT THE TERMINALLY ILL HAVE A CHOICE AND DO NOT FEEL THEY ARE A BURDEN ON THEIR LOVED ONES.

PLEASE CONSIDER HOW ALL LAWS & RESTRICTIONS WHICH APPLIED IN THE NETHERLANDS HAVE NOW BEEN ALTERED AND MAGNIFIED.

PLEASE CONSIDER THE FEAR THAT IS EXPRESSED BY THE OLD IN THE NETHERLANDS.

PLEASE REMEMBER HOW ABORTIONS WERE ORIGINALLY TO PROTECT THE LIFE OF THE MOTHER AND OTHER VERY GOOD REASONS. - NOW IT IS BEING USED AS A CONTRACEPTION IN SO MANY CASES -

PLEASE CONSIDER -BILLS TO TERMINATE ANY LIFE WILL ULTIMATELY LEAD TO THE TOTAL DESTRUCTION OF A CARING SOCIETY.

MAY YOUR GOD GO WITH YOU IN THIS DECISION.

N Oliver

SUBMISSION 735 1

Ms E M Wells

Unit 2/898 High St Rd

Glen Waverley Vic

19th March 1995

To the Select Committee

into the Rights of the Terminally Ill

Dear Sirs/Madams

I don't think anyone should choose when they are going to die.

It opens a very messy situation.

I don't believe in corpus's, kept alive medical science - should heal or relieve pain (this may kill). But active euthanasia, assumes people know what they are doing - there is no second chance people could change their mind.

Every human life is valuable, alleviate pain and suffering by all means. My own mind feels terrible when my body is sick but when I am not in pain, I feel goof.

God gave life - he takes it.

I blame medical science for a lot of misery in old age. It keeps bodies alive when they should be in the ground .

People should have a right to say NO to useless medical treatment.

SUBMISSION 736 1

Allen & Betty Wilson

25 Barker St

Cambridge Park

NSW 2747

047 218536

Dear Committee,

We support voluntary euthanasia and want to see it legal. My first husband died shocking death paralysed from neck down from multiple schlorosis and lingered for 3 years unable to do anything and couldn't end his own life, also watched family members die agonising death from bowel cancer, lung cancer and my 87 year old mother fell and broke hips, severe diabetic, blind and crippled lasted 11 months in a nursing home and wanted to die all the time. My husband is almost bed ridden now. 72 years, severe emphysema and bronciestas heart attack 5.1.95 and

no quality of life. I am 62 diabetic and severe rheumatoid arthritis so haven't much to look forward to. Have books final exit but hope don't need to use it. Good luck with your submissions. I hope it will soon be legalised all over Australia very soon. You may use this letter any way you feel may help.

Sincerely Betty Wilson

SUBMISSION 737 1

Rights of the Terminally Ill Act 1995

To the Select Committee on Euthanasia

It is my opinion the above mentioned Bill should be passed and made law.

There has been much made of the opinion that members should have a conscience vote. I agree it is a matter of conscience as to whether one takes advantage of the matter contained in the above mentioned Bill.

However my concern is that should the Bill be defeated, then only those who are opposed to the Bill have had their conscience vote. If the Bill is passed then all may decide as their conscience dictates and they take advantage or decline the opportunity to relieve their suffering should the need arise.

I cannot see how any elected member could possibly vote against the Bill and feel that he/she has represented his/her electorate fairly.

Gladys Garton

PO Box 221

Humpty Doo 9836

signed

G M Garton

SUBMISSION 738 1

PO Box 43263

CASUARINA NT 0811

March 22nd 1995

The Chairman

Select Committee on Euthanasia

GPO Box 3721

DARWIN NT 0801

Dear Sir,

Firstly, I write to commend the Hon. Marshall Perron MLA for introducing such a Bill which I feel the silent majority of the NT's population see as being a subject that has to be addressed.

I agree that a choice for euthanasia should be available to all citizens. This of course doesn't compel people to use this service.

I would also like amendments made to the effect that consideration be given for a situation where, as the result of a serious car/work accident, the person is virtually kept alive on life-support machines. If the person concerned had in fact advised family that if this situation ever arose in their life that the option of euthanasia be in fact used. In other words, if I had told my husband I didn't want to be a vegetable and if it was also noted in my will, then he should be able to sign the consent forms for termination of life.

The proposal "the patient must ask in writing for assistance to hasten death" would be impossible under the circumstances above. This could be open to abuse as have been mentioned via the media blow-out on this euthanasia issue. But, if it could be proved that the couple concerned are a very close loving couple by several character witnesses who would indeed not profit by the termination then I feel this should be taken into consideration. At the moment families make the joint decision to turn off life support machines when there is no hope of recovery and this I believe should encompass the right to euthanasia.

A further comment that disturbs me is that our L.A. members may vote on this issue by a conscience vote. I believe this situation doesn't in fact reflect their own electorates. Members should vote according to the majority voice in their electorates or else resign as they aren't in fact representing their voters.

On religious grounds, euthanasia is in fact against all religious teachings but I feel in the end every choice and decision is in fact between you and (your) God. May God grant the Assembly the guidance to make the right decisions on this important issue and not give into minority groups pressure.

Yours faithfully

(Mrs) C Burnett

SUBMISSION 739 1

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48 Ferry Ave.

Beverley Park NSW

2217

21st March 1995

The Select Committeee on Euthanasia

Parliament of the Northern Territory

PO Box 3721

Darwin N.T. 0801

Dear Sirs/Ms.

I write to you in support of the legal voluntary euthanasia bill now referred to your Committee.

I present to you the case of my late brother who was born in April 1910 and died on the 19th June 1991. At the age of 2½ years he developed polio and from then on he was confined to a wheelchair with the use of only one hand and weakened spin muscles. Despite this he achieved remarkable independence. He had an alert mind, was outgoing and had many friends. For the last 15 years, because his body weakened and osteoarthritis set in he lost his ability to dress himself, was confined to a nursing home and even lost the ability to use the remote control to his T.V. or move any part of his body. Consequently his skin broke down and despite nursing care, he developed large bed sores and ulcers. His mind still was very alert and he requested his doctor to help him end his life, but the doctor had to tell him he couldn't do this.

My brother then decided to refuse food and would only take a small drink of water. This continued for about 6 weeks and he suffered great stomach pains as well as pain from the ulcers and arthritis.

He eventually had haemorrhage from a stomach ulcer and he begged my and the other members of his family to request the doctors at the hospital to which he was sent to stop the blood transfusion etc and so let him die. Thankfully after persistent persuasion from us, treatment was withdrawn and his life ended.

I always had great pride in my brother's courage and attitude to life, and I resent that after 78 years in a wheelchair, he had to go through great suffering at the end of his life.

I therefore hope sincerely that the present bill before your Parliament be passed, - V.E. be legalised throughout the country eventually.

(Mrs) Betty Hawkes

SUBMISSION 740 1

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3 Byrd Ave

Kingsford

21-3-95

The Secretary

Select Committee on Euthanasia

Parliament of the Northern Territory

Darwin

Dear Secretary

I would like to state that my husband and I are in favour of Voluntary Euthanasia.

We have been members of Vol. Euth. for many years and we have now reached the ages of eight one and eighty five. We have no desire to end our lives in a vegetable state, lasting indefinitely or in a painful state where there is no pleasure in living.

My own sister tried to commit suicide after six years of struggle with cancer. Unfortunately she was revived after being found in a coma and it was a very traumatic time for her until she eventually died after seven years of stress and strain.

Thanking you

Yours sincerely

Dorothy McCawley

SUBMISSION 741 1

R J William Lodge

274 Glebe Pt Rd

Glebe 2037

To,

The Select Committee on Euthanasia

I wish to express my feelings about euthanasia.

To let a person suffer when nothing can be done for them, is to me uncivilised.

Therefore I support the Bill sponsored by the Leader of the Government of the Northern Territory.

Mary Lewis

SUBMISSION 742 1

PO Box 8130

Bargara

Qld 4670

20-3-95

The Select Committee on Euthanasia

Parliament of the Northern Territory

PO Box 3721

Darwin

DARWIN 0801

I wish to express my support for the legalization of voluntary euthanasia (under clearly defined conditions and with proper controls) and I sincerely hope that this committee will recommend legislation which makes this a legal act.

I believe that I have the moral right to terminate my life if physical or mental suffering from a terminal illness becomes very severe.

I believe that a doctor who has the compassion and bravery to assist me in such an act should be praised whereas the present law would brand him a criminal.

I hope that in the deliberations of this committee, compassion and common sense will win over the self-righteous opinions of the right-to-lifers.

Voluntary euthanasia will become legal before very long and I hope that the parliament of the Northern Territory will lead Australia in this respect.

N. E. Lancaster

SUBMISSION 743 1

PO Box 8130

Bargara

Qld 4670

20-3-95

The Select Committee on Euthanasia

Parliament of the Northern Territory

PO Box 3721

Darwin

DARWIN 0801

I sincerely hope that the deliberations of this committee result in legislation which legalizes voluntary euthanasia.

I believe that I have the moral right to terminate my life when and how I wish to do so and if circumstances arise such that this is necessary in order for me to escape from the pain and indignity of a terminal illness, I will most certainly exercise this right whether it is legal or not.

I think that such an act on my part should be legalized in order to save relatives and friends from any anguish or embarrassment resulting from my act of escape. I would also hope that the legalizing of voluntary euthanasia (under strictly controlled conditions of course) will eventually lead to a doctor being allowed to assist in such a merciful act.

(Mr) Blair K. Alldis

SUBMISSION 744 1

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40 Orient Avenue

Orient Point

N.S.W. 2540

March 21st 1995

Select Committee on Euthanasia

Parliament of the Northern Territory

PO Box 3721

Darwin NT 0801

Dear Sir,

I made up my mind that Voluntary Euthanasia should be possible many years ago when as a young woman along with my family I looked after my father for three years who, from being a vital man of 49 was reduced by a stroke to being a totally dependant invalid, paralised and no hope of recovery, who wished for death every day until his release by pneumonia.

I have had a stroke myself five months ago but still have great quality of life but if I lose that and am a burden to myself and my family I feel very strongly that I should have the legal right to have medical help to end my life.

Yours Sincerely

Anne L Adams

SUBMISSION 745 1

"The Granary"

25 Miller Ave

Rosedale 2536

The Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

Darwin NT 0801

Dear Committee Members,

I write to give my strongest support to the bill supporting Voluntary Euthanasia.

The situation in Holland with freedom to decide one's own fate is one which I think we should copy and certainly is much easier for the medicos and the families of the people who wish to die with dignity.

Yours sincerely

(Mrs) P.A. Newton

SUBMISSION 746 1

"Kiri"

Apple Tree Flat

via Mudgee NSW

2850

20-3-95

Select Committee on Euthanasia

Northern Territory

I am in favour of Voluntary Euthanasia. When in a case of terminal illness medical assistance instead of easing the burden of a vegetable existence prolongs the agony with no hope of any improvement, is to my mind cruel and unjust. In my case (elderly but in reasonable health) it would be comforting to know a terminal illness would be dealt with, with compassion.

I have known elderly people who instead of existing in a helpless condition would welcome deliverance.

I have held this view for many years and have not been at all impressed by the arguments put forward by those against Voluntary Euthanasia.

Yours sincerely

James F Prince

SUBMISSION 747 1

Villa 92,

Bayview Gardens

36 Cabbage Tree

Bayview 2104

21st March, '95

Select Committee on Euthanasia,

Parliament of the Northern Territory,

P.O. Box 3721

Darwin. N.T. 0801.

Over forty years ago my mother told me about the Voluntary Euthanasia Society. She was worried about a lingering, painful death. She was fortunate. When she was dieing from cancer she had been given morphine for only a few days before she died.

About ten years ago I became a life member of the Voluntary Euthanasia Society in the hope that when it is my time to die, if I need help to die with dignity, it will be possible to have that help legally.

I do not mind the Right-to-life people having their own beliefs and being anti voluntary euthanasia. I do mind them inflicting their views on me.

Yours faithfully,

Deirdre Schimmel

SUBMISSION 748 1

Ms V M Long

23/2 Birkley Road

Manly NSW 2095

Wednesday, 22 March '95

The Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

DARWIN NT 0801

Dear Sir,

Re: Voluntary Euthanasia

I support the view that people should have control over their deaths with dignity, as they had over their lives. The Medical Profession should be empowered to assist an individual upon his or her request to terminate their lives in the face of enduring any future impossible situation involving extreme or severe pain with no likelihood of recovery.

I, for one, will be ending my own life when I can no longer look after myself and become, in my opinion, an

unnecessary burden to both myself and society. My life is my responsibility!

I have been in a critical death and dying situation myself. The Medical Profession provided every opportunity for me to live and I did. I was unconscious, in intensive care. In this situation in which I had no conscious say, I am very pleased it was in the hands of the Medical Profession to think for me. Otherwise, I believe in the right of a conscious decision to be made in law by someone dying and assisted by the Medical Profession.

Thank you,

Yours faithfully

V M Long

SUBMISSION 749 1

21-3-95

14/26 Orchard St

W. Ryde N.S.W.

2114

Ph. 8073474

Dear Sir,

Through personal experience I have seen several very close friends and relatives die without dignity and have witnessed the tribulations and suffering the friends and relatives have gone through.

First was my sister who was very close to me. She could not talk, feed herself, toilet or wash herself and wrote on my hand. Please let me die.

The second one was my brother who had war injuries and ended up with a gangrene leg. It caused him to scream with pain and was very hard to handle for the family. He eventually died in a hospice in Burwood. The staff were very kind to him and us.

The third was my husband who for 12 months before he passed away used to sit in bed and begged God to let him die. All the medical staff could do was to keep on reviving him. He looked so in peace when he eventually passed away. I will always think of him that way. We had been married for 50 years and though I still miss him terribly I know he is at peace.

I could tell you of many more cases but I think it states my case for V.E. enough.

Yours sincerely

Mrs Daphne Young

SUBMISSION 750 1

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104 Buxton Street

Deakin ACT 2600

22 March 95

The Convener,

Select Committee on Euthanasia,

Parliament of the Northern Territory,

P.O. Box 3721,

DARWIN NT 0801.

Dear Convener,

This is a plea to your Committee to make provision in the law for terminally ill people to have their wish granted to die with dignity.

Here are the outlines of just three cases in our circle of friends:

1. Pauline from breast cancer. The disease spread to internal organs. She asked to die but was given more drugs.

2. Mavis from uterine cancer, spread to other organs, eventually to the liver. She should have died six months earlier. New drugs were a disaster and she died in agony.

3. Don, from throat cancer, spread to stomach and liver. He wasted away in agony.

Yours sincerely,

Mrs S. F. Story

SUBMISSION 751 1

(Mrs) Rhonda Taylor

12 Dandenong Road

Terrey Hills NSW 2084

22 March 1995

Select Committee on Euthanasia

Parliament of the Northern Territory

Box 3721

DARWIN NT 0801

Dear Sirs and Madams

I wish to register my heartfelt support for the Bill presented by Marshall Perron. I believe that it is imperative that Australians be given the right to seek the assistance of their medical practitioner if and when the time comes that they have no quality or purpose of life, and no treatment can be administered to correct this. Surely this decision should be the right of each individual patient, and we should not be forced to live (or to suffer) under belief systems held by others in our community. As a supporter of voluntary euthanasia, I ask only that I have the assurance that I can die with dignity, if necessary with the legal help of my doctor and at the time of my own choosing. As the call is for *voluntary* euthanasia, no patient or doctor would be forced to take part in such a situation, whereas opponents of this Bill seek to impose their personal values on the rest of our society. We in this "lucky country" have a good life, and it would be great to be assured of a good death as well! Careful legislation could ensure this for future generations of Australians.

Let me never again witness a scene like the agonizing last few days of my aunt who, aged *85* and within days of

dying of complete kidney failure, and in terrible pain with a stomach infection, was denied adequate pain because the resident doctor pointed out that "further morphine could affect her breathing and she could die". This lovely, genteel lady died after calling out piteously for release for two and a half days...

I hope that you will have the foresight and courage to show the way.

Sincerely,

Rhonda Taylor

SUBMISSION 752 1

21/3/95

To whom it may concern;

This letter is to confirm my support of voluntary euthanasia. As a nurse I have seen much unnecessary suffering and distress caused by law abiding (and court fearing) doctors and nurses who are pressured to do anything rather than nothing when confronted by a no win situation (death)., Their ethical codes state that they must "do no harm", however by prolonging a persons suffering (life) and/or denying them their wishes this is indeed what they are doing. Palliative care does not support euthanasia so it is not suitable to everyone. If the law supported us we could then support our patient's final wishes. Individual religious beliefs are precious but should never be forced upon everybody. Death is a part of the life cycle that should never be legislated by any government. Choice is all we ask for, after all suicide is not illegal so why should voluntary euthanasia be illegal?

Yours etc

W Wilson

W Wilson

17 Nowland Way

Bradbury NSW 2560

SUBMISSION 753 1

RATIONALIST ASSOCIATION OF NEW SOUTH WALES

58 Regent Street,
Chippendale N. S.W. 2008
22nd March, 1995.

The Secretary,
Select Committee on Euthanasia,

Parliament of the Northern Territory

P.O. BOX 3721

Darwin N.T. 0801

Dear Sir/Madam,

It has been the longstanding policy of this Association to support voluntary euthanasia. Some members have witnessed loved ones suffer great pain, for long period, for no avail. We have heard their pleas for euthanasia to

allow their peaceful, painless, inevitable demise. But of course up to the present it has been illegal to fulfil their just, individual liberty.

One person's freedom finishes where another person's rights begins. A person does not have the right to deny another person's freedom - where that person's freedom does not affect the rights of the denier.

Claims of authority of scripture are irrelevant as our governments are of secular nature. Furthermore, authority of scripture cannot withstand the rigours of validity testing philosophy, science and commonsense.

In the unlikely event that the majority of the population do not approve of voluntary euthanasia, it also is irrelevant as the rights of the minority have to be protected. It is the duty of government to decide legislation on their merits i.e. what they consider the best for society and the individual. It should not be decided by response to scare tactics.

Thanking you for this opportunity to participate in an important decision.

Yours faithfully,

Peter Hanna.

Honorary Secretary.

SUBMISSION 754 1

Not a miserable letter but a happy card from a 70 year old woman who hopes that your bill will be successful, that all Australia will follow your example, and VE will be available to me should I need it!

Sheila Mason

37 Dunoon Ave

Pymble

NSW 2073

SUBMISSION 755 1

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78 Alawa Crescent

AI.AWA N.T. 0810

The Chairman

Select Committee on Euthanasia

Legislative Assembly of

the Northern Territory

Dear Sir,

I would like to take this opportunity to express my support for the Private Members bill introduced by the Chief Minister.

I believe that the crux of this matter is that the passage of the bill will for the first time give the people of the NT a legal choice.

What I do object to is the current situation where the wishes of others are forced upon me. I believe that the choice

should me mine.

I believe that voluntary euthanasia should be a matter of personal choice and would urge that the Committee advise the Legislative Assembly that the bill should be passed.

yours faithfully,

Rae Standish

SUBMISSION 756 1

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78 Alawa Crescent

AI.AWA N.T. 0810

The Chairman

Select Committee on Euthanasia

Legislative Assembly of

the Northern Territory

Dear Sir,

I would like to take this opportunity to express my support for the Private Members bill introduced by the Chief Minister.

I believe that the crux of this matter is that the passage of the bill will for the first time give the people of the NT a legal choice.

What I do object to is the current situation where the wishes of others are forced upon me. I believe that the choice should me mine.

I believe that voluntary euthanasia should be a matter of personal choice and would urge that the Committee advise the Legislative Assembly that the bill should be passed.

yours faithfully,

Peter Standish

Phone: 350 2681

SUBMISSION 757 1

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90 Grandview Avenue,

Pascoe Vale South, Vic. 3044

Phone: 350 2681

22 March 1995.

I am writing to you to request you to use the power that is yours to oppose the proposed euthanasia legislation for the Northern Territory.

Each one of us has a duty to care for others. No "playing God" by our leaders can avoid this responsibility. Even the human consequences of this ruling should be sufficient to deter thinking leaders from such legislation. I refer to

the situation in Holland which I am sure you are aware of.

Moreover doctors are supposed to nurture and protect life. If this law is brought in we need a new group of registered executioners to perform the task - not doctors.

I am alarmed at the devaluation of human life inherent in this proposed ruling. As a consequence I urgently ask you to oppose the Bill.

Sincerely,

Sr. Marina J. Handley,

B.A. - M.Ed. University of Melbourne.

SUBMISSION 758 1

A C Gardiner

P O Box 646

Leeton NSW

21-3-95

My wife Gladies Mary Gardiner passed away on Monday 17th of January '94 at 3.3am at St Vincents Hospice. My wife died with needless pain the undignified death I have ever seen. I've seen cats and dogs put down at the vets with dignity. I've seen seven members of my family pass away some with cancer, they never had the pain my wife had mainly because Gladies's cancer was into the bone. I believe there is no drug that can stop that pain. I also think if the people opposing the Voluntary Euthanasia had love ones die in very bad pain, if they were anywhere human they would want it. I would like to write more, no time. Thank you.

Yes to Voluntary Euthanasia.

Tony Gardiner.

SUBMISSION 759 1

"Salspur"

Maitland Vale

N.S.W. 2320

Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

Darwin N.T. 0801

Dear Members,

My husband and I wholeheartedly support legislation which will provide people with the legal right to seek and be given the means to end their lives if that is their wish.

As Tony Wright says: "Isn't it time that, as a community, we supported our doctors and shared the load of

responsibility, taking away from them and their patients the sense of an illegal "hole in the wall" activity?

Let society face up to the facts and allow patients to ask, and individual doctors to agree or decline, without the stigma and threat of breaking the law.

I have just lost my mother aged ninety to the cruel and painful ravages of cancer. She was fortunate in being cared for in her last three weeks in a palliative care hospital but even so, the day before she died she asked me would I bring in to her "all those tablets in the cupboard" so that she could "finish them all up - and me too!" My reply was that I wouldn't know what effect that would have and might only make her feel worse.

I hope that someone else did what I couldn't and gave her relief from pain.

Yours faithfully

P.A. Bore

SUBMISSION 760 1

49/3 Hornsey St

Rozelle 2039

March 20th '95

Dear Committee,

This letter is to give my honest and sincere support to your proposed bill for voluntary euthanasia.

I strive in my life to live with honesty and truth. I desire to be able to die in the same way, legally.

To be asking Doctors to take the responsibility - maybe - is most unjust.

And the thought that in extremities one might not be able to find such a doctor, that thought horrifies me.

I add my voice to yours, in sanity, truth and honesty, let us vote for Death with Dignity.

Sincerely,

Christine Beaumont

SUBMISSION 761 1

Unit 77, Nazareth Village,

74 Tills Street

Cairns, Q. 4870

20th. March, 1995

The Select Committee on Euthanasia,

Parliament of N.T,

P.O. Box 3721,

Darwin, N.T.

Dear Sirs,

I am writing to express my wholehearted support for the Bill recently introduced in Parliament to enable terminally ill people to request assistance in ending their lives on request.

I have been a nurse for the greater part of my life. I shall never forget the first time I had a request from a patient who was in constant agony and terminally ill. He said to me, 'If your dog was in the condition I am you would have it put down to end its agony, but because I'm a human I am expected to put up with agonising existence'. I was shocked and very upset and could not sleep that night.

Since then I have had many similar requests and felt a coward that I could not risk my freedom to comply with any of these requests.

For myself the terrible indignity of being dependant on other people for the everyday things of life would be for me sheer Purgatory.

I am a member of the Cairns Branch of The V.E.S. and together with my fellow members applaud Mr. Marshall Perron for introducing such a Bill.

Yours sincerely,

Mrs. Helen Pansini

80 yrs. old.

SUBMISSION 762 1

Select Committee on Euthanasia

Parliament of the Northern Territory

PO Box 3721

Darwin

N.T. 0801.

Fax: 089--816158

20-3-95

I, petitioner Karen Williams, support the Euthanasia Bill has been proposed by Marshall Perron.

Recently a close friend of her brother was terminally ill and took his own life. I feel that he could still be alive today; instead he was afraid to delay in taking his life and his fear of further debilitating illness which possibly caused a painfully 'botched-up job'. The risk was to secretly wait till the last days and lose the ability to carry it out successfully. Instead, he preferred his choice of life and death to perform in a competent and dignified manner but had to forfeit his family being around at the end because of legalities interfering with his planned death.

Death is never timely, yet in such tragic health circumstances, a person should be able to choose their own time which suits, and in regard to their immediate family.

Yours sincerely,

Karen Williams.

SUBMISSION 763 1

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14 Bandicoot Drive

BLACKBUTT NSW 2529

20 March 1995

Select Committee on Euthanasia

Parliament of the northern Territory

PO Box 3721

DARWIN NT 0801

Dear Sirs

Having retired 35 years on the road with the NSW Ambulance Service during which the Services assessed I had attended between 50000 and 60000 emergency and accident calls I must write in strong support Voluntary Euthanasia.

Cases come to mind where with our modern skills and Paramedic training we revived patients suffering horrific injuries only to cause them and their families prolonged pain and suffering as medical science fought to keep them alive many times only to exist as a vegetable. One such case was a man who 'lived' for seven weeks as a vegetable then died again. The suffering that family endured made me regret that I had resuscitated him. Another was a 15 year old youth found in the surf at a Sydney beach and after an unknown time of immersion was resuscitated by lifesavers, Ambulance officers and Paramedics. The last time I saw him he had been living as a vegetable for 4 years in Prince Henry Hospital the stress and trauma causing the parents to divorce and the whole family broken up.

My own son suffered severe brain stem damage in a motorbike accident at the age of 19. He is now 29 has not been capable of working since the accident will never marry or have children and is easy prey to gangs and thugs when he shuffles along the streets. Or the case of an overdose of drugs by an addict who inhaled vomit and severely damaged his lungs - brain dead occupying a bed in intensive care at enormous cost a day and will remain in that state until he dies.

There are many such cases I have attended and to me the quality of life is of paramount importance - not a life full of pain, suffering and emotional trauma for the patient and his family. As my wife says - we show much more compassion to our animals by putting them down when they are suffering than we do to our beloved families.

In many cases euthanasia can only save enormous suffering and mental trauma for the patient and those that love them.

Yours faithfully

B H PURDY

SUBMISSION 764 1

PERSONAL

'Phone 54 2610 69 Wirrah Close

Area Code (070) Bayview Heights

Date 20/3/1995 Qld., 4868

THE SELECT COMMITTEE ON EUTHANASIA

PARLIAMENT OF THE NORTHERN TERRITORY

P.O. BOX 3721, DARWIN, N.T., 0801.

Dear Sirs and Ladies -

I the undersigned, support the cause of voluntary euthanasia on demand, subject to reasonable control, for the following reasons:-

(1) In a Democracy, which we in Australia are supposed to live under - we have The inalienable RIGHT to decide when we shall depart this life. NO other person or Group should be permitted by Law to deny: the individual this DEMOCRATIC BASIC RIGHT. (Perhaps Democratic Law requires an "overhaul"?)

(2) Being 80 years age next August 2nd., I have extremely strong personal feelings on the subject. What right have the "Right to Lifers" to decide MY fate, because of THEIR beliefs? [It's a FACT that Johanne Wolfgang Von Goethe -the famous writer and philosopher stated last century -"belief is the end of rationality"]. I am a medical researcher, and can assure you that the pain people endure in certain circumstances - even 'though they may be "believers" seek death as a Friend - a release from such agony as only the Malleus Malificarum could describe - The agony those against Voluntary Euthanasia would inflict upon suffering humanity, is little different to that inflicted upon innocent people in the fifteenth century, during The Inquisition.

(3) It should be clearly understood by the Members of the Committee, that the sheer Power of irrational "believers" who make a big noise and have Bills passed or defeated, has no relation to the SILENT MAJORITY" who also vote.

(4) In the event your Bill is passed, you will go down in history, as the Group who stood up to the "irrationals", and brought TRUE DEMOCRACY to at least ONE State in our beautiful Country.

VERY TRULY YOURS -

CORDIALLY,
Jack Fearnley

Director SCISEARCH INTERNATIONAL- a self funded non-profit Organization, up-dating modern technology (especially medical) for the benefit of people everywhere.

SUBMISSION 765 1

21-3-95

To Select Committee on Euthanasia

I write in support of the Bill for Legal Voluntary Euthanasia. It is unjust that doctors who wish to assist the death of their patients at their request should not legally be allowed to do so.

Holland has laws that allow this. Such laws are sane, humane and mature.

(Mrs) Carol Hudson

6 Tenterfield St

Concord West

NSW 2138

SUBMISSION 766 1

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41 Station Road

Oxford NSW 2508

22/3/95

The Select Committee on Euthanasia

Parliament of the Northern Territory

As a chronic sufferer of ill-health for many years I welcome your intended legislation and would hope that it will be followed by other legislatures around Australia.

In recent years I and my wife have seen several of our friends suffer unnecessarily and would wish that it need not be so. As long as certain safeguards are written in to legislation and as long as the termination is at the express wish of the user euthanasia seems a necessary part of the "quality of life" movement.

I find it objectionable to implicate my doctor - a most caring person - to the possibility of criminal charges when my time has come!

Yours faithfully

Jack W Beeching

SUBMISSION 767 1

Box 69, PO

Armadale, Vic. 3143

22.3.1995

The Select Committee

Into the Rights of the Terminally Ill Bill,

C/o The Secretary,

M/s Pat Hancock,

Legislative Assembly,

G.P.O. Box 3721

DARWIN N.T. 0801.

Dear M/s Hancock,

The enclosed verse expresses everything I wish to put before the Select Committee dealing with the above Bill, requesting that it not be passed.

Thanking you,

Yours truly,

MARIE PRINCE

THE TERMINATORS

THEY TERMINATE A PREGNANCY WITH MOTHERLY CONSENT

BY SUCTION, SALINE, CRUSH TECHNIQUE- THE END, QUITE PERMANENT.

NO MORE SMALL FEET OR BEATING HEART, MATURING TO FRUITION -

BUT WAIT! "A BLOB OF TISSUE" IS THE EXPERT DEFINITION.

IT'S THEREFORE NOT YET HUMAN - SO IT'S NOT INFANTICIDE -

EUPHEMISTIC "TERMINATION"- YES, ONE MORE BABY DIED.

THE OTHER END OF LIFE IS NOW ATTACKED - SENIORS, BEWARE! EUTHANASIA IS THE HANDMAID OF TERMINAL PATIENT CARE.

PREVENTING PAIN "WITH DIGNITY" PREPARE TO BREATHE YOUR LAST

BY DOCTOR'S HAND - OR SUICIDE IF TERMINALLY ILL RIGHTS BILL'S PASSED.

CONSENT THROUGHOUT OZ GUARANTEED?? IN HOLLAND, THEY ENSURE THAT SOME DEPART **WITHOUT** CONSENT - **GUILTY THE HANDS** - THE LAW -**WHERE IS IT?** EUTHANASIA - EXPEDIENCY - WHAT TWINS

EXPEDITING THE EXPENDABLES - AND WHO NOW CALLS THEM "SINS?"

GUILTY THE HANDS - CONSENT OR NO - PLAYING GOD'S A DANGEROUS GAME;

HIS POWER ALONE TO GIVE AND TAKE - WHO OTHER MAY SO CLAIM?

GUILTY THE HANDS - CONSENT OR NO - FOR WHO PLAYS GOD AND WINS?

HIS IS THE POWER TO GIVE AND TAKE - **HE** NAMES SUCH MURDERS - SINS!

M.C.PRINCE

SUBMISSION 768 1

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5 Maslen Cl.

Frankston 3199

15/3/95

The Convenor

N.T. Select Committee on the Rights of the Terminally Ill Bill

GPO Box 3721

Darwin 0801

Dear Sir/Madam,

I am writing to express my very grave concern at the proposed euthanasia legislation for the Northern Territory.

The progress of illness is unpredictable. I personally know someone who was given 6 months to live but 5 years later is driving his grandchildren around.

God alone must decide when death should take place.

Please oppose this bill.

Yours sincerely

Margaret Geehman

SUBMISSION 769 1

Graeme Anderson P.O. Box 27,

Lightning Ridge

Resident Potter. N.S.W. 2834

Telephone (068) 29 0375

Dear Sirs,

I would like to convey my support for the proposed bill for legal voluntary euthanasia.

Some years ago my mother, in her 80's, died from cancer, after suffering for a long time. I have the highest regard for the care and treatment she received at the Bush Nursing Hospital in Yackandandah (Vic), but on the occasions I was able to travel down to visit her, she often expressed the wish that her pain and life could end.

I regret that I was powerless to help. Mother was mentally alert, and she would have appreciated the chance for a peaceful death, in the company of loving family members, at a time of her own choice.

I trust the bill will succeed and be passed by the Government.

Yours Sincerely

Graeme Anderson

SUBMISSION 770 1

Coo-ee Lodge

Gilgandra 2837

18/3/95

Select Com. on Euthanasia

Parliament of N.T.

P.O. Box 3721

DARWIN NT 0801

Dear Sir/Madam,

I am a sufferer of Huntington's Disease. I am in favour of the V.E. and not just in last year of living. If no cure is in sight then I feel it is up to the patient to be allowed the right to ask Dr to end her life.

Yours faithfully

(Mrs) Jean Hobden

SUBMISSION 771 1

Queensland

Right to

Respect life

Innisfail Branch:

P.O. Box 259,

Innisfail Qld 4860

Phone: (070) 61 2536

Fax: (070) 61 6202

20/3/95

The Chairman,

Select Committee on Euthanasia

G.P.O. Box 3721

Darwin 0801

Dear Sir,

On behalf of my association, and the frail and elderly to 'not perfect' people of Innisfail, I urge your committee to throw out any euthanasia talk with all your energy.

'Human rights' means a right to live and a right to die - with dignity at the time appointed by mother nature, not by a doctor and the family. This sort of mercy killing would lead to a lot of problems. You must all realize this fact. Modern medical procedures and drugs have eased the pain of dying patients lately so please don't change this area of hospital care, where love and compassion still overpower evil deeds.

Yours faithfully

Mrs June Sultana J.P.

SUBMISSION 772 1

DORNBUSCH FAMILY

PO Box 38783

WINNELLIE NT 0821

22nd March 1995

Select Committee on Euthanasia

GPO Box 3721

DARWIN NT 0801

Dear Sirs

With reference to the Euthanasia Bill at present before Parliament, we, as a family, have discussed this measure and are all agreed that, if it ever happens, each of us has the right to request Euthanasia, to alleviate pain and suffering, not only for the sufferer, but for the other members of the family.

To us, this a freedom of choice within the family and has nothing whatsoever to do with anybody else.

Yours faithfully,

(PAUL DORNBUSCH) (NORMA DORNBUSCH) (LYNN DORNBUSCH)

SUBMISSION 773 1

Talarm Rd

Macksville 2447

20th March

Select Committee on Euthanasia

Parliament of the Northern Territory

Dear Members,

I am writing to express my support for the bill for legal voluntary euthanasia.

I would certainly want to end my life with dignity if I had a terminal illness and was in great pain and I respect this decision and feel it should be legalised for people in this position.

Yours sincerely,

May C.E. Gibson

SUBMISSION 774 1

The Select Committee into the R.M.B. 1105

Rights of the Terminally Ill Bill Grip Road,

C/- Ms Pat Hancock, Toora

Legislative Assembly, Vic 3962

G.P.O. Box 3721

Darwin N.T. 0801

Dear Pat,

Re Euthanasia Bill

I am very concerned at this proposed legislation for the Northern Territory. First it devalues human life and secondly it will open up many avenues whereby this act can be administered.

This legislation affects all Australians.

All measures must be taken to see that the sick, frail, elderly and suffering are given the best possible case and are kept from undue pain by the many measures that are available today, without the though that these people would

have to resolve to taking their own lives.

I urge you to oppose this bill.

I remain,

Yours sincerely

(Mrs) Joan Clarke

SUBMISSION 775 1

Leon Miguel

Lot. 1San Miguel Rd

Hope Valley WA 6167

21 March, 1995

Dear Committee,

I would like to register my opposition to the Rights of the Terminally Ill bill that is currently being considered.

I believe that the bill is unnecessary, as only 4-6% of elderly people desire euthanasia (British Medical Journal, 1994); clearly, this a minority of the population.

Secondly, I believe that the bill will allow patients to be pressured into euthanasia. This is the case in Holland, where some elderly patients are pressured into euthanasia by either family members or medical staff.

Finally, if euthanasia becomes a common practice, medical staff will view patients as dispensable, and the quality of care will be compromised.

For these reasons, I ask you to recommend that this bill be rejected.

Yours sincerely

Leon Miguel

SUBMISSION 776 1

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109 Nareen Gardens

Bias Ave

Bateau Bay

NSW

To Whom It May Concern,

I am a strong supporter of voluntary euthanasia and pray for it to become law, after having watched my dear one dying with tubes in her stomach which she repeatedly pulled out. She could not swallow properly, she would not speak to tell of her needs or feelings, yet they hung onto her for three more months of her pension payments before she could take no more, 'God forgive them'. You are charged with cruelty to animals.

K. Dicker

SUBMISSION 777 1

VOLUNTARY EUTHANASIA SOCIETY

OF NEW SOUTH WALES (INCORPORATED)

ACN 002 545 235

5th Floor, 55 Mountain Street P.O. Box 25

Ultimo NSW 2007 Telephone: (02)212 4782 Broadway 2007

Patron:

Professor Peter Baume AO

20 March 1995

The Chairman

Select Committee on Euthanasia

Parliament of the Northern Territory

P 0 Box 3721

DARWIN N. T. 0801

Dear Chairman

Submission for consideration by the Committee

The Voluntary Euthanasia Society of New South Wales is a member of the World Federation of Right to Die Societies, and exchanges views and information with Voluntary Euthanasia Societies in all States of Australia.

A survey undertaken during 1994 indicated that 81% of Australians were in favour of legislation being enacted to permit Voluntary Euthanasia in the case of a person dying with great suffering and without dignity; an increase over the previous survey when there were 63% in favour. It is pleasing to note the marked increase in our membership and in enquiries made on a daily basis since the Chief Minister of the Northern Territory introduced legislation "Rights of the Terminally Ill", coming soon after ABC T.V. coverage of the subject, and our own Annual General Meeting.

We applaud Marshall Perron's initiative in tabling his proposed legislation and we commend it to you with its safeguards in place to ensure that there can be no abuse of the legislation.

It is widely believed that many doctors already practice euthanasia - being illegal to do so - and indeed the President of the Australian Medical Association Dr Brendon Nelson has publicly admitted twice taking this step, once at the request of a dying patient and once without such request.

The State of Victoria already recognises Advance Directives, and South Australia presently has a similar Bill "Consent to Medical Treatment" before its Parliament; but this is not enough.

Select Committee on Euthanasia

The Northern Territory Parliament has a unique opportunity to lead the way in Australia by enacting the Private Member's Bill tabled by Marshall Perron and in doing so, perhaps the remaining State and Territory Governments will realise that this is something the majority of people desire, and not let the strident minority dictate their

policies. We believe that people in great suffering should be given the legal "Right to Choose" the when and how of the ending of their lives.

Yours faithfully

TONY WRIGHT

PRESIDENT

SUBMISSION 778 1

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21 Devin Ave.,

West Coburg

March 22nd

Dear Ms Hancock

I am writing to you to urge you to use your influence in voting AGAINST the proposed Euthanasia legislation to be introduced in the Northern Territory.

Life is precious and who are we to decide when that life should end and what doctor or doctors who are trained to save lives could undertake such an act.

So much for so-called dying with dignity.

Yours sincerely

Nessa Lynch

SUBMISSION 779 1

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6 Keswick Rise

Eltham Vic 3095

20th Mar 1995

Select Committee

into Rights of Terminally Ill Bill,

Dear Members of the Committee,

I am writing to you to express my alarm at the proposed euthanasia legislation for the Northern Territory. This legislation affects all Australians, and creates more problems for doctors, relatives and patients.

Are we going to follow the Dutch model where doctors can be prosecuted for <u>not</u> assisting patients to die?

I ask you to oppose the Bill.

Yours Sincerely

Clare Zavadish

SUBMISSION 780 1

'Pinewoods'

Goadja Rd

Mittagong

17-3-95

Chairman,

Select Committee on Euthanasia

Parliament of Northern Territory

Darwin

Dear Sir,

I write to support the bill sponsored by the leader of the Government to achieve Legal Voluntary Euthanasia.

Having watched my mother die - over a long wretched period of two years - from cancer, no help to end the hopeless situation, even when reduced to a comatose state which continued for months - I urge you to fight for Legalisation of Voluntary Euthanasia.

I fully support you putting forth this Bill.

Yours sincerely

L. Hindmarsh

SUBMISSION 781 1

Dorothy Matlak

57 Hawthorne Ave

Chatswood NSW 2067

21 st March, 1995.

The Secretary,

Select Committee on Euthanasia,

Parliament of the Northern Territory,

DARWIN, N.T. 0801.

Dear Sir/Madam,

I am writing in support of the Bill currently before your House, legalising voluntary Euthanasia - doctor-assisted, in carefully assessed situations.

In support, I would like to tell you of the recent situation of an uncle -- he died of colon cancer early this year. He was 85 years of age.

After struggling for many months, living by himself in increasingly messy circumstances (his own choice), with treatments, ill-health, general malaise, more treatments... he was admitted to an acute-care hospital for ameliorative intervention -- with mightily little result -- on three occasions. Finally, he was transferred to a hospice, straight

from hospital, without the opportunity to 'settle his affairs' - causing him great distress.

At the hospice, during the last three weeks of his life, he was kindly, and I presume medically soundly cared for. He was virtually unconscious during that time, BUT, when 'turned', changed an cleaned, and when attempts were made to give him food or liquids, on many if not most occasions, attempted to open his eyes, looked pleadingly at whoever was sitting with him, ... and moaned. This surely indicates that at the least he was severely uncomfortable, and most likely that, perhaps just below the level of consciousness, in pain.

I am certain, from my knowledge of this kind old man, who always hated being 'a nuisance' to anyone, that had he had the opportunity to express his wish, he would have chosen to peace-fully end his life at the time his medical condition was so totally hopeless!

I commend the persons sponsoring this humane Bill in your Parliament.

Yours sincerely,

SUBMISSION 782 1

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36 Wisdom Rd.

Greenwich 2065

N.S.W.

20-3-95

The Chairman

Select Committee on Euthanasia

Parliament of the Northern Territory

P.O.Box 3721

Darwin, N.T. 0801

Dear Sir

I would like to express my support for the bill in favour of legal voluntary euthanasia.

It seems to me very wrong that we cannot extend to human beings the merciful end that is granted universally and without question to suffering animals.

Most of the practical objections put forward against it - its opportunity for concealing medical incompetence, the manipulation of the system by unscrupulous doctors or relatives - apply equally to the present practice whereby doctors apply their own standards of ethics, morality and compassion, with out any of the safeguards that legalization provides.

Yours faithfully,

Mary J Jeffriess

SUBMISSION 783 1

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58 Kyle Parade

Kyle Bay

2221

Sydney

Dear Mr Premier

Thank you for your bill for voluntary euthanasia. It will save humanity from much needless suffering. Cats and dogs are better off than we are. To let an animal suffer is an offence and we are animals so it also should be an offence.

75% of the population want euthanasia so the majority must prevail.

Yours sincerely

Mrs Christine Fraser

SUBMISSION 784 1

20.3.95

7/15 Birriga Road

Bellevue Hill NSW 2023

Select Committee of Euthanasia

Parliament of the Northern Territory

Mr Perron - you are great!

Dear Sirs/Mme,

I am 86 now - I was a teenager when my dear mother visited every day her cancer ridden brother. Every day, she came home crying, because, as she said this terrible suffering of my uncle, were those of a victim in a torture chamber -

"Torture" is one of the most hated and feared word in our dictionary. But not only terminally ill cancer victims, suffer and suffer, there are other ailments too. We were not asked if we wanted to come into this world.

It should be our right, to decide when and how we want to leave it - I shall never forget the wonderfully griping human courageous film from Holland which showed us how peacefully, simply and quickly a person can be helped to reach the - for all of us - inevitable end. When shall we become as human and wise as the Dutch - ?!!!

Thanks for reading my letter.

Yours sincerely

Caroline Gaspar

SUBMISSION 785 1

Christine Heberlein

85 Deepwater Road

Castle Cove 2069 N.S.W.

Physiotherapist M.A.P.A.

Feldenkrais Practitioner

Sydney, 22nd March '95

Dear Sir/Madam,

I consider it to be my right to make decisions as to when I want to leave this life. I would want doctors looking after me, to respect that decision and to assist me. I don't think doctors on their own can be made to make these decisions but should anyone have stated what they would like to have done with them, should they have a life threatening disease or suffered a severe stroke or head injuries their wishes should be respected.

I love life and would like to end mine in peace, calm and with little anguish, pain and suffering. I have a partner but no children - my interest is in my life alone and I don't want strangers to make decisions. I would like to have the opportunity to carry my wishes regarding resuscitation, saving or prolonging life on an I.D. I would carry on me. After all I have a right to say what will happen with any organs!!!

I work as a physiotherapist. I have seen many "miracle" where life has been worthwhile with devotion and care from the medical system and loved ones but I also have seen much pain , despair, agony, depression, anxiety and the futility of maintaining a life which is no life.

Please give me my legal rights to do and decide what I would want and what I would want my friends and family to be able to achieve!!

Thanking you for your efforts and your respect towards life and humanity!!

C. Heberlein

SUBMISSION 786 1

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23 Cockatoo Drive

Mundaring

W.A. 6073

18 March, 1995

Select Committee on Euthanasia

Parliament of Northern Territory

Post Office Box 3721

Darwin N.T. 0801

To the Committee Members

I would like to add my voice to all those people wanting to see Euthanasia legalised.

Yours faithfully

Johannes Hendrik Adam Newmeyer

SUBMISSION 787 1

Kevin McCormack

63 Lawson Ave,

Frankston 3199

19/3/95

Ms Pat Hancock,

Secretary Legislative Assembly,

GPO Box 3721,

Darwin, N.T.0801.

Dear Ms Hancock,

I am writing to you to express my alarm at the proposed euthanasia legislation for the Northern Territory. This legislation affects all Australians. I am concerned that vulnerable, sick and elderly Australians will travel to the Northern Territory to "avail" themselves of this deadly service. Acceptance of patient killing will further devalue human life and will place under scrutiny those whose lives are a burden to society.. I ask you to oppose the Bill.

Yours sincerely,

Kevin McCormack.

SUBMISSION 788 1

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76 Dent Street

Ashburton 3147

21-3-95

Dear M/S Hancock,

The proposed euthanasia legislation for the Northern Territory is a cause for alarm for all Australians. To legally protect doctors, who kill or assist their patients to commit suicide, presents a frightening future for the seriously ill.

The Nazi devaluation of human life resulted from the thinking of the previous decade, that some lives are not worth living. We also have the recent experience of Holland, where patients in need of surgery are afraid to go to hospital, as they could be legally killed.

Let us protect all human life and profit from the lessons of history.

Yours sincerely

(Miss) Margherita Griffin

SUBMISSION 789 1

5/25 The Glen Road

Arncliffe NSW 2025

21/3/95

Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

Darwin N.T. 0801

I wish to inform you that I am very much in favour of euthanasia. Having seen my mother and close friends die in pain and discomfort and with loss of dignity. I heartily endorse it. One of my friends was 92 years, no hope of recovery yet she had to live for over two years, almost a vegetable. Another friend aged 83 years is suffering a living death - Alzheimers Disease - no hope of recovery. These people have lived their lives, they cannot possibly recover. We would put animals out of their misery. Money spent uselessly on these people could be better spent on research for sick children.

Irene Bradshaw

SUBMISSION 790 1

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19 Scott Street

MORTDALE 2223

N.S.W.

20/3/95

Select Committee on Euthanasia,

Parliament of the Northern Territory,

P.O. Box 3721

DARWIN NT. 0801

Dear Select Committee Members,

I am a widow, 75 years old and I wish to give my strong support for a Bill to legalise voluntary euthanasia.

All my adult life I have held the view that a mature person should have complete control over one's death, as one has had control over one's daily life. I fear painful, undignified living much more than death itself.

In 1992 an event occurred which made my conviction even stronger. In Nov. 1992 I was seriously injured in a motor accident and this resulted in serious multiple fractures of both legs, a right hand injury, back injuries (as well as facial, nose and mouth injuries).

Two plates were inserted in my right leg - some bone fragments were too small to be screwed to the plates and co-joined where they could, not necessarily in the correct position. My right ankle was completely smashed and required a bone graft - a piece of bone was removed from by hip for this purpose. The left foot had to have broken bones screwed together and the ankle was fused making any flexion movement impossible.

To date (2½ yrs later) I have had 6(?) or 7(?) surgical operations, and I still have the prospect of more surgery on right ankle (the result of which will "fuse" the right ankle also), and a joint replacement on a finger on my right hand.

My mobility is poor and very painful - I can only walk a few yards (with aid) and I cannot use public transport. Although I was a confident and competent driver (over 30 yrs driving without a single infringement) I will never drive again - legs too painful, constant pain in my back and constant "flash-backs" to my accident.

I am in constant pain all day. I wake every 1½ - 2 hrs at night, despite a sleeping tablet, because of pain; I seldom have more than 3-4 hrs sleep per night, always broken, disturbed sleep.

My legs have been so injured that they have gross sympathetic nerve damage which sends weird, confused messages to my brain and back to legs - feelings of pain, pain, pain, heat, cold, liquid dripping down legs, crawling feelings on legs, steel bands around legs etc I have had a grab-bag of drugs for this nerve damage without help - the only drug now offered to me is oral morphine which, so far, I have refused. I have had every type of physiotherapy.

2

I live alone, so I have very little diversion from pain. I go to an occasional concert but cannot stay the full programme.

I have no idea how long I can stand this painful life, neither can I guarantee that I will endure it for ever. Constant pain is a poor companion. But to whom can I turn when I've had enough and be sure of help - legal help. I always have on hand a spare extra bottle of my sleeping tablets for the time when I've had enough but I'm fearful that (a) a bottle may not be enough, (b) that I may vomit and not achieve death. From literature I've read, one needs a helper to make sure and if I involve a friend or a family member, that person under present laws could be held responsible and charged at Court.

A Bill legalising voluntary euthanasia would provide an answer - not only for me (when the pain is too much for too long) but for others dying in pain and misery. I have emphasised "voluntary" (above) - it's a matter of choice. The existence of a Voluntary Euthanasia Bill isn't there for people who are well, happy, full of joy, have children to raise. Neither is it for people who are sick and suffering but determined to hold on to life. It's there for people to make choices about their own death with dignity, in their time and for their reasons.

Sincerely

Joy Brown

SUBMISSION 791 1

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68 Lambell Street

Panania NSW 2213

21 March 1995

To

Select Committee on Euthanasia

Parliament of Northern Territory

Darwin N.T.

Dear Committee,

In your deliberation on euthanasia I urge you to recommend legislation that will not penalize doctors or other health professionals who follow out a patient's expressed desire for a painless and dignified death.

Yours faithfully

(Mrs) Betsey Pike

SUBMISSION 792 1

To the Hon. E H. Poole MLA

Chairman of the Select Committee on Euthanasia

Dear Sir.

I have worked as a Registered Nurse for a period of around five years, and before that I worked for three and a half years as a student nurse, in hospital based training. During this time, I had the opportunity to work with many patients who were dying of many different illnesses. I found this experience valuable in many ways, both for myself as a person and as a nurse. Not the least part of this was the opportunity to work closely with the patient and their family. Dying is not, as we tend to believe. a time of agony, loss of dignity. being 'out of control'. It is. however, a time of suffering, either for the patient and their family, or, in the case of sudden death, just for the family. The suffering can be physical in the form of pain, discomfort, nausea and so on, much of which can be relieved, and the suffering always includes a large psychological and emotional component for the patient and their family. It is never an easy thing to know that we are going to die soon, and it is never easy to watch someone that we love dying. In my experience, people who die of slower illnesses come to view their imminent death with peace, and they value every breath of life that they have. They are able to make peace with themselves about their lives, reconcile with those with whom they need to be reconciled. and make peace with their families and friends, speaking about their lives and the love they have felt. In the early stages of dying after being diagnosed with a terminal illness it is quite usual for the patient to feel angry and depressed. For some, this depression can last quite a while where the question 'why me' is often asked. and there is a fear of the future. a fear of suffering. In the midst of a depression, no one is able to make reasonable decisions or to 'connect' on any more than a superficial level with anyone else.

I remember one lady whom I nursed for a long time. She was diagnosed with cancer and became deeply depressed. She was admitted to hospital under a very caring GP and she started to 'die'. For one year she remained in hospital on a morphine infusion while her faithful husband visited with her for most of the day. but she was unable to really speak with him. After the year, her depression lifted and she went home to be with her husband of many years. This was a wonderful time for them both where they could talk about their lives and their experiences, where they could love each other and know that they were loved. When this lady was admitted again to hospital, she and her husband seemed to be at peace, and she died at peace.

It is a fact that we are all going to die. but it is not something that we can really understand. No matter how old we are. we always think that death is somewhere in the far future. For most of us. the fact that our bodies and the bodies of our loved ones will cease to breathe and to live is inconceivable. During the last thirty or forty years, medical science has advanced so quickly that we have come to place much faith in it. We believe that medicine can cure everything. except the common cold. and that everything that medicine tells us is infallible. We believe this although the world of medicine has made some quite astounding blunders in this same period of time. The use of the drug Thalidomide to control morning sickness in pregnant women is an infamous example. The recommendation that asthma sufferers in the fifties should smoke cigarettes is another example of a wobbly decision. The fact is, that medical science has no certainties at all and fewer certainties seemingly. as further

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development occurs. We all are aware of cases where a person in a coma has lived despite the predictions, and has regained consciousness up to several years later, all that time whilst in the coma being aware of everything going on around them. I remember an elderly lady of around 90 years old who had a massive heart attack and was unconscious. It was decided that there was no doubt that she would die and so she was removed from Intensive Care and placed in a private room where her relatives could remain with her. She was given no treatment apart

from general nursing care. After a period of several hours she woke up. sat up, and asked for some lunch! She lived to go home and look after herself.

On the other side of the coin, there are patients for whom all the medical technology and diagnostics are used but simply fail to get better for no clear reason. They simply become sicker and sicker despite everything we can do. I nursed two such patients in an Intensive Care situation, both were elderly Aboriginal males.

As well as all this uncertainty. there is another facet to this discussion. I have never been asked by any patient, no matter how sick, to 'put them out of their misery'. Usually, it is the relatives who seem most impatient for the end to come, and to place this in the best of contexts, it is probably because it is very hard to see someone that you love very sick, and harder to know that they are dying. In addition to this, there is also a new sickness present especially in our elderly population, and this is the mentality of not being a 'burden'. I have heard this expressed in my own family by my grandparents, when comments are made such as 'You can come and live with us.' Who knows, maybe they see us clearly for what we are - a selfish generation. However, this sentiment has also been expressed in many families as 'I hope I'm not too much of a burden to you when I get old and sick'. It would be a very sad thing if dying people requested to end their lives simply because they didn't want to cause any trouble for anyone. when effectively they would really rather live out their lives. It would also be very sad for unscrupulous families to leave the person in no doubt that they would prefer a planned death so that they could properly prepare things, etc. Elderly people. in particular, are at risk for this because of several reasons: the 'burden' mentality; the fact that in our society the elderly have little status; and the fact that many elderly people feel quite helpless when they get sick and rarely quiz their doctors on alternative treatments and/or drugs.

An example that illustrates that unscrupulous families do exist is the case of a man in his eighties who was admitted to the ward on which I was working. He was admitted following a collapse and was generally in a very dirty condition. It seemed that he hadn't bathed for a long time. It turned out that he lived alone as a recluse had all his groceries delivered and never saw his family. When his family was contacted to notify them that he was in hospital. they immediately arrived on the ward at 11pm with a solicitor and said 'Dad, you have to make your will'. We assume that he did so, and probably in their favour, because he was in a position of helplessness. Even though his life might not seem all that happy to us, it was. nevertheless his life and there were no indications that he had ever wished to end it. Instead, if the family suggested to him that it really might be better all around if he died now, what medical tribunal would not be able to find grounds enough for euthanasia? After all, we all are suffering from a terminal illness and this is commonly known as old age.

We are a culture that doesn't know how to cope with suffering any more. When we have a problem we escape from it, whether it be in our marriages, in our work, with our

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children. or with our parents. We need to understand that to suffer doesn't kill us. but instead can result in happiness, an increase in self knowledge and compassion for our fellow man. If we have a headache we are encouraged not to put up with it, but to take a 'mild, gentle to the stomach pain reliever', maybe when we are faced with watching a relative die we can encourage them to take the same option on a more permanent basis. Worse still. we can do the figures and quantify their life on a fiscal basis, and basically decide that their life doesn't warrant the cost it would entail. How can a life be fiscally quantified? Does it depend on the success we have experienced. aristocratic blood, our level of education. how many children we have, or how much money we have saved or spent in our lifetime? All life is equal in worth and it is impossible to put a price on our heads. Just as medical science can only make an educated guess about someone's life expectancy. and has many times been confounded, how is it that we can make a qualitative judgment based on a premise that will always be flawed?

Since our advanced societies were conceived, taking another person's life. or even our own has never been considered a right but something forbidden and penalised. Most people who take a life in self defence, in a car accident or in war, experience a remorse that may last all their lives. Will this change simply because legally

speaking, what, we have done is all right? Many doctors and nurses who have given the wrong treatment or drug to a patient that results in that patient's death, have, even if legally exonerated, been unable to continue to practise because of their feelings of guilt. This does not depend on the quality of the patient, but on the fact that the medical and allied professions have a charter to preserve life as their basic premise. This is their 'raison d'etre'- their reason to be.

The best quality medical and nursing staff, in my opinion, are the ones who always experience a sadness at the death of any of their patients, whether that death is expected or not. To be involved in this profession does not mean that one becomes immune to death and unaffected by it. If we asked people who would they prefer to look after their loved ones - someone who is affected by whether their patient lives or dies. or an uncaring robot for whom death means nothing, and who is able to kill without remorse? For I am saying that the latter does not exist except as a psychotic in the wards of an insane asylum, or between the pages of a Thomas Harris novel.

In conclusion, it is possible that with the intention of compassion for the dying. we can introduce legislation that in fact denies them, their families and their health professionals. their inherent dignity and worth as human beings.

Catherine Patteson.RN.

9 Jacksonia Circuit,

Nightcliff. 0810,

(089) 480280.

SUBMISSION 793 1

GPO Box 4184

DARWIN NT 0801

Select Committee on Euthanasia

GPO Box 3721

DARWIN NT 0801

Dear Sirs and Mesdames

(I don't know the composition of the Committee)

Initially I had written something along the lines of the attached to the Chief Minister after the death of my dearly beloved of the last 22 years whose farewell was held the day before the announcement of the Euthanasia Bill, something I could have done without at that point in time. I had not got around to editing the letter and mailing it when it was decided the Bill had to go before a committee. So the attached submission is to the memory of someone who dearly wanted and needed euthanasia. (We had discussed the topic long before he got sick and both had agreed it was what we each would have wanted for ourselves.)

I am not extrovert enough to be able to appear before a committee and hope that the attached written submission can be taken into account.

Yours faithfully

PAULINE HUBBARD

22 March 1995

2

SUBMISSION IN SUPPORT OF THE BILL FOR VOLUNTARY EUTHANASIA

I hereby register my support for the Bill for Voluntary Euthanasia.

My reasons are very compelling. On 23 January 1995 my partner of the past 22 years, Chris, finally died weighing about 35 kilos and looking like someone who had been a long time in a concentration camp. Last August he had his stomach removed and on 9 September we returned to Darwin from the Royal Adelaide Hospital. He had two spells in the RDH before returning there for the last time on 20 December staying there until he died on 23 January. By the second visit he was begging to 'be put to sleep' as life was just so unbearable. However the obstruction which was causing the problem then was overcome and he returned home for another couple of weeks but it was obviously downhill thereon. He hated being how he was and having to take morphine. Eventually the morphine started to befuddle the brain which, initially, he was aware was happening and that must have been the most devastating part for him. So much for palliative care - it may kill the pain but it is the mental part which is so unbearable both for the sufferer and those close to them. So you see this Bill should have been in force long ago so Chris could have died still with some dignity and in his own home - not in that ghastly place (but here is not the place, I realise, to give my, our, views of the RDH).

But I have to go further. I don't think the Euthanasia Bill should be solely for the terminally ill. For someone with multiple sclerosis I would like to think that if I should end up with the progressive type as opposed to the type where exacerbations come and go, and where there was no chance of any more remissions, just gradual decline ahead (but not terminal), I could ask to 'be put to sleep'

Ten years ago my father wished to 'be put to sleep'. He was not 'terminally' ill. He had what the doctor surmised were mini-strokes which left him sometimes all too painfully aware of what was happening to him and at other times he was just not 'with it'. He decided the only thing to do was refuse all medication and sustenance and starve to death. He had to be hospitalised and it took 2 weeks for him to die which was a tremendous strain on my mother and me.

Over the last eight months I have had to have two family pets put down. It was extremely painful for me but out of compassion for them I had to do it as they had both reached a point where they would never improve (they were both old) and it was kinder to put them out of the misery they had just reached and would have continued in. It was a relief that I had the option of doing this for them.

Why must children, the mentally incompetent, the illiterate (or those who cannot write because of their illness) who might be either terminal or condemned never to become well again and have to live an atrocious existence, not have the option to die with dignity and without torture? I know there may be those who could exploit this but don't make the majority have to suffer for what a minority might do.

Insofar as protecting the right of doctors to decline to assist in euthanasia there is a solution. I would suggest those medical people not against the idea (obviously these would be the truly compassionate ones - the odd 'nut' would presumably be able to be weeded out) be registered

to carry out euthanasia. I would certainly like to see it occurring not within the confines of a hospital but either in the person's home, or maybe in a caravan taken to a location they would like to die in, maybe with family, friends, pets, with them, with their favourite music playing; or in a special 'parlour' where a favourite film could be shown on a big screen, music played, again with family, pets, etc there, maybe partaking if they were able of their favourite food and/or drink. Something peaceful and pleasant, and occurring long before the person reached the pitiful stage to which my Chris recently was forced to live.

As soon as one is mature enough to make the decision that they wish to die with dignity by euthanasia then there

should be some central point where they can register that desire. They could always change their mind, like changing a Will and have the request in the register deleted. With regard to the young/retarded, etc, then perhaps the opinions of say three doctors should be sought and acted upon.

I watched "Death on Request" on TV where the man had a motor neurone disease and was not exactly classed as terminal, where he died so peacefully. I hope all the Ministers, church people and 'right to lifers' watched it though I doubt it would have swayed the fanatics.

I did what the Chief Minister's full page advertisement requested and rang the electoral office of my MLA (Shane Stone). When I rang he had been shown in the NT News as being one of those who had not declared his views, however a few hours later he was on the ABC News appearing to be very much against it. I don't know if my support of the Bill was registered or not by the electoral office.

It is not very 'christian' of religious fanatics to make people have to endure the torture of some illnesses and for their family and friends to have to endure the torture of seeing loved ones in such a state. I find religion a very dangerous thing for many reasons. I wholeheartedly agree that religious opposition should not deny others the right to make their own decisions and sincerely hope common sense will prevail and this Committee will not let the vociferousness of the vocal minority win over the supposedly 80% in favour of euthanasia.

Obviously, yes, I am emotional, but probably, just probably, not quite as emotional as that bishop who said the Chief Minister was being emotional!

Thank you for reading this submission.

PAULINE HUBBARD

22 March 1995

SUBMISSION 794 1

Submission to the Chairman

Select Committee on Euthanasia

GPO Box 3721

DARWIN NT 0801

21st March 1995

This submission will be restricted to four points, assuming my definition would in essence correlate with that of the Committee:

Euthanasia:

"Intentionally taking life for compassionate motives, whether by an act or an omission.

It is

- voluntary, when it is at the request of another person in respect of himself or herself

- non-voluntary when there has been no request by the person, either because he/she was mentally incompetent, or was competent and was not asked, and

- involuntary when it is in defiance of a request that it not be done".1

The four points of this submission are

1. The killing of the innocent

2. Palliative care

3. Increasing life-span

4. Relationship to abortion.

1. The killing of the innocent.

Western society has long found capital punishment repugnant and, in fact, continues to distance itself from it. When one of the main concerns is that the death may at a later time be found to have been that of an innocent person, governments have no logical grounds on which to promote, support or legislate in favour of euthanasia. Yet capital punishment could be carried out just as "humanely" as euthanasia.

Suicide (of the innocent) is another concern. Medically assisted suicide is not an "easy way out". It is a variant of voluntary euthanasia in which there is no valid ethical distinction between the two, both in intention and in their moral equivalence.2

2. Palliative Care

(i) Medical specialist, Dr Brian Pollard, finds that medical schools have failed to give palliative care its due priority in their curricula, and it is common to hear stories of failure by doctors to relieve severe pain, yet the means are available.3

2

By contrast I understand the Roman Catholic Church has no quarrel against the use of strong pain-killing measures as the doctor advises for the comfort of the patient.4

(ii) It is a sad reflection on our society that people come to feel their lives are "not worth living" or "unproductive" or "an imposition" for whatever reasons. These people, as innocent citizens, are as much deserving of care and compassion as any other sick or ailing person. There should be no discrimination just because one person's sickness or ailment ends in healing and another's in death.

(iii) It is a common human failing to attribute to others our emotions. Yet a simple example is that what gives me contentment may have no attraction to another at all.

A corollary of this fact is that I may feel my loved one would be happy to end his/her life under certain conditions and controls, and the loved one may agree in consideration of me and perhaps other external circumstances, yet his/her inner self is not at peace with such a "solution"5

Thus such a solution is not "humane" and is contrary to our natural desire to grant loved ones their "dying wish," which is always one of their secret, inner selves.

3. Increasing life-span

The average age of the population is getting higher. People, whether healthy, or receiving medical care for any variety of illnesses or ailments, are living longer. This is so of the young eg AIDS sufferers, and the elderly, and the infirm of any age bracket. It is a government's duty to facilitate their living, not their dying.

Humanity cannot be uplifted and at peace with itself if its culture is death.

Hence governments everywhere must act to cater for this increasing life-span of those under medical care, by the provision of palliative care in all that that entails. It should even include the counselling of the "nearest and dearest" of the patients. The true meaning, which is very uplifting, can then be given to the expression "death with

dignity".

4. Relationship to abortion

Thinking people, alert to the less honourable side of human nature and evidence overseas were always aware that an abortion culture would lead to an euthanasia culture. Arguments based on a blinkered compassion, generally aided and abetted by a media which seldom shows the will or ability to raise discussion much above the emotional level, fail to see that taking innocent life is never an answer to a person's distress. Supporting the person and helping them through their time of trial is.

Annually over 80,000 babies are lost to Australia. Had they been born alive and not forcibly born dead, people would have been employed to provide clothing, housing, food, education and so on. This, of course, would have greatly benefited the economy, and the average age of the population and thus the continued availability of sufficient tax-payer dollars.

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Governments themselves are responsible for the scene that now, for example, the Federal Social Security Minister, Peter Baldwin, has issued "a warning to pensioners that Australia will never be able to afford, a universal aged pension." 7 That is not good enough and they must reverse the situation they have allowed develop. Informed voters have always called for that. Further, and to the particular point of this submission, the public will be even more judgemental, if governments now say they have no money for palliative care units, staff, training and other requirements for effective functioning.

Conclusion

There is an axiom in legal circles that hard cases make bad law. Legislators must look beyond the personal and/or the emotional to the full pictures.

(signed) M. A Ross 21.3.95

(Mrs) M.A. Ross

30 Henry Street

Rockhampton QLD 4700

References

1, 2, 3 Dr Brian Pollard, MB. BS- Anaesthetist, Australian Lecturer, Author of the books Euthanasia: Should We Kill the Dying and The Challenge of Euthanasia.

Quotes from the paper "Euthanasia Here and Abroad" given in Brisbane 10th Sept, 1994, but also contained in the books.

4 Sacred Congregation for the Doctrine of the Faith Declaration on Euthanasia St Paul Publication, Sydney 1980, Ch 3. p.11.

5 Dr Toni Turnbull - General Practitioner for 20 years. Adelaide (S.A) of her address "A Pro-Life Journey" given in Rockhampton (Qld) 12th September 1994.

6 The figure generally quoted. However, even in 1990 the Australian Parliamentary Pro-Life Group publicly stated that "at a conservative estimate there are 85,000 deliberate abortions in Australia each year or 1 abortion for every 3 live births". (from the brochure "The Abortion Funding Abolition Bill - Questions and Answers") To-day's estimate is markedly higher.

7 The Courier Mail, Brisbane, Qld. Monday 20th March 1995, p.3, and "Briefly", p.1 new summary.

SUBMISSION 795 1

W G Alcock

Box 157 P.O.

Port Macquarie

2444

20.3.95

Select Committee on Euthanasia

Parliament of Northern Territory

Box 3721 P.O.

DARWIN NT 0801

Dear Sir

I am a supporter of euthanasia and have prepared Advance Directives in case I lose quality of life and/or get a terminal illness which will result in pain and suffering in my final years.

I am now 80 years of age and want to end my life without trauma and I am firmly of the view that everyone should be able to elect for euthanasia according to the guide lines proposed by Marshall Perron.

I had a friend with cancer of throat and you could hear him gasping for breath from front door of hospital. I implored his doctor to help him die and he obliged.

I have another relative aged 85 with dementia - he has no quality of life - his mind has gone does not recognise anyone and his body functions have failed - the smell in his room is unbearable. I cannot get a doctor to assist him to die. I would be prepared to help him but I haven't the medication required - it is very sad to just watch him in such a condition with no hope.

One old lady told me once. "I am not afraid of dying but I am afraid of living until I die".

Please do what you can to legalise euthanasia. It will be the most compassionate thinking that has ever been done for the aged.

Yours Sincerely

W G Alcock

SUBMISSION 796 1

P J O'Shea

2/81 Lord St

Richmond 2121

Melb. Vic

Dear Ms Pat Hancock

I trust you will oppose the Bill for euthanasia in the Northern Territory.

As life is Precious and Sacred.

God think the sick and old are very important and he wants them to live on and die peacefully as one are all meant to do when he is ready for them with dignity not take drugs.

Yours sincerely

Peter J O'Shea

SUBMISSION 797 1

O.L.S.H. Convent

PO Box 4406

Darwin NT 0801

23/3/95

Dear Ms Hancock,

I am writing to you to express my deep concern at the Chief Minister Marshall Perron's euthanasia bill. The Northern Territory has a very poor domiciliary palliative care programme and no hospice. I believe if it had these latter services there would be no need to resort to euthanasia. Doctors do not need a licence to kill, but the resources to give good palliative care. Our elected representatives should be providing these services not euthanasia.

Yours sincerely

Yvonne Berecry F.D.N.S.C.

SUBMISSION 798 1

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104 Ryland Rd

Rapid Creek

NT 0810

22nd March '95

Dear Ms Hancock,

I am writing to express my concern over Mr Perron's euthanasia bill. Rather than provide a means for euthanasia shouldn't the N.T. government be looking to develop palliative care services, provide specialists, hospices so that we can more adequately care for our dying. Killing a suffering patient is not the same as getting rid of their suffering. I believe in the sanctity of life.

Yours sincerely

Kathryn Elizabeth King

SUBMISSION 799 1

2/19 Everard Rd

Ringwood

Victoria 3135

21 - 3 -95

Dear Ms Hancock

I am alarmed that the international dragon of euthanasia should once again raise its ugly head, but this time in our beautiful country of Australia. I have never been to the Northern Territory, but I can only assume that the constant heat and humidity has fuddled all your brains, so from the cool climate of Melbourne let me give you an insight into the Victorian forerunner of your designs for these old helpless people who stand in the way of their greedy grasping children inheritance. The state of Victoria has more than its share of old peoples homes, many I might say well run and happy luxurious places and then the ones, many of which have been closed by local city councils, which would have seemed better set in a Charles Dickens Novel, locked away for their own good. I witnessed at first hand a gentleman who could only have been in his mid sixties and had managed to 'escape' from a 'maximum security twilight home' at 3.30am simply because there was 1 night nurse for the entire place. Of course, we assess everything in dollars so he probably got what he was paying for, or more to the point what his family were paying for. He was dressed in a suit which he obviously slept in, there was urine down the back from the neck to the ankles, and he wanted someone with a car to take him back to his home, which he didn't realise no-longer existed having been sold by his living family so even the meagre pittance these people are obliged to pay to have their 'loved ones' incarcerated you are offering them an even cheaper and easier way out, and please don't give us this stuff about Mercy Killing.

I have seen many people die in my lifetime, many of whom in their robust days have said "when my time comes I hope they just give me a needle and send me off" but don't believe it when their time did come they clung to life and the suffering that went with it, and this is when they are washed in great waves of repentance (NEARER MY GOD TO THEE).

Please forgive me if I am losing you Ms Hancock, but you seem to be caught up in a purely materialistic world far removed from Christianity, I wonder what kind of world we would live in now if Pilate had given Christ a needle. Just to make sure we are doing everything for the right reasons and not introducing a scheme that has a few dollars tagged on the end, I would like to introduce a couple of amendments to your proposed 'BILL'

(1) Only people who have left all their worldly goods to some charitable organisation, i.e. World Vision, St Vincent de Paul, Salvation Army, Mother Teresa, Not the Cats home in case one of the family own it.

(2) No medical practitioner may receive payment of any kind for this service or whatever drugs are used, and the decision must be made by 3 doctors, two of which must come from the public health system.

This will ensure that the advertising media don't get in on the action like 'The blogg's

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terminology clinic'. Will see your loved ones off in peace and tranquillity (no strapping down or gags) or what about Safeways, New Cheaper Euthanasia Dept, Myers 2 for the price of one, and then it wouldn't be complete without Billy's bottle shop a better way I feel that Clause (1) will just about scuttle your bill on Euthanasia.

Please give serious consideration Ms Hancock, to what you are doing this is a minefield and could end up as something far removed from what you originally saw as a humane act, don't be remembered in the same class as Hitler and Stalin.

I pray you will have the courage to clearly reconsider.

Bill Collins

SUBMISSION 800 1

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10 Hindle Drive

Vermont Vic 3133

21st March 1995

To Whom It May Concern:-

I am writing to express my deep concern at the Rights of the Terminally Ill Bill introduced by Mr Marshall Perron. By introducing the principle that the terminally ill may request Euthanasia the whole attitude of the community to the terminally ill can be changed, maybe not immediately but gradually and insidiously.

Some patients who are terminally ill may request euthanasia to save being a burden to relatives. The difficulties in enforcing safeguards must be apparent. In Holland, where safeguards are supposed to operate, elderly people have been afraid to go to hospital in case they are victims of euthanasia.

In the Melbourne "Age" of 28/2/95, the Director Medical Oncology and Palliative Care, Heidelberg Repat. Hospital, Dr John Zalcberg, stated in part of his letter "good quality palliative care provides substantial relief for the vast majority of patients with advanced cancer". He concludes his letter with these words "When forming the basis of legislative action, polarised opinions, often based on painful, personal experiences or theoretical philosophic arguments, must be balanced by careful consultation with skilled practitioners working in the oncology or palliativecare fields to ensure that we protect those least able to help themselves in our society the sick and the frail".

It would be far better to support expert palliative care for the terminally ill than to promote a climate of despair, which I feel would be the result of the passing of this Bill.

Yours sincerely,

(Mrs) D. Carney.

SUBMISSION 801 1

P.O. Box 2547

DARWIN 0801

23.03.95.

Dear Ms Hancock,

I am writing to you to express my alarm at the Chief Minister Marshall Perron's euthanasia bill. The Northern Territory has no Medical Oncologist very limited Radiotherapy services, not a single palliative care specialist, an adequately resourced domiciliary palliative care programme and not a single hospice. Marshall Perron should not be giving doctors a licence to kill. Our elected representatives should be providing the above services not euthanasia.

Yours sincerely,

Beverley Dyer.

SUBMISSION 802 1

19A Gardyne Street

Waverley, NSW 2024

19 March 1995

Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

Darwin N.T. 0801

Dear Sir/Madam,

I am writing to you to express my firm belief in voluntary euthanasia.

I am 66 years of age, in good health and enjoying life at present. However, I could envisage a future time when, due to mortal illness, pain, incapacity etc., I might feel that life is no longer tolerable. It would greatly ease my mind if I knew that at that stage it would be within my power to decide whether my life could be ended legally, peacefully and with dignity.

At present we seem to show more compassion towards our pet animals whom we have no difficulty in "putting down" when the time comes, so as to spare them unnecessary suffering. Don't human beings deserve the same consideration?

I strongly believe that in a civilised, democratic society such as ours, individuals should have control over their deaths as well as their lives.

Yours faithfully,

Marianne Ryan

SUBMISSION 803 1

15 Owen St

LINDFIELD 2070

Dear Sir,

I would like to say that I am a firm believer in V.E.

Recently I lost a very dear friend who suffered dreadfully for many months and it was terrible to sit by and watch.

Actually I don't think she ever asked to help end it all, but had it been law perhaps it would have been mentioned.

Good luck with your campaign.

Yours sincerely,

Joy Millicen.

SUBMISSION 804 1

2/12 Spring Street

Hastings

Victoria 3915

21.3.95

Dear Phillip Mitchell,

I am writing to you to express my alarm at the proposed euthanasia legislation for the Northern Territory., This legislation affects all Australians. I am afraid vulnerable, sick and elderly Australians will travel to the Northern Territory to "avail" themselves of this deadly service. Acceptance of patient killing will further devalue human life and will place under scrutiny those whose lives are seen as a burden to society. I ask you to oppose the Bill.

Yours sincerely,

Joyce Stowers.

Enclosed copy of submission, addressed to Loraine Braham.

SUBMISSION 805 1

A PETITION

TO THE HONOURABLE THE SPEAKER AND MEMBERS OF THE LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY:

WE THE UNDERSIGNED RESPECTFULLY SHOWETH THAT WE ARE TOTALLY OPPOSED TO ANY FORM OF EUTHANASIA, DEFINED AS THE INTENTIONAL KILLING OF A PERSON FOR COMPASSIONATE REASONS, AND FOR THIS REASON, OBJECT TO THE "RIGHTS OF THE TERMINALLY ILL BILL". THIS BILL, WHICH IS INTENDED TO LEGALISE VOLUNTARY EUTHANASIA UNDER CERTAIN CONDITIONS, IS AN OUTRIGHT DENIAL OF THE PRINCIPLE OF THE SANCTITY OF LIFE.

YOUR PETITIONERS THEREFORE HUMBLY PRAY THAT THE MEMBERS OF THE LEGISLATIVE ASSEMBLY REJECT THE "RIGHTS OF THE TERMINALLY ILL BILL" IN TOTALITY.

AND YOUR PETITIONERS, AS IN DUTY BOUND, WILL EVER PRAY.

Petition signed by 9 residents of The Northern Territory.

SUBMISSION 806 1

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21 March, 1995

The Select Committee into the Rights of the Terminally Ill

C/o Secretary

Ms Pat Hancock

Legislative Assembly

GPO Box 3721

DARWIN N.T. 0801

Dear Ms Hancock,

I read recently, with horror, of the proposed legislation on voluntary euthanasia to be introduced into the Northern Territory Parliament. Although this is Territory legislation I believe that it has serious ramifications for all Australians, especially the elderly.

The availability of legal euthanasia will put pressure on the old and the frail to "not be a burden on society". It also puts doctors in an invidious position, considering that in the past it has rightly been their role to preserve life, not to take it or assist in taking it.

I also read or heard recently that some country in Europe (Holland I think), is introducing legislation to require doctors to provide euthanasia services. Even though such extension of the legislation is presumably not presently envisioned here it is obviously a bad path to start down.

I therefore ask you to oppose the bill.

Yours Sincerely

Peter L. Larkins

30 Smyth Street

MOUNT WAVERLEY VIC 3149

SUBMISSION 807 1

Piroska Ruby Bliem

36 View St.

Chatswood 2067

NSW.

Select Committee on Euthanasia

Parliament of Northern Territory

Dear Sir/Madame

As a VES member for many years I would like to fully support the introduction of Legal Voluntary Euthanasia everywhere, and congratulate the Northern Territory for getting there.

I believe that is a Human Right to live and die as we wish.

Without the Legislation of Voluntary Euthanasia, we are forced to end our life before it would be necessary, because of the fear of not being able to do it alone when the right time comes.

Legalised Voluntary Euthanasia would put our mind at ease, knowing that our Doctor can be our help to the end, without incriminating himself.

Yours faithfully,

P.R. Bliem.

SUBMISSION 808 1

21/3/95

9 Grevillea Circuit

Nightcliff. N.T. 0810

SUBMISSION TO SELECT COMMITTEE ON EUTHANASIA

Chairman: Hon Eric Poole MLA

Parliament House

Mitchell St

Darwin 0800.

Dear Committee,

I am opposed to the proposed euthanasia legislation.

The complexity of the issues and the ethical and practical dilemmas have defied extensive considerations by health professionals, ethicists, lay committees, "expert" and legislators worldwide. I do not think it is appropriate for the Territory to push ahead of the rest of society I am particularly concerned that this should be considered in the N.T. when, from my personal professional experience, our palliative care facilities and our aged care/nursing home options are currently inadequate.

Yours sincerely

Bart Currie

Specialist physician

Royal Darwin Hospital

SUBMISSION 809 1

Norman John Balke

Unit 4, 26 Carnoustie Circuit, Northlakes, NT 0812

PO Box 40101, Casuarina, NT 0811

Phone (089) 277171

Fax (089) 454819

Mobile 015 715978

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21 March 1995

The Chairman

Select Committee on Euthanasia

GPO Box 3721

Darwin NT 0801

Dear Sir,

I am writing to submit my response to Chief Minister Perron's Private Member's Bill entitled *Rights of the Terminally Ill.*

By introducing this Bill Mr Perron has erupted a very emotional debate which seems to have overshadowed the essence of the Bill - to end the pain and suffering of terminally ill people. Since the introduction of this Bill into the Northern Territory Parliament, we have all been giving our advice and opinions on the Bill, and all of it centres on emotional and religious attitudes of the community.

I would like to make it clear that I support this Bill with my whole heart. I have had the unfortunate experience of watching loved ones die slow and painful deaths through cancer and liver disease. The pain, both emotional and physical, suffered by patient and family is similar to that of torture, something which every civilised country detests.

However, I have also looked at the introduction of this Bill with an open mind, and after reading it, and listening to both sides of the argument I have still found that the argument and benefits for the introduction of this bill outweigh the arguments against it.

Euthanasia, also mercy killing, practice of ending a life so as to release an individual from an incurable disease or intolerable suffering. The term is sometimes used generally to refer to an easy or painless death. There are three types of euthanasia. **Voluntary euthanasia** (as outlined in Chief Minister Perron's Private Members Bill) involves a request by the dying patient or that person's legal representative. **Passive or negative euthanasia** involves not doing something to prevent death that is, allowing someone to die; **active or positive euthanasia** involves taking deliberate action to cause a death.

Euthanasia has been accepted both legally and morally in various forms in many societies. In ancient Greece and Rome it was permissible in some situations to help others die. For example, the Greek writer Plutarch mentioned that in Sparta infanticide was practised on children who lacked "health and vigour." Both Socrates and Plato sanctioned forms of euthanasia in certain cases. Voluntary euthanasia for the elderly was an approved custom in several ancient societies.

Following traditional religious principles, Western laws have generally considered the act of helping someone to die a form of homicide subject to legal sanctions. Even a passive withholding of help to prevent death has frequently been severely punished. Euthanasia, however, occurs secretly in all societies, including those in which it is held to be immoral and illegal.

Organisations supporting the legalisation of voluntary euthanasia were established in Great Britain in 1935 and in the United States in 1938, and recently, in Australia. They have gained great public support, but so far they have been unable to achieve their goal. In the last few decades, Western laws against passive and voluntary euthanasia have slowly been eased, although serious moral and legal questions still exist.

Critics point to the so-called euthanasia committees in Nazi Germany that were empowered to condemn and execute anyone found to be a burden to the state. This instance of abuse of the power of life and death has long served as a warning to some against allowing the practice of euthanasia. Proponents, on the other hand, point out that almost any individual freedom involves some risk of abuse; they argue that such risks can be kept to a minimum by using proper legal safeguards. Community attitude also takes a different view of the acts of Nazi Germany. Today we would compare our lack of compassion and our willingness to sit and watch people suffer more to Nazi Germany than the introduction of this Bill, and I strongly believe that Chief Minister Perron's Bill addresses the question of the protection of the individual.

The medical profession has generally been caught in the middle of the social controversies that rage over

euthanasia. Government and religious groups as well as the medical profession itself agree that doctors are not required to use "extraordinary means" to prolong the life of the terminally ill. What constitutes extraordinary means is usually left to the discretion of the patient's family. Modern technological advances, such as respirators and artificial kidney machines, have made it possible to keep persons alive for long periods of time even when they are permanently unconscious or irrevocably brain damaged. Proponents of euthanasia, however, believe that prolonging life in this way may cause great suffering to the patient and the family. In addition, certain life-support systems are so expensive that they cannot be provided for all potential patients.

The Pro Life Movement push their view that everyone has the right to live, and I agree. We all should have the right to life, but we are also on control of our own lives, and when the pain and suffering caused by an incurable illness drastically affects the quality of life, we should all have the right to say enough is enough and be given the legal right to leave our life with dignity. I believe that by denying the terminally ill the right to die we are subjecting them to cruel, inhuman and degrading treatment.

We have also heard statements that more money should be spent on palliative care, another statement to which I agree. But palliative care does not always work and is not always the solution for people with chronic terminal illnesses.

During the last months of my Aunt's life she was lying helpless in bed. The large doses of painkillers had no effect of her as she lay in bed suffering immense pain. Her condition

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lead to gangrene in her legs and because of her age and existing illness she could not have her legs amputated. Each day a doctor would come in and cut away the rotting flesh. She felt it all. It was devastating to watch her suffer for the many months under these conditions, until she died. Palliative care would not have helped her.

Some opponents of euthanasia have also voiced their fear that the increasing success that doctors have had in transplanting human organs might lead to abuse of the practice of euthanasia. It is now generally understood; however, that physicians will not violate the rights of the dying donor in order to help preserve the life of the organ recipient.

Australia is one of the worlds leading democracies. The Freedom of choice is an individuals basic right, and under the United Nations Universal Declaration of Human Rights, which was signed by Australia on 10 December 1948, you, the elected representative of the people, have the duty to uphold and protect those rights.

Article 1 of the Universal Declaration of Human Rights states that:

"All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in the spirit of brotherhood."

If this Bill fails to pass I will ask all who oppose it Where is your reason, your conscience and your spirit of brotherhood when you sit back and let loved ones lay helpless in a bed suffering a long and painful death.

Article 5 of the same Declaration states that:

"No-one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

There have also been people in the community who have compared the effect that this Bill will have on the community to that of the Euthanasia Bill in Holland. This tactic is very false and misleading. The two Bills are entirety different. The Dutch bill prohibits doctors and nurses from being punished if they participate in bringing about the end of a patients death. There are almost no guidelines for the enforcement of the Bill.

The controversy over voluntary euthanasia, however, is likely to remain intense because of opposition from

religious groups and many members of the medical profession. However, as the elected representative of the people, it is your responsibility to uphold the people's wishes. If it is shown that there is majority support for this Bill then it is your duty to obey the voice of the people. This is no doubt a difficult decision that the members of our government will have to make, but we live in a society where the Freedom of choice is a fundamental right. The choice to die for a terminally ill person, should also be part of that choice.

Yours Sincerely,

Norman Balke.

AUSTRALIANS

FOR

CONSTITUTIONAL MONARCHY

DEFEND the CONSTITUTION

SUBMISSION 810 1

NORTHERN TERRITORY

ANTI CANCER PATRON: His Honour the Administrator of **FOUNDATION INC.** the Northern Territory

21 March 1995

The Chairman

Select Committee on Euthanasia

GPO Box 3721

DARWIN NT 0801

Dear Mr Poole

Thank you for the opportunity to present our views as they relate to the Rights of the Terminally Ill Bill 1995. The most recent Australian Bureau of Statistics figures indicate that cancer is now the leading cause of death. Services requested of our Foundation have indicated a similar trend in the incidence and related deaths from cancer in the Top End, and this is borne out by the recently published *Northern Territory Health Outcomes.*

The paramount issue is patient, family and carer support. In order to address the needs of Territorians, who are faced with a diagnosis of a terminal illness, surveys of patients, carers and families should be carried out to enable development and implementation of finely timed services to be instituted. An optimum mix of hospital, hospice and community-based palliative care service could then be aimed for. The Foundation can readily identify the following issues which affect quality of care indicators and, if addressed, would assist with better health outcomes.

- A nationally linked Cancer Information Service is currently being implemented by the Australian Cancer Society through its member organisations.
- 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 specialization, 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.

The Foundation would be pleased to provide any further information as required.

We look forward to your Committee's findings.

Yours faithfully

Corina Braakensiek

Executive Officer

AUSTRALIAN

CANCER SOCIETY POSTAL ADDRESS: PO Box 42719 CASUARINA NT 0811 Ph: (089) 27 4888 008 678 123 Fax: (089) 27 4990

MEMBER OFFICE ADDRESS: Shop 2, Casuarina Plaza, Casuarina, Northern Territory 0810

SUBMISSION 811 1

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9 Sergison Circuit

Rapid Creek 0810

23 March 1995

Dear Ms Hancock,

I am writing to express my concern regarding the euthanasia bill. I feel this very important bill, which has huge ramifications for our society has been totally inadequately discussed and debated. There is great danger it will be pushed through in a rush with no safeguards or protections.

I want to see debate and discussion, so informed decisions can be made. Euthanasia has not been defined. The majority of people do not realise what will happen when this is requested.

My elected representative will not be presenting my views if he votes for this bill.

I strongly urge anyone who affects this bill to oppose it.

Yours sincerely,

Mrs D.I. MEAKINS.

SUBMISSION 812 1

SISTERS OF CHARITY OF ST. ANNE

63 Woodroffe Avenue, P.O. Box 1192.

Woodroffe Palmerston N.T. 0831

Palmerston N.T. 0830 Telephone: (089) 32 3355

Facsimile: (0891 32 3365

Dear Ms. Hancock, 22 March 1995

The Religious Community of Sisters of Charity of St. Anne who lives at 63 Woodroffe Ave. in Palmerston and who runs a Child Care Centre at number 61 on the same Ave, wants to let you know that:

OUR CONGREGATION SERVES THE COMMUNITY IN MANY DIFFERENT COUNTRIES WITH AMONG MANY THINGS, NURSING HOMES FOR THE ELDERLY, WHERE WE TRY TO PROVIDE HIGH STANDARD PALLIATIVE CARE

WE FIND IT TOTALLY WRONG TO LEGALISE EUTHANASIA.

KILLING PEOPLE WHO ARE OLD AND SICK IS NOT THE SOLUTION TO THE PROBLEMS OF THEIR EXISTENCE AMONG US; RATHER WE OUGHT TO CARE FOR THEM AND TREAT THEM WITH GREAT PATIENCE AND RESPECT. IN DOING THIS THE COMMUNITY SHOWS ITSELF TO POSSESS GREAT DIGNITY AND TO BE FULL OF THE KIND OF VALUE THAT MAKES OUR WORLD A BETTER PLACE TO LIVE IN.

WITH THE CORRECT SORT OF PALLIATIVE CARE OLD PEOPLE DO NOT FEEL A BURDEN ON SOCIETY NOR DO THEY WANT TO BE KILLED. WE SHOULD DO OUR BEST AS A COMMUNITY TO MAKE OLD PEOPLE FEEL WANTED, RESPECTED AND LOVED, RATHER THAT A BURDEN WHICH WE MOVE OUT OF THE WAY AS A MATTER OF CONVENIENCE.

WE PRAY THAT THE GOVERNMENT, RATHER THAN MAKING THE EUTHANASIA LEGAL, WILL GIVE OUR SOCIETY THE OPPORTUNITY TO FOUND CENTRES IN THIS COUNTRY WHERE OLD CITIZENS WILL RECEIVE THE RIGHT KIND OF PALLIATIVE CARE.

Try to do your best and the blessing of the Lord would be with you.

Yours sincerely,

Signed by 4 Sisters of the Community of Charity of St. Anne.

SUBMISSION 813 1

Chairman John Lillecrapp

Select Committee on Euthanasia 166 Kurrajong Drive

PO Box 3721 Alice Springs 0870

Darwin 0801

Dear Sir

Euthanasia, whatever its forms or motives is murder. It is gravely contrary to the dignity of the human person and to the respect to the living God, his creator. Thats it in a nutshell!

It depresses me that Mr Perron would need to take over as God and move a private members bill on such a controversial subject as a persons right to live.

Why pick on the elderly what about our young AIDS victims, young terminally ill people, our mentally sick people our depressed youth out of work poor ego's low self esteem, the physically handicapped ,the mentally handicapped the list is endless. If this legislation is passed then any legislation can be passed that concerns the lives of people. ***It is totally wrong and should be opposed*!** This bill will open the floodgates for all cases from life to death.

Politicians, are there to serve the people of their Electorate, it is a disgrace that power goes haywire and the lives of

people are involved. Please recommend that this Bill is morally wrong. The right to life is paramount.

As a Tax Payer I resent my taxes going to support abortions and now maybe Euthanasia. I resent life being interfered with. People lives should not be tampered with.

I think of my mother who is 75 being able to end her life when the Medical Team finds it too tough or the family are tired of waiting for their inheritance and pressure her into consenting to ending her life.

I agree with the Catholic Church's comments that there needs to be greater access and funding for palliative care for the Northern Territory. In general not enough money or research has been carried out regarding this area of care. Euthanasia is not the alternative.

PLEASE RECOMMEND TO THE NT ASSEMBLY THAT THIS BILL ON EUTHANASIA, SHOULD BE ABANDONED.

Yours Faithfully

John Lillecrapp

ph 523100

SUBMISSION 814 1

WEST AUSTRALIAN VOLUNTARY EUTHANASIA SOCIETY (Inc.)

W.A.V.E.S.

P.O. BOX 7243, CLOISTERS SQUARE, PERTH 6850

TELEPHONES: 276 5568 384 8646

Member of World Federation of Right-to-Die Societies

Patron: Janet Holmes a Court

Please reply to:

6 Printer St

Dianella WA 6062

Tel: 276 5568

Select Committee On Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

DARWIN N.T. 0801

21st March 1995

On behalf of the approximately 1,200 members of the West Australian Voluntary Euthanasia Society (WAVES) and the approximately 75% of people who, in public opinion polls consistently show support for the legalisation of voluntary euthanasia (VE), I should like to express appreciation of and support for Chief Minister Marshall Perron's Rights of the Terminally Ill Bill 1995. It does not deal with all possible aspects covered by its title but it offers a large step toward all-embracing legislation regarding VE.

WAVES has existed for 15 years and, in growing to its present membership has had on its books many times the 1,200 at present registered. Many members have died - some of them in ways which had prompted them to unavailingly join the Society. Some were fortunate enough to find doctors compassionate enough to help them to a final release from suffering greater than they wished to bear. It has been said that the best witnesses to the need for legalising of VE are not available to testify - they are dead. Were Marshall Perron's Bill to become an Act it would represent a great step toward removing the need for further testimony.

It is to be hoped that the Select Committee sees this matter as one of personal choice and one that requires resolution. Public opinion seems to be strongly in favour of legalisation of VE. Many members of the medical profession have declared their support and admitted that they have carried out acts of VE. Surely it is time to introduce means for the proper and open practice of a carefully regulated system that takes account of the rights of the terminally ill who are suffering more than they wish to bear and who ask sincerely and consistently for direct help aimed at inducing as peaceful and gentle a death as possible. Potential problems should be met and dealt with and not used merely to block the introduction of relevant legislation.

I enclose a copy of the Aims and Objectives of this Society.

Ralph R White PhD President

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WEST AUSTRALIAN VOLUNTARY EUTHANASIA SOCIETY(Inc.)

W.A.V.E.S.

Patron: Janet Holmes a Court

P.O. Box 7243, Cloisters Square, Perth 6000

Member of World Federation of Right-to-Die Societies

STATEMENT OF AIMS and OBJECTIVES- MAY 1988

1) The Society is a law reform organisation. It is not a self-help Society.

2) WAVES campaigns for the legalisation of **voluntary euthanasia** for adults who are suffering more than they wish to bear from illness or disablement for which no cure or treatment **acceptable to them** is available, and who have made their wishes known when they were of sound mind.

"Voluntary", in this context, means - at the sincere, understandable and consistent request (however expressed) of the sufferer. Or, if she/he is unable to communicate at the time, in accordance with instructions in a Living Will, if one was previously signed when the person was of sound mind.

"Euthanasia" means a gentle, peaceful death or the inducing of a gentle, peaceful death.

3) WAVES does not intend to campaign for the legalisation of euthanasia that is not requested by the sufferer (non-voluntary or involuntary euthanasia - often called "mercy killing"). For example, the euthanasia of deformed infants.

4) WAVES seeks legalisation of **PASSIVE VOLUNTARY EUTHANASIA** and **ACTIVE VOLUNTARY EUTHANASIA.**

PASSIVE VOLUNTARY EUTHANASIA is the removal or withholding of treatment (which may be life-sustaining) at the request of the sufferer, in the hope of inducing a gentle, peaceful death in the near future.

Relief of pain or other distress by palliative treatment (which may incidentally hasten death) is often necessary to achieve a gentle, peaceful death in such circumstances. Hospices in Western Australia already provide such treatment, mostly to cancer patients. It is, however, not relevant to some cancer patients - and certainly not for many people whose suffering is intense but for whom death is not imminent. For example, multiple sclerosis, stroke and arthritis sufferers, for whom withdrawal of treatment would not bring about a peaceful, gentle death in a short time. Indeed, withdrawal of treatment might greatly increase their suffering.

Western Australia common (court-decided) law principle holds that a doctor commits an assault if he/she continues treatment when a patient refuses it. Statutory (Parliamentenacted) Criminal Law says that a doctor is guilty of unlawful killing if a patient dies as a result of his/her not carrying out treatment. However, in Western Australia, there have been instances where Jehovah's Witnesses have refused life-sustaining blood transfusions. The most recent concerned a young woman who died as a

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consequence of refusing a blood transfusion following childbirth. The coroner did not send the doctors for trial. The hospital Medical Director later said that the hospital endeavoured to accede to patients' wishes.

WAVES wants this principle that doctors must not treat people against their wishes to be affirmed in Statutory Law, and for it to apply even should death be hastened because of lack of treatment. And for it to apply also to **all** adult people as a **RIGHT**. And to all doctors - as a duty.

5) **ACTIVE VOLUNTARY EUTHANASIA** is the actual administration of the means to a gentle, peaceful death, by choice of the person concerned. This can be brought about by:

a) the person him/herself (suicide)/, or

b) the person assisted by another person or persons (assisted suicide), or

c) a deliberate act of euthanasia administered by another person.

In Western Australia it is not illegal to commit suicide or to attempt to. It **is** illegal to assist suicide or carry out a deliberate act of euthanasia. WAVES campaigns for law reform to legalise these actions in circumstances outlined in Item 2, above.

(Deliberate acts of euthanasia are being legally carried out in Holland by doctors at the request of both terminally ill and chronic sufferers who fulfil certain guidelines. Family members and others can be - and commonly are - involved in discussions but are not allowed to prevent sufferers from receiving voluntary euthanasia).

Doctors and other carers who have conscientious objections to participating in acts of active voluntary euthanasia should be excused from participating. In such instances it must be ensured that the patient is immediately placed in the care of those who **will** carry out his/her wishes.

6) WAVES believes that **suffering** includes not only pain but also impairment of bodily functions and loss of social interactions, and that the sufferer is the best judge of the tolerability of these. He/she should determine when suffering should be ended by gentle, peaceful death. All information possible should be given to patients to help them in decision making. Doctors and other carers should not be subjected to any criminal, civil or professional action for participating in acts of voluntary euthanasia.

If some people feel themselves enriched by suffering, or see it as a fulfilment of their religious principles, WAVES supports their right to do so. But those who wish to end their suffering so that **they** and not disease take charge of their lives and deaths, should be able to do so - and the means to achieve a gentle, peaceful death should be available to them as a human right.

7) **LIVING WILLS** are made out by persons while of "sound mind" to give instructions concerning their medical treatment in circumstances where they are likely to suffer permanent and distressing impairment AND ARE UNABLE TO COMMUNICATE AT THE TIME. As long as people are capable of rational

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communication they are able to express their wishes regarding medical treatment. If such a person has signed a LIVING WILL its existence serves to verify the sincerity of those wishes, but the real purpose of a Living Will is to act as witness to a person's wishes when he/she can not communicate. WAVES does supply a form of Living Will to its members but these are not legally binding at present. However, even now, they may influence some doctors to withhold life-sustaining treatment if the patient is, for example, in a coma and not likely to recover.

Waves works toward:

a) giving Living Wills legal status,

b) making Living Wills legally binding,

c) making the instructions in Living Wills legally binding on members of the medical profession, with protection against any person (including family members) being able to prevent the sufferers wishes being carried out,

d) the creation of an official register of Living Wills which doctors must be obliged to consult,

e) ensuring that the legal validity of a Living Will, made while the person was of "sound mind", will continue if the person subsequently ceases to be of "sound mind".

SUBMISSION 815 1

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6 Hartley St.,

Alice Springs 0870

March 23rd., 1995.

Dear Sir,

We, the undersigned, wish to state that we are totally opposed to any form of euthanasia, and for this reason, object to the "Rights of the Terminally Ill Bill". We believe that human life is sacred and that noone has authority to take it away. As an alternative, we suggest that the lack of palliative care in the Northern Territory and, in particular, Alice Springs be addressed and the matter rectified. We believe that the N.T. Government should make palliative care an urgent priority in order to reduce pain and distress of the terminally ill.

Yours sincerely,

Joan Tierney,

Monica Maidment

Mary Allchin

Marie Pierre Chapman.

SUBMISSION 816 1

P.O. Box 80

Alice Springs 0811

22nd March, 1995

The Chairman,

Select Committee on Euthanasia.

Dear Sir,

I wish to lodge my strong protest against the proposed legislation described as the Voluntary Euthanasia Bill.

It seems to me that if government resources were allocated to provide adequate palliative care resources throughout the Territory there would be no grounds whatsoever for such a piece of legislation as your committee is considering.

Yours faithfully,

Dorothy L. Keane.

SUBMISSION 817 1

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1 Babbage St

A/S.

22.3.1995.

Dear Ms Hancock.

I am alarmed that Euthanasia is even being considered by our representatives in the Legislative Assembly.

They seem to be considering human lives as equal to the cattle industry, like a disposable commodity: this is dangerous and nothing short of madness.

I believe the peoples representatives were to safeguard the laws that protect those who could not protect themselves.

How vulnerable is our trust in you all.

How urgently we need to turn to The Scriptures for direction for our Australia: The Great South Land of the Holy Spirit. Only righteousness will exalt our nation: - for sin is a reproach to any people. Proverbs 14:34.

As you see I am totally opposed to euthanasia.

Thank you,

PATRICIA BIRD.

SUBMISSION 818 1

T E Reid. MB ChB

Box 40394

CASUARINA NT 0811

20 March 1995

Chairman

Parliamentary Select Committee on Euthanasia

Parliament House

Darwin NT 0800

Dear Mr Poole

I write as a member of the Northern Territory community and as a medical practitioner.

As a member of the community I support Mr Perron's bill and I consider this is a matter for the community to decide. Health professionals should comment on the principle of euthanasia as individuals not as members of the health profession. The technical aspects of providing euthanasia will require medical input.

I wish to comment on two of the antieuthanasia arguments recently publicised in Darwin.

It has been suggested that if the bill becomes law doctors and nurses will be free to kill people at will. I cannot see that the legislation will affect this ability which is already available. Indeed Dr Nelson, President of the Australian Medical Association, claims to have already used it.

I respect the spiritual view of those who regard the right to end life as belonging to a religious entity and not the individual. As far as I can see there will be no compulsion on anyone to avail themselves of the right to euthanasia and I cannot understand why those who do not hold religious beliefs forbidding euthanasia should be deprived of this right.

Yours faithfully

T.E. Reid

SUBMISSION 819 1

Chairman, 22/03/1995

Select Committee on Euthanasia

PO Box 3721

Darwin 0801

Dear Sir,

RE: EUTHANASIA BILL - DEFINITELY NO

Abortion - remember extreme cases only??? every pregnancy a wanted one;

No more unwanted children - thats the story today isnt it? Our society has really benefited.; we have no homeless children

no deprived children

look! look! look! - Our caring Politicians really speak out on the abuse of abortion. Euthanasia-extreme cases only ..... to start with. Start the snowball rolling and it will continue(like abortions) - The misfits in our society from mentally retarded - to psychiatrically disturbed.

NO! NO! NO! not immediately but like abortion little by little weeding out all the medical problems

As a Nurse I'm disgusted. I nurse because I care, with hands on experience over 20 years, I feel qualified to talk on this matter.

Death is part of life. We need palliative care to support our dying and there will always be caring nurses happy to do this work. Please support us in our role.

PALLIATIVE CARE IS THE ANSWER NOT EUTHANASIA.

Lets live up to our reputation as a lucky country and build a caring society where there is compassion and tolerance for everybody.

Yours Sincerely,

Margaret Lillecrapp

166 Kurrajong Drive

Alice Springs 0870

SUBMISSION 820 1

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53 Riverview Ave.,

Kyle Bay

Sydney 2221

Dear Premier,

Congratulations to you for your guts in trying to bring civilised dying to us. We all have to face it, and, to know we do not have to suffer hideous death because we can ask for deliverance is fine. The "right to lifers" could one day be wishing voluntary euthanasia was legal.

The very best to you.

Mrs Irene Ralfe.

SUBMISSION 821 1

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109 Princes Highway

BURRILL LAKE NSW 2539

22/3/95

Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

DARWIN N.T. 0801

Dear Sir/Madam,

As a life member of the Voluntary Euthanasia Society of New South Wales I wish to support the bill legalising euthanasia.

I am in good health myself but count that as blessing which others do not enjoy. How anyone can condemn another fellow human being to endless suffering is beyond my comprehension. If we have an animal in pain it is regarded as inhumane to let them live but we have to watch our loved ones slowly ebb away.

I feel it is most unfair to expect a doctor to risk his career to end a patients prolonged suffering and if it was not for fear of prosecution many more people could die with dignity. I wish to end my life when it is no longer useful or rewarding and congratulate the Northern Territory for leading the way towards enlightenment in this regard.

Yours faithfully

(Mrs.) M. Lamb

SUBMISSION 822 1

1/1A Thomas St

Birchgrove 2041

22/4/95

Select Committee on Euthanasia

Northern Territory.

Submission on Euthanasia

Dear Sirs & Mesdames,

At my mature age I have known of people who have suffered a breakdown of bodily organs who experienced extended indignity and remorse at needing so much nursing, and prolonged pain and vain pleas to have it all ended. The carer is ill after the long ordeal.

V.E.S., Voluntary Euthanasia Soc. meetings are packed to capacity there is a great interest and demand for legislation to free doctors from fear of prosecution and to follow Hollands lead.

Yours faithfully

(Mrs) Lilian Emmett.

SUBMISSION 823 1

The Select Committee into the Rights of The Terminally Ill Bill

c/o Secretary, Ms Pat Hancock

Legislative Assembly

G.P.O. Box 3721

Darwin N.T. 0801.

30 MacGregor St - Parkdale,

Victoria.

20.3.95

Dear Ms Pat Hancock,

I wish to express my concern at the proposed euthanasia legislation for the Northern Territory. This legislation affects us all.

Please consider the vulnerable sick, and elderly Australians who will travel to the Northern Territory to "avail" themselves of this deadly service.

Please consider this will devalue human life, and place under scrutiny those whose lives are seen as a burden to society.

I am 92 years of age, and still living a useful life, but I tremble for the less fortunate.

I ask you to please oppose the Bill, and I ask you to remember these words, "As you would", says Christ, "that men should do to you; do you also to them in like manner".

With every good wish.

Yours sincerely,

Dorothy Mendes.

SUBMISSION 824 1

Holy Spirit of Freedom Community

P.O. Box 313,

Pemberton,

W.A. 6260

14/4/95.

Dear Sir,

I write to express my opposition to legalised patientkilling. Only God ought have the power to decide when I, or any other person, may die.

I have seen enough people in distress who have spoken of their desire to die who, after a crisis has passed, are happy to be alive, to know that one's desire to die, as expressed, may not in fact be their true desire of the heart.

Three years ago our family was told that Mum, who had had a coronary, was unlikely to survive the night. So we gathered from different parts of Australia on overnight flights. We were all together my morning, so "certain" was her death. Now, she is alive still and active, and a joy to still have with us. No doctor knows for sure when a patient will die!! No doctor should have the right to put a patient to death!

I exhort you to reject the bill introduced by Marshall Perron.

Sincerely yours,

Frank & Lu Feain.

(Mr & Mrs Feain).

SUBMISSION 825 1

Right to Life Australia

National Office: 233 Brunswick Road, Brunswick. P.O. Box 70 Brunswick East, Victoria 3057

Telephone: (03) 387 7098. Facsimile: (03) 387 2182

24 March 1995

MR. ERIC POOLE

Chairman

Select Committee on Euthanasia

Northern Territory Legislative Assembly

DARWIN N.T. 0800

Dear Mr. Poole,

Please find enclosed the submission of Right to Life Australia on the Rights of the Terminally Ill Bill 1995.

Yours sincerely,

MRS. MARGARET TIGHE

Chairperson

2

Right to Life Australia

National Office: 233 Brunswick Road, Brunswick. P.O. Box 70 Brunswick East, Victoria 3057

Telephone: (03) 387 7098. Facsimile: (03) 387 2182

Submission on

RIGHTS OF THE

TERMINALLY ILL BILL 1995

(Northern Territory)

"...most people want to legalise euthanasia out of compassion

with the suffering patient. But it is a deadly compassion.

There is another way to help. Let us end the patient's pain,

not the patient's life".

DR. KAREL GUNNING, M.D.

Rotterdam, HOLLAND

RIGHT TO LIFE AUSTRALIA

MARCH 1995

3

RIGHTS OF THE TERMINALLY ILL BILL 1995

The core provisions of this Bill are:

- Allows a person who two doctors agree is "likely to die within 12 months"
- to have his life terminated with medical "assistance" - either self or other administered.
- Legalises the prescription, preparation and administration of lethal substances.
- The patient to have attained 18 years of age and be diagnosed as having a terminal illness causing "severe pain or suffering or distress".
- The patient to be fully informed of the medical treatment, including palliative care, available and
- claiming "there is no medical treatment reasonably available that is acceptable"
- Allows another person to sign the Request Certificate on behalf of - and to administer the lethal drug to - a patient who is physically or emotionally incapable of signing selfadministration.
- Allows medically assisted death to be recorded as "natural" and non-reportable to the coroner.

4

RIGHT TO LIFE AUSTRALIA COMMENTARY ON THE RIGHTS OF THE TERMINALLY ILL BILL 1995

The concept of special "rights" for the terminally ill is spurious. Never before in the history of civilised humanity has the assisted killing of one person by another/s been conceived of as a "right" or a privilege of the victim (Nazi concentration camps and Jonestown are ready examples).

The terminally ill patient already has the same rights as everyone else to appropriate medical, palliative and psychiatric care, compassion, social and economic support, and the best in pain management. These basic rights are being unmet or inadequately provided which is leading to calls for the "right" to terminate one's life.

A human "right" must be universal. We cannot confer the "right to be killed" on a select group of persons and deny it to others. Therein the inescapable, danger of a Bill like this. There are others in our community who could claim to be - or more insidiously be claimed to be - suffering, in pain and distress (e.g. the elderly, the quadriplegic, people who are HIV positive) and to whom the "right" to have their lives medically terminated should be extended.

We could just as easily offer assisted suicide to starving Africans - just as surely a terminal illness if untreated - as an expedient remedy for their suffering as other aid but no one of compassion would even contemplate this.

The tone of this Bill is very pessimistic. The presentation of the Request to a terminally ill person will have a profoundly negative psychological impact, a case of the worst scenario at the most vulnerable time. It offers the patient a terminal lack of hope (not necessarily for miraculous recovery or a wonder cure but hope to be able to live the remainder of his life with dignity, peace and fulfilment). The Bill underwrites an attitude of valuelessness, to himself and to society as a dying person, despair about the progress of his illness (particularly the patient's ability to cope with pain), fear of particular treatment which may be available (leading to suicidal non-acceptance) and great apprehension about agonies in dying.

We should also remember that a prognosis is only a probability based on statistics in the literature that are averages not certainties or derived from the doctors necessarily limited experience. So many other factors will interpose between diagnosis and death such as lifestyle, acceptance or non-acceptance of available treatment, psychological adjustment, social and economic supports - just plain "luck".

A prognosis is not a death sentence with a date of enactment. We all know people who were given gloomy predictions and who lived to confound medical opinion or who may have eventually succumbed to the disease but

many months or even a few years after, during which time they witnessed and enjoyed important family events.

One thing is predictable if this Bill is passed - the accuracy of a prognosis of death within 12 months will leap!

5

Concomitant to the creation of a legal right to terminate the life of a terminally ill patient and the production of a Certificate of Request is the duty of doctors to present such a patient on diagnosis with the availability of this "option".

This is quite different from the spontaneous, unsolicited, unprompted requests now made of the medical profession (and usually addressed with better pain management, counselling, etc.).

The routine presentation of a Certificate of Request is actually telling a patient who may not have contemplated suicide that this is an acceptable course of action. Indeed that it is, if not actually recommended, usual for someone with his illness. And what of subtle (or not so!) pressure from relatives armed with this legal death dealing document? How can a doctor attest to the lack of such co-ercion when even his own support of the certificate is endorsement.

A dying patient needs affirmation of our value of his life and our commitment to easing his remaining life - not the life denying option of legal euthanasia. How unwanted and worthless a dying person will feel if presented with this killing certificate and a web of accomplices prepared to preside over his premature death. All the more so since we know palliative and pain relief resources are inadequate in the N.T.

We have the doctor who prescribes the medication and who could assist in administering it by injection, the pharmacist who makes up the prescription - Dutch pharmacists have drawn up a special "pharmacopoeia" of lethal combination of drugs for the doctor's assistance. Then there is the care-giver who holds the glass of water to the patient's lips as the lethal tablets are washed down; the doctor's colleague who co-signs the request form is also implicated, likewise the adult who is willing to sign for the patient in the event that he/she is "physically or emotionally unable to sign the "certificate of request". Add to this list of accomplices the relatives or friends who may sit by and keep the patient company as he/she procures death.

It is well known among professionals who deal with dying patients that a request for euthanasia is usually an appeal not for release from life but relief from those things which are making dying difficult such as loneliness, need to reconcile with family members or one's religion, unmet desire to fulfil last wishes, inadequate pain management. (Appendix A)

6

PART 1 - PRELIMINARY

2. **Interpretation**

(1) "assist"

A patient who has signed a "Certificate of Request for Assistance to End my Life" may be assisted in the administration of a lethal substance if he is "not...emotionally capable" of self-administration. (N.B. Someone else can also legally sign the certificate on behalf of a patient emotionally incapable of signing for himself!)

Obviously such a patient is indecisive, unwilling, reconsidering - at worst under duress. And yet for the purposes of the Bill he can have been declared by two doctors competent and to be making the decision freely and voluntarily. And he can be killed.

4. **Response of Medical Practitioner**

(1) and (2)

Presumably the requirement for two medical practitioners to witness the Request and vouch that the conditions of the Bill are being met is to have a safety check of a second opinion.

This is a deadly farce.

A medical practitioner whilst attracting no recrimination for refusing to give "assistance" (i.e. refusing to be an accomplice to patient killing) is bound to advise a patient of other medical practitioners who are willing.

In any case an assistance - thinking doctor is hardly likely to refer a patient to a doctor who is not similarly minded so patients will be denied balanced medical opinion. Is there to be a register of doctors willing to assist by co-signing Request Certificates and administering lethal drugs? (If there is not a formal register there will certainly be an informal one!) To whom will this list be available? Other doctors, patients, relatives, the general public? What's to stop relatives doubting their ability to cope with a dying member of the family (or for other reasons e.g. as beneficiaries) shopping for compliant doctors - especially if the patient is vulnerable e.g. emotionally, financially, elderly.

We already see this occurring with prescription drug addicts.

Is there to be a register of doctors who are not willing to give assistance. At the very least there should be the obligation to seek another opinion from a doctor with a different view. (Many of us would prefer to receive our bad news in any case from a life affirming doctor).

7

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6. **Conditions under which medical practitioner may assist a patient to end his life**

(a) Patient has attained the age of 18 years.

Making the irrevocable decision to end one's life is not the same as qualifying to drive, to vote or see R rated movies. Does society really believe an 18 year old has the maturity, experience or perspective to make this choice?

(b) Just as a prognosis is a guesstimate there is the possibility of misdiagnosis of an illness. Elsewhere our legal system gives major weight to the benefit of the doubt - neither convicting nor executing where doubt exists no matter how small. Yet this Bill is prepared to legalise patient killing on the basis of a diagnosis of terminal illness on "reasonable grounds". And why choose the period 12 months within which the terminally ill patient is likely to die.

Being arbitrary a simple amendment in the future could change this to a 3 year, or a 10 year prognosis for death or omit reference to period altogether. Thus legalising euthanasia at any stage for a patient with a life threatening illness - AIDS patients in particular come to mind. Much less demanding on non-coping relatives and non-coping government budgets than catering to the needs of the long-term dying or seriously ill.

"suffering"

This term is ambiguous being used variously to mean "has", "physical pain", emotional/psychological distress, even social/economic problems. Killing on the basis of ambiguity is open to abuse especially since some if not all of these "sufferings" are relievable with appropriate support and adequate resources.

A patient who is not in physical pain (the interpretation most lay people will assume) but experiencing other distress can have his life terminated.

(c) Second medical opinion - see comments under 4(1) and 4(2).

(d) "The illness is causing the patient severe pain or suffering or distress".

This does not redress the criticism in (b) above. Pain is not defined as physical nor as unrelievable.

The actual request certificate signed by the patient and two doctors does not include this wording. The patient merely attests that he has been informed that he is "suffering from a terminal illness": "suffering" meaning "has".

(e) "There is no medical treatment reasonably available and acceptable to the patient that will relieve the patient's severe pain or suffering or distress;"

8

Appropriate pain management and other palliative measures should be reasonably available to terminally ill patients. If they are not then this is a right which should be attended to - not the expedient creation of a right to be killed. So the lynch pin of this clause is the suicidally deliberate non-acceptance of ordinary, available, warranted, appropriate treatment by patients seeking to end their lives.

Rejection of necessary treatment (as opposed to a cure) can turn a normally treatable illness into a terminal illness e.g. diabetes, thus qualifying a patient for medical euthanasia. Non-acceptance of warranted available treatment to relieve pain, distress or suffering is a psychological not a physical problem (e.g. depression, hopelessness) and should be compassionately attended to with counselling, anti-depressants etc.

(f) "...the patient's decision...made freely, voluntarily and after due consideration".

How is a doctor to ascertain this? How "free" and "voluntary" is a decision made under the understandable emotional anguish and fear in discovering you have a terminal illness. Fear of pain and disintegration of bodily functions is as likely to provoke signing of the certificate as actual pain.

Note again that references to "pain", "suffering and distress" in the Bill are nowhere qualified as being "physical" or "unrelievable" and are not even mentioned in the certificate.

From this omission in the Certificate, which after all is what the patient sees and signs, it appears it can be completed and a lethal drug administered merely in fearful anticipation of pain, distress or suffering.

In fact there is no time factor built into this Bill between diagnosis/prognosis, signing of the Request and administration of the lethal prescription. There is no "cooling off" period to protect patients from a hasty decision, from the despair of a "bad day", from their own and their family's emotional vulnerability. There is nothing to prevent patients being medically killed within hours of diagnosis.

The Bill does not require the patient to be in the final stages of their illness.

The obligation upon the doctor to provide the opportunity to a patient to withdraw the request for assistance need only be the question "Are you sure about this?" moments after completing the request form. There is no prerequisite delay to allow for contemplation of the decision.

What of a patient who lapses into a comatose state having previously signed a Request Certificate which is in his records. Who decides when to administer the fatal dose (when his hospital bed is needed?).

Or is the patient's request revoked because he is now incapable of experiencing the pain, suffering or distress he feared/was feeling when making out the Request form? This issue is simply not addressed.

9

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7. **Patient who is unable to sign Certificate of Request**

The Bill allows another person to sign on behalf of a terminally ill patient who has (supposedly) made the oral request to have their life terminated but is "emotionally unable" to sign. As discussed elsewhere the competence of such a patient should surely be questioned before someone else signs his life away - as should the "free" and "voluntary" nature of his request.

If a person is emotionally unable to sign is he emotionally capable of consenting?

It is impossible to imagine what the designers of this Bill intend by this section. If we witnessed a scene like this in a movie we would be immediately detecting coercion and picking the "bad guys" trying to "do in" the helpless patient. Only this is real life.

The proxy signatory need have no qualification other than attaining the age of 18. He could be the 19 year old cleaner passing in the hospital corridor, your sick teenager's school friend, a grasping relative, the doctor's receptionist - a total stranger.

There is no provision on the Request Certificate for indicating the signatory is not actually the patient (i.e. the intended victim) or for recording the relation of this signatory to the patient, if any.

8. **(1) and (2) Right to Rescind Request**

The patient may rescind the Request for assistance at any time and in any manner. But to whom? What if the person he tells is unfamiliar with the seriousness of the request or worse has his own reasons for not conveying the patient's change of mind or merely leaves a message at the nursing station or doctors rooms. It seems that a patient will be given ample opportunity to finalise a request for death but will have to be very insistent about conveying his desire to rescind and to make sure it is recorded. What if he is not able to notify the doctor who holds the Certificate e.g. if bedridden.

The patient's doctor is to destroy the certificate and note the fact on his medical record "as soon as practicable". Since there is no specification of a delay between signing the request and administering the lethal drug "as soon as practicable" may well be too late if the patient is in a hospital setting - remember if the patient has completed the Request but is "emotionally not capable" of self administering the drug another party can give it to him.

11. **Certification of Death**

(2) "A death as a result of assistance given under this Act shall not, for that reason only, be taken to be unexpected, unnatural or violent for the purposes of the definition of "reportable death" in the Application of Part 4 of the *Coroner's Act"*.

10

In other words sanctioning dishonesty in recording the death. The patient's death certainly has not been unexpected! But it is deceptive to record the cause as "natural death" and therefore not reportable to the Coroner.

12. **Copy certificate of request to be sent to Coroner**

The Medical Practitioner is not required to put any notation on the actual Death Certificate indicating the patient died as a result of medically assisted euthanasia other than to attach the Certificate of Request.

A "cover-up" - for example, if assisted deaths for a particular doctor or hospitals' patients escalate to dramatic/suspicious numbers - could be as simple as slipping off a paper clip separating the Death Certificate from the Request Certificate.

13. (2) In a strange twist of definition, assisted death is to be taken as "medical treatment" for legal purposes.

11

HON. MARSHALL PERRON'S PRO'S- DUBIOUS,

CON'S- DANGEROUS

Originator of the Rights of the Terminally Ill Bill 1995 (N.T.), Hon. Marshall Perron, M.L.A. has been promoting it with emotive language about death bed agonies, talk of the right of terminally ill patients to choose death with dignity, assurances of safeguards against nonvoluntary euthanasia or the broadening of its application to other categories of patients and insistence that such a decision is a free, voluntary and personal choice.

All of these arguments are exposed as flawed by a close examination of the Bill and of Hon. Perron's statements revealing his motivations in sponsoring it. If the Bill is passed, it will have fatal consequences for many Territorians (and out of state patient travellers) for many will kill themselves or be killed needlessly.

PALLIATIVE RIGHTS - THE COMPASSIONATE ANSWER

Hon. Perron is fond of the dramatic expression "to bring to an end the torture many endure on the death bed" in speeches and media releases promoting the Bill.

To start with, patients diagnosed as terminally ill are unlikely to be in "tortuous" pain at the beginning of their 12 month life expectancy prognosis and with good pain management, may not suffer unbearable pain even on their death bed. And yet the Bill allows someone to terminate their life from day 1 of the prognosis and/or completion of the certificate. Despite a provision in the Bill requiring a person to be in severe pain or suffering or distress this expression is not repeated in the certificate.

Hon. Perron's negativism about the ability of health, hospice and medical services in the Northern Territory to alleviate pain, distress and suffering in the terminally ill is, it appears, justified.

It is clear from the letter by Dr. John Zalcberg (The Age, 28/2/95) that in fact the patient being "fully informed of... medical treatment, including palliative care available to me..." as a condition for completion of the Request Certificate is going to be of sore comfort to a terminally ill patient in the Northern Territory. Services available are woefully inadequate to meet their special emotional and physical needs and would naturally incline a patient to pessimism.

Dr. Zalcberg finds it "ironical (that) the Northern Territory, one of the few places in the world to consider legalising euthanasia, has no medical oncologist, very limited radiotherapy services, not a single palliative-care specialist, an inadequately resourced domiciliary palliative care program and not a single hospice" (Appendix B).

Hon. Perron talks about choice but his government is surely stacking the weight on the side of a simple, expedient, cost-effective solution - death - by failing to address the lacks exposed by Dr. Zalcberg. Just how genuine is the "choice" for the terminally ill patient?

Hon. Perron would be showing real compassion by ensuring such patients have the life affirming "right" to appropriate care and services rather than the dubious "right" to be killed. He should be pressing for urgent resourcing of palliative care in the Northern Territory.

To forestall charges of minimalising or insensitivity to the physical pain a dying person may experience, the Right to Life movement has never had any quarrel with the use of opiate medication in whatever quantity necessary to control pain even if the large dosage required unintentionally contributes to the patient's death.

Administering drugs as part of a pain control schedule is ethically divorced from giving a deliberately lethal prescription with the express intention of ending the patient's life (see Appendix C).

LEGAL EUTHANASIA CAN'T BE CONTAINED

Insistent too is Hon. Perron that the bill "contemplates no externally imposed end of life decisions for the aged, the disabled or for anyone else" (Second Reading Speech, Rights of the Terminally Ill Bill, Hon. Marshall Perron, MLA, 1995).

In its actual terms, perhaps it does not. But a legislated "right" to terminate life to end suffering, pain or distress will very readily be "contemplated" for extension for patients other than terminally ill competent adults with a 12 month life expectancy. What of quadriplegics (see Appendix D), the psychiatrically distressed, the elderly suffering with Alzheimer's Disease, AIDS patients, the perceived "suffering" of the comatose patient. Should they be denied the "right to have their lives terminated"?

The Netherlands experience demonstrates the impossibility of containing legalised/legally tolerated killing (see below)

Dr. Karel Gunning, M.D. of Rotterdam in the Netherlands writes,

"Not only more and more categories of cases are added, also the numbers of cases are frightening. The government-appointed Remmelink committee (named after its president, a former attorney-general) reported in 1991 that on a total annual mortality of 130,000, euthanasia was applied in 2,300 cases, that is not yet 2 percent. But the committee defines euthanasia as 'ending a patient's life at his request'. Using the internationally accepted definition 'consciously causing a patient' we come to quite different conclusions: a recent article by the investigators of the committee showed that in almost 22,000 cases (nearly 17%) the doctor had the intention (implied or explicit) to end the patient's life, 12,000 times without the patient's request.

According to the new law the euthanizing doctor must fill out a form with about 50 questions, showing whether he has complied with the guidelines. This form is given to the coroner, who gives it to the public prosecutor, who must decide whether to prosecute the doctor. If, reading the report, he finds no reason to prosecute, the case is dismissed. But this decision is based on the report of the doctor, who has committed a crime. According to our Supreme Court no one can be expected to assist in his own condemnation. As the chief witness, the patient, is dead, it is very hard to prove that the doctor's report is not truthful. The new law protects the doctor as much as possible, but

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takes away all safeguard from the patient. Thus the doctor becomes a very dangerous man. Even Hippocrates, 400 years before Christ, knew this. That's why he made every doctor swear never to kill.

Few people realise what it means to allow a doctor to decide when is the time for a patient to die. A friend of mine, an internist, was asked to see a lady with lung cancer, being very short of breath and having at most a fortnight to live. After the examination he asked the patient to come to the hospital for a few days. She refused, being afraid to be euthanised there. 'But I myself am on duty this weekend. Come on Saturday morning and I'll admit and help you'. So the lady came. On Sunday night she breathed normally and felt far better. The doctor went home and, being off duty on Monday morning, came back Monday afternoon. Then the patient was dead. The doctor's colleague had said: 'What is the sense of having that woman here. It makes no difference whether she dies today or after 2 weeks. We need that bed for another case'. So the lady was euthanised against her explicit wish.

Some years ago, I was discussing with a colleague that, in order to kill a patient with morphine, you need to give huge doses. At first he denied it, but then he said: 'Yes, you may be right. I remember a case of an old man, who might die any day. Then this son came to see me and said: 'Doctor, my wife and I have booked a holiday, which we can't cancel. We don't want to come back for father's funeral, so please arrange that the burial is over before we leave'. The doctor told then, that he saw the old man one morning and gave him a huge dose of morphine and came back in the evening to declare death. But the old man was not dead at all. He was sitting happily on the edge

of his bed, having had an excellent day without pain. This colleague told the story as if it was the most normal thing to do, complying with the family's desire to have father buried before the holiday started.

We understand that most people want to legalise euthanasia out of compassion with the suffering patient. But it is a deadly compassion. There is another way to help. Let us end the patient's pain, not the patient's life'

Dr. Karel Gunning

President

World Federation of Doctors who

Respect Human Life

Rotterdam, HOLLAND

14

BILL'S KILLING CATEGORIES ELASTIC FOR VULNERABLE PATIENTS

In fact the category of people who could end their lives under this bill is broader than what most people in the community would envisage.

Most people think the term "terminal illness" applies to cancer with the certain outcome being death within say, 12 months or two years. What they don't realise is that many illnesses which may be incurable, but eminently treatable - or indeed they may be even be curable - can become terminal illnesses because the patient has rejected warranted life-saving treatment and so will die as a result, e.g. diabetes, heart disease, severe asthma attack, etc. Under the terms of the N.T. Bill, patients in this category, who rejected treatment simply because it was not "acceptable" to them and whose illness was causing "suffering or distress" and who would be "likely to die within 12 months" could have euthanasia.

It is not far fetched to put anorexics in this category or the paranoid schizophrenic refusing medication, "distressed", "suffering" and suicidal. Which also begs the question why a patient would not accept suitable warranted and available treatment for his condition.

It is quite legitimate to question the emotional competence or at the very least the emotional vulnerability of such a rejecting patient invoking the Request Certificate. And to explore his possibly unrealistic fears about the treatment or family or economic pressures on him to refuse before allowing him to sign away his **right to both treatment and life**. Maybe he is not as fully informed as the certificate requires him to be. Maybe the information provided has been presented with pessimism rather than affirmation of the worth of his life until natural death.

Given two patients with the same diagnosis, the same prognosis but different doctors - one could very well opt for hasty medical suicide - the other for the use of his remaining time for reconciliation with friends or family, as a special period of contemplation, as an opportunity to fulfil last wishes.

The skill and knowledge of a doctor in presenting a case to his terminally ill patient is an uncontrollable factor exercising influence on a patient's decision.

Mr. Perron assures his colleagues of safeguards in the Bill protecting the vulnerable in the community.

Where is the protection for terminally ill patients in the "nuisance", "worthless" group - the elderly, the alcoholic, the destitute, those without family support, even the irascible - attended by euthanasia favouring doctors at public hospitals (conscious of scarce beds, limited hospice services, medical budgets)? What is to stop two doctors declaring such a patient has 12 months - as opposed to 18 months or 3 years - to live so the patient can be dispatched now after being encouraged to sign the Certificate (a grim forecast of "pain, suffering and distress"

could procure this!).

There is **no protection** for such vulnerable terminally ill patients. That arbitrary 12 month prognosis that Mr. Perron has settled on is sufficient to put them into the killing category.,

15

"NO QUESTIONS ASKED" MEDICAL SUICIDE EVENTUAL OBJECTIVE

Hon. Perron rather lets the cat out of the bag in his Media Release of Feb. 1st, 1995 (Appendix E) revealing his intentions behind the Bill as "providing those who face sure death the right to choose when they die". Is there a human being who fails to fit this description? **This Bill is obviously an opener to legalised medically assisted suicide for any who choose for whatever reason.**

ASSURANCES OF PERSONAL CHOICE NOT SUBSTANTIATED

Hon. Perron is adamant that the Bill would allow no-one but the terminally ill patient to make the decision to end his life (Second reading Speech, op. cit., p. 3).

This is simply not the case. Part 2 Section 7 of the Bill clearly provides for a substitute signatory - any person who has attained 18 years of age - to sign the Request Certificate on behalf of a patient who has made an oral request but is "physically **or emotionally** unable to sign".

And the interpretation of "assist" for the purposes of the Bill includes the "administration of the (lethal) substance" to "a patient (who) is not...emotionally capable of administering it" i.e. to himself. Such a patient would obviously be experiencing ambivalence, doubt, perhaps even fear or duress. Does this sound like someone making a decision freely and voluntarily? Someone who is so upset he cannot sign the Certificate nor administer to himself a supposedly desired lethal prescription? We would also have to question the wisdom of a doctor vouching for the "competence" of such an "emotional patient".

ENDING WHOSE SUFFERING?

In his Background Paper "Rights of the Terminally Ill" (February 1st, 1995) Hon. Perron openly canvasses the argument that "voluntary euthanasia provides a way out; a means of ending intolerable anguish, both for terminally ill patients and those who care for them" (page 3) saying that the victims of a terminal illness are aware of "the suffering their prolonged agony causes their relatives".

Maybe Hon. Perron has got it back to front. Perhaps we should be putting the relatives out of their suffering! The answer of course is not to kill the patient but for loving counsel for the whole family, social and economic support and good pain management for the patient to help cope with this stressful experience.

Although recognising the quite understandable trauma experienced by families with a terminally ill member, Mr. Perron misses the obvious connection between this and the possibility of overt or covert pressure by relatives on the patient to unwarrantedly agree to medical suicide.

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Similarly, Hon. Perron is all for voluntary euthanasia to spare medical staff the "torment" of the ethical dilemma of "hating to see patients suffer needlessly" but fearing jail if they "relieve patients of their burden" (Background Paper, op.cit. p. 3). Thus doctors who are inadequate to deal with the pain management of their patients - and only a limited number of doctors have the specific training or the time to offer true palliative care (Dr. John Zalcberg Appendix A) - can co-sign a death request to relieve themselves of the living reminder of their lack in this area.

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CONCLUSION

Rights of the Terminally Ill Bill 1995

The proposals addressed in this Bill address the situation of only one patient at a time (with the expedient "treatment" of killing the patient) rather than attempting to improve the whole field of palliative care and pain management which would have universal and long term benefits and is life affirming rather than life threatening.

The proponents of the Bill would be demonstrating genuine compassion for the situation of the terminally ill by striving to have the Northern Territory excel in the provision of these services.

The Bill misconstrues assisted medical killing of terminally ill patients as a "right". Rather it is a grave "wrong" legalising the death of hope, the death of courage - and the death of the patient.

It is Right to Life Australia's heartfelt contention - more than justified by the Netherlands's experience - that legally sanctioned euthanasia cannot be constrained to the intended group of patients and soon expands to other categories of people especially the vulnerable in our community.

As argued here, assurances of "safeguards" are hollow - and in any case will never sufficiently protect vulnerable persons once we accept patient killing as a "right", as "medical treatment". How easily this "right" can take on the tone of a "duty".

The very availability of patient euthanasia can become a message that this is the expected course of action for terminally ill patients. Providing assisted death as a "solution" to "pain, suffering or distress" exonerates society from providing highly resourced palliative options.

Right to Life Australia passionately urges Members to oppose the Rights of the Terminally Ill Bill 1995.

Enclosed with submission:

Appendix A: Article "Wanting to die more often a cry for help" by John Zalcberg, Heidelberg, from The Age, Wednesday 8 February 1995

Appendix B: Article "Irony behind NT's euthanasia push" by John Zalcberg, Heidelberg West, from The Age, 28 February 1995

Appendix C: Leaflet "Euthanasia Issues ... True Dignity Through Pain Management", by N.T. Advocates for Patient Care.

Appendix D: Article "The moral dilemma in legalising euthanasia" by Richard Leonard, Jesuit Priest, The Sydney Morning Herald, Thursday, 9 February 1995

Appendix E: Media Release by Marshall Perron, Member for Fannie Bay, "Rights of the Terminally Ill - Reforming the Law".

SUBMISSION 826 1

SUBMISSION BY FR A. CORRY M.S.C. O.A.M,

to the SELECT COMMITTEE

23rd MARCH 1995

I am pleased to make this Submission to the Select Committee on Mr Perron's Private Members Bill entitled "Rights of the Terminally Ill"; my submission further elaborates the details of an earlier letter I wrote to each

member of Parliament; it consists of five points.

1) **Religious Attitude to Suffering,**

I am opposed to Euthanasia, as I am a committed Christian and believe life is a gift of God, that we return to Him, at His time. As suffering can be associated with death - as it was with Christ's death, it is important to have a Christian understanding of the place of pain (of all kinds) in God's plan. Currently on Imparja Television at the close of each day's programme - on "On Track" - I am speaking on this topic. For your information, I enclose the text of these seven talks (given 20th - 26th March 1995).

I notice in his Second Reading Speech, Mr Perron makes mention of suffering. I quote:

"I am not a student of Religious Theory. Perhaps it could be argued that having witnessed great suffering makes one a better person? Therefore society needs people to suffer so the rest of us can learn from them?" (P.8)

The "On Track" talks form Appendix 1.

2) **No Country Permits Euthanasia by Law,**

Many countries have considered and discussed the question - but have decided against legalizing it; England in 1992 commissioned a Select Committee to enquire into Euthanasia; its findings were published in a report (early 1994) which firmly rejected the legalisation of voluntary euthanasia.

Since no country has approved it after considerable investigation one wonders at Marshall Perron's statements in his Second Reading Speech:

P 12. "Some may view passage of this Bill as Revolutionary social change. It is no such thing."

P 15. "No-one should be overawed by the thought that this Bill is breaking new ground. It is NOT a step into the unknown."

I include an extract from Dr Brian Pollard's Book on Euthanasia -

It forms Appendix 2.

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3) **Individual Autonomy Versus Common Good.**

Marshall Perron in his Second Reading, P15, quotes John Stuart Mills on Liberty - however by underlining a different section of the quotation the importance of the Common Good is emphasised - rather than individual autonomy. I quote:

"The only freedom which deserves the name, is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs or impede their efforts to obtain it."

Mr Perron had underlined the word "Impede."

On Page 8 of his Second Reading Mr Perron had questioned the validity of the axiom "Laws are made for the common good and at times individuals must suffer for the greater good of others." He asks (P 8), "What 'Greater good of others'" is achieved by depriving the terminally ill of Euthanasia? I have attempted to answer this question in a letter to the "Alice Springs News".

That letter is presented in Appendix 3.

This appendix also includes an article by Dr John Fleming.

4) **Voluntary Euthanasia is a disincentive to striving for excellence in the care of the terminally ill.**

David J. Roy, CharlesHenri Rapin and the Board of Directors of the European Association for Palliative Care declare:

"We should firmly and without qualification oppose the legalisation of Euthanasia as both unnecessary and dangerous. We should vigorously promote programmes of Education in Palliative Medicine and Palliative Care rather than jumping on the band wagon of hysterical pleas for the decriminalisation of Euthanasia."

How far from the mark is Marshall Perron when he says in his Second Reading:

Page 8 - "What 'greater good of others' is achieved by insisting that unrelievable suffering by an individual must not be stopped even if they want to die."

I recommend the reading of Brian Pollard's Book, "The Challenge of Euthanasia" (Page 25 56). And I include the Article from Volume No 1 of the European Journal of Palliative Care as Appendix 4.

5) **Opinion Polls.**

Marshall Perron makes much of them. On page 9 of his Second Reading Speech he quotes the Sunday Territorian and the Australian Newspaper; both had conducted an opinion poll which favoured Euthanasia. On page 14 of this same speech he relies on this statistic. I quote:

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"Eight out of ten Australians, many of whom I am sure would consider themselves to be Christians want Voluntary Euthanasia decriminalised."

My query is:

How can a head count be acceptable in resolving such a complex question as Euthanasia - when the knowledge and understanding of the question, among those questioned cannot be ascertained?

In support of this section, I add two A4 pages - called Appendix 5.

Fr A. Corry M.S.C. O.A.M.

P.S. With this written submission I also make application to make an oral submission at some suitable time.

With thanks

A. Corry.

Enclosed with submission:

Appendix 1: Copy of 7 "On Track" talks presented between 20.3.95 and 26.3.95.

Appendix 2: Extract of book, "The Challenge of Euthanasia", by Dr Brian Pollard, pages 6061.

Appendix 3: Copy of letter sent to the Editor, Alice Springs News, 17th March 1995; copy of letter by Charlie Carter, Alice Springs, entitled "Euthanasia comments miss point", Alice Springs News, 8 March 1995; and copy of article by Dr John Fleming, entitled "Holland shows how euthanasia leads to active killing", News Weekly, 25 February 1995.

Appendix 4: Copy of article by David J. Roy, CharlesHenri Rapin and the Board of Directors of the European Association for Palliative Care entitled "Regarding euthanasia", European Journal of Palliative Care, Volume 1,

Number 1.

SUBMISSION 827 1

SOUTH AUSTRALIAN VOLUNTARY EUTHANASIA SOCIETY INC.

Patrons: Society Address: SAVES

Sir Mark Oliphant, AC, KBE, FRS, FAA. PO Box 2151 Kent Town

Emeritus Professor JA Richardson South Australia 5071

Please reply to: 16 Kincraig Cr, Holden Hill, SA 5088

Tel: 264 3548

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20 March 1995

The Chairman

Select Committee on Euthanasia

GPO Box 3721

DARWIN NT 0801

Dear Chairman

SUBMISSION IN SUPPORT OF THE RIGHTS OF THE TERMINALLY ILL BILL

Enclosed please find a hard copy on A4 of our submission and also a 3.5" floppy disk version in WordPerfect 5.1.

Please contact me if you would like clarification of any particular point or further information.

Sincerely,

Mary Gallnor,

President, SAVES

Board Member, WFRTDS

(World Federation of Right to Die Societies)

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SUBMISSION TO THE

SELECT COMMITTEE ON EUTHANASIA

LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

FROM THE SOUTH AUSTRALIAN

VOLUNTARY EUTHANASIA SOCIETY

PO Box 2151 Phone: 08 379 3421

Kent Town SA 5071 Fax: 08 265 2287

20 March 1995

THE CASE FOR VOLUNTARY EUTHANASIA

PREAMBLE

The South Australian Voluntary Euthanasia Society, Inc. (SAVES) was founded in 1983. Its membership is approaching 1000, including some from the Northern Territory. It is a member of the World Federation of Right to Die Societies.

Over the last 12 years, SAVES has diligently pursued its primary objective, a change to the law so that in appropriate circumstances and with defined safeguards a medically assisted or induced death becomes an available option in medical practice. These circumstances include the free and informed request of the patient and the free exercise of professional medical judgement and conscience by the doctor. As part of this process SAVES has studied the extensive literature relating to voluntary euthanasia, has attended international, national and state conferences and forums, has published its own literature on a range of aspects of voluntary euthanasia and has explored the topic with the health care and legal professions and with politicians. SAVES made a detailed submissions to the South Australian Parliamentary Select Committee on the Law and Practice Relating to Death and Dying in 1991 and participated in the extensive debate that followed the Select Committee's Interim Report the following year.

Following the rejection of the principle of voluntary euthanasia by the SA Select Committee, SAVES prepared a draft Voluntary Euthanasia Bill, intending this to be basis of broadly based ongoing discussions once the SA Consent to Medical Treatment and Palliative Care Bill had been processed through parliament. A private member's Voluntary Euthanasia Bill was introduced independently of SAVES in the lower house (the House of Assembly) in March 95 and the debate on that Bill is proceeding.

It is against this background that SAVES makes this submission in support of the Rights of the Terminally Ill Bill. It is based on material from the third edition of the SAVES handbook, The Right to Choose, currently in the final stages of preparation for publication. References in support of various statements made in the submission are not provided here but are available from SAVES should they be required and will be included in the handbook when published.

SAVES endorses the Bill as a progressive piece of legislation incorporating necessary but not excessive safeguards. It cannot be considered the ultimate Voluntary Euthanasia Bill, nor does it purport to be, because it makes no provision for the suffering non-terminally ill (which includes those in unwilling total dependence on others), or for advance declarations to take effect should a patient become incompetent, or for the appointment of health care trustees to ensure the patient's wishes are respected in the latter event. However, SAVES accepts that progressive legislation can sometimes only be achieved one step at a time, that experience must be gained before the community and its law makers are ready for the next step. This is not the same as the so-called slippery slope because the boundaries of voluntary euthanasia are clear from the outset. The barrier against the abuse of individual rights is the absolute nature of the voluntary requirement protected by legal sanction, the integrity of the medical profession and a vigilant free press.

INTRODUCTION

We share with all forms of life the certainty of death. It is natural to hope that it will come to us peacefully without prolonged suffering or distress. At present this hope is not always realised. Because of prejudice, taboos,

misunderstanding and the legal position in our society, people who have good reason to seek a medically assisted or induced death are unable to obtain it and have to endure periods of intolerable suffering and, possibly, unwanted total dependency on others. Many would be saved great anxiety about their final days if they knew that a quick and peaceful death could be available to them in such circumstances.

DEFINITION

Euthanasia From the Greek, meaning "good death"; a death which is peaceful and humane. Also, "the act of inducing a good death".

Voluntary Euthanasia A good death brought about at the express wish of the person concerned a personal and rational choice.

SAVES advocates voluntary euthanasia as an option in medical practice for competent adults who have requested this help. The doctor's involvement must be equally voluntary. There must be appropriate safeguards, and the patient must be suffering from an incurable, distressing illness or condition, or have deteriorated mentally or physically to the point of being totally dependent on others. There must be no available treatment which is acceptable to the patient to provide adequate relief. SAVES therefore uses the following working definition of voluntary euthanasia:

A medically assisted or induced

quick and peaceful death

at the request of

and in the interests of a patient

in which prescribed safeguards are followed.

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THE MORAL CASE

The case for voluntary euthanasia is founded on four moral principles:

Personal Autonomy In a liberal democracy we should be free to make decisions about our own conduct, provided we do not do so to the detriment of others. Laws that respect our freedom require no justification: those that deprive us of liberty do. The question is not, "Why should voluntary euthanasia be permitted?" but, "Why should it be prohibited?". Whatever suffering or deterioration we may be prepared to accept for ourselves in the dying process, we should not deny to others the right to say when they have had enough. To be taken seriously, the case against voluntary euthanasia has to establish that its acceptance would cause more harm than results from the current prohibition.

Compassion for Suffering This principle is embodied in medical and nursing practice and in the Christian ethic. A preoccupation with the absolute form of the sanctity of life principle, requiring that every vestige of life be preserved as long as is humanly possible, regardless of the effect on, or wishes of the sufferer, is not compatible with compassion.

Concern for the Quality of Life There is far more to human life than a beating pulse, the drawing of breath, or the reaction of nerves to a stimulus. Life encompasses selfawareness, the ability to communicate with others and to pursue meaningful activities. In that sense, to be alive is to have a conscious identity, to be a person. When life no longer has that quality, but has been permanently replaced by an existence burdensome to oneself and others it makes little sense to speak of "a right to life". It becomes "an obligation to life" if we can under no circumstances surrender it.

Respect for Human Dignity Dignity is an essentially human element in quality of life and its loss is for many the ultimate humiliation. There are few who find it easy to contemplate the irreversible loss of control over mental and/or bodily functions which can be a consequence of the ravages of disease, particularly with advancing age. Their desire to die with dignity should be respected. In such circumstances they should be allowed the option of a quick and peaceful death.

THE NEED

The great **progress in medical science** over the last few decades has led to a marked increase in the number of people who live to advanced years. There has been a corresponding increase in the number of those who are faced with a terminal, painful and often prolonged illness, or with the certain prospect of decline into totally dependent senility. Medical science has also improved the chances of a person's survival in the event of severe accident or disease, survival not infrequently accompanied by permanent gross disabilities. An increasing number of people, particularly the elderly and latterly, those afflicted with AIDS, are claiming the right of access to a quick and peaceful death when, in their view, life is no longer worth living and its quality cannot be restored.

Public Opinion Polls In the first survey on euthanasia in Australia by the Roy Morgan Research Centre in 1946, 42% favoured letting a patient in great pain die while 41% said the doctor should try to keep the patient alive. Majority support for letting the patient die was first recorded in 1955 (53%).

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In the May 1994 Morgan Gallop Poll, 78% of those polled answered "yes" to the following unambiguous question, only 22% answering "no" or "undecided".

"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 a doctor be allowed to give a lethal dose or not ?"

Polls conducted in Britain, Canada and the United States all show support at a similar level. Even allowing for the limitations of public opinion polls, there is no doubt of widespread and growing support for the principle of voluntary euthanasia.

The percentages by religious persuasion answering "yes" to the above question were:

Anglican 84%

Presbyterian 81%

Roman Catholic 73%

Uniting Church 77%

In a study of some 310,000 attenders from 6,700 congregations of twenty denominations in Australia, 42% agreed that "people should able to choose to die to relieve suffering from an incurable illness"; 28% were uncertain; 30% disagreed.

Medical Opinion In a questionnaire received by 1,667 medical practitioners in New South Wales and the ACT in 1993 they were asked, *"Do you think it is sometimes right for a doctor to take active steps to bring about the death of a patient ?"* 1,268 (76%) responded, of whom and 59% said "yes".

When asked, *"Do you think the law should be changed to allow doctors to take active steps to bring about a patient's death under some circumstances ?"* 58% of respondents said "yes".

The results were similar to those obtained in a 1988 survey of doctors in Victoria. A survey in 1991 of doctors and nurses in South Australia reported that 45% of doctors and 60% of nurses who replied were in favour of legalising

voluntary euthanasia.

Although it is apparent that there is support from a great many doctors, medical associations here and overseas, apart from the Netherlands, do not accept voluntary euthanasia as a legitimate measure in medical practice. SAVES is urging the Australian Medical Association to recognise the division among its members and adopt a neutral position. **Dr Nelson, President of the Australian Medical Association**, has expressed the view that regardless of the law, doctors will follow their conscience and medical judgement in the interests of their patients. We agree that whether or not a doctor provides voluntary euthanasia in a given situation should be a matter of conscience and medical judgement of the doctors concerned. We do not agree that the doctor should be expected to break the law in this respect. This is what forces acts of voluntary euthanasia to be carried out surreptitiously without the benefit of training, supervision, consultation or guidelines.

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Nursing Opinion The opinions of Australian nurses were tested in 1991 by a survey carried out in Victoria. A questionnaire was sent to approximately 2000 nurses with current practising certificates, of whom 913 (49%) responded. 55% said "yes" in answer to the question:

"In the course of your work, has a patient ever asked you to hasten his or her death (whether by withdrawing treatment or by taking active steps to hasten death) ?",

while 95% of those answering "yes" considered that a patient's request to have death hastened can sometimes be rational.

75% of respondents supported the introduction of voluntary euthanasia with guidelines such as apply in the Netherlands; 68% would be willing to be involved in the practice of voluntary euthanasia under those conditions. The greater support for voluntary euthanasia among nurses compared with doctors (75% versus 58%) may reflect the closer relationship they often form with incurably ill patients.

The strong support from the general public, from doctors and from nurses is a clear indication of need.

The Human Aspect

"If one of the main obstacles to the public recognition of the right to die comes from those who object to suicide and voluntary euthanasia on philosophical or religious grounds, another perhaps even more important obstacle is, I believe, the widespread ignorance about death and dying, and a failure to understand how a civilised society might sensibly and responsibly deal with the requests of the hopelessly ill who want to die. We must add to the abstract philosophical discussions about the right to die the experiences of those who have dealt with death and dying at first hand, and provide a sketch of a professional and social response appropriate for a liberal and pluralist society." (Dr Helga Kuhse, Director of the Centre for Human Bioethics at Monash University.)

Many people of middle age, and some younger, have known of a relative or friend who was forced to endure a distressful illness or condition to the bitter end when all humanity cried out that their plea for a quick and peaceful death be respected. For those who are not convinced there is a wealth of published accounts of such cases. (eg: Kuhse in Willing to Listen, Wanting to Die, Marilynne Seguin, in A Gentle Death). The need for the option of voluntary euthanasia in human terms alone is overwhelming.

MEDICAL ASPECTS

The Medical Ethic

The doctor's duty is to preserve life and relieve suffering, acting always in the patient's best interests. A dilemma arises when the preservation of life is no longer compatible with the relief of suffering and the patient wishes to die. The withholding or withdrawal of "futile and burdensome" treatment, or increased dosages of drugs for

symptom relief, which may hasten death, are generally accepted as sound medical practice. But doctors are not agreed on whether it can ever be right to take action for the purpose of ending life.

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The medical ethic is commonly spoken of as if it precluded voluntary euthanasia and the Hippocratic Oath may be quoted in support. But the oath was devised long before medicine developed the knowledge, techniques and skills that exist today and it is no longer generally accepted as a definitive statement. The modern version is the Declaration of Geneva adopted by the World Medical Association in 1968 and amended in 1983. The relevant portion reads:

"I will maintain the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge contrary to the laws of humanity."

The meaning of "*respect for human life*" and "*the laws of humanity*" has not been interpreted in the medical profession as disallowing medical abortion, over which doctors remain divided, so it can hardly be claimed to disallow voluntary euthanasia, over which doctors are similarly divided.

Medical Objections

Objections commonly raised against voluntary euthanasia are responded to in the next section. But there are some of particular medical concern. It has been claimed:

(1) that **palliative care can meet the needs of the hopelessly ill** for a dignified end to their lives, so that none would reasonably wish to be helped to die. The claim is less widely made now than it used to be. A number of palliative care workers have come to accept that it is not achievable, either now or in the foreseeable future. It is not primarily pain which is to be combated, there are other more intractable and distressing symptoms.

(2) that **the practice of voluntary euthanasia would lead to loss of patient confidence** in doctors. The "best interests" principle suggests the reverse. The knowledge that in the last resort a compassionate doctor would be willing to consider a request for a medically assisted death would be a source of comfort to those who think that they might one day need that help, but it poses no threat to those for whom it is unacceptable.

(3) that **doctors would abuse the trust** placed in them; it would become an "easy fix". This ignores both the extent to which a practice which is now unregulated would become safeguarded by law and carefully monitored, and the traumatic experience for the doctor in ending a patient's life. It challenges professional and personal integrity. It calls for great compassion and a degree of courage. It is no "easy fix".

(4) that there would be **less effort devoted to finding cures**, or improving standards of palliative care. It is far more likely that research to combat disease and improve health care would proceed unaffected. Indeed, it might well prove an added spur to research in order to reduce the occasion for voluntary euthanasia.

(5) that it **would create a division between participating and nonparticipating doctors.** Voluntary euthanasia is likely to remain a controversial issue for some time. Resolution will come, we believe, when the supposed harmful consequences do not eventuate. The practice will then become accepted as a valid option in final clinical care without stigma, though always voluntary for the individual doctor.

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(6) that the **medical profession is not yet ready** to take this step. This is unfortunately true, so the possibility exists that when legislation is eventually passed it will find the profession unprepared; its members without the training opportunities and support services they need for the task.

It is not to be expected that the Association will endorse voluntary euthanasia in the near future, but it is reasonable

to hope that it will drop its opposition in favour of a neutral stance. This would acknowledge the division of opinion among its members and allow the Association to uphold the conscience both of those who oppose the practice and those who support it.

OTHER OBJECTIONS

Religious Objections

We refer here only to objections from Christian sources and make no attempt to explore views held in other faiths.

The Sanctity of Human Life This concept, in its absolute form, regards human life as a gift from God, who alone may decide when it shall end, so that it may not be given up, or taken by another. Personal autonomy is overridden by God's purpose, which is not said to be thwarted if life is medically prolonged. Although most church leaders adhere to this tradition, a majority of their adherents appear not to. Although inconsistent, it is widely accepted in Christian religious tradition that there are circumstances where it is justifiable to take life, such as in selfdefence, defence of the lives of others, judicial execution, or a "just war". But the exceptions do not extend to the individual's choice of a quick peaceful death in place of intolerable suffering, or a noncognitive existence.

The concept takes no account of life's quality, holding that all life, regardless of the ravages of disease or injury, even in a persistent vegetative state and permanently devoid of meaning and awareness for its possessor, is of equal worth in the sight of God. For many this suggests a remote, even cruel God, acting from obscure motives far from what might be expected from a loving God.

A doctor who is regarded as God's agent in preserving life can in the circumstances justifying voluntary euthanasia be thought of with equal logic as God's agent in bringing life to an end.

The Value of Suffering Some believe that suffering should simply be endured, either because it is deserved in that we are sinful, or it is ennobling, or has a redemptive value in the eyes of God, sharing the suffering of Jesus. It is also argued that there is scope for spiritual growth in the extended experience of dying, although this can hardly apply if conscious existence has ceased. It has even been said that voluntary euthanasia would deprive others of the spiritual benefit they could derive from the exercise of compassion towards the dying person.

Scriptural Authority There is no Biblical reference that relates directly to voluntary euthanasia. Principles such as the sanctity of human life and the value of suffering are derived from doctrinal interpretations of passages in the Bible. At one time it was argued that voluntary euthanasia was prohibited by the sixth commandment, translated in the King James Bible as "Thou shalt not kill". It is now accepted that the sixth commandment prohibits unlawful killing and is correctly translated as "You shall do no murder" (NEB). When voluntary euthanasia is lawful it will be dissociated from

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murder and irrational suicide. In any event, it is misleading to refer to it as "killing", with the implication of violence against an unwilling victim. In voluntary euthanasia there is no violence or victim, only "a gentle act of merciful clinical care".

In so far as religious objections are portrayed as "revealed truth" they cannot be argued, but must be respected as part of our right to freedom of religious belief. A similar right is inherent in the concept of voluntary euthanasia. All should be free to live and die according to their own values. No patient, doctor, or medical facility, would be required to participate against their conscience. Those who oppose voluntary euthanasia in principle should not seek to deny the option to those for whom it is morally right.

Pragmatic Objections

In Australia's democratic and multicultural society people are free to adopt any system of belief, or none, but not to

impose theirs upon others. It follows that objectors to voluntary euthanasia must argue not merely that it contravenes their beliefs, or is "contrary to the Will of God" as an Adelaide pastor put it, but that it would harm society. The purpose of legislation is to protect the social order not to enforce a particular morality.

The Slippery Slope It is claimed that acceptance of voluntary euthanasia would weaken respect for life and lead unavoidably to lifetermination on grounds which do not include the express wish of an incurably ill adult patient. There is no evidence to support this alarming speculation. In fact, voluntary euthanasia shows greater respect for life, not less. We can have scant respect for life if we require people who are incurably ill and suffering intolerably, or permanently deprived of conscious life, to live on in that condition against their will.

Harm to the Family It is argued that the alternative of voluntary euthanasia would make family members less inclined to support a sick relative, whom they might even pressure to take up the option. Or the patient might feel guilt over the burden being carried by the family and seek release for their sake. A voluntary euthanasia law would require two doctors to be independently satisfied that the request was both freely made and rational in the light of the patient's condition. The belief that such requirements could and would be easily circumvented is farfetched. On the other hand, the desire to avoid distressing others is a valid motive in someone who is incurably ill and suffering without prospect of relief.

Society is Placed at Risk Once voluntary euthanasia is available, it is claimed, the sick, disabled and elderly would live in fear of becoming victims of nonvoluntary euthanasia or being disposed of as a burden. But no one would be entitled to request euthanasia on the grounds that they were sick, disabled, or elderly, but only if two independent doctors had, at the patient's initiative, certified that they were incurably ill and irremediably distressed. The government and the health care profession would be responsible for ensuring that the public and patients were fully informed of the safeguards, so that none need fear such abuse.

The Problem of Regulation In conjunction with the slippery slope contention it is claimed that voluntary euthanasia could not be effectively regulated; there would be too many loopholes and opportunities for abuse. An irrational comparison is attempted with the legalisation of abortion where, it is contended, a law designed to restrict the practice to defined circumstances has resulted

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in abortion "on demand". The dissimilarities are obvious. Abortion ends a life at its beginning, at the request of and for the sake of its mother; voluntary euthanasia ends a life that has been effectively completed, at the request of and for the sake of its possessor. The abortion campaign has always sought abortion on request and the pressure for this remains; voluntary euthanasia is proposed only in prescribed circumstances under special safeguards; euthanasia on demand is not wanted.

THE ROLE OF THE MEDICAL PROFESSION

Voluntary euthanasia should only be carried out by medical practitioners. It is from their patients that the request will come; it is they who have the skills to assess the condition and advise the patient, the means to comply with the request, and the professional integrity and organisation to administer and monitor the practice.

Voluntary euthanasia is a measure of last resort, a final treatment option for doctors dealing with irremediable suffering, if the patient so wishes. The request must come from the patient and the right of the doctor to refuse must be absolute. There must be safeguards prescribed by law as well as sound practice guidelines developed within the profession. The procedure is intensely personal and never to be undertaken lightly.

Voluntary euthanasia is currently practised outside the law without the benefit of professional guidelines, training or consultation. Both patient and doctor are compromised; many patients die in unwanted and avoidable distress; even those who are helped to die do not necessarily obtain as good a death as their circumstances might permit. Is it not better that voluntary euthanasia should be practised openly and under rules that respect both the status of the

doctor and the rights of the patient ?

In condemning voluntary euthanasia and opposing legislation medical associations are contributing nothing to the resolution of this unsatisfactory situation. They are also failing to represent perhaps half their members, just as they would be if they gave support. The same quandary is presented by abortion, recognised by the World Medical Association in a statement, to the effect that the Association cannot take a stand on abortion because of the division of opinion among doctors. It therefore supports the individual conscience of the doctor. Although the two measures are different in practice and from an ethical viewpoint, it would be consistent for the Association to adopt the same position on voluntary euthanasia.

The regulation of medical conduct rests primarily with the profession in such areas as training; ethical standards; corporate support; and the sharing of professional wisdom and experience. The medical profession enjoys a high reputation in these regards and there is no doubt that it could respond properly to the introduction of lawful voluntary euthanasia.

The ultimate sanction in medical conduct is provided by the Medical Board and the Medical Practitioners Professional Conduct Tribunal, or their equivalent in a given State, charged with the responsibility of "maintaining high standards of competence and conduct by medical practitioners". It can be assumed that these arrangements will operate to regulate the practice of voluntary euthanasia and that sound practice guidelines will be formulated by the Medical Board or its equivalent.

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It is clear that voluntary euthanasia is needed. Inevitably it will one day be lawful. It is important that the medical and related professions should by then be adequately prepared. Rather than blindly oppose the concept, or seek arguments for rejecting it, doctors individually and the profession corporately should be critically examining the practice, considering the implications of a change in the law and suggesting how this might be done. The change can come about with, or without, their collaboration and input; the choice is theirs.

CONCLUSION

The debate on the Bill will determine whether legislation that establishes the right of the terminally ill in the Northern Territory to choose the manner of their dying and facilitates the participation of medical practitioners in that process is to be enacted. If the Bill fails it will be necessary to muddle along a little longer under the present law that *"condemns a significant number of dying patients to intolerable pain and distress and imposes on a number of caring medical practitioners the threat of prosecution and professional ruin for doing what they believe their professional duty requires"*.

Surely this cannot be the preferred alternative of the NT law makers ?

SUBMISSION 828 1

Knights of the Southern Cross (Australia) Inc

National Secretariat

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TO:

The Chairman

Select Committee on Euthanasia

GPO Box 3721

Darwin NT 0801

SUBJECT:

Enquiry into **Rights of the Terminally Ill Bill 1995**

Submission prepared by:

Knights of the Southern Cross (Australia) Inc

Robert Power Michael Cassidy

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Rights of the Terminally Ill Bill 1995

(encompassing "Euthanasia")

Submission to Select Committee

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Rights of the Terminally Ill Bill 1995 (encompassing "Euthanasia")

Submission to Select Committee

1. Party Making Submission

The Knights of the Southern Cross is an Order of Catholic men who are united throughout Australia as a fraternal order with objects which include the advancement of Australia and the fostering of the Christian way of life throughout the nation. Our Order does not concern itself with party politics but its membership includes members of all major political parties. The major national charitable work of our Order is concerned with care for the aged. Our work for the aged is done through Southern Cross Homes Australia which presently accommodate approximately 4,000 elderly people in home units, hostels and nursing homes in all States and the Australian Capital Territory, and which provide as far as possible ongoing care. Day care centres are also conducted in several of our major complexes and a philosophy and standard of accommodation and care has been established which has the approval and support of the Commonwealth, State and Territory governments. In summary, we are an organisation which is directly involved in providing to elderly people the care and support which will enable them to live out their lives and to die with dignity.

2. The Enquiry

Although the specific terms of reference are the subject of some criticism later in this submission, we note that the Bill has been referred to a Select Committee which has a general mandate to enquire into the provisions of the Bill. Implicit in such a mandate is an obligation to enquire into how the lives of individuals, families and communities in the Northern Territory may be improved. These goals are not dissimilar to the intent of the objects of our Order.

3. The Terms of Reference

Any enquiry into options for dying would be expected to have as its motivating philosophy the care of the dying by the community and an in depth enquiry as to how that care might be improved. The terms of reference, however, (Appendix 1) require the Committee to enquiry into only the provisions of this Bill. The Committee is thus limited in a fundamental way in considering the options for the care of the dying.

Among the provisions of the Bill are clauses to establish a "right" to be assisted in suicide in certain circumstances and a "right" for some person or persons to commit homicide or to assist a person to commit suicide neither of which is justifiable under existing law (Section 3). Section 6 is subsidiary to Section 3. Section 17 contemplates provision for the protection of those who might be expected to assist in the suicide or perpetrate the homicide. These actions constitute euthanasia which we totally condemn. The Roman Catholic Church through its Sacred Congregation for Doctrine of the Faith has clearly defined the teaching of our Church as being totally opposed to euthanasia in any circumstances again as recently as 5th May, 1980 (Appendix 4). Furthermore, in a paper written by Mr Nicholas Tonti-Filippini, the sometime Director of St Vincent's Bio-ethics Centre, the ethical problems of the "right-to-die" concept are highlighted (Appendix 5).

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For the Committee to recommend that the Bill be passed into law it must satisfy itself that the existing law is deficient. We have reported the existing law in summary Appendix 2.1 and in detail Appendix 2.2.

We draw attention to the speech of Mr Norman St John-Stevas MP on the 7th April, 1970 in rebuttal of a Private

Members Bill to legalise euthanasia introduced in the House of Commons. He reports that the House was extremely hostile towards the bill and there was no division. The speech of Mr St John-Stevas (Appendix 6) condemns euthanasia and states "… **that the burden of proof is upon those advocating a change so fundamental as to deprive our society of an essential protection and expose us to a whole variety of dangers**."

He emphasised that there is a clear moral distinction between administering a pain killing drug in the knowledge that it **may or will shorten life** and administering a drug **with the direct intention to kill**. The safeguard of that distinction is contained in the professional and ethical standards of the medical profession supported by the law. If either of those safeguards is removed then the patient and the doctor are exposed to equal danger.

4. Public Meetings

We have already indicated that as a body of Catholic laymen we support the position of the Catholic Church in utterly opposing euthanasia. We are confident that many others in the NT and wider Australian community support our view. This has been demonstrated in the response to various public meetings on the issue. For example, when the ACT community became aware that the issue would be presented to their Legislative Assembly they took the opportunity to express their view overwhelmingly opposed to euthanasia.

Two public meetings were held in 1993 on a proposal to legalise "euthanasia" (intentional killing) of the "terminally ill". One took the form of a debate and the other a learned address with both concluding with periods of questioning of the speakers by the public.

Generally the feeling at the meetings was one of approval of the opportunity to express individual and collective opinion on questions of fundamental importance such as those raised by this enquiry.

The meetings emphatically rejected the concept of legislation which would facilitate assisted suicide or homicide in any of its forms embraced by reference to the term "euthanasia". The meetings supported the right of all human beings to live with dignity, to receive professional care and support during illness and thus to meet the inevitability of death with dignity and in accordance with the natural law.

A report of these meetings is attached (Appendix 7).

An address given at two similar meetings by Bishop Mulkearns of Ballarat outlining the Christian philosophy of euthanasia is also attached (Appendix 8).

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5. Submission

We accordingly submit that the Committee's response to the terms of reference should be in accordance with the views of the majority of people in the Northern Territory and throughout Australia. We are confident that that majority is opposed to euthanasia as expressed at the various public meetings held on the issue of legislative change such as that in the Rights of the Terminally Ill Bill 1995.

The response should be:

1. Under present law the right to refuse burdensome and officious medical treatment already exists (Appendix 3). There should be no change.

2. There should be no legislation permitting an individual to direct that he or she be assisted in committing suicide by any other person or persons (Appendix 3).

4. No additional protection is required for medical or health professionals other than those now existing in the legal system in the Northern Territory.

5. The matters covered in the provisions of this Bill, not already adequately covered by legislation, do not confer a benefit on the community of the Northern Territory and therefore should not be passed into law.

6. Recommendation for Future Action

We strongly urge that the Select Committee broadens its investigations so as to consider:

(a) The circumstances in which most people die

(b) The quality of care facilities available to the dying

(c) Funding of such current facilities

(d) The need for additional funds and facilities

(e) The need for broader community education into dying

(f) The desirability for extensive hospice services

and reports to the Assembly on its findings in these areas as part of this current enquiry.

7. Concluding Statement

In conclusion we refer the Committee to a passage from the parliamentary speech of Mr Norman St John-Stevas MP which not only states our ethical belief but also encapsulates what we believe should be the directions for future enquiry by the Legislative Assembly of the Northern Territory and this Committee, for we believe that such future direction must be consistent with the general mandate of promoting the welfare of all people in the Northern Territory.

"The final state of an incurable illness can be a wasteland, but it need not be. It can be a vital period in a person's life reconciling him to life and to death and giving him an interior peace. This is the experience of people who have looked after the dying. To achieve that needs intense loving and tactful care and co-operation between relations and medical attendants. This painstaking conscientious, constructive approach to the dying is, I believe, more human and compassionate than the snuffing out proposed by those who are well-intentioned, but who seem to understand little of the complexities of the needs of those they are attempting to help."

APPENDIX 1

REFERENCE TO THE SELECT COMMITTEE

INQUIRY INTO RIGHTS OF THE TERMINALLY ILL BILL 1995

To take evidence and submissions on the Rights of the Terminally Ill Bill 1995 and report to the Assembly by 16 May 1995.

While we applaud the invitation of public submissions to the Committee, we note that little has been done to expand on the concerns of the Committee to enable directed public comment or to provide adequate time for public consideration of the fundamental issues embodied in the Bill.

We consider a number of issues implicit in the Committee's enquiry. Having regard to the greatly increased technological capacity to sustain life, the Committee should deliberate on:

(1) the fundamental question as to whether, and under what circumstances, if any, a person should have a "right" to die,

(2) whether it is desirable and practicable for the Government to take legislative or other action establishing a "right" to die,

(3) the "right" of an individual to direct that in certain circumstances he or she be allowed to die, or to be assisted in committing suicide or to be killed and the form which such a direction, should take,

(4) the "right" of an individual who has not and is incapable of giving such a direction to be allowed to die, or be killed,

(5) the "right" of another individual or medical practitioner to make a decision that a person who has not given and is incapable of giving such a direction should be allowed to die, or be killed,

(6) protection for medical, nursing and other professionals who allow an individual to die, or assist an individual in suicide, including the need for guidelines for carers in the use of life sustaining equipment and procedures and the need for continuing counselling and after care,

(7) relevant literature, legislation, judicial decisions and other relevant developments in Australia and overseas including, but not limited to:

(i) the Quinlan case in the USA,

(ii) the Barendregt case in the Netherlands, and

(iii) the Californian and South Australian Natural Death Acts, the Victorian Human Tissue Act, the ACT Transplantation and Anatomy Act, and the Yale Legislative Services Model Bill: Medical Treatment Decision Act, 1978.

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APPENDIX 2.1

EXISTING LAW - SUMMARY

In this submission, we indicated that the right to refuse treatment already exists in law and needs no further legal definition. Similarly, the right of a representative of an incompetent person to refuse life-sustaining treatment exists in circumstances in which the representative is a parent or legally appointed guardian.

In our submission, the law as it currently applies to death is examined in more detail. Specifically, the common law, as modified in part by statute, applies in the following ways

1. Death is adequately defined in Australian law, for example, the Commonwealth's Transplantation and Anatomy Act 1978.

2. All persons have a right not to be trespassed upon without their consent.

3 All persons are under an obligation to provide adequate care to persons to whom they have accepted a duty of care. As a corollary of this duty, a deliberate withholding of some necessity with the intention of bringing about death is homicide.

Each of these legal principles is outlined in more detail in Appendix 2.2 to this submission. In our submission, the effect of the current law is threefold:

First, death is clearly and adequately defined as in, for example, the Transplantation and Anatomy Act 1978. Second, the current law imposes a duty on doctors and others to provide ordinary and adequate care. Such duty is but an application of the law of negligence which imposes an obligation of care, according to the standards of the ordinary competent member of the class of persons assuming such care, upon all persons, be they doctors or others

when assuming such a duty. Third, a person has a right to refuse treatment and such right is protected by the law of trespass.

A number of matters are appropriate for comment in the light of the current law.

First, it has been argued by Mr Justice Kirby and others that it is inappropriate for the courts to be forced to develop and decide the law in this area. In our submission, the law is clear, and the courts at the most would be called upon to interpret its application in a particular case. For the reasons outlined in the appended papers, we believe that the alternative of specific legislation is fraught with difficulties. We do recognise that there is a need to properly educate all members of the medical profession and the general community about their rights under the current law. While it is our experience that those doctors involved in the management of the acutely ill on a day to day basis generally have little difficulty with the application of the law in such a manner that rights and responsibilities are maintained without loss of either, there may be some advantage to educate the community generally.

In this context, the case of John McEwan clearly illustrates the need for the rights of individuals and the responsibilities of doctors to be understood. As we understand the circumstances of his case, some confusion surrounded the duty to provide ordinary care and his right to refuse treatment. In our opinion, his right to refuse treatment was consistent with the absence of a duty to provide burdensome treatment.

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In our submission, the current law recognises a consistent principle in its application, namely, that there is a duty to provide ordinary care, but no duty to provide treatment that is burdensome, officious or unwanted by the patient. This is a duty that avoids the significant difficulties of "living will" legislation and other legislation to deal with dying, yet maintains the principle that persons should not have the "right" to dispose of the life of others except in extreme cases at the hands of the State.

Accordingly, we maintain that the existing law is adequate and the burden of proof must lie with those advocating any fundamental change.

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APPENDIX 2.2

EXISTING LAW - DETAIL

1. The Common Law

In the past, the statute laws of Australia and Britain have never attempted to define death and have left its diagnosis to the medical profession. The classical criteria for determining death were the cessation of respiration and circulation of the blood.

The common law defined death as a moment when life had ceased, "Defined by physicians as a total stoppage of the circulation of the blood and a cessation of the animal and vital functions consequent therein, such as respiration, pulsation etc" (Black's Law Dictionary, 4ed, 1959, 488)

In the vast majority of cases, these will continue to be the criteria for the legal determination of death.

2. New Technology

The common law reliance on cessation of cardiac and respiratory functions creates a dilemma when the cardiorespiratory system is sustained beyond the death of the brain by life saving apparatus that is now available in most hospitals. Can death be legally determined?

The problem is particularly brought into sharp focus where organs are sought for transplantation whilst circulation continues or shortly after circulation ceases, such as with a kidney transplantation. If the source of the organ is a young, otherwise healthy patient who dies in hospital from causes unrelated to the condition of the organ concerned the diagnosis of death may be extremely difficult.

3. Legal Cases

Two cases serve to illustrate the difficulties with the common law definition of death.

In R. v Potter (unreported c. 1963) a man stopped breathing some fourteen hours after being admitted to hospital with head injuries sustained in a fight with the accused person. He was then connected to an artificial respirator for twenty-four hours, after which a kidney was removed and transplanted. The respirator was thereafter disconnected, and there was no spontaneous breathing or heartbeat. At the coroner's inquest, the question arose whether the accused had caused the victim's death. Medical evidence showed that the patient had no hope of recovery from the brain injury. The coroner's jury found that the removal of the kidney had not caused the patient's death and returned a verdict of manslaughter against the assailant.

Following this decision, a surgeon could have been at legal risk, the argument being that the removal of the organ had occurred prior to death as traditionally defined by the common law.

Similar problems were raised in a Californian case of People v. Lyons (California Supreme Court, Oatland, 21.5.74, cited in Horan) in which the jury was confronted with determining whether the bullet from a defendant's gun caused the death of the victim, or whether the death occurred as the result of the removal of organs from the deceased's body by the physicians.

In this case, the judge instructed the jury that:

"Death is the cessation of life. A person may be pronounced dead if, based on the usual and customary standards of medical practice, it has been determined that the person has suffered an irreversible cessation of brain function...."

Compare this instruction with the traditional definition of death at common law.

4. Brain Death - a New Definition?

The instruction to the jury in the Californian case referred to the concept of brain death.

The problem facing doctors and legislators alike was that death is a continuum, that is, parts of the body die at different periods after, for example, the heart ceases to beat.

In order to resolve this dilemma, the death of the brain was examined, with a consensus emerging amongst doctors that the irreversible cessation of all brain function including brain stem function precluded a patient ever again regaining consciousness, memory, knowledge, thought, feeling, sight, hearing, touch, speech or any other sense of any kind.

These cases must be contrasted with types of coma or unconsciousness in which recovery may or may not occur, such as the Karen Ann Quinlan case.

The acceptance of the concept of brain death may be traced to the 1968 Report to the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, and legally to the seminal article by Alexander Capron and Leon Kass in 121 University of Pennsylvania Law Review 37(1972).

Although the Harvard definition was later taken up by various medical bodies the concept was not without some debate. Some argued that brain death meant cerebral death, however death of the cerebrum alone has not generally

been accepted by either the medical profession nor the public as real death.

Without going into the debates about the extent of brain death, the position today may be summarised as an acceptance generally of the concept of total brain death. In America, the American Bar Association supported this concept in 1975. In 1979, the American Medical Association published a model definition of death Act based on the same concept and the ABA Uniform Death Act. More than half of the American States have adopted one or the other of these drafts. In Australia, the Law Reform Commission in its report Human Tissue Transplants (No 7, 1977) also proposed a definition of death to encompass both the traditional definition of death and brain death.

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5. An Appropriate Response?

The definition of brain death as a total cessation of all brain function is proper.

In their seminal article, Capron and Kass postulated four conceptual levels for a possible definition incorporating brain death

1. The basic concept or idea

2. General physiological standards

3. Operational criteria

4. Specific tests or procedures

The law can respond best by setting general physiological standards. The basic concept is for philosophers; and operational criteria and specific tests or procedures are for the medical profession.

6. Current Australian Law

The Parliament of the Commonwealth of Australia passed the Transplantation and Anatomy Act in 1978. Section 45 of the Act states:

"For the purposes of the law of the Territory, a person has died when there has occurred

(a) irreversible cessation of all function of the brain of the person; or

(b) irreversible cessation of circulation of blood in the body of the person".

This definition incorporates the Brain death concept in (a) and the Common Law definition in subsection (b). Subsection (a) is framed to emphasise the totality of brain death.

There are a number of advantages of this definition:

1. Permits judicial determination of the ultimate fact of death.

2. Permits medical determination of the evidentiary fact of death.

3. Avoids religious determination of any fact.

4. Avoids prescribing the medical criteria.

5. Enhances changing medical criteria.

6. Covers known tests: brain, heart beat and breathing.

7. Covers death as a process.

8. Covers death as a point of time.

9. Avoids euthanasia.

10. Covers both civil and criminal law.

11. Covers current medical practices.

(see Horan & Marzen "Death with Dignity and the 'Living Will': A commentary on Legislative Developments" Journal of Legislation Vol. 5, 1978).

7. The Moral Realm

The new definition of death would also appear to meet Catholic religious teachings whereas an acceptance of cerebral death alone would not. To quote Grisez and Boyle (Human Life Review, 1978):

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"Death is the permanent termination of the integrated functioning characteristics of a living body as a whole. In human individuals beyond the embryonic stage of development, death occurs when there is a complete and irreversible loss of the functioning of the entire brain".

Although this brief is not to venture into the refusal of medical treatment type of legislation, one problem with such legislation is acceptance of a different standard of death.

8. Some Examples

The definition does not mean that a person who has spontaneous respiration and circulation but has a brain lesion which makes him comatose can be declared dead. So too, the hydranchephalic child cannot be declared brain dead because he probably has a thalamus and upper brain stem. Similarly, an anenchephalic child who has voluntary respiration and circulation is not capable of being declared dead although his condition is incompatible with life and will not live more than a few hours.

9. The Criteria

The definition of death as contained in the Transplantation and Anatomy Act leaves the actual criteria to the medical profession. To a large extent, the tests are derived from the criteria suggested by the Harvard School in its Report.

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APPENDIX 3

THE RIGHT TO REFUSE TREATMENT AND THE "LIVING WILL"

1. INTRODUCTION

In Australia, legislation in the form of the Natural Death Act (South Australia) and the Victorian Refusal of Medical Treatment Bill has been introduced into Parliament. The legislation is generally referred to as "Living Will" legislation. Such provision is included in the Bill now before the Committee.

In order to discuss such legislation, it is first necessary to examine the reasons for its introduction into our legislatures.

"Living will" legislation is proposed to enable death - to allow individuals to die with dignity according to their own wishes. Specifically, it proceeds on a number of assumptions, namely:

· that people have insufficient control over their treatment, and

· that people are being kept alive beyond the point of brain death by the utilisation of various life support systems.

The third assumption is that incurable pain often wracks patients with terminable illnesses, although the experience of the modern hospice movement, both here and overseas, suggests that the terminally ill can be cared for in conditions which preserve dignity and alleviate pain.

Our purpose is to examine briefly the first two assumptions before turning to the proposed refusal of medical treatment and "living will" legislation generally. Our comments are critical of the legislation but this criticism does not proceed from a particular moral position. Rather, it proceeds from a belief, having examined the legislation, that it is both unnecessary and ultimately unworkable.

A. The claim that persons have insufficient control over their treatment

A commonly advanced argument for "living will" legislation is the said existence of insufficient control by patients over their medical treatment, especially in circumstances of terminal illness.

The recognition of an irreversibly poor prognosis and the avoidance of meddlesome over treatment is part of current good medical practice. To state that some members of the medical profession may have been reluctant in the past to inform their patients frankly of their prognosis and discuss possible alternative forms of treatment, including non-treatment apart from the relief of pain and the provision of nourishment, is not to infer the need for legislative intervention of this sort today.

Patients do have a right to control their own treatment. The common law always has held that a person has a right not to be touched without his or her consent. For a doctor to ignore this right is an assault. Unfortunately, the passive attitude and possible ignorance of many patients may have led this principle to have been obscured.

The proposed legislation overlooks the fact that the law already gives the competent person the responsibility to consent to treatment, hence the right to refuse that treatment.

The situation of the incompetent person is made difficult, not by the obscurity of the law, but by the need to ensure that appointed guardians are acting in the patient's best interests.

What is required is further education of medical students, doctors and the public alike to ensure that informed decisions can be made by individual patients.

B. The claim that patients are being kept alive unnecessarily by life support systems

"Living will" statutes also have stemmed from the fear of medical technology among proponents of the legislation. The assumption is that there is a widespread use of life support systems to keep alive people who would otherwise die of an irreversible illness. In fact, in good medical practice today, life support systems are used to determine whether an illness is irreversible. An artificial respirator, for example, may be used for a time on a patient with severe lung disease, usually of sudden origin, to determine whether treatment can reverse the pathological process.

The exception to this routine is the use of chronic dialysis for kidney failure - a treatment only pursued after an open discussion between patient and doctor with a view to the patient's overall long term prognosis.

There has been much confusion injected into the current discussion about "living wills" by the use (or misuse) of the term passive euthanasia. To turn off a respirator when a patient has irreversible brain damage and is incapable of maintaining his or her respiration has nothing to do with euthanasia. It is a judgment as to an irreversible situation. Involved in the confusion is a misunderstanding of the function of so-called life support systems. An

artificial respirator supports the function of spontaneous respiration during a period in which a pathological process may be reversed. If this is not possible, for example, in the case of irreversible brain damage, to turn off a respirator is a recognition of an irreversible situation.

The judgment as to when an illness is irreversible, and the avoidance of excessive and useless treatment, always has been part of good medical practice. A change in the law is not required to create a situation where doctors recognise a poor prognosis and avoid useless over treatment.

Such decisions ought to be made on proper medical grounds, that is, that of irreversibility of pathological processes, and not on subjective judgments as to the "usefulness" to society of that patient.

C. Active and passive, voluntary and involuntary euthanasia

In discussion about "living will" legislation, proponents of the statutes have drawn distinctions between active and passive, voluntary and involuntary euthanasia.

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But if a doctor deliberately lets a patient die who was suffering from a routinely curable illness, the doctor would certainly be to blame for what he had done, just as he would be to blame if he had needlessly killed the patient. Charges against him would then be appropriate. If so, it would be no defence at all for him to insist that he didn't "do anything". He would have done something very serious indeed, for he let his patient die.

The idea that there is a clear moral difference between deliberately killing and deliberately allowing to die is open to doubt.

The law does not regard passive euthanasia any differently from active euthanasia at least in principle, and both are equally cases of homicide. Criminal liability attaches to omissions as much as it attaches to acts: in the medical situation, for example, if a doctor, intending that his patient shall die, or knowing that death will probably ensue, omits to do what professional conduct demands, may well have committed murder. Murder is the crime of unlawful homicide with malice aforethought, as where death is caused by an unlawful act done with the intention to cause death or bodily harm. The general rule of law is that a person is presumed to intend the natural, reasonable and probable consequences of his acts. A doctor who decides not to employ a mode of treatment which would prolong the life of a patient may, in the legal sense, be presumed to intend the death of that patient. (Whether a jury would convict a doctor in such circumstances is another question.)

Thus claims that "living will" legislation has nothing to do with euthanasia are incorrect. It is arbitrary to select one meaning of euthanasia ignoring the wider implications of "living will" legislation. The term euthanasia means to kill in a merciful manner. In the present debate, the proposal is that the law should sanction the putting painlessly to death those suffering from incurable and painful disease.

Whilst the distinction between deliberately killing and deliberately letting die in circumstances where proper treatment would reverse any pathological process is doubtful, the provision of heroic, useless treatment is not good medical practice. Direct intervention to end life is not licit but the use of drugs to alleviate pain and suffering in terminal patients is not only licit, but is a desired medical intervention to avoid unnecessary suffering. We must clarify what is being meant when people speak of "letting die".

It is not necessary that all available means be used to prolong life to its ultimate. Good medical judgment can be the basis for the termination of treatment when that treatment is no longer beneficial to the patient.

The distinction sought to be drawn between active and passive, voluntary and involuntary euthanasia is confusing and adds nothing to the clarification of this area of medical practice.

2. THE REFUSAL OF MEDICAL TREATMENT PROVISION

The terms of the provisions relating to refusal of medical treatment indicate clearly the real difficulties faced by a legislature seeking to provide a codified, simplistic solution to situations requiring diagnosis, treatment, discussion and care with patients on an individual basis. Even if the underlying philosophy of the Bill were accepted, this proposed legislation provides a clumsy, uncertain and probably unworkable answer.

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While it is not our intention to detail all the objections to the Bill, a number of the more important deficiencies illustrate the problems with "living will" legislation.

First, the Bill defines a terminal illness as "the patient is likely to die within 12 months as a result of the illness" and continues: "there is no medical treatment reasonably available and acceptable to the patient that will relieve the patient's severe pain or suffering or distress."

This definition may be interpreted to mean anything. For example, leukaemia is often a terminal illness in the sense that it does ultimately bring about the patient's death. Is the patient enduring "severe pain or suffering or distress"? And what does "likely to die within 12 months" mean? The death may yet be some years after the illness was diagnosed.

The Victorian Health Advisory Council have suggested a quality of life criteria in the definition of a fatal condition, thus providing a means by which the presently existing right to refuse medical treatment would be transformed into the provision of mercy killing in conditions where the quality of life, as adjudged by others, is said to have diminished to a point where it should not exist. What is the criteria: social, economic, convenience? And who decides? The medical profession? Relatives who themselves have not yet come to terms with the inevitability of death and prefer to hasten its course?

This Bill is based on the false assumption that it is impossible to relieve pain at the same time as prolonging the life of terminally ill patients. To use leukaemia as an example again: this condition can allow sufferers to live happy, productive and useful lives for several years after the initial diagnosis.

Second, the technical aspects of the Bill present a quagmire of legal problems. A "living will" must be exercised in writing but can be revoked verbally. How is a doctor to know the final wishes of his patient? Uncertainty abounds. In the place of good medical judgment the legislation would leave doctors liable for damages arising out of the uncertain application of the general principle in individual cases.

Further problems involve the witnessing of declarations made pursuant to the legislation.

More importantly, "living will" legislation contemplates a declaration made ahead of time authorising euthanasia. It is difficult however to term such a declaration an informed consent. The requirement of particularity (the requirement that the consent must be given in respect of a particular treatment concerned) is not present. The consent is given at large. It is given without sufficient information being provided to the patient about the nature and consequences of the procedure involved, and their alternatives, to allow the patient to come to a reasoned decision. Should the law entertain a situation in which it requires full, detailed and informed consent for most medical procedures but not for another procedure which actually brings about the death of the patient?

These comments about the refusal of medical treatment provisions indicate deficiencies in "living will" legislation generally. It is therefore necessary to consider the need for such legislation at all and the ramifications of its introduction.

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3. THE NEED FOR LEGISLATION

The extent to which "living will" legislation in fact serves the end it purports to further - the dignified death - is open to serious question. Legislation of this nature both in the United States and in a proposed form here is at once confusing to all parties involved and obscures the problem of a humane and dignified death.

As indicated earlier, the competent adult may refuse medical treatment pursuant to the common law rule, which requires no statutory recognition, that any unconsented touching is a battery. Thus, for the adult who remains competent through terminal illness and for his medical practitioner, the "living will" legislation is legally superfluous. That patient may reject medical treatment as a matter of choice and that choice may be respected by his attending doctors.

Such legislation ostensibly provides an opportunity for a written and enforceable expression of patient choice should the person become incompetent during terminal illness. To justify "living will" legislation upon this ground alone, however, presumes that the medical practitioner would be liable for failure to extend heroic treatment to the patient in the absence of a specific refusal by the patient. But short of abandonment, the medical practitioner is under no obligation to initiate or continue heroic or useless treatment. Indeed, medical practitioners customarily with familial consent discontinue or fail to initiate such treatment without violating the ethical norms of the community or their profession - and there is, as yet, no reported case, civil or criminal, in which liability has been attracted for the discontinuance of treatment for the terminally ill. The question for each case is what is good medical practice.

Furthermore, "living will" legislation increases rather than decreases the decision or burden upon the medical practitioner. In addition, the legislation does not clarify the area of greatest need - those patients who reach the terminal stage while comatose or incompetent and who have never executed a 'living will.'

Some of the problems which arise from the introduction of such legislation include questions of informed and voluntary consent, the role of medical practitioners and the uncertainty occasioned by the future operation of the patient's declaration.

A. Informed and voluntary consent

As indicated in relation to the discussion of the refusal of medical treatment provision, a major problem arises in attempting to provide for informed consent in "living will" legislation. The requirement that the consent must be given in respect of the particular treatment concerned is not present. As Professor Yale Kamisar, of the University of Michigan Law School, indicated in a commentary on American legislation in this area: "Even reasonable assurance of informed and voluntary consent in this area meets almost insurmountable difficulties."

The statutes so far enacted in the United States of America confront the problem of consent either clumsily or not at all, apparently content with gross declarations of principle and sentimental evocations of Ideal Death. Where exceptions are made in view of circumstances where the directive might not fully represent informed consent, they tend to defeat entirely the original intent of the statute.

B. The role of medical practitioners

Ironically, legislation intended to relieve medical practitioners from decision-making responsibilities in relation to heroic treatment accomplishes exactly the opposite. All the enacted legislation ostensibly provides immunity for the medical practitioner for discontinuance or failure to initiate heroic treatment (though civil or criminal liability never has been attached in any case). But in so doing, it is implied that there is liability in the absence of a directive or when the directive is invalid. Further, instead of making a medical decision based upon whether treatment would be heroic or useless - and conferring with the patient and family as to whether it should be pursued anyway - the physician is to become embroiled in issues outside his competence and in endlessly frustrating procedural controversies. Whether the treatment is extraordinary and the patient is terminally ill are the decisions which still

must be made.

Even if the current refusal of medical treatment provision was redrafted to remove some of the uncertainties relating to the witnessing of a declaration and revocation, how is the medical practitioner to know that these procedures have been correctly and freely done by the patient? And why should the medical practitioner become involved in such matters when his task surely is to attend to the care of a dying human being? In what sense is the dignified natural death thereby ensured? While desirable from one point or view, the safeguard procedures are potentially so complex that the medical practitioner is likely either to disregard the will where the patient was qualified by execution, or mechanically comply in all circumstances upon the presumption that the will was always legally binding.

The medical practitioner also may be reluctant to withdraw or withhold life-sustaining treatment unless a directive has been executed by the patient, even though there is no legal obligation to extend heroic or useless care. Such legislation inhibits the medical practitioner's efforts to treat the dying patient with dignity and shackles him in an unnecessary and burdensome framework of legal procedure.

Moreover, the legislation removes an important area of medical practice from the usual legal principles by which medical conduct is controlled.

Rather than permitting standards of medical practice to develop in this area in the traditional manner, such legislation attempts the impossible task of particularising medical decision-making. Would the legislature attempt to determine under what circumstances an appendix may or must be removed? It is significant that the Bill in fact is not being demanded by the medical profession. A better, more flexible and ultimately more humane approach would be to permit the determination of customary standards to remain in the hands of the medical profession. Only if medical practitioners overstep the bounds of legal or ethical propriety should society intervene.

The adoption of brain death as a definition of death in the Transplantation and Anatomy Act is of more constructive benefit to the promotion of good medical practice than any "living will" legislation. By enacting this definition, the legislature has approved the considerable body of scientific evidence supporting the concept that death occurs when a person suffers irreversible cessation of all brain function. More importantly, the adoption of the definition has lent support to the increasingly more accepted view among medical practitioners that good medical care

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involves the avoidance of heroic or useless treatment. The legislative adoption of the brain death definition provides assurance for medical practitioners that this attitude is correct. It also renders "living will" legislation superfluous. The ascertainment of the scientifically and medically verifiable fact of death, thus avoiding the need to prescribe useless or heroic treatment, is far more preferable to the uncertain, subjective, inflexible "living will", with its consequent removal of medical treatment for the terminally ill to the realm of opinion and legal procedure.

C. Consent to future treatment

An unavoidable feature of "living will" legislation is its operation over a period of time in which medical practice undoubtedly will change. What is extraordinary treatment may change radically over the life time of the declarant, thus throwing into confusion definitions o life-sustaining procedures. Furthermore, general declarations cannot be conceived to anticipate all the particular options available in the context of particular disease or injury over the life time of the declarant.

Death is not ennobled merely by transferring decisions which encompass it to printed paper in a form determined by the state.

4. CONCLUSION

Moreover, the adoption of a Code of Medical Professional Ethics such as that suggested by the St Vincent's Hospital Bio-Ethics Centre recently would clarify any misunderstandings on the part of young or inexperienced doctors whilst allowing medical treatment and practice to develop in the traditional way, free from unnecessary legal procedure.

(See Annex A)

Further, the education of doctors and nurses in ethics and the law would provide the assistance now lacking in the proper determination of these issues.

Proper medical care of terminally ill and elderly patients renders the proposed legislation unnecessary. The fact that requests for euthanasia can arise is an indictment of the quality of our technical and personal care. Proper medical care and attention to the factors causing distress renders the question irrelevant.

The logical consequences of a law change are manifestly undesirable. It must be recognised that the proposal of voluntary euthanasia arises in a twentieth century society in which death has been hospitalised and is not a part of common experience.

Legislation of homicide by consent would result in unreasonable pressure on all terminally ill patients. There are those at present who consider that they are a burden to their family and some are even made to feel this. If the law were changed to permit "living will" legislation, there would be patients manipulated into this course of action and others who would sign away their lives mistakenly thinking it was what their families wanted.

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Further logical consequence of a change to the law would be the changed role of doctors and nurses. The present relationship is one of trust, based on the conviction that the doctor will work only to the patient's good. If the medical profession becomes involved in the termination of life as a result of legislation in this area, there would be a loss of trust to the detriment of the patient.

This legislation also would place unrealistic pressure on disadvantaged people in our society. Once the principle of "a life not worthy to be lived" was accepted, we would then find a widening of the indications to cover other disadvantaged people - the ones least able to stand up to their rights to proper care. This legislation is quite clearly the thin edge of the campaign for euthanasia.

The legislation assumes that a legal means is the best method of dealing with the problems of dying. The constructive solution to the problems raised by terminal illness is better medical and nursing care. To this extent, palliative and hospice care programmes need to be promoted. It is instructive to note the comments of Lord Raglan who was the proposer of the Euthanasia Bill which came before the British House of Lords in 1969. Lord Raglan subsequently changed his mind! At the London Medical Group Conference on 5 February 1972, he said that he could not envisage any bill with adequate safeguards and that euthanasia in any case would be unnecessary if terminal care all over the country was brought up to the standard he had seen in the hospices.

The real choice we must make is whether we, as a society, care enough about people to act constructively to relieve the distress of terminal illness. The alternative is to throw up our hands in horror and accept the philosophy of despair, eliminating the patient as well as the problem.

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ANNEX A to Appendix 3

STATEMENT OF CONDITIONS

With due regard to their level of competence and the availability of medical resources, health care professionals

accept the responsibility to carry out whatever justifiable procedures are appropriate to a patient's condition. Every procedure carried out by medical or nursing staff on hospital patients must be justifiable according to the following conditions.

A procedure is **justified if and only if**:

(a) Free and informed consent has been obtained from the patient, if he or she is competent; free and informed consent has been obtained from an incompetent patient prior to his or her having become incompetent; free and informed consent has been obtained from an incompetent patient's responsible representative acting in the patient's best interest; or the attending physician, in the event of consent being unobtainable in time, or in the event of an incompetent patient's consent or responsible representative's consent being non-existent or otherwise unavailable, judges that the procedure is in the patient's best interests, and

(b) In the judgement of the patient's physician;

(i) The procedure will improve or maintain the patient's standard of health by effecting a cure, arresting a health or life threatening condition, or relieving pain or other distressing symptoms, or

(ii) The procedure will provide information which will be helpful in the diagnosis or prognosis of the patient's condition or will advance the interest of medical research which will be of some benefit to the patient or other members of the community; or

(iii) The procedure is designed to provide donor tissue for use in treating another patient, and the loss of the tissue from the donor does not deprive him or her of life or *of* the functional integrity of his or her body; or

(iv) The procedure is carried out on a patient who has suffered complete and irreversible brain death, and is undertaken for the purposes of ascertaining cause of death or the nature of the patient's condition, or for the purposes of removing tissue for research or therapeutic reasons, and the procedure is not contrary to the previously expressed wishes of the patient or the wishes of the patient's immediate responsible family; and

(c) The treatment of a patient's condition is not of such a burdensome or intrusive nature, and the probable benefit to the patient so marginal that the overall effect is not beneficial to the patient in his or her own judgment, in the judgment of an incompetent patient's representative acting in the patient's best interests, or in the judgment of the physician attending an incompetent, inadequately represented patient; and

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(d) The procedure does not risk the life or health of other patients or the medical or nursing staff without their informed consent, and

(e) The risks to the life or health of the patient are outweighed by the probable benefits and

(f) The procedure is not designed to shorten or terminate the patient's life.

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APPENDIX 4

EUTHANASIA - Roman Catholic Church Sacred Congregation for Doctrine of the Faith, 5 May 1980

"By Euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and the methods used.

It is necessary to state firmly once more that nothing and no one can in any way permit the killing of an innocent

human being, whether a foetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying. Furthermore, no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it either explicitly or implicitly. Nor can any authority legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offence against the dignity of the human person, a crime against life, and an attack on humanity."

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APPENDIX 5

EUTHANASIA - MR TONTI-FILIPPINI

The "right to die" could mean the right to refuse life-sustaining treatment or the "right to be assisted in suicide".

The "right of an individual to direct that he or she be allowed to die or be assisted in dying" would encompass both the right to refuse life-sustaining treatment and the right to be assisted in suicide.

The "right of an individual who has not and is incapable of giving such a direction to be allowed to die, or assisted in dying" would encompass involuntary active and passive euthanasia, that is, homicide.

For the sake of removing the ambiguities, therefore, it would be better to refer to:

(A) the right of a competent patient to refuse life-sustaining treatment.

(B) the right of a representative of an incompetent patient to refuse life-sustaining treatment on the patient's behalf.

(C) the right of a competent patient to direct that he or she be assisted in suicide or to have a fatal treatment administered.

(D) the right of the representative of an incompetent patient to direct that a fatal treatment be administered to the patient.

The right of a competent patient to refuse treatment already exists in law and needs no further legal protection.

The right of a representative of an incompetent patient to refuse life-sustaining treatment on the patient's behalf exists in the circumstances in which the representative is a parent or a legally appointed guardian of the patient who is a child or has been declared mentally incompetent.

Where the patient has no such legal representation, as is the case with most adult patients, the representatives of the patient still have a role to play in informing the treatment team of the previously expressed wishes of the patient and of that which they judge the patient would have wished had he or she been competent to express a wish. In practice, the wishes of incompetent patients are thus represented by his or her relatives and form a part of the physician's decision about whether or not treatment should be given.

Thus in practice, rights (A) and (B) are protected.

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A possible means of reinforcing (B) has been proposed in the Right to Refuse Medical Treatment Bill, 1981, which would be a refusal of life-sustaining treatment in the event that he or she suffers from a fatal condition from which there is no prospect of temporary or permanent recovery.

The difficulties with such a legislative proposal are, firstly, that it would be an attempt to make certain that which must remain uncertain. That is, the terms "temporary or permanent recovery" and "fatal condition" are vague and

imprecise, and in practice would be of uncertain application. Ultimately, their application would rest with the treatment team, and hence would leave the position as it is, a decision by the patient's physician as to whether life sustaining treatment should be applied.

Secondly, the likely effect of the existence of such a document would be to make a patient's physician even more fearful of legal interference. That fear would in many cases make a physician reluctant to explain the medical circumstances to the patient's relatives when that information might later be used in a legal action against the physician. Without that information the relatives would be unable to represent the patient's wishes adequately, and hence the nett effect of the legislation would be to reduce the representation of the wishes of incompetent patients who had completed a "living will". The legislation would therefore be counterproductive to the purposes it is in fact designed to serve.

In order to give a competent patient a right to direct that he or she be assisted in suicide or have a fatal treatment administered would require a change in the Criminal Law such that homicide were permitted in such cases. That is, to legalise voluntary euthanasia.

In order to give the representative of an incompetent patient the right to direct that a fatal treatment be administered to the patient, would require a similar change in the Criminal Law such that involuntary euthanasia would be legalised.

We completely reject such proposals for change to the law.

Trust and confidence in the health care professions is totally dependant on the extent to which doctors are known to uphold an absolute respect for the dignity and worth of each patient. If that respect is diminished or compromised then the trust and confidence would collapse. The nature of the control which patients give to the heath care professions is a necessary feature of the provision of treatment and support of those who are ill. The current high levels of care and support could not be maintained if the relationship between a doctor and a patient were subject to the suspicion that the health care team might deliberately bring about death or that the team did not have an absolute respect for the dignity and worth of the patient.

The lobby for euthanasia reflects a lack of understanding of the circumstances of health care, of the palliative services available and of the nature of illness, suffering and death.

The fundamental needs of the dying are met when they know that there is support available, that they are valued and respected, and that adequate measures for the relief of distressing symptoms are available.

The existence of a death service would be completely contrary to the need for support and respect.

The euthanasia solution is thus no solution at all.

In addition, the proposal for euthanasia is based on the premise that suffering is more important than the individual, that a life with suffering ought not to be lived. That premise is to be rejected for its reduction of meaning and purpose in a human existence to the level of that of an animal. We are valuable in ourselves, and that value is not dependant on our having valuable use and function.

However, in thus rejecting the proposal for a "right to die", for euthanasia, we support the legal and ethical distinction between passive euthanasia and the decision not to apply an overly burdensome or intrusive life support measure when that treatment itself causes more harm than benefit. The decision not to apply burdensome measures in such circumstances is clearly distinct from a decision which is designed to bring about death by either active or passive means. In such circumstances in which there are no reasonable means of providing life-sustaining treatment, it is appropriate hat the emphasis be on providing symptom relief.

APPENDIX 6

EUTHANASIA - SPEECH OF REBUTTAL - MR N. ST JOHN-STEVAS MP

An article by Norman St John-Stevas MP, a distinguished author and parliamentarian. He served in recent Conservative governments under Heath and Thatcher as Minister of State for Education, Minister for the Arts, Chancellor of the Duchy of Lancaster and Leader of the House of Commons. He is also regarded as one of the foremost and intellectually gifted catholic layman in Britain today. A graduate of Oxford and Cambridge Universities, he holds doctorates in Law from Yale and London Universities.

Euthanasia

The subject of this Bill is the question involving life and death. It is, therefore, a very grave and important issue. I would like first of all to congratulate the Hon. Gentleman, the Member for Yarmouth (Dr H. Gray) on the manner in which he has presented his case. I would like to congratulate him, too, on his courage, which always commends itself to the House. I believe that many Hon. Members with majorities less exiguous than his might shrink from espousing such a controversial question in what is likely to be an election year. But it is doubtless because, like myself, he is a Doctor of Philosophy and so is able to adopt a disinterested attitude.

One great achievement of our age is that we have been enabled to conquer disease and illness and increase life expectancy in a way no other age has seen. I believe this to be a substantial blessing. Life is an uncovenanted gift, and if one can extend its scope and span, the possibilities for achievement and happiness are proportionately increased. But as one welcomes the advance of medical science one would be shallow indeed if one did not see the very real and complex problems with which we are faced by this prolonging of life. It is true that more people are exposed today to the chance of terminal illness than in the past. While more will survive, they may well find themselves surviving in a state where their powers and faculties have waned or wasted away.

The response of the supporters of euthanasia to this very real problem is to allow such people as painlessly as possible to be put, at their request, out of their misery. This is a response which I recognise is inspired by compassionate concern and by humanitarian motives. I do not doubt that, but equally I do not doubt that it is neither truly compassionate nor humane to facilitate euthanasia as proposed in the Bill.

My approach to the problem, first of all, as it must be, given my beliefs, is religious. In common with the majority, though not all, who find themselves heirs to the Judaeo-Christian tradition, I believe that it is ultimately God, not man, who has the disposal of human life. In the last analysis we are the created, not the Creator, and we are bound by the given of our condition.

Having said that, it is necessary to recognise that the hallmark of our humanity is freedom and that the glory of being human is precisely that we can transcend the limits of our nature. Between the two poles of our freedom and creaturehood there is inevitably a tension, never sharper than today when an advancing technology is putting greater and greater powers into

the hands of man. It is on our resolution of that tension that the future of our humanity depends.

In helping us to resolve the particular tension which the Bill presents, there is one reasonably sure guide, namely, the moral values that are shared in our society that constitute both its inherited and its developing wisdom. It is now proposed to do away with part of that wisdom, namely, the fact that we deny to any individual the right to dispose of the life of another and that life can only be taken in extreme cases at the hands of the state. Many who do not share my theological presuppositions will, I think, subscribe to that view, because to do away with it would

deprive our society of an essential protection and expose us to a whole variety of dangers.

The burden of proof that this is not so must lie upon those advocating this fundamental change. They must show that it will not undermine respect for the value of life. They must show that the safeguards they propose are adequate. I do not believe that this burden of proof has been discharged by the proposer today.

The central point of the case put forward by the Hon. Member for Yarmouth was that the Bill presented a transfer of choice, that the Bill would take away a right from the doctor and confer it upon the patient. I think that that is a profoundly inadequate analysis of the situation. I believe that the Bill would not transfer a right but would create an entirely new right of allowing one person to kill another, albeit at that person's request.

It is not true to imply that a doctor at present has a discretion to dispose of life. A doctor, whatever his views, is under a duty to preserve life. The knowledge that that is so is the basis of the patient-doctor relationship. That does not mean that there is a duty to prolong life at any cost. That would be neither good morality nor good medicine. Lord Horder, a very great doctor, once said that the good doctor will know how to distinguish between prolonging life and prolonging the act of dying.

There is surely a clear moral distinction between administering a pain-killing drug in the knowledge that it may or will shorten life and administering a drug with the direct intention to kill. The safeguard of that distinction is contained in the standards of the medical profession, supported by the law. Take away either of those safeguards and the patient and the doctor are exposed to equal danger.

Let us consider the case of old people in particular, whom the Bill sincerely intends to help. What kind of agonising moral pressure could open up to a sick old person if the Bill were to pass into law? It is not only unscrupulous relatives who might create pressure - they would be a minority - but the mental processes of the old person that would do so. He would be asking himself, 'Should I cease to be a burden to those who are looking after me? Are they thinking that I am a burden? Should I take this step or should I not?' What then has become of the peaceful, easy death which is held out by the supporters of the Bill?

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I believe these to be powerful arguments, but, strong as they are, my most rooted objection to the Bill is that it is a short-cut: it offers a simple solution to problems of the highest complexity. The problems that arise today in our society from the need and desire of those suffering from incurable disease to die in peace and in dignity are much more complicated than mere relief from physical pain.

There is an inner misery and loneliness which afflicts such people which needs to be assuaged. What causes more agony to dying people in these conditions than anything else is the sense of being written off when they are, in fact, alive; being treated as dead when they are still living. It is precisely this mentality that I fear the Bill will induce not only in the dying person, but also in relatives and medical attendants.

The final stage of an incurable illness can be a wasteland but it need not be. It can be a vital period in a person's life reconciling him to life and to death and giving him an interior peace. (Interruption.) This is the experience of people who have looked after the dying. To achieve that needs intense loving and tactful care and co-operation between relations and medical attendants. This painstaking, conscientious, constructive approach to the dying is, I believe, more human and compassionate than the snuffing out proposed by those who are well intentioned, but who seem to understand little of the complexities of the needs of those they are attempting to help.

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APPENDIX 7

PUBLIC MEETINGS

1. The Public Meetings

(a) On 10 June 1993 a debate on the broad issues entitled "Euthanasia: a Compassionate Solution" was held in the Erindale Theatre, Canberra.

(b) On 7 July 1993 a public forum on "Current Medico-Moral Questions: Euthanasia, When to Treat, Resource Allocations and the Dignity of the Human Person" was held in the Lecture Hall, Calvary Hospital, Canberra.

2. Principle Speakers

(a) The debating speakers were Mr M Moore, MLA and Rev S Geer (Teen Challenge)

(b) The keynote speaker at the public forum was Prof Wm May, the Michael J Gibney Professor of Moral Theology at the John Paul II Institute for Studies on Marriage and Family, Washington DC.

3. Pre-publicity

Radio and newspapers were used to advertise the meetings inviting all members of the public to attend. Both meetings drew near capacity crowds.

4. Summary of Talks

The only points made favouring euthanasia were made by Mr Moore whose views are available to the Committee. The following points were also presented:

1. Patients already have the right to refuse Medical treatment.

2. An acceptable definition of death has already been established.

3. The proposals suggest a quality of life which is insupportable.

4. The legalisation of euthanasia indicates that the law should forfeit its right to help the helpless leading to dominance of the strong and powerful.

5. A cautionary note that today's options become tomorrow's mandate.

6. The debate seems to be aimed at ways or mechanics of doing away with the seriously ill and dying but not into the needs of the seriously ill and dying.

7. There is no reasonable and consistent standard of care for the seriously ill and elderly and an enquiry along such lines is necessary.

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8. The legalisation of euthanasia indicates that human life should be assessed purely on subjective quality thereby allowing man to be the arbiter of life and to have such authority embedded in law.

9. Proponents of euthanasia alleged a "right to die"; we need to distinguish between a right and a liberty:

(a) A person has a right in the strict sense if and only if other persons have an obligation to do 'x'.

(b) A person has a liberty to do something if and only if others do not have a right that they not do it.

So All innocent human beings have a right to life in this sense that all other persons have a strict obligation to refrain from killing innocent persons.

The alleged "right to die" is really a liberty claim, that is, that you have a liberty to kill yourself. The alleged liberty

is a true liberty if and only if others have a right that you not kill yourself or seek to be killed mercifully.

They do have a right that you not do this because if you do so it will undermine their true right to life which means that others have an obligation not kill them.

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APPENDIX 8

DYING WITH DIGNITY - AN ADDRESS BY BISHOP MULKEARNS

Australians have been faced in recent times with a bewildering spate of legislative activity with regard to questions which are of fundamental importance to our society. The matter has been complicated by the use of emotive language of which we have to be careful. For example, proposals are put forward as being "reforms". So we have the Law Reform Commission and talk of Abortion Law Reform and so on. "Reform" in its common usage is understood as implying improvement, even it can be taken to mean simply re-formulation.

We can be inhibited when faced with proposals for law "reform" by the fact that we don't want to seem to be against progress. But we cannot afford to be taken in. Changes proposed for our laws are not necessarily for the better and we have an obligation to examine them carefully and to object to them if they will make our society worse rather than better.

It is hard to resist the impression that the current spate of proposals for legislative change are not simply aimed at bringing our laws up to date. They seem to be aimed at changing our society. They appear to me to be exercises in social engineering through which the secular humanists in our community are seeking to impose their vision on society on all Australians.

A point which has been made in recent debates on such issues as have been discussed tonight is that Australia is not a secular society. We might equally have to say that it is not a Christian Society. But it is at least a pluralist society, that is a society that recognises different points of view and has not handed over to any group the right to decide what form it should take. So it is not true that Australia is a secular society. And that means that Christians have as much right as any other group in society to put forward their views as to how society should be formed. For too long we have been inhibited by those who claim that the forceful presentation of our views on such subjects as abortion, marriage law and euthanasia is an unjustified effort to impose our views on a society which does not share them. It is no such thing. It is an effort to have our say in shaping the type of society we want because we think it is in the best interests of the community.

I therefore applaud the initiative of the Knights of the Southern Cross and the Catholic Women's League in sponsoring this meeting tonight. In addition to offering an opportunity to the citizens of Ballarat to become more informed on the issues raised, it shows to our fellow citizens and to our parliamentarians that it is not only the Bishops of the Church who are concerned about what is going on in our society in this area but the laity of the Church. I did not ask anyone to call this meeting and it would probably have had less impact had I done so. Bishops are expected to have certain things to say about abortion, infanticide and the killing of the aged. It is good for the community to know that lay men and women share the concern of Church spokesmen and want their politicians to know it. We are very much aware of the fact that law does more than merely reflect the existing moral convictions of a community, and that it also plays a part in forming such convictions. We want our society to be helped by its laws to value human life and not to regard it as disposable. I mentioned earlier the fact that language can be used in deceptive ways. It is clear that you are aware the Government enquiry is not only concerned with "Dying with Dignity". That sounds like an innocent enough phase. We all have a right to die with dignity. But the first right of a patient is the right to life. And when

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"Dying with Dignity" is a phase used to describe the taking of the life of a child or an aged person it is simply a euphemism aimed at covering up the real horror. Euthanasia used to be called "mercy killing". That description tried to mitigate the deed, but it did admit that it was killing. "Dying with Dignity" may have application in some cases (and these cases seem adequately covered by existing laws), but in most cases it is a cover-up term for a much more insidious procedure. I believe that life is a gift from God and that human life is sacred and inviolable. That view is exclusively a Catholic one only if the Commandments apply only to Catholics. In an address to Disabled Persons in November of last year, Pope John Paul II said: "In certain nations, the abrogation of the right to life of the unborn or even of the newborn has been 'legalised' when it is a question of disabled human beings. At this moment, I would like to remind the legislators, statesmen and rulers of such nations and of all the nations of the earth of the powerful word of God: "Thou shalt not kill, which is intended to protect, safeguard and defend human beings, every human being, from the moment of conception".

In a letter to the people of the Catholic Diocese of Ballarat on the subject of abortion, written on April, 29th 1973, I wrote "We have here a question of fundamental principle. Is life sacred because it is human or is something else required? In other words can we eliminate human life because it is Jewish (as Hitler did), because it is old, retarded or unwanted, or simply because we are over-populated? Who would be safe, and why should they be?"

It gives me no pleasure to be able to say "I told you so". The fact is that the right to life has not been respected at its very beginnings in Australia and we now have a situation where there is serious discussion about whether it should be respected at other times or whether human beings should be culled in a society which might find this an easier solution to that of showing love and compassion to the most needy.

It is to the credit of the medical profession that it has enjoyed up to the present time a reputation for striving to respect and preserve life. God forbid that certain groups of "experts" should be empowered to play God and authorise the elimination of infants, children and the aged who fail to meet their criteria for entering into the community or remaining in it. To kill children or the aged is not a Christian or even a human solution to problems associated with their care.

I leave you with a thought from Sister Mary Regis Dunne, who spoke at a seminar on Euthanasia in Canberra last year "Whether we know it or not our own attitude to death is that which colours our attitude to life. Whether we know it or realise it or not, it is that attitude to death in the society which shapes that society and which shapes that nation".

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APPENDIX 9

DUTY OF CARE

The duty to provide adequate care to persons to whom a duty has been accepted is clearly a part of the law of negligence in this country. Where the abandonment of the duty involves a deliberate act of withholding care with the intention of causing death, and not just some neglect of the duty of care owed, the law has traditionally regarded this as homicide should the death occur.

l. The Common Law

The classic statement of the common law on matters of this kind is that of Darling J. giving the judgment of the Court of Criminal Appeal in R. v Gibbins and Proctor 1918 l3 C.A.R. 134. Gibbins was the father of a 7 year old girl, Nellie. Proctor was not the child's mother but she lived with Gibbins as his common law wife. Nellie died of starvation and the two appellants were convicted of murder. In summing up the case to the jury the trial judge, Roche J. said:

"If you think that one or other of these prisoners wilfully and intentionally withheld food from that child so as to

cause her grievous bodily injury as the result of which she died, it is not necessary for you to find that she intended, or he intended, to kill the child there and then. It is enough if you find that he or she intended to set up such a set of facts by withholding food or anything as would in the ordinary course of nature lead gradually but surely to her death."

In dealing specifically with the case of Proctor, Darling J. said:

"She had charge of this child her duty was to see that the child was properly fed and looked after and to see that she had medical attention if necessary .She neglected this child undoubtedly, and the evidence shows that as a result the child died. So a verdict of man-slaughter at least was inevitable. But it is necessary to go further and see whether it was murder the jury came to the conclusion that she had done more than wickedly neglected the child; she had deliberately withheld food from it and we therefore come to the conclusion that there was evidence which justified the jury in returning a verdict against her, not merely of manslaughter, but of murder."

From the foregoing it follows that if a person having the care of a child deliberately withholds from it some necessity such as food, clothing or medical treatment with the intention of thereby killing the child that is murder. If this withholding does not in fact kill the child, or cannot be proved to have had this affect, then, provided always chat the withholding is done with the intent that the child should die, this is attempted murder.

Though most omission cases are founded on neglect, it is arguable that in deliberately withholding food and medical treatment and foreseeing the consequences that the child may die may amount to manslaughter or murder. Though the circumstances of R. v Instan 1893 l O.B. 450 and R. v Stone 1977 Q.B. 354 were vastly different from the kind of clinical judgment involved in allowing a child to die there is some analogy to be drawn. In Instan a niece was held to have a moral duty to care for her helpless 73 year old aunt who for the last 10 years of

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her life was suffering from gangrene in her leg. The niece offered her aunt no food and called no medical help. She was convicted of manslaughter as she had a duty to her aunt and her failure to offer her food and calling medical help had accelerated her death.

In R. v Stone, the appellants, a partially deaf and almost blind man of low average intelligence and no appreciable sense of smell and his mistress who was ineffectual and inadequate, were convicted of the murder of the man's elderly sister. She was morbidly anxious not to put on weight, denied herself proper meals, spent days at a time in the room and within 3 years became helplessly infirm so that she did not leave her bed, but she did not complain. The mistress who took the sister such food as she required, attempted to wash her with the aid of a neighbour, who advised the mistress to go to the social services. The licensee of a public house which the appellants used to visit advised the mistress to obtain a doctor. The sister had refused to give the appellants the name of her doctor, whom they had unsuccessfully tried to find. An attempt by the man to obtain his own doctor for her was unsuccessful, but the appellants did no more to enlist outside professional help although aware of the poor condition of her health. They did not mention anything to the social worker who used to visit their son who lived with them. Some three weeks after the attempt to wash the sister she died from toxaemia spreading from infected bed-sores, prolonged immobilisation and lack of food. If she had received medical care in the intervening period she would probably have survived.

The appellants were charged with her manslaughter. The jury were directed to consider the circumstances in relation to each of the appellants according to their individual knowledge of the sister's condition and their appreciation of the need to act and the consequences of inaction in view of procurable facilities and to determine whether the prosecution had established a gross neglect of duty of care amounting to reckless disregard of the sister's health and well-being. The appellants were convicted. On appeal, the Court of Appeal held that the jury were entitled to find that the appellants had assumed duty of care in relation to the sister and that their reckless indifference to the possibility of injury to her through omission was sufficient to ground the conviction.

As stated earlier, these two cases are not the same as the matter being discussed here but they do reflect in an analogous situation that the present law requires those with a duty of care to others unable to care for themselves the responsibility of exercising that care with due diligence.

2. The Dr Arthur Case

Much confusion has been injected into the discussions of this area of the law by the result in the Arthur case. However, as a number of commentators have noted, the direction given to the jury in the case was not in accord with the generally accepted principles of the care owed to patients, and the case must be distinguished from the general body of the law.

3. The Case of Re 'B' (a minor) (1981)

On the 28th of July, a female mongoloid child was born to parents who did not know of the child's condition before her birth. She was also born with an intestinal blockage which would be fatal unless operated on soon after birth. For the doctors to perform the operation to remove the obstruction, the consent of the child's parents was required.

On being informed of their child's condition, the parents refused to give their consent. The doctors abided by their decision. However, the Court of Appeal later pointed out, the doctors drew the attention of the local civil authority to the situation and the latter declared the child a ward of the court. At that stage, the local authority applied to the High Court for an order giving the council the care and custody of the child and thereby authority to consent to the required surgery.

Mr Justice Ewbank heard the matter at first instance. He granted the necessary orders and there upon the child was transferred from the hospital where she was born to a second hospital. At the second hospital, surgeons would not carry out the operation because the parents had withheld their consent. So, the local authority went back to Mr Justice Ewbank who after hearing the parents, ordered that consent to the operation be withheld.

On the same day, the matter went on appeal to the Court of Appeal and was heard by Lord Justices Templeman and Dunne. Lord Justice Templeman posed the question: "Was it in the best interests of the child that she should be allowed to die, or that the operation should be performed? The criteria on which he replied in reaching his decision were:

1. Was the child's life going to be so demonstrable awful that it should be condemned to die; or

2. Was the kind of life so imponderable that it would be wrong to condemn her to die?

The decision, with which Lord Justice Dunne agreed, was that it would be wrong to terminate the child's life because, as well as being a mongol, she had another disability. Therefore, the child was allowed to live. The court said Mr Justice Ewbank had erred because he was influenced by the parents views, instead of deciding what was in the best interests of the child.

4. Objections to the reasons for this decision

The reasons advanced by the Court of Appeal for deciding whether a child is to live or die may be objected to for a number of reasons. These reasons are set out hereunder:

1. The court did not advert to the **fact** of human life, but rather to the concept of **quality** of human life which an infant could expect. This means that the Court has an enormous inherent discretion which affords potential for wrongful exercise of discretion being based on erroneous statement of fact.

2. How does a Court reach the conclusion that a particular life is potentially so hopeless that in the circumstances it

is proper to terminate it soon after birth? What considerations should be taken into account? Is the Court able (indeed, is a doctor?) to predict the type of life to be expected 5, 10 or 20 years' hence?

3. If it is proper and lawful for life to be terminated on the basis that all the criteria have been satisfied on the medical evidence, then why cannot foetal life be extinguished on the same basis - that medical knowledge will have reached sufficient sophistication that a child's condition may be conclusively monitored?

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4. Once there is acceptance of the theory, then why cannot the same criteria be adopted in respect of adult mongols with severe conditions, and to the elderly whose bodily functions have so broken down that life can only be described as "demonstrably awful".

To adopt a distinction based upon infancy is arbitrary and cannot be rationally justified.

5. Where doctors who decide to terminate life, not by refusing to operate in circumstances like those of the case in point, but who inject, say, retarded infants with sedatives so that their bodies do not respond to normal desires, for example, to be fed, the doctors would seem to be criminally negligent: see Akerle's case (1943) A.C. 255.

6. If this decision was to be adopted generally, the law will always be imbued with uncertainty, because each Court must listen to evidence and make up its mind as to the child's likely future. **Ad hoc** decisions will abound. Different judges may take into account quite different considerations in deciding upon the quality of any future life. Judges may have no experience of 'success stores', nor a proper understanding of the medical evidence.

7. There is a question of the capacity of parents, soon after their child's birth, to give an informed and balanced 'consent' to medical treatment.

8. Proponents of the rights of the parents to have the final choice advert to the question of the 'painlessness' of the death of the child should no operation be permitted. Is the fact of pain decisive when the question is of the life of the child?

9. Had the decision been otherwise, the doctors - not the parents - would have been the judges of whether the life should be sustained. As to the question of legal rights, would the medical profession be the proper body to decide what is lawful and what is not?

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APPENDIX 10

CONSENT AND TREATMENT: THE CASE FOR SPECIFIC LEGISLATION

The Australian Medical Association in a submission to the Western Australian Law Reform Commission stated that it was of the opinion that the dangers of enacting legislation on the withholding of consent for treatment are far too great and complex to be overcome, no matter how limited the legislative provision.

Others, such as Mr Justice Kirby, believe there should be legislation "because the current legislation is not, apparently, adequate, clear or being observed." Some, such as Dr Kushe, have gone further and suggested that deformed babies be given a lethal injection.

This approach however is open to a series of objections:

Such legislation refers to the **quality** of life rather than the **fact** of life,

There is no means by which a distinction can be made between a **slight** deformity and a **gross** deformity.

How are doctors able to predict the circumstances of that life in say 10 or 20 years time?

The AMA submission does not refer to those with terminal illness but to those who, with the provision of vital medical treatment, would otherwise live for many years.

Even the example chosen by the AMA, that of Down's Syndrome, is most inappropriate. As a multitude of parents will testify, both here and overseas, these children are able to enjoy a fruitful life.

What is the difference between the young, the old, the disabled?

It is suggested that doctors should "help" the parents to decide. Does this mean "convince", and what protection is there against undue influence?

Some suggested legislation refers to a series of other factors to be taken into account, mostly economic. Are all lives to be henceforward judged according to their utility?

The English Criminal Law Reform Committee in its 1980 report entitled Offences against the Person recommended against the introduction of any separate offence of 'mercy killing' or any special sentencing discretion in these cases.

Mr Justice Kirby said recently that once a baby was born, it was a legal person, "a human creature born into this world and entitled, indubitably, to the full protection of the law."

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Conclusion

Nowhere has a case been convincingly advanced for the removal of that protection. In fact, its removal leaves open the spectre of a law supposedly tailored to the provision of the 'greatest good to the greatest number' but, in fact, providing only for those who can shout the loudest to protect their rights, while the rights of the young, the weak, the disabled and possibly the old are trampled upon.

If the law is to protect the dignity and integrity of all human beings, as Christians believe it should do, then efforts to place new interpretations on the existing law or to change the law ought to be resisted vigorously.

SUBMISSION 829 1

Northern Territory

Hospice and

Palliative Care Association Inc.

PO Box 42255

Casuarina NT 0811

The Chairman

Select Committee on Euthanasia

GPO Box 3721

DARWIN NT 0801

Submission regarding the Rights of the Terminally Ill Bill 1995

After careful consideration and much discussion with our members, the Northern Territory Hospice and Palliative Care Association is pleased to have the opportunity to comment on the proposed Rights of the Terminally Ill Bill 1995

The Northern Territory Hospice and Palliative Care Association in conjunction with the Australian Association of Hospice and Palliative Care is developing a policy statement on voluntary active euthanasia. (see attachment I)

The Northern Territory Hospice and Palliative Care Association welcomes all open and frank discussion within the community about all aspects of death and dying, including voluntary active euthanasia.

However, we believe that legalisation of voluntary active euthanasia is not and should never be a substitute for the proper provision of palliative care.

Our association recognises that there is a wide divergence of views about voluntary active euthanasia in the Australian society; within the caring professions including the palliative care community.

The Northern Territory Hospice and Palliative Care Association believes that much of the interest in voluntary active euthanasia reflects a concern about the lack of adequate support for people who are dying. We will continue to campaign for improved services, education and research in all aspects of palliative care.

Hospice and palliative care is not accessible to all Territorians. The Association considers that:

a) An assessment/review of current palliative care services both urban and rural be conducted.

b) A review of the adequacy of current funding arrangements for community based palliative care services throughout the Northern Territory, especially community nursing hours, be conducted.

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c) Hospice beds are currently not available for clients needing in-patient facilities for symptom control, respite for families or as a place of death when dying at home is not possible. Without a hospice patients must be inappropriately nursed in an acute care hospital.

d) A Northern Territory network of information support and ongoing education for palliative care personnel be established.

e) Improved access to specialist palliative medical services including appropriate interstate resources, current best practice in treatment and practice needs to be implemented.

f) Adequate funds in the Patient Assisted Travel Scheme must be allocated to definitely include escorts where palliative treatment and care needs to occur in interstate facilities.

With respect to the proposed Rights of the Terminally Ill Bill, the Northern Territory Hospice and Palliative Care Association, while not wanting to debate on either side of the voluntary active euthanasia debate, considers:

a) That the specialised knowledge base of Palliative Care and Pain Clinics should be integrated into any proposed legislation. Specifically, in section 6c), a specialist in palliative care and pain management be one of the two medical practitioners referred to.

b) Anecdotal evidence around practices in Darwin indicates that at times accepted treatments and practices interstate are not offered to Northern Territory patients, mostly due to lack of local expertise and palliative care medical specialists. We would therefore look to include in section 6e) and f) that all interstate resources be utilised and made available to all Territorians.

c) With regard to part 2, number three of the proposed legislation, many hospice and palliative care teams only

admit clients likely to die within six months.

Hospice and Palliative care services must be equally accessible to all Territorians. We again reiterate that voluntary active euthanasia is not and should never be an alternative to palliative care.

Included to support our submission are the Northern Territory Hospice and Palliative Care Association policy statement on voluntary euthanasia, and our standards documents.

We would of course be available to provide any further information or assistance.

NT Hospice and Palliative Care Association

24/03/95

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Northern Territory

Hospice and

Palliative Care Association Inc.

PO Box 42255

Casuarina NT 0811

POLICY STATEMENT ON VOLUNTARY ACTIVE EUTHANASIA

24 March 1995

The Northern Territory Association for Hospice and Palliative Care:

Defines **Hospice and Palliative Care** as a concept of care which provides co-ordinated medical, nursing and allied services for people who are terminally ill, delivered where possible in the environment of the person's choice, and which provides physical, psychological, emotional and spiritual support for patients and for patients' families and friends. The provision of hospice and palliative care services includes grief and bereavement support for the family and other carers during the life of the patient, continuing after death.

Defines **Voluntary Active Euthanasia** (VAE) as the deliberate action to terminate life by someone other than, and at the request of, the patient concerned.

We

1. believe that legalisation of voluntary active euthanasia is not a substitute for the proper provision of palliative care services to all Australians.

2. welcome open and frank discussion within the community, and particularly with the health professions, about all aspects of death and dying, including voluntary active euthanasia.

3. believe that public interest in voluntary active euthanasia reflects a concern about lack of adequate support of people who are dying, and will continue to campaign for improved services, educated and research in all aspects of palliative care.

4. recognise that there is a wide divergence of views about voluntary active euthanasia in Australian society, and also within the caring professions, including the palliative care community.

5. recognise and respects the fact that some people rationally and consistently request voluntary active euthanasia.

6. state that currently accepted palliative care practise does not include deliberate ending of life, even if this is requested by the patient.

7. acknowledge that, while all pain and symptoms can be treated, complete relief is not always possible in all cases, even with optimal palliative care.

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8. assert that palliative care experience shows that skilled adjustment of the morphine does for pain relief does not cause death.

9. believe that dying is a natural process and that the refusal or withdrawal of futile treatment is not voluntary active euthanasia.

Enclosed with submission:

Northern Territory Hospice and Palliative Care Association Inc, Leaflet "Furthering the Aims of Good Palliative Care in the Northern Territory.

Australian Association for Hospice & Palliative Care Inc booklet 'Standards for Hospice & Palliative Care Provision, March 1994.

SUBMISSION 830 1

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18 Fellows Street

Latham ACT 2615

22.3.95.

Select Committee on Euthanasia

Parliament of the Northern Territory.

Dear Committee Members,

I write to express my strong support for moves in the N.T. to legalize Voluntary Euthanasia. I am hopeful it will set a precedent that the ACT and the States will follow.

My desire to have access to V.E. follows my mother's illness and death. She was bedridden for a year, unable even to roll over, let alone get up and wash and toilet herself. We were unable to get her into a nursing home, and I couldn't care for her because a bad back prevented me from lifting her, so she went to my brother and his wife. My mother's daughterinlaw had to engage (along with her husband) in 24hour care that was incredibly demanding far more so than caring for a baby because of the heavy lifting*. This was done lovingly and willingly, but the situation was a nightmare for everyone.

Since my mother's situation was brought on by a weak heart which I could well have inherited, it seems not unlikely that I could suffer the same kind of decline Who will care for me in a similar situation? My son and some poor future daughterinlaw? I think not! I have no intention of putting my loved ones through such an ordeal.

In an Advance Directive I have expressed my strong desire to be assisted to die if I ever become unable to take care of myself. But I have no reason to hope that my wishes will be acted on, since they would be illegal. Therefore I find myself needing to watch for a strategic time to commit suicide a time when I am still well enough to do it, without acting unnecessarily early. This situation is obviously most unsatisfactory: I have no confidence that I could carry out the suicide efficiently; my action would doubtless be hurtful to my family; and I might act

unnecessarily early, or on the other hand might miss the opportunity if overtaken by a sudden stroke or heart attack. It would be wonderful if I could depend on being assisted to die when the time was right.

I urge you to do all you can to have Voluntary Euthanasia made legal. So many of us would be so grateful!

Yours sincerely,

(Mrs) Barbara Shield.

* My sisterinlaw, though she never complained, suffered sleep deprivation and back strain, and had to abandon virtually all other activities, including those involving her own children.

SUBMISSION 831 1

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22 March 1995

The Select Committee into the Rights of the Terminally Ill Bill

C/- Secretary, Ms Pat Hancock

Legislative Assembly

GPO Box 3721

Darwin NT 0801

Dear Ms Hancock

Rights of the Terminally Ill Bill

As a doctor who has worked for over 14 years in a cancer hospital (Peter MacCallum Cancer Institute), treating patients in pain from cancer and providing palliative care, I am taking the liberty of writing to you regarding the Rights of the Terminally Ill Bill, based on my experience during that time.

I sympathise with the Chief Minister in his mother's distressing death, and understand his concern for others who may be in a similar situation. Euthanasia is regarded by some as a measure to avoid the suffering of an illness when death will be eventually inevitable. It is also seen as providing a degree of choice and control over the time and manner of dying.

However, I suggest that legislation to allow euthanasia would not be a safe or satisfactory alternative for the following reasons:-

1. With modern technology, errors in diagnosis are rare, but still possible. It would be tragic for euthanasia to be carried out if the person was not in fact terminally ill.

2. Prognosis or future life span may be very difficult to estimate accurately. Some may live a normal active life for many years after their disease has spread to the stage where death will occur eventually. It may be very difficult to say whether or not a person will die within 12 months. There are well documented cases of spontaneous cure of

widespread disease although these are exceptionally rare. However, as with capital punishment, if you get it wrong, it's too late!

Example: A 23 year old woman had cancer of the colon, diagnosed microscopically, which had spread throughout her abdomen. No active treatment was possible and she was expected to die within a few months. Three and half years later, she was alive and well and all of the signs of the disease had disappeared. No explanation was attempted.

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(Med Journal of Aust 17/2/86). In a case like this, euthanasia would have been an irretrievable disaster.

3. Sick and elderly patients are very vulnerable, and they could be under pressure from relatives to request euthanasia, as we now see them gently coerced in other areas affecting their care.

Example: a man (outpatient) was completely dominated by his wife and the only way to speak to him apart from her, to ascertain his real feelings, was when he was having an Xray. He would have liked to be admitted to a hospice, to die in peace, but if he requested this, his wife's response would have been "like the third World War".

4. If euthanasia were an option, it would add to the distress and guilt of those who wondered whether they were too great a burden on others. At present, they are protected by euthanasia being illegal, and it could cause tremendous stress if this protection were removed. **By allowing some people the right to choose, you would force on everyone the obligation to make a choice.**

Example: a woman having outpatient treatment was down from the country staying with friends. She took an overdose (fortunately, non-fatal), because she thought she was too much of a nuisance. However, the friends assured her of their love and need for her, and she accepted their hospitality.

5. In the Netherlands, where active voluntary euthanasia has been "sanctioned" under certain conditions, surveys have found that in 1991, 1,000 people had involuntary euthanasia, ie. without their consent1. Also, a recent study among general practitioners (in the Netherlands) discovered that 38% of the euthanasia cases were never reported. Generally speaking, doctors are making their reports more acceptable than they are in reality; and in case of any complications or inadherence to the rules, the case is not reported2.

Euthanasia in the Netherlands is not restricted to those suffering with a terminal illness. A recent television program showed a young girl with anorexia nervosa was given euthanasia.

Thus, it appears in the Netherlands that once euthanasia was deemed to be "acceptable", it became impossible to control it, despite the promulgation of conditions and safeguards.

I feel that there are a number of **misconceptions** in relation to euthanasia:

1. That many patients desire euthanasia. In fact, many health personnel have noted that requests for euthanasia, or suicide attempts are quite rare among patients with terminal illness. Usually, when life is threatened, it becomes very precious. Sometimes, as with some young people's suicide attempts, euthanasia requests or suicide threats may be a cry for help.

Example: one man said "When I get out of here I'll shoot myself". His pain was relieved. He didn't.

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Example: a mother of a large family repeated "I wish I could go to sleep and not wake up". She had no pain and said she was comfortable. Finally, we discovered that she was concerned her family had gathered, some from interstate, to be with her. The staff had believed her death to be imminent, when fact she improved and was not

actually dying yet. She felt that she was interrupting the busy lives of her family. When they were sent home and arrangements were made for her to return to the little country hospital near home she was contented.

It is less unusual for family and friends of the patient to request euthanasia, not recognising that it is sometimes their own, rather than the patient's distress which they wish to end.

2. That public opinion surveys show that a large majority of the population support euthanasia.

This has been tested by Morgan Gallop Polls from 1946 to 1993, asking the hypothetical question "if a **hopelessly** ill patient, in **great** pain, with absolutely **no** chance of recovery asks for a lethal dose, so as not to wake again, should a doctor be allowed to **give** a lethal dose or **not**?

Who is hopeless? Can we ever be absolutely certain that there is no chance of recovery? Why not relieve the pain? The great advances in pain management since 1946 make this scenario extremely unlikely in 1995, if it was then? This sort of questions does a disservice to dying patients, suggesting they might suffer **great** pain which could only be relieved by killing them.

In any case, legislation should be based on informed opinion, rather than public opinion.

3. That large numbers of doctors and nurses already practise (active) euthanasia, therefore it should be legalised. In other words, palliative care and pain relief is really slow stream euthanasia. Due to some widely held myths about morphine, I believe that some health professionals who have given morphine for pain, believe that they "hastened death".

There have been surveys of Victorian doctors and nurses by Dr Kuhse and Professor Singer, and recently of South Australian doctors published in the Medical Observer, all showing considerable numbers who "hastened death".

The respondents were not asked **how** they had actively ended the patient's life. Due to the widely held belief that morphine hastens death, I think it is highly likely that some of these patients would have died from their **disease**, while morphine kept them comfortable, and the doctor or nurse attributed their death as due to the morphine.

The view is frequently repeated. Lawyers, ethicists and others distinguish between:

i) using opioids (narcotics) to relieve pain **"when one foresees that it will shorten life** and

ii) when death is deliberately intended.

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This suggests that using morphine for pain relief is surrogate euthanasia.

More than 30 years ago, the judge, Lord Devlin said that a doctor "is entitled to do all that is proper and necessary to relieve pain and suffering even if the measures he takes **might incidentally shorten life"**.

Writing to "The Age" (4/3/92), Professor Lanham, Professor of Law at Melbourne University said, "What is clear is that the law now allows a doctor, with the patient's consent, to administer pain-killing drugs in whatever quantity and at whatever interval is necessary to relieve pain, even though the doctor knows that the **drugs will shorten the life span of the patient"**.

The believe that morphine causes death is quite frequently expressed.

Examples:

(i) A youth dying at home of a spinal cord tumour was brought into hospital with the question, "Is he dying or is it the morphine?" It was apparent that he was dying of the disease, and the trip was really unnecessary, but his professional carers and family were hoping that he might recover if the morphine was stopped.

(ii) A son at the bed of his dying mother asked "Is she dying or is it the drugs you've given her?" We explained that she was dying and that her medications wouldn't produce those effects on a healthier person. He said, "I understand, but my brother thinks you've given her too many drugs."

As a result of statements quoted above, patients are led to believe that if they take pain killers, it will shorten their lives and decide to put up with the pain. This results in unnecessary suffering. It is **unrelieved pain** that causes stress, and, it is believed, may accelerate death. Last year, the leading international journal "Pain" had an editorial entitled "Pain Can Kill".

Dr Robert Twycross of the Sir Michael Sobell House hospice has said "although sometimes the use of a narcotic analgesic may marginally shorten a patient's life, however the correct use of morphine is more likely to prolong a patient's life rather than shorten it, because he is more rested and pain free."3

Pain relief can help a patient to sleep better, be less stressed and be able to move about more. As well as improving quality of life, ability to move may diminish deathaccelerating complications, such as pneumonia, bed sores and thromboses.

There are many analgesics and techniques for relieving pain, but with morphine and other opioids the dose is "titrated". The dose used is the one that will relieve that person's pain. In some cases, quite massive doses are used.

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Example: the starting dose is about 5-10mg morphine given every 4 hours by mouth (30-60mg per day). One man required 3,600mg per day by injection, which is about 3 times as potent as when taken by mouth. He didn't die of an overdose, he didn't remain in a drowsy or drugged state, and his morphine dose was dropped to 1/3 of this amount after he recovered from the surgery and the crisis which necessitated the high doses.

However, people **may** be overdosed. When this happens there are several medications which can be used to reverse the effect.

Example: a man was inadvertently given too large a dose by continuous injection using a syringe driver and admitted to hospital unconscious. He was given another injection to reverse the effect and was awake and talking in a couple of minutes.

I suggest that, due to the long held teaching and belief of the medical profession and others, doctors and nurses have given morphine, perhaps increased the dose, and when the patient died, have felt that they had hastened death, when the patient had in fact died naturally.

I suggest a better way to "die with dignity" is with the aid of pain control and palliative care.

Palliative care has been defined as "the total active care of patients whose disease is not responsive to curative treatment" (World Health Organisation, 1990). They state that "control of pain and other symptoms, and of psychological, social and spiritual problems is paramount." The goal is achievement of the best possible quality of life for patients and their families.

The aim is to keep the patient comfortable while he dies form his disease. This may include sedation, or withholding or withdrawing active interventions in the final phase. It may not be possible to relieve pain and other symptoms totally and permanently, but they can be relieved to a large extent. With frequent assessment and adjustment of various medications, most of the distress can be alleviated. However the solution to suffering should not be to kill the sufferer.

Enclosed are some papers relating to euthanasia.

I hope that these observations may be helpful to the Committee. Please let me know if I can be of any further

assistance.

Yours sincerely

Nell M Muirden MBBS DTM&H

Head, Palliative Care/Pain Control Unit

Peter MacCallum Cancer Institute

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1. Van der Maas P J, van Delden J J M, Pijnenborg L, Looman C W N: Euthanasia and other medical decisions concerning the end of life. Lancet 1991:3 3 8:669-674.

2. Zylicz Z. The story behind the blank spot. American J of Hospice & Palliative Care, JulAug 1993: 30-34.

3. Twycross R G. Euthanasia - A Physician's Viewpoint. Lecture. Oxford, Sept 1980.

Enclosed with submission:

- *Copy of Declaration on Euthanasia of World Medical Association Assembly, October 1987.*
- *Editorial from Lancet, Volume 343, 19 February 1994, pp 430-431*
- *WHO list of members of Committee on Cancer Pain Relief and Active Supportive Care, Geneva, 310 July 1989*
- *"Cancer pain relief and palliative care", report of WHO Expert Committee, 1990*
- *Copies of newspaper articles and Letters to the Editor*
- *"Regarding euthanasia", article by David J. Roy, CharlesHenri Rapin and the Board of Directors of the European Association fro Palliative Care, European Journal of Palliative Care, Volume 1, Number 1.*
- *"The Euthanasia and PhysicianAssisted Suicide Debate: Issues for Nursing" by Nessa Coyle, Coyle - Vol 19, No 7, Supplement, 1992.*
- *The American Journal of Hospice & Palliative Care, July/August 1993, pp 3134*

SUBMISSION 832 1

21.3.95 38 Fernbank

2 Kitchener Street

St. Ives 2075

Select Committee on Euthanasia,

Parliament of Northern Territory,

P.O. Box 3721m

Darwin

Dear Sir,

I write to register my total endorsement of Euthanasia and to state that I sincerely believe it to be every person's right to have their wishes carried out in this regard.

Yours faithfully,

D.I. CHISHOLM.

SUBMISSION 833 1

March 22nd, 1995.

Unit 3, 135 Manning Road,

East Malvern, Vic, 3145

Tel: 03-571-8905

Select Committee into the Rights of

the Terminally Ill Bill,

C/o The Secretary, Ms Pat Hancock,

Legislative Assembly,

GPO Box 3721,

DARWIN, N.T. , 0801

Dear Ms Hancock,

I write to convey my alarm at the prospect of a voluntary euthanasia bill being considered by the N.T. parliament. I believe that the Chief Minister, Mr Perron, who is proposing the Rights of the Terminally Ill Bill, is gravely mistaken in this matter.

I think that we should learn the lesson of modern mercy killing, the lesson from the Weimar Republic and Nazi experience. In the 1920s some doctors and lawyers in Germany, a civilised and Christian country, began arguing in favour of "the life which is unworthy to be lived" concept. Doctors began making fatal "quality of life" decisions against the disabled, the mentally ill and incurable patients. It should be remembered that these people were German and Austria citizens.

The arguments of the provoluntary euthanasia lobby that mercy killing of patients who request death will not lead to nonvoluntary killing do not match with experience. The Germans could not "contain" socalled "compassionate" killing and the present day Dutch people cannot either.

The State has an important duty to defend life: eg to prosecute murderers, to protect the lives of its citizens in a physical sense, as in these examples, but also in a moral or ethical sense. Even if I wanted to be "mercifully" killed or to commit suicide, the State cannot allow this without opening a "Pandora's box" where people will have their lives taken from them without their consent. Dr Fleming of Adelaide (News Weekly, 25.2.95) makes a good comparison with the slave trade.

The weak and vulnerable need society's protection and the State has a duty to itself and all its citizens to safeguard the inalienable right to life of human life, even where a confused and depressed patient requests a mercy death. It is a matter of justice for all of us. Should a State legislate voluntary euthanasia or anything else unworthy of the human and his/her dignity, it would be a grave injustice, and would do great damage to society.

I hope that what I have written here is of some help to the Select Committee. I urge the Committee to weigh the current Dutch experience and to listen to advocates such as Dr John Fleming and Mrs Margaret Tighe they are far more knowledgeable and wise than myself.

Yours sincerely,

Mark J. Colgan

SUBMISSION 834 1

Paul Hense,

33 Prince Street

MOSMAN. N.S.W. 2088

(02) 953.6362 (H)

(02) 694.5722 (W)

22nd March, 1995.

Select Committee on Euthanasia

Parliament of the Northern Territory

P. O. Box 3721

DARWIN. N.T. 0800

TO WHOM IT MAY CONCERN

I understand the Select Committee on Euthanasia of the Northern Territory is considering a bill to legalise voluntary euthanasia. I write to you as a concerned citizen and health professional in support of this proposed legislation.

I am employed as a social worker in a large state hospital. During this time I have worked with both HIV/AIDS and spinally injured patients In the course of my clinical duties the issue of euthanasia has been raised by patients, epecially those with HIV/AIDS. Commonly this would be in the context of the latter stages of disease progress, when patients would be alert but obviously concerned about the future. In this particular situation, loss of dignity, emaciation (with the possible need for tube feeding) loss of mental capacity would be typical worries expressed by patients. The desire to end life, and have some control over this, more commonly than not with the assistance of medical professionals, was often put to me. There was often an additional worry that any attempt to end life in these difficult circumstances, might result in a failed attempt which in itself would result in further difficulties.

Often people would need to go through the difficult process of finding a doctor who would listen to their plight and help in the persons decision to end life. The emotional difficulties involved in this are apparent. The law, by making a doctor's involvement in this process illegal, only exacerbates the pain of the seriously ill decision maker.

The issue remains - whose life is at stake? The individual should make the decision whether to end his/her life, without the intrusion of the state. The proper role of government is to make sure the decision to end life is done properly, establishing certain safeguards so that a proper, considered decision is made.

As I understand the bill that is currently before the Northern Territory Parliament, there are checks so that a person needs to be alert, any decision made is checked by at least two doctors, and the person concerned must be suffering a terminal illness. These constitute safeguards which go to preserving the dignity of life whilst also accommodating the right of individuals to make decisions for themselves.

2

No doubt the Committee will receive submissions emphasising the sanctity of life above all other considerations. These views primarily come from ideological positions divorced from the everyday realities of people who have debilitating diseases with no real quality of life. It is only when you listen to and attempt to help, people actually suffering severe complaints, where science and society cannot help, do you realise the necessity for legislation to exist whereby people are free to pursue their own life choices.

I wholeheartedly urge support for the proposal to institute a legislative framework for voluntary euthanasia, i.e. for assisted termination of life as put forward by the bill proposed by Chief Minister Perron.

Yours faithfully,

Paul Hense

SUBMISSION 835 1

"Bilyara"

Holman Place

Cowra N.S.W. 2794.

23-3-1995

Dear Sir or Madam,

I write to express my alarm at the proposed euthanasia legislation for the Northern Territory. I do not believe as a Christian that we have the right to take away or have taken away our lives to me this is murder. I believe we should be taken only in God's time. I believe it will indeed devalue human life and will place under scrutiny those whose lives are seen as a burden to our society. I do ask you please to think before you decide on such a Bill.

Yours sincerely,

Miss M. Barnes.

SUBMISSION 836 1

TO WHOM IT MAY CONCERN

I am a first year law student at NTU. During senior high school, I studied the topic of Euthanasia in several subjects, exploring various legal, social and scientific aspects. Although my letter may not be of an equal calibre to those which you may receive, I believe I have researched this issue sufficiently to an extent that I able to offer a fairly reasoned opinion.

Undoubtedly, arguments both for and against Euthanasia are justifiable and credible, due to the vast array of issues involved. I am a strong advocate of Voluntary Euthanasia, and support the proposal of its decriminalisation. The legalisation of Voluntary Euthanasia would allow the wishes of an increased number of terminal patients to be respected and implemented; not being a mandatory course of action, it would not directly infringe upon those who do not approve of the concept of Euthanasia, however would offer a choice to many terminally ill patients. This is a choice which should be the patient's alone, and one which should not be restricted by limitations within a society.

It seems almost ironic in such a democratic society which constantly advocates humanitarian ideals, freedom of speech and the rights of the individual, a person is currently prevented by law from making a choice between life and death which should be theirs, and consequently forced to endure suffering in a situation where even animals are shown compassion.

One of the strongest objections of those who disapprove of the principals of Voluntary Euthanasia involves the concept of 'taking' a life, particularly on the grounds of religion or conscience; life is seen as a gift which should be valued, preserved and respected, as we do not have the right to 'play God' and end a life prematurely. Certainly, these reasons would justify a terminally ill patient to deny Voluntary Euthanasia, or alternatively, a doctor to implement it, however do not justify denying the choice between life and death for those who support Euthanasia. In our democratic society, individuals are free to follow any or no belief they choose; nevertheless, these should not condemn the individual beliefs of others.

Another argument against Euthanasia is the concept of a 'natural' death which many believe should be granted. Many terminally ill patients however, are eventually forced to rely on various life supporting mechanisms and medication to maintain life, thereby prolonging the eventual and inevitable outcome of death, thereby still denying a 'natural' death. This may result in intense pain and further suffering which is cruel and unnecessary; the patient forced to endure a life which has lost all purpose, direction, and quality.

The law should embody and reflect values within a society, and have the ability to modify to meet changing needs and values. Undoubtedly, legislation in this area will need to be greatly secure and guarded in an effort to avoid inordinate abuse of Euthanasia; ultimately however, I pray the anticipated difficulties in implementing laws in respect to Voluntary Euthanasia, if legalised, will not be cause for rejection of the "Rights of the Terminally Ill" Private Member's Bill. The increasing support for the decriminalisation of Voluntary Euthanasia is shown significantly through polls in not only Australia, but many countries worldwide. The more recent introduction of a Bill similar to that of the NT, in South Australia, perhaps also indicates widespread support of this issue.

2

Perhaps a significant issue related to the Euthanasia debate is the issue of a 'Notice of Direction', commonly referred to as a 'Living Will'. *"A living will is the drawing of a legal document whereby in the event of a future terminal illness, artificial life support or life sustaining procedure would not be used."** Currently a legal practice in the Northern Territory ("Natural Death Act 1988"), and South Australia ("Natural Death Act 1983"), the 'Notice of Direction' is a form of Passive Euthanasia, whereby the necessary treatment for the patient is either withdrawn or withheld. By performing Passive Euthanasia however, further pain and suffering will still often occur needlessly, with the eventual outcome of death. By comparison, when Voluntary Euthanasia is induced, the result is usually a distress-free, painless, dignified death. 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?

For the sake of humanity, a person should be entitled to decide whether s/he lives or dies and should therefore be given a choice. If a person has a right to live, they should have a right to die. An individual's life should not be controlled by the controversial limitations in a society, nor should any basic right be denied to any person. The legalisation of Voluntary Euthanasia will grant to all concerned a simple, fundamental right of choice.

Kylie Chin

March 22, 1995

GPO Box 4404

Darwin NT 0801

(089) 815538

*Healey, K, (1992), *Whose Life Is It?,* The Spinney Press, Australia.

SUBMISSION 837 1

Kamilaroi Cres,

Manilla. 2346.

22.3.1995.

Select Committee on Euthanasia,

Parliament of the Northern Territory,

P.O. Box 3721,

Darwin. N.T. 0801.

I wish to support the right of individuals to have control over their deaths when life becomes unbearable.

I support Voluntary Euthanasia.

It is so unjust that doctors have to break the law to assist the suffering terminally ill and those incapable of looking after themselves who no longer want to rely on family and friends to do it for them.

Please legalise V.E. let the individual choose and leave the judgement to God.

Yours sincerely,

L. Christensen.

SUBMISSION 838 1

THE SECRETARY, JOAN DOHERTY

G.P.O. BOX 3721, P.O. BOX 8982

DARWIN ALICE SPRINGS

N.T. N.T.

0801 0871

21/03/95

DEAR PAT,

I WRITE TO EXPRESS MY FEARS, ABOUT THE INTRODUCTION OF EUTHANASIA IN THE NORTHERN TERRITORY.

HOLLAND PERMITS EUTHANASIA, AND OVER HALF OF THOSE PUT TO DEATH THERE, WERE DONE SO ,WITHOUT PERMISSION.

RIGHT NOW THERE ARE REPORTED MOVES TO EXTEND THE CONDITIONS FOR EUTHANASIA, TO THOSE WHO ARE NOT DYING, JUST SIMPLY ILL.

IT IS OF NO CONSOLATION WHATSOEVER, TO BE TOLD "IT WON'T HAPPEN HERE".

NO FAMILY SHOULD LOSE THAT RIGHT, NOR AN INDIVIDUAL, TO LIVE A FULL AND JOYOUS LIFE

YOURS SINCERELY,

JOAN DOHERTY.

SUBMISSION 839 1

P O Box 9175

ALICE SPRINGS

NT 0871

22nd March 1995

Chairman

Select Committee on Euthanasia

G P O Box 3721

DARWIN

NT 0801

Dear Sir/Madam,

It is against a doctor's Hippocratic oath to take his patient's life.

Licensing doctors and nurses to kill patients would mean they could do just that.

Yours faithfully,

Peter R Bannister

SUBMISSION 840 1

P.O. Box 9175,

Alice Springs,

Northern Territory 0871,

Australia.

Wednesday, March 22, 1995

Chairman,

Select Committee on Euthanasia,

G.P.O. Box 3721,

Darwin,

N.T. 0801.

Dear Sir/Madam,

I am totally opposed to the proposed legislation on euthanasia being brought into law.

Euthanasia is an act of killing, and in all societies killing innocent people is deemed to be wrong. There is no more reason to kill terminally ill people than anyone else. Dying is the last part of life, and to kill someone before that time has come is to deny them participation in that period of their life.

With adequate pain relief, which is perfectly possible, with moral support and loving care, with a purpose in life still intact and a feeling of worth in society, the terminally ill have no cause at all to want to be killed. The will to live is natural. The wish to die is not.

The Hippocratic Oath states in part, "To please no one will I prescribe a deadly drug, nor give advise which will cause his death" This has stood doctors and their patients in good stead for two and a half thousand years. Why should this be changed now?

Abuse of the proposed legislation would be impossible to evaluate or to prove, but it . would inevitably occur. All laws are abused, and we cannot allow it to happen when the law is about killing people.

I find it totally incredible that serious thought can be given to this legislation before we have even started to make any palliative care facilities available for our terminally ill. That is where our energies should be directed.

If someone wants to be killed it is my contention that society has totally failed them.

Yours faithfully,

(Mrs.) R. Jane Bannister

Registered Nurse

SUBMISSION 841 1

64A Clark Rd

Nth Sydney 2060

NSW

22/3/95

Select Committee on Euthanasia

Parliament of the Northern Territory

PO Box 3721

Darwin NT 0801

This letter is being written to give support to the proposed VE bill.

- I support it on the basis of the right of individuals to have control over their deaths as they do over their lives.

- Since suicide is not a crime, providing someone with the means to commit suicide, at their request, is not crime.

- It is unjust that people have to find a doctor who is willing to break the law to get assistance in dying.

- The present situation, in which many doctors defy the law to end the lives of the suffering and terminally ill patients, is much more objectionable than a legally controlled situation, as in Holland. I myself remain grateful to nurses who allowed a much loved motherinlaw suffering Alzheimer's and a stroke to cease her life peacefully holding my hand.

Yours, in hope,

Ellen Bannister.

SUBMISSION 842 1

43/95 Stanhope Rd.

Killara 2071

21.3.95

Select Committee on Euthanasia

Darwin.

Sirs,

Having nursed four members of my family through many years of slow death - I fully endorse legal voluntary euthanasia.

It is quality of life not length of life that is more important for all concerned.

Yours faithfully,

Margaret A. MacGregor.

SUBMISSION 843 1

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88 Roden Cutler Village

10 Edward St.

Gordon 2072 N.S.W.

Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

Darwin N.T. 0801

Dear Sirs,

re Support for the Euthanasia Bill

As a member of the Euthanasia Society for many years and thus with very definite views on this subject, I feel I must write to add my plea for this to become law and legal.

I helped to nurse both my parents through long illnesses, so know what this means. Also I am now living in a Hostel and see so many round me being kept alive, without a good quality of life, so my beliefs are more entrenched than ever.

With best wishes for the success of this Bill.

Yours faithfully,

Joan A. Aird.

(Mrs J. AIRD)

SUBMISSION 844 1

Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721 Darwin N.T. 0801.

Arthur L. de Munitiz

18/3 Glen Street

Paddington

Sydney 2021 NSW

Phone: 02 360-5265

20 March 1995

Submission to Committee

I understand that you will accept letters from persons outside the Northern Territory.

If so, please note that I am a supporter of the proposed legislation because in the not too distant future (I am nearly 65) it will possibly obviate the need for me to adopt doityourself techniques which I personally know are far from reliable and because the present ban on euthanasia simply imposes the will of a few religious fanatics on the general population.

Arthur de Munitiz, Paddington.

SUBMISSION 845 1

4/592 Pacific H'way

Killara NSW 2071

Select Committee on Euthanasia

Parliament of Northern Territory

P.O. Box 3721

DARWIN NT 0801

I should most vehemently support the proposed legislation for legalised euthanasia. Choices have been made in all aspects of Life, and I should like to be able to end it if the circumstances were such that I didn't know if I was Arthur or Martha, dribbling my soup, maybe incontinent and suffering a painful, incurable disease.

To die with a little dignity should be everyone's right.

Mrs Margaret Woods.

Have been a V.E.S. (NSW) member for year.

SUBMISSION 846 1

1a Waterfall Rd

Oatley

N.S.W. 2223

22/3/95

Ph (02)5794889

The Secretary

The Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

DARWIN N.T. 0801.

Dear Sir/Madam

Making Euthanasia Legal.

I am 68 years old. There is no way I want to become a vegetable! Once my enjoyment of life is reduced to the state where I don't know what I am doing, or I am bed bound - then I wish to die. I feel individuals should have the right to commit suicide if they wish.

Doctors should have the right to give patients a lethal drug if it is clear the patient does not wish to live or does not have the mental capacity to know if they want to live or not.

I wish to support the Northern Territory's bid to achieve legal voluntary euthanasia.

Yours Faithfully,

RALPH NEWBOULT.

SUBMISSION 847 1

Lot 93 Albert St

KENDALL 2439

21. 3. 95

Select Committee on Euthanasia,

Parliament of the Northern Territory,

PO Box 3721,

Darwin, N.T., 0801.

Dear Sir/Madam,

Firstly, I'd like to congratulate the leader of the government for sponsoring the bill for the legalisation of voluntary euthanasia.

Having been a nurse for many years, and having witnessed the loss of dignity, choice and intractable pain that

some people suffer when in the grips of a terminal illness, I feel most strongly that these people have the right to choose whether or not they wish to end their lives.

When the quality of life is intolerable, with no hope of improvement, surely individuals can choose to ask for their lives to be ended with the assistance of the medical profession - and this should not be deemed to be an unlawful act.

Yours faithfully,

Ms KERIN LEVY.

SUBMISSION 848 1

Select Committee on Euthanasia,

Parliament of the Northern Territory,

P.O. Box 3721,

Darwin, Northern Territory, 0801

Dear Sir/Madam,

I write to you on this important subject for I understand that a bill in support of voluntary euthanasia is to be presented to your Parliament and you would like the support of the ordinary person.

I wholeheartedly support this measure. Nothing is more heartbreaking than to see a human being, without the capacity of being able to read, think, talk or recognise anyone lying in a state of complete isolation and knowing such a person would wish to end such misery.

Please do all you can to persuade the doubter.

Of course there will be doubters but it is my earnest wish that you will continue your campaign until it brings the results we so desire.

Yours faithfully,

(Mrs) M.H. Gibson.

SUBMISSION 849 1

Lovegrove Street

Ludmilla NT

23 March 1995

A SUBMISSION ON THE PROPOSED

RIGHTS OF THE TERMINALLY ILL

The "Rights of the Terminally Ill" have raised their head over the years in other guises. We are old enough to remember this very debate being carried on as "Mercy Killing". It seems that we as a society, like to cloth our intentions in euphemisms. The real question is - should a society legalise the right of any one segment of itself to kill itself, and/or demand assistance to that end.

We do not believe the government has the right to legislate "morals" in any way. To "relieve the suffering" is

surely different from "killing in order to relieve suffering". One is a social responsibility - the other social genocide. Laws which govern relationships in our society are designed to keep people from injuring themselves or injuring other members of the society.

The terminally ill, of any age, must have access to first class supervised palliative care including the necessary pain relieving drugs that are now available. Family and friends would receive counselling and "life prolonging" steps could be a personal decision of Dr/patient/family.

Our family has had personal experience in the "art of dying". It was not easy, but then life never has been, and the ending was just the "on goingness" of the human race. We hope we have not come to the point of legally choosing to kill each other - no matter how we try to dress it up.

Do not pass the "Rights of the Terminally Ill" bill for the simple reason that it is wrong.

EM Edwards JD Edwards

(refer to attachment)

2

Questions

1. Why the magic age of 18? Certainly younger people suffer as much as older people.

2. Would the terminally ill/old ever feel pressured (real or imagined) to end their lives so as to relieve the suffering of family and friends? Certainly these people could feel that they were a burden upon others.

3. Would the rights of the spouse and close family such as adult children be considered? Certainly there is a possibility of major family conflict at the death bed.

4. Why give the terminally ill, who are in pain, a legal way out and not provide the same "service" to the severely handicapped in acute pain? Certainly the quality of life is no different.

5. Why a lethal injection? Certainly it should be the choice of a "competent" person to choose the method of dying such as gassing, smothering, shooting, etc.

6. Will assisted suicide be made legal, no matter the method chosen?

7. How, in our society, could a person ask to be killed, legally, when an accepted universal ethos, of our society, is not to harm each other?

SUBMISSION 850 1

24/3/95

Dear Ms Hancock

I am writing to express my alarm at the proposed euthanasia legislation for the Northern Territory.

This legislation affects all Australians as it would be inevitable that vulnerable sick and elderly Southerners would travel to the Northern Territory to use the deadly "service" proposed by Marshall Perron. I ask you to oppose the Bill.

Yours Sincerely,

Michael Stackpole.

Mr Michael Stackpole

7 Garden St

Hampton

Victoria 3188.

SUBMISSION 851 1

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23 - 3 - 95.

Dear Comm.

I am strongly in favour of V.E. for N.T.

Sincerely,

M. FERGUSON.

SUBMISSION 852 1

1/22 Kenilworth Pde.

Ivanhoe Vic. 3079.

24.3.95.

The Select Committee for

Rights of the Terminally Ill Bill

c/o Ms Pat Hancock.

Dear Committee,

I am writing to you to express my alarm at the proposed euthanasia legislation for the Northern Territory. This legislation affects all Australians. I am afraid vulnerable, sick and elderly Australians will travel to the Northern Territory to "avail" themselves of this deadly service. Acceptance of patient killing will further devalue human life and will place under scrutiny those whose lives are seen as a burden to society. I ask you to oppose the Bill.

Yours sincerely,

(Mrs) M.A. Beriman

SUBMISSION 853 1

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98 WAITOMO ST,

BROAD BEACH Q. 4218

23. 3. 95.

The Chairman

Select Committee on Euthanasia

N.T. Parliament

Darwin.

May I make my modest contribution to your deliberations concerning the Introduction of the Euthanasia Bill. Though not a N.T. Electoral Roll I regard this as something of National Importance.

I am 82 years of age and am in perpetual horror of being incapacitated, unable to persuade anyone to give me the necessary drugs to end suffering. Please do something to give old people the opportunity to make their exodus with some dignity.

Thanking you,

E.H. JONES.

SUBMISSION 854 1

"Sunshine Park" Aged Hostel

10 Brady Rd

Lesmurdie 6076

West Australia

22nd March 1995.

Select Committee on Euthanasia

Dear Sirs,

I am writing to advise you that I agree with Marshall Perron's Bill for the Rights of the terminally ill.

When I entered this Hostel in 1990 it was only required that one be over the age of 60 and capable of looking after oneself.

However in 1991 the Federal Govt made it into a Hostel for the Frail Aged and now the residents entering are mainly dementia patients or those who are very frail indeed.

Associating with people in these conditions has made me very conscious that the quality of life is far more important than the length of life. So much so that in 1993 I joined W.A.V.E.S., the Society for Voluntary Euthanasia in W.A.

I have discussed my concern with the Hostel doctor and signed a Declaration and advised him that I do not wish, in any circumstances, to be put on life supports.

However I realize that such "Living Wills" are not legally binding and am prepared to support any moves towards making them so. Although for myself I am in favour of Passive Euthanasia I am prepared to support moves for Active Euthanasia for those who desire it.

Sincerely,

Elizabeth Harris.

SUBMISSION 855 1

SUSAN FORREST FLINN 17, Helen Street

South Golden Beach 2483

N.S.W.

21. 3. 95

Dear Sirs

It is with great hope that I write this plea to consider the change of laws regarding Euthanasia.

I listened, via mail, to my mothers plea for help whilst still alive and alone in the U.K. then the suicide she committed in 1990 at aged 81 years, totally alone, and terminally ill.

I cannot imagine what must have been her thoughts, but so wish that she could have died with dignity in care, perhaps a hand.

Surely it is your right and mine to have a say in how we choose to end our lives should we have the need because of dreadful illness and unbearable pain.

Thank you for accepting this letter and for considering this much needed legislation.

Yours sincerely,

Susan Forrest Flinn.

SUBMISSION 856 1

21/1 Spencer St,

Wamberal. 2260

23rd March '95.

Select Committee on Euthanasia.

I am writing to support your cause in the Northern Territory for Voluntary Euthanasia. I am a current member of the NSWales Society after experiencing the recent death of my husband, who died of pancreas cancer.

Hoping you have success with the parliamentary Bill as it will no doubt help other States in Australia.

Yours faithfully,

(Mrs) P. Perrin.

SUBMISSION 857 1

The Chairman

Select Committee on Euthanasia

GPO Box 3721 DARWIN NT 0801

Two pages and one enclosure

subsequent to the submission

of (Mrs) M.A. Ross, 21st March 1995

22.3.95

In page 3 of my submission, section (iii) I refer to the need for others (whether doctors, carers or relatives, for example) to realize it is the patient who needs to be at inner peace with death, and palliative care, not euthanasia is the required approach.

Reference 5 used an address as a basis on which to compare my point. I have now located a magazine extract giving Dr Toni Turnbull's account of a situation supporting my point. Copy enclosed.

On the reverse side of my enclosure is an account of a different situation for which others' emotional response may be "euthanasia", and, again, how wrong, abused and shortsighted are decisions to euthanise proving to be. There is not one valid reason that can rationally support any government to do down the euthanasia path. It is from the same edition as Dr Turnbull's case history.

To recap my fourth point (page 5 of the abovementioned petition), governments must find the money for palliative care. Decisions must be made to facilitate the rebalance of the age of the population; every suggestion must be examined in the full picture before a decision is made, and that includes the projection into the future; and governments must provide quality palliative care, and fund other groups (eg church groups) which offer palliative care the first two points having a definite bearing on the third.

(Mrs) M.A. ROSS

30 Henry Street

ROCKHAMPTON QLD 4700

22nd March, 1995.

Enclosed with submission: "Doctor, kill me!", by Dr Toni Turnbull, Light, February 1992

"Grandma's lesson", by Mary Ann Kuharski, Light, February 1992

SUBMISSION 858 1

Mrs P. Robson

162 The Comenarra Parkway,

Wahroonga.

N.S.W. 2076

Dear Sir,

I wish to add my urgent request to the many others for your most intense consideration towards the humane need for "voluntary Euthanasia" to become an accepted and lawful necessity in our country.

More than enough, I'm sure, has already been provided as proof throughout the years to prove that more and more people, for all manner of genuine and reasonable thinking measure, add up to an increasing pressure to bring about change in previous personal and community fears. Until, by now, I most definitely suggest that indeed! There is every need in this, as in all other directions as well ... to take responsibility for oneself in life and in death likewise. Only the "merciful" element being that part with which we should be able to approach and expect such help as a doctor should then be able to supply with clear conscience and within lawful structure.

Hoping and trusting in the hastening towards this end.

Yours sincerely,

P. Robson.

SUBMISSION 859 1

Box 523, Malanda, 4885.

March 23rd, 1995.

Phone 965018

The Chairman,

Select Committee on Euthanasia,

G.P.O. Box 3721, DARWIN, NT 0801.

Dear Sir,

With a feeling of great concern - even apprehension - I am writing to you as a fellow Australian, with regard to the proposition to introduce euthanasia legislation into the Northern Territory, and what is more, to have the State made the killing fields for the rest of the country.

It makes my blood run cold to learn that in this socalled lucky country, you may not be very lucky if you are incapacitated, seriously ill or terminally ill, and living in the Northern Territory. Because as sure as night follows day, as has happened in European countries, particularly Holland, what was introduced as voluntary euthanasia, became involuntary euthanasia.

Even in South Australia a recent report has alleged that doctors and nurses revealed that of the 19% who had taken active steps too bring about the death of a patient, 49% had never received such a request from a patient. The world is so used to violence, murder and mayhem. What is tolerated now would have been unthinkable a few years ago. We have been so desensitized to evil there are some who would argue that killing innocent people is even meritorious - and showing mercy.

We all know that doctors are not infallible in diagnosing how long a person has to live, even how ill he or she really is. The medical profession after all, is supposed to heal, not deal out death. What palliative care does the Northern Territory offer?

I ask you, please consider the ramifications is this legislation is passed, and for the sake of our country do not allow practices such as euthanasia to be considered.

Yours sincerely,

(Mrs) Rita Svendson.

SUBMISSION 860 1

Dr Peter Ferwerda

MBBS FRACGP Dip. Obs. RCOGP

P.O. Box 552

Croydon Vic. 3136

Dear Ms Hancock

May I please express my concern at the proposed legislation for the Northern Territory which has implications for all of us Australians.

In my original country Holland, doctors are now forced to terminate the lives of those who request euthanasia, or refer them to someone who will, otherwise the doctor can be punished in law.

This was announced in a recent publication of the official newsletter of the Netherlands Health Commission "Trefpunt".

I personally am very alarmed at developments in this area and fail to see the need to legislate in this area at all, since the terminally ill are already adequately treated under current conditions.

Yours Sincerely,

Peter Ferwerda.

SUBMISSION 861 1

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24 - 3 - 95

Warragul

29 Gladstone Street

Dear Committee members,

I am writing to you to express our alarm at the proposed euthanasia legislation for the Northern Territory. This legislation affects all Australians. We are afraid vulnerable, sick and elderly Australians will travel to the Northern Territory to "avail" themselves of this deadly service. Acceptance of patient killing will further devalue human life and will place under scrutiny those whose lives are seen as a burden to society. We ask you to oppose the Bill.

Yours sincerely,

Adrian and Johanna Commadeur.

SUBMISSION 862 1

P.O. Box 357

COOROY. QLD 4563

22 - 3 - 95.

To whom it may concern,

RE: Rights of the Terminally Ill Bill

I would like to express my opposition to legalized patientkilling.

Each and every person suffering from "terminal illness" has the right to receive the best of palliative care that is possible, and to not to die prematurely at the hands of professionals who should be doing their utmost to encourage and nurture patients rather than "terminate" them.

Please consider, "neither is there any creature that is not manifest in his sight: but all things are naked and opened unto the eyes of him with whom we have to do". HEBREWS 4:13.

Everybody who is responsible, either actively or passively, will in time be judged by the Creator of us all.

The good news is that as it is written in the first of epistle of John, "If we confess our sins, he is faithful and just to forgive us our sins, and to cleanse us from all unrighteousness". 1 JOHN 1:9.

Therefore, I urge you, this day, to reconsider what you have allowed to happen in the introduction of this "Bill" and to do everything in your power to dissolve it.

Our days are numbered by GOD - not by YOU!!

Yours Sincerely,

(Mrs) Bernadette Isaac.

SUBMISSION 863 1

Sample letter of ProLife News:

Dear Mrs Pat Hancock,

I am writing to you to express my alarm at the proposed euthanasia legislation for the Northern Territory. This legislation affects all Australians. I am afraid vulnerable, sick and elderly Australians will travel to the Northern Territory to "avail" themselves of this deadly service. Acceptance of patient killing will further devalue human life and will place under scrutiny those whose lives are seen as a burden to society. I ask you to oppose the Bill.

Yours sincerely,

Bernard McHugh.

SUBMISSION 864 1

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2 Gothic Pde

Currimundi

Qld 4551

21-3-95.

Dear Sir,

I realise this letter will be late, as it should have arrived in N.T. by 24th. The Newsletter advising me of this matter, did not arrive until Monday 20th.

But anyway, I wish to tell you that I think it is necessary for people to have the chance, to say when they wish to have their life terminated, especially in cases of cancer, where the pain is so bad, that they cannot endure it.

I would like to be able to say to a Doctor to help me, if I could not endure my pain, especially as I am 74 years of age, and would not want to have days and nights of agony. I have not seen anyone die, but I did watch my Mother, a very independent lady, go through years of debilitating sickness and knew she was aware of what she had to put up with. When she finally passed away, (I was not with her sadly) I could not cry, as my tears were all gone and my thought was "Thank God, she is now at rest".

I only hope I never have to go through the pain she experienced and sincerely hope Qld will follow NT in becoming a State with Voluntary Euthanasia.

If only people who are against VE could see something of the sorrow and pain of some patients, I feel sure they would come to understand why we need the law to say we can help ourselves with our Doctor's help - and for him or her not to be penalised.

I saw the Video of the Doctor in Holland helping a chap to experience a peaceful end and sad as it was, I wish we

could have the law for it to happen in Australia.

Thanking you, I do hope you read this and taken my views into account, even though it is arriving late.

Sincerely,

Mrs. Dulcie Rose.

SUBMISSION 865 1

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5 Farnham Ave.,

ROSELANDS 2196

22.3.95.

Select Committee on Euthanasia,

Parliament of the Northern Territory,

Darwin. N.T.

RE: SUPPORT FOR VOLUNTARY EUTHANASIA LEGISLATION

Dear Sirs,

In expressing my support for the legalization of voluntary euthanasia, I ask you to consider these questions:

1. Who, except the individual concerned, should have the right to make a decision on a matter of such intimate and personal significance to that individual as the continuation or relinquishing of life?

2. If an individual is physically capable (s)he can end her/his life: to achieve this desired end, why should assistance be legally denied to a person who is simply physically incapable of achieving it by his/her own action?

3. This assistance can be, and sometimes is, achieved through the cooperation of another; if the disabled individual has clearly at any time indicated that such action is what (s)he desires, why should the helper be deemed to have acted illegally?

I would go further than the proposed legislation, and submit that a person is entitled to voluntary euthanasia who at any time has signed, and never cancelled, an "Advance directive", stating his/her request in the event of a serious mental or physical condition making life what (s)he no longer considers worth living.

Please consider the individual's right to selfdetermination and, where necessary, to assistance in achieving it.

Sincerely,

Dorothy Endicott.

SUBMISSION 866 1

Mrs E. BURGIN

136 Wood Road,

YAGOONA NSW 2199

Thursday March 23.

Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

DARWIN N.T. 0801.

Dear Sirs,

I am writing to state my support for legal voluntary euthanasia.

I am aged 65 yrs and in good health at present. However I watched my mother who had good physical health until in her 70's when she deteriorated mentally and spent the last 15 years of her life in a nursing home.

During t his time her mental state continued to deteriorate and she suffered a fracture of the neck of the femur about which Doctors were reluctant to do anything - only through pressure from me she was admitted to hospital and a repair done - ward sister even telling me that it was unlikely that my mother would pull through the operation and she could not understand why it was being carried out.

My mother lived at least another 810 yrs. Unfortunately because of her mental state she was uncooperative after the operation and never walked again.

A few years later my mother had a compound fracture of the shaft of the femur (cause unknown). Hospital Doctors at first were only inclined to splint her leg but under pressure for something more to be done she was put into traction and on a drip (quite unnecessary as she ate well but needed to be fed). After a period in traction her leg was put into plaster from groin to ankle and remained so for 6 months (during summer) - her hand was of no further use to her having become frozen from being bound up to prevent removal of the I.V.

My mother lived on for a number of years after this in total care until her whole system eventually broke down and in a pitiful state she eventually died at age 92 yrs.

It is possible I could suffer a similar fate and I do not want this for myself or for my family.

If an animal had been kept alive in the state of health my mother endured several times over this period prosecution by the RSPCA would have been in order.

My mother did not want to live on like this, she had seen her sisters suffer a similar fate and had expressed this opinion.

2

It is most certainly my wish to be helped out of my misery if I should suffer a similar fate, rather than be kept alive only to suffer more pain and indignity.

Hoping that voluntary Euthanasia will eventually be allowed by law.

Yours faithfully,

(Mrs) Eileen Burgin.

SUBMISSION 867 1

23/3/95 Mrs Boubela,

Unit 31, Onslow Gardens,

6A Greenknowe Avenue,

Potts Point, N.S.W. 2011.

I am afraid this letter will not reach you by 24th March. I did not receive the Newsletter until today.

However, I write as requested in case it is of some use. I am a widow an only child, no cousins in NSW, and am really alone. I have severe osteoarthritis which is getting worse. I am 79 yrs old. I can drive, I have a disabled licence, and this has enabled me to be mostly independent. While this is the case, I will continue, but if I lose my independence, living would become pointless, and I would be a burden to others and myself.

For those circumstance I became supporter of Voluntary Euthanasia. I should add I have a few other disabilities.

I hope the bill meets with some success and thank those concerned for their efforts.

Sincerely,

Sheila Boubela.

SUBMISSION 868 1

S. NICHOLAS

46 Epping Road,

DOUBLE BAY 2028

March 23rd '95.

The Secretary

Select C'tee on Euthanasia

Parliament of the N.T.

P.O. Box 3721

Darwin. N.T. 0801.

Dear Secretary

I write in support of the proposed bill to legalise Voluntary Euthanasia in the N.T.

It is my strong belief that the present situation in which it is illegal for doctors to end the lives and suffering of terminally ill patients is abhorrent and objectionable.

I hope that this situation can be reversed VERY SOON!

Yours faithfully,

(Mrs) Sheila Nicholas.

(aged 81).

SUBMISSION 869 1

Mrs. Ilse ROBEY, 34/20 Gerard Street

CREMORNE N .S .W. 2090

20/3/1995.

To the

Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

DARWIN N.T. 0801

Dear Friends,

As a Member of the Voluntary Euthanasia Society of New South Wales, I am most interested in the great initiative of the NT Chief Minister.

I am convinced that as a result of the steady advance of medical science a very large percentage of the elderly are kept alive by "unnatural means", well past their "use-by date" if I may put it so bluntly. And it is important to take into consideration not only their own personal suffering but that which is inflicted on their nearest and dearest; to those who love them most, they inevitably become a burden and all too often what once was a most loving relationship turns to helpless despair.

What is worse than seeing a loved one, a dear, intelligent woman of 93 lying disabled on a crumpled bed, thirsty, convulsed by kinetic involuntary movements, unable to utter one single plea for help because of a stroke she suffered which in addition to her pre-existing ailments has finally robbed her of her speech? VE would enable this suffering to be ended humanely.

The Medical profession which has the means of coming to the aid of the ailing and of their family and carers ought to be empowered to do so not only within the law but with its full support.

Even if this would entail a small element of risk once VE is enshrined in law, we must not forget that there is no means of legislating against criminal intent.

I am 81 and I sincerely hope that when my "use-by date" approaches there will be no problem for my family and my doctors to affect a PEACEFUL RELEASE.

Yours faithfully,

Ilse Robey.

SUBMISSION 870 1

FRANKLIN L. ROSENFELDT, M.D., F.R.C.S.E. 15 Dunstan St.,

North Balwyn,

Victoria 3104.

Tel. 857 6036.

22/3/95

Secretary

Select Committee on Euthanasia

Dear Ms Hancock,

As a cardiac surgeon and medical researcher I am writing to express my concern about the proposed euthanasia bill.

In our department at a teaching hospital decisions are often made to allow terminally ill patients to die sometimes with assistance in the form of narcotics.

I do not believe the law needs to be changed. Experiences in Holland is very negative for medical ethics when you look into it.

Doctors in palliative care don't request this for their patients - they are experienced in giving pain relief even if it hastens death.

This b ill is a danger to the helpless patient.

Yours sincerely,

Ass Prof Franklin Rosenfeldt.

SUBMISSION 871 1

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117 Bentons Rd

Mornington

23-3-95

Dear Mrs Hancock,

I am writing to express my concern at the proposed legislation to introduce euthanasia.

I am asking you to oppose this Bill. It is contrary to any Christian nations principles. It is man playing GOD. Stand for righteousness.

Yours Sincerely,

Wendy Hart. RN

SUBMISSION 872 1

Chairman,

Select Committee on Euthanasia,

GPO Box 3721

DARWIN N.T. 0801

Dear Sir,

Please don't just listen to the Church, the Doctor's or Government Members when considering the Voluntary Euthanasia Bill - Listen to the people of the Northern Territory. Consult the elderly, not the young and firm on their feet as the young think it is not going to happen to me so why bother thinking about it.

I am an elderly lady and if I was ever in this situation I would like to be able to put an end to my suffering. Please pass this Bill.

Yours faithfully,

Elsie A. Garling

43 Allwright St.

WANGURI N.T. 0810

22.3.95

SUBMISSION 873 1

20A Seymour Grove

Brighton. 3186

20th March 1995.

To -

The Select Committee into the

Rights of the Terminally Ill Bill

c/- Ms Pat Hancock, Secretary.

Dear Ms Hancock,

I am writing to you to tell you of my distress at the suggested euthanasia legislation for the Northern Territory. This legislation will have an impact on most Australians. I suspect that ill and elderly patients will make their way to the Northern Territory to 'benefit' from this 'fatal' service.

Toleration of patient killing will certainly extend the disabling of family life; and will permit judgement of those whose lives are thought to be a constraint, or restriction on society.

I ask you to oppose the Bill.

Yours sincerely,

Margaret O'Brien.

Miss M. O'BRIEN

20A SEYMOUR GROVE

BRIGHTON, 3186.

SUBMISSION 874 1

To:- Select Committee on Euthanasia

Parliament of the Northern Territory

P.O. Box 3721

DARWIN N.T. 0801.

I support the N.T.'s push towards legal Vol. Euthanasia and sincerely hope it is successful.

Perhaps only people who had nursed a loved one suffering a hopeless, painful disease should be allowed a vote on this issue.

One often hears people saying "they should be reported keeping a sick dog like that; it should be put out of its misery". But does a human being get the same sympathy? No.

I have nursed husband, mother, a neighbour, two cousins and many friends through to final stages of cancer and it was not a sight for delicate stomachs at the end. At one stage neighbours three doors away complained about the terrible, distressed sounds coming from my house. "Can't you do something?" they asked.

What did they want me to do? Medication and devoted nursing had failed. As the patients were totally incapable of attending to themselves it was up to me. Did I shoot them? Smother them? Overdose them?

It is unjust that people have to find a doctor who is willing to break the law to get assistance in dying with some remnants of dignity to manage a peaceful death.

Eunice Flynn

3/14 Oxford St,

Sutherland NSW 2232

21st march, 1995.

SUBMISSION 875 1

Box 14, Batchelor

N.T. 0845

23-3-95.

Dear Sir,

My husband and I are in favour of the Euthanasia Bill.

Yours faithfully,

(Mrs) F.J. Marshall

I concur: (Mr) R.J. Marshall

To the Select Committee on Euthanasia

GPO Box 3721

Darwin NT 0801.

SUBMISSION 876 1

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

Telephone (06) 205 0166

Facsimile: (06) 205 0431

Postal Address

GPO Box 1020

Canberra ACT 2601

Michael Moore MLA

Independent

Mr Eric Poole

Chairman

Select Committee on Euthanasia

GPO Box 3721

DARWIN NT 0801

24 March 1995

Dear Mr Poole,

I enclose the followingf materials by way of information rather than a submission to the Select Committee on Euthanasia.

1. Presentat Speecy for the Voluntary and Natural Death Bill (16 June 1993)

2. Select Committee on Euthanasia Report, *Voluntary and Natural Death Bill, 1993.*

3. Hansard transcript of the presentation of the above report (14 April 1994)

4. The Medical Treatment Bill 1994 which was accepted and passed by the Assembly.

5. An article on Voluntary Active euthanasia,*The right to die with dignity.*

If you wish any further information, do not hesitate to call me.

Wishing you all the best in your deliberations.

Yours sincerely,

Tina van Raay

for

Michael Moore MLA

Enclosed with letter copies all of the articles listed above.`

SUBMISSION 877 1

VOLUNTARY EUTHANASIA SOCIETY OF VICTORIA INC.

70 Greville Street

Prahran, Vic, 3181

Ph: 521 3297

Fax: 521 3302

21 March 1995

Ms Pat Hancock

Secretary

Select Committee on Euthanasia

GPO Box 3721

DARWIN 0801

Dear Par

As discussed today, I enclose 7 complimentary copies of "Willing to Listen - Wanting to Die", edited by Helga Kuhse.

We believe that this books is a valuable contribution to any discussion on voluntary euthanasia, therefore we hope that members of the Select Committee will find it a useful resource.

I have enclosed two spare copies, so that they may be used by anyone else who would find them helpful resource material.

Yours sincerely,

Kay Koetsier

Executive Officer.

Enclosed with submission book entitled WILLING to listen WANTING to die, edited by Helga Kuhse, Penguin Books.

SUBMISSION 878 1

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11 Cooper Rd

Wamboin N.S.W. 2620

23/3/95

Dear Chairperson,

I write to support the Rights of the Terminally Ill Bill, introduced into the Northern Territory Parliament, and presently before the Committee.

It is, I believe, of the utmost importance that active euthanasia be allowed and that the Northern Territory enact legislation regulating this difficult area. To leave the present law standing would be to leave suffering patients to the chance that a humane doctor would be prepared to risk ending their agonies.

The present law cannot be justified upon the basis that it accords with the moral beliefs of the Catholic minority for that would entail the imposition of those beliefs (which are not doubt strongly and sincerely held) upon the rest of society.

It is indispensable that both the death and the assistance should have been freely chosen. That is essential but not sufficient. It is also necessary that he circumstances should satisfy society's very real interest in the relief of suffering.

There are times when difficult issues need to be grappled with. That is, I suggest, the position with legalizing euthanasia which has the overwhelming support of the community. It is a serious matter to subject the compassionate termination of deep suffering to the criminal law.

Yours sincerely,

(John Greenwell)

SUBMISSION 879 1

Mr P Adamson

Member for Casuarina

Shop 3, Cascom Centre, Bradshore Terr,

CASUARINA NT 0810

29/395

3 Oslo Lane

Willetton

W.A. 6155

Dear Mr Adamson,

We are writing to express our grave concern over the proposed legislation on Euthanasia in the Northern Territory.

We believe that the proposed bill rather than benefiting them, will diminish the legal position of the rights of the sick and dying. We believe that the issue is a complex one and that the needs of the terminally ill have not been sufficiently studied. It would seem that, rather than legislation to kill people, the emphasis should be on more and better palliative care. We urge you to vote against this legislation.

Yours sincerely,

M.J. Gonzalez.

G.M. Gonzalez.

Copy: Hon M Perron MLA, Hon E. Poole MLA, Hon M. Reed MLA,

Mr M Rioli MLA, Mr. R. Setter MLA, Mr. S. Stirling MLA,

Dr R Lim MLA, Hon D. Manzie MLA, Hon T. McCarthy MLA,

Mr P Mitchell MLA, Mrs N Padgham-Purich, MLA Hon Mick Palmer, MLA

Mr J Bailey MLA, Mt T Baldwin MLA, Mr N Bell MLA, Mrs L Braham MLA, Mr D Burke MLA, Hon. B Coulter MLA, Mr B Ede MLA, Hon. F Finch MLA, Hon S Hatton, MLA, Mrs M Hickey MLA, Mr W Lanhupuy MLA, Hon S. Stone MLA

SUBMISSION 880 1

Sunday Ridge Rd

Simpson 3266

6-4-95

Hon Marshall Perron,

Dear Sir,

I am strongly opposed to your bill proposal in favour of euthanasia. It is simply "murder".

Remember at some stage it may be your turn to be killed - without your consent.

Yours sincerely

D J O'Keeffe

SUBMISSION 881 1

Women's

Ministries.

6 Admirals Crs.

Taylors Lakes. 3038

28-3-95.

Dear Mr Perron,

I wish to write my objection to the Euthanasia Bill called the Rights of the Terminally Ill patients bill.

It is a disgusting thing to think that we as Australians will consider such a thing as devaluing a human life to this extent.

I wish to oppose this bill and also the ladies of my church (of which there are 1500 people) would also back me as a committee member for the State of Vic.

Yours faithfully,

Noelle Fenn (Mrs).

SUBMISSION 882 1

SUBMISSION TO THE "SELECT COMMITTEE ON

EUTHANASIA."

By Pastor Mark A. Hampel B Th, STM

INTRODUCTION

As people working with the young Aboriginal people of the Northern Territory and having a deep concern for the social well being of our society we are very perturbed by The Rights of the Terminally III legislation presently before the Northern Territory parliament. We are opposed to the Bill for the following reasons;

* it is unnecessary

* it is not possible to contain the practice of Euthanasia within the proposed guidelines

* it violates a fundamental principle of society -'the inviolability and sacredness of life itself.

IT IS UNNECESSARY

While applauding the ideal of, 'relief from suffering.' as a good motive for one human being to have toward another, it must be pointed out that to actively assist someone to take their own life. or to kill them at their request In order to obtain that relief is an uncalled for excess, somewhat akin to swatting a fly with a sledgehammer.

Dr. Lloyd Morgan1 *for* example rejected the call for active euthanasia "because it is unnecessary in most sees", and because the choices of dying in pain or being killed are **not** the only choices available given modern palliative care, Another physician, Dr. Brian Pollard who has served for 30 years as an anaesthetist. and is now working full time in the service of caring for the dying in a general Sydney hospital is also of the opinion that euthanasia is unnecessary "because the fearsome palm of a terminal illness can be totally eliminated or at least made bearable with modern medication."2

The potential of palliative care to meet the needs of dying persons is still too little understood. not only by the community but also by some health professionals and educators. A 1991 public opinion survey conducted by McGregor Marketing in which 400 people from the Adelaide metropolitan area 18 years of age or older were surveyed, revealed the following.

42% of the public were not aware of ability of modern medicine to control severe pain

66% did not know there were places providing dying patients with pain relief and care but without treatment to prolong their lives.3

Our society has the ability to provide good palliative care. 'We know now better than ever before how to control pain, and our knowledge is improving continually.

Under acceptable suffering can now be prevented in most cases; and few patients need to fear severe prolonged pain in a terminal illness, Dr. David Cherry of the Pain Management Unit, Flinders Medical Centre, South Australia says that the management of pain is now sufficiently precise that patients can generally decide for themselves on an acceptable level of pain relief. This involves trade off between reduction of pain and minimisation of side effects such as drowsiness.4

2

The bill in question states under Point 6. a of the "conditions under which medical practitioner may assist', that, a *medical practitioner may assist a patient to end his or her life only if the...the medical practitioner* has *informed the patient of...other medical treatment including palliative care, that might be available to the patient."* .While this looks good on paper it is a ridiculous suggestion when the facts are that the Northern Territory has ,"no medical oncologist, very limited radiotherapy services, not a single palliative care specialist, an inadequately resourced domiciliary palliative care program and not a single hospice".5

IMPOSSIBLE TO CONTAIN

Another problem I have with the proposed Bill for Euthanasia is that it presumes it is possible to contain the practice of voluntary euthanasia within clearly defined parameters and unambiguous boundaries. Supporters of voluntary euthanasia such as Marshall Perron claim that euthanasia can be domesticated, that it will not lead to other forms of mercy killing which violate the patient's right to autonomy or right to choose. Yet a study of euthanasia in historical perspective leads one to the well documented conclusion that voluntary euthanasia invariably degenerates into involuntary euthanasia.

For example the Netherlands experience over the 70's, 80's & 90"s shows that even though strict guidelines and procedures are laid down in law including the following.

* the request for euthanasia

- is to come from the patient

- is to be well considered, durable and persistent,

- is to be free and voluntary,

the reality is that in 100s of cases the medical fraternity has failed to do this. Evidence from the Netherlands now available in official Dutch reports and reported on in the British Medical Journal, The *Lancet*, contains abundant evidence that euthanasia is not restricted to the so called "strict medical guidelines" laid down by the Dutch courts 6 results of these reports indicate that about 0,8% of the 38.0% of all deaths involving "euthanasia and other medical decisions concerning the end of life" were "life terminating acts without explicit and persistent request".7 In numerical terms this amounts to about 1000 Dutch citizens in a single year being euthanised without their exploit request and consent. 8 Medical doctors are clearly ignoring the strict guidelines set down in the law. Have we any reason to doubt that the same thing will happen in Australia too.

A 1991 South Australian survey by two academics at Flinder's University reveals a similarly disturbing willingness on the part of Australian medical personnel to ignore and break the law. This survey which investigated the attitudes and practices of 298 doctors and 278 nurses in that state toward death. dying and euthanasia9 that already 19% of doctors and 19% of nurses have taken active steps to bring about the death of a patient. Even more disturbing is the fact that 49% of doctors and nurses who had taken active steps to encl patients lives had never received a request from a patient. Clearly. if Australian medical staff are so readily violating the law, even now contrary to their own vows to preserve life, (which they express in the Hippocratic Oath) and their patients wishes. there would be little to stop them violating in even greater degree, the clearly defined conditions outlined in the bill as is currently the case in The Netherlands.

Furthermore is very hard to believe that those who actively promote the cause of voluntary euthanasia will not carry the principle of using the, medical fraternity to kill people further when one reads some of the things they have written.

3

Consider the following statement under the heading "The Right To Choose Death" by Professor O. Ruth Russell (The New York Times. February 14,197.2):

Surely it is time to ask why thousands of dying, incurable and senile persons are being kept alive - sometimes by massive blood transfusion, intravenous feedings, artificial respiration and other heroic measures - who unmistakably, want to die." There are thousands of 'dying, incurable and senile persons' who are alive - not through any, extraordinary means but just plain 'alive.'

Hasn't she experienced, as I have, people who were supposedly incurable, who did express the wish to end it all, but who through continued medical treatment have been restored to health and now think completely differently about living. Daniel Myen is another proponent of euthanasia who has gone on record as saying, its not just a right to suicide. but in some cases, a duty.

The duty to suicide occurs when through my continued living lack of autonomy, misery, isolation, uniformity, unfruitfulness, incurability, lameness, pain, insensitivity, disgrace, madness, sin threaten to become the norm for humanity and my suicide is the only means *available to me to prevent this.10*

The media of course often pick up on statements like this as witnessed during the current debate in the Advertiser in South Australia over this issue. In this day of manipulation and the vast potential for a like minded media to put pressure on people -is it not right to expect the leadership of our country to protect and exalt a high view of life in

the face of these pressures rather than the low view being spread around in many quarters today. Which brings me to my third point.

EUTHANAS1A DESTROYS THE INVIOLABILITY OF LIFE PRINCIPLE

My last big objection to this Bill is that it cheapens the value of human life. Our society has until recently this century. generally regarded human beings as special, unique and non expendable. We have upheld the value that the lives of all people no matter how infirm or socially useless they might be deserve to be protected. (Legislation protecting the disabled, economically disadvantaged, the aged etc,. witnesses to this.) Life has been held to be valuable in and of itself. not on the basis of it's perceived worth in someone else's opinion. Human life was held to have a transcendent value.

Part of the reasoning behind this is that life is a mystery. Humankind is unable to manufacture It. We can only passively receive it. As we receive it: naturally, it should also end naturally when the body ceases to function on it's own volition. Citizens lived secure in the knowledge that the State and its agencies, ie., hospitals, defence and police forces etc... existed for the purpose of protecting life and enhancing the manner in which It is lived.

In passing legislation such as The Rights of the Terminally Ill, the state would be saying that life itself no longer has such high value in its eyes. This would signal a change of enormous proportions. The state would be saying in a general sense that a foundational value of our civilization, fundamental to our continued existence as a humane culture, is no longer sacrosanct.

The view that to legislate to legalize euthanasia is somehow tampering with fundamentals is recognized in the 1971 Report 'The Problem of Euthanasia' prepared by a Special Panel appointed by the Board of Science and education of the British Medical Association. Here it was stated that,..

4

There is a feeling, promoted by the Euthanasia society, that a person has a 'right to die'. religious attitudes and legal practice have been built on a fundamentally different principle: 'the right to live', The ethic of the right to live derives partly from Canon and Roman Law. It is also found in the Hippocratic oath in the pre-Christian era, and has in recent years been reaffirmed in the Nuremberg Code, subscribed to by the majority of nations, races and creeds of the word, and in the European Convention of Human Rights. Any concession which makes a breach in this principle is dangerous and raises new problems. Clearly, euthanasia legalisation would be · licence for killing of human beings.

Dietrich Bonhoffer argued similarly,

Since all rights are extinguished at death, it follows that the preservation of the life of the body is the foundation of all natural rights without exception and is therefore invested with a particular importance. The underlying right of natural life is the safeguard of nature against intentional injury, violation and killing. The body does not exist primarily to be sacrificed, but in order that it may be preserved..11.

If euthanasia were to be legalized by our politicians they would be responsible for undermining the foundational principle of our society, namely the inviolability and inallablility of life itself. Some undesirable consequences, which would probably result from this legislation were it to be passed are...

The relationship that exists between doctor, nurse and patient would be eroded. (Who could be sure they wouldn't be euthanised against their wishes?)

Nurses could in time be forced to act against their conscience as is the case with abortions. "Most nurses are no longer allowed to practice their rights not to assist in an abortion; they even get disciplined if they exercise their rights in this area."2

Once the idea of euthanasia gains acceptance, the ideal is soon forgotten and traded for pragmatic, arbitrary and economic factors. With the greying of Australia for instance, euthanasia is an easy alternative especially for the underprivileged whose rights are already diminished.

Young people who already have a high suicide rate will be tempted to kill themselves when they face difficulties, after all, society says it is OK.

CONCLUSION

For these three main reason, and many others which could be cited we ask you not to pass this bill. It sends a destructive message to the people of the Northern Territory.

Yours sincerely

Signed by 17 citizens.

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1 Means available to aid right to die, The Age, March 9 1992, 51.

2 cited in book report by Dr Daniel Overduin, Life News, August 1989,4.

3 Reference paper on Euthanasia, by the Social Responsibilities of the Diocese of Adelaide of the Anglican Church of Australia, August 1991, pp19-21.

4 Ibid.,

5 Dr John Zalcberg, Irony behind NT's Euthanasia Push, The Age, 28 February, 1995

6 Paul J. van der Maas Johannes J.M. van Delden, Loss Pijnenborg, and Caspar W.N. Looman, Euthanasia and other medical decisions concerning the end of life", The lancet, 338.8~68, September 1991, 669.

7 Ibid., 670

8 John Flemming, Bioethics Research Notes Occassional Paper No. 1, June 1992, 2.

9 Stevens, Christine and Hassan, Riaz "The management of Death , Dying and Euthanasia Attitudes and Practice of Medical Practitioners and Nurses in South Australia", a submission to the

Select Committee and the law and Practice relating to death and dying.

10 Daniel Mynen, "Zur ethischen Beureilung der Selbsttotung" (Deutsche Gesellschaft fur humanes Sterben, 1982)

11 Dietrich Bonhoeffer, Ethics, SCM Press, London 1955, 131.

12 Doris Kubisch, Nursing Sister at Yirara College, Alice Springs.

SUBMISSION 883 1

TO THE

SELECT COMMITTEE ON EUTHANASIA

GPO Box 3721

DARWIN 0801

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SUBMISSION FROM:

Pastor Norman W Wurst. (pastor of the Lutheran Church of Australia)

and

Mrs Joy D Wurst, (First Vice-president of 'Lutherans For Life' Australia)

ADDRESS: PAPUNYA. Via Alice Springs 0872 Telephone: 089-568513

This submission opposes the introduction of law proposing voluntary euthanasia. Such a law would leave unprotected the lives of the most vulnerable members our society. Our opposition is submitted under the following headings:

1. The definition and meaning of the term 'Euthanasia'.

2. Euthanasia transgresses human rights as set down by the UN Universal Declaration of Human Rights.

3. Moral and ethical values which are just and humane.

4. Good medical practice.

5. The social rights of families, minority groups, and the physically and mentally disadvantaged.

1. THE MEANING OF THE TERM 'EUTHANASIA'

The Lutheran Church of Australia has adopted the following statement, which we endorse, and quote in part:

EUTHANASIA OR MERCY KILLING

Prepared by the Commission on Social Questions. Adopted by the General Synod, 1981 Convention.

1. Definition of Terms and Practice

The word 'euthanasia' (derived from the Greek *eu* and *thanatos)* has three primary meanings in common English usage: a) a gentle and easy death; b) the means of bringing about a gentle and easy death; and c) the action of inducing a gentle and easy death. The term is a synonym for mercy killing, and this involves either assisting a patient to commit suicide or administering 'painless' or 'merciful' death to a patient.

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2. Various Forms of Mercy Killing

Current 'social' vocabulary distinguishes between

a) voluntary euthanasia -

the deliberate ending of life in a painless manner at the request of a patient;

b) involuntary euthanasia -

the deliberate ending of life in a painless manner without the consent of the patient;

c) convertible euthanasia -

the deliberate ending of life in a painless manner when the patient is at the time unable to give consent but who has

consented previously;

d) compulsory euthanasia -

the deliberate ending of life in a painless manner against the wishes of the patient.

In addition to these terms, we also have the phrases 'passive' or 'negative' and 'active' or 'positive' euthanasia. The term 'passive' or 'negative' euthanasia is particularly dangerous because it sounds like the acceptable medical practice of 'allowing a patient to die'. The term 'euthanasia' must never be used in the context of dying because euthanasia, with or without a qualifying adjective, always means killing. 1

2. EUTHANASIA, HUMAN RIGHTS, AND THE UNIVERSAL DECLARATION

The right to life of all people is fundamental to all other rights, and is protected in the UN Universal Declaration of Human Rights (Art.3). law which allows the breaking of the fundamental inalienable right to life in a civilised society is a very serious departure from obligation to the UN Declaration.

The *Universal Declaration of Human Rights* was approved by the General Assembly of the United Nations in Paris, France, on December 10, 1948. The major author of the Declaration was Nobel Prize winner Ren Cassin. Cassin "locates the ideological roots of the Declaration in the Ten Commandments."

This *Universal Declaration of Human Rights* is founded upon the notion that there are human values and that these values are inherent in the human individual. In the *Preamble* the Declaration states that "the foundation of freedom, justice and peace in the world" is the "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family".

As far as the Declaration is concerned there are human values *inherent* in all members of the human family because of their "inherent dignity". Since "dignity" is about true worth or excellence ["dignus" L. means worthy], and, in the context, human worth, then the claim for the inherent dignity of human beings is a claim for basic human values.

Further, the *Preamble* links human dignity, human values with human rights which are described as "inalienable rights", rights of which we may not be deprived and cannot deprive ourselves. I must not be sold into slavery and I am to be restrained from selling myself into slavery.

3

These human rights which reflect human values must, says the *Preamble*, "be protected by the rule of law" otherwise humankind may be driven, "as a last resort, to rebellion against tyranny and oppression". This protection of the rule of law is necessary not only for human beings to live together peaceably within the State, but also so that nations may live together in peace.

The *Universal Declaration of Human Rights* presents itself to the world as "a common standard of achievement for all peoples and all nations" and as a guide for every structure in society and for every individual in order that the rights identified in the Declaration may have "their universal and effective recognition and observance" secured.

The question as to whether member nations of the United Nations are bound legally to the Universal declaration is a disputed question. What is not disputed is that member nations are morally bound by the Universal Declaration, have bound themselves to it of their own free will. And by the end of 1988 there were 159 member states representing a total estimated population of 5,040,770,000. The world population in 1988 was estimated to be 5,130 million. This means that about 97% of the world belonged to nations that were member states of the United Nations and were thereby committed, at least morally, to the Universal Declaration of Human Rights.2

The Declaration has been followed by other 'Declarations' (= formal written announcements), 'Conventions' (=

Agreements), and 'Covenants' (= legal agreements). It is basic to all other human rights statements, and is therefore, a document worthy of respect and justification.

3. MORAL AND ETHICAL VALUES WHICH ARE JUST AND HUMANE

We believe that euthanasia in all its forms is contrary to the Word and Law of God as revealed in the 'Holy Scriptures'. Our opposition to proposals for euthanasia legislation is based on the understanding that the right to life of every person must be protected by law because:

a. Voluntary euthanasia does not eliminate the existing dangers of uncertainty of diagnosis, errors of observation, and the mis-interpretation of patient's wishes. We are particularly concerned that the wishes of those people in our society for whom English is a second language, are greatly at risk. Since we work with traditional Aboriginal people in Central Australia, we are aware of the difficulties of communication. We would predict that ascertaining the wishes of such people would not be possible in many cases, and these already disadvantaged people would be at an intolerable risk. Aboriginal people would not normally even countenance the suggestion that mercy killing be considered for anyone.

b. There would inevitably be moral pressure from relatives and the community on patients and doctors to avail themselves of euthanasia even though the real wish of the patient is against it.

c. Our society does not tolerate any sentencing of a person found guilty of a serious crime if any reasonable doubt exists as to the person's guilt. In many places capital punishment has for that reason, and others, been abolished. As euthanasia involves certain death of an innocent person, we must not tolerate any margin of error or uncertainty as to the patients wishes, or as to the diagnosis of incurability. Neither can be absolutely ascertained.

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d. Euthanasia puts at risk those who have incurable and fatal disease, those who are severely incapacitated, and those people who are hopelessly mentally, or physically defective. These people, young or aged, need the benefit of modern technology and understanding medical care, rather than the administration of 'death on demand'.

e. Euthanasia legislation and practice extend the 'life not worth living' concept which has already been introduced in a number of state liberalised abortion laws.

4. GOOD MEDICAL PRACTICE

a. Medical practitioners' roles will change irrevocably if voluntary euthanasia is introduced. Their right to object to killing will be very difficult to maintain. Good medical practice since Hippocrates (5th century BC), requires that the medical professional work to cure illness, relieve pain, and protect life.

b. Advances in medical treatments will also be affected if the practice of euthanasia becomes widespread. The pressing need to keep on seeking both better palliative care, and better treatments for the terminally ill will not be as evident, or receive the time and care in research which they deserve.

c. The move to legalise euthanasia has to be understood against the background of the question of pain. What must be seen as a rise in propaganda about suffering to an almost hysterical pitch in recent times, does not correspond to any sudden increase in the number of people dying in pain! In fact, the Hospice movement, bringing better care and more controlled use of improved drugs has greatly reduced the problem. It is well recognised, but not universally understood, that dying need not be associated with terrible pain and agony any more. In this sense it has been stated by one nurse that Hospice care 'makes euthanasia an outdated concept'. The professor of palliative care at Flinders Medical Centre has stated that no one needs to die in uncontrollable pain.

This last week saw a statement by a group of Victorian doctors who are in favour of euthanasia for the relief of pain and suffering - not-with-standing the opposition of the AMA. A startling perspective on pain by a pioneer of

Dutch euthanasia was announced two years ago. Dr Peter Admiraa1 an anaesthesiologist and clinical pharmacologist, has stated that essentially all pain can be controlled and that euthanasia for pain relief is unethical. This challenges many commonly held views and highlights the need for positive education of both medical carers and the public generally. It seems to be clear that many doctors are already using medical drugs in a controlled manner which do not kill the patient but relieve them of distress.

5. SOCIAL RIGHTS

An engineer of the Netherlands legislation is reported to have stated that the move from voluntary to in-voluntary, and compulsory euthanasia was expected and inevitable (at the time of writing this submission we are unable to indicate the source of this statement but believe it to be essentially correct).

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Again, Dr Jonathan H Pincus of Yale observes: 'I have yet to hear guidelines for euthanasia which would not lead to terrible abuses even in the opinion of those physicians who are sometimes willing to practice it ... Inevitably, this form of "therapy" would spread to situations in which at present it would be unthinkable'. And to the argument that the experience of Nazi Germany "can't happen here," Professor Kamisar responds: 'It can't happen here. Well, maybe it cannot, but no small part of our Constitution and no small number of our Supreme Court opinions stem from the fear that IT CAN HAPPEN HERE UNLESS WE DARN WELL MAKE SURE IT DOES NOT by adamantly holding the line, by swiftly snuffing out what are or might be small beginnings of what we do not want to happen here ... (Emphasis in the original.)' 3

We do understand that many who support euthanasia do so with sincere motives. This was certainly also the case in Germany between 1939 and 1945. There we had the terrible example of legalised euthanasia in actual practice, and it should be a permanent warning to us against allowing doctors to dispense death instead of medicine. It has taken only a few short years for us to repeat, and again contemplate something the world vowed never again to repeat. Nevertheless, the same sincere views are still with us today, and have resulted in the same political and media pressures. These pressures could produce the same results in any country which dismantles the legal safeguards for human life. We have to conclude that although such views may have been sincere, they were sincerely wrong.

The supporters of earlier euthanasia practice simply had not realized that when legal safeguards for the helpless are eroded, even a little, there are fanatics who will move in and change mercy into massacre! Human society is based on the belief that human life is to be protected because it has an inherent value, and when violated will result in the destruction of communities and at the expense of society generally.

Another important social right is that of family and friends. Like preparing for births we should prepare just as carefully for death. Time spent with spouse and children may allow issues to be resolved. There is also the potential personal growth to take place as a result of time shared. This may involve being sensitive to spiritual pain. We can use gentle touch, a sense of humour and empathy to facilitate sharing and growth. All this may involve a commitment of time and effort, but all those involved can work together to meet the patient's needs and at the same time affirm life. There is no doubt that the world needs positive creativity in this area - a creativity of which it has heard so much but seen so little.

CONCLUSION

The limited time given by the terms of reference to make submissions to the Select Committee allows only this hasty submission. The argument we have put forward can probably be well summed up with a quote from 'And now ... EUTHANASIA' by Fr. Paul Marx, O.S.B., Ph.D. (p.8l).

Dr. Richard Lamerton of St. Joseph's Hospice, London, flatly states that a terminal patient who is in unbearable pain is receiving poor treatment. Hospices use no elaborate equipment and aim to prevent pain rather than relieve

it. Skilled and loving nursing care is absolutely essential, and efforts are made to involve friends, relatives, and volunteer helpers in this care. Speaking of hospices, Dr. Elisabeth Kübler-Ross said:

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... They apply "the true art of medicine" to every patient. They surround them with love. faith, and excellent medical-emotional support, which allows the patient to live until he dies.4

On a more personal note, the writers are grateful for the experience encountered at the death of a father and father-in-law. Having cancer of the pancreas and liver undetected until its later stages, Mr Wurst lived life in its limited but full and positive way. Finally, in hospital he still gave his life meaning by the way he faced his fate and distress. With what seemed minimal pain alleviation he was able to take on the unavoidable and still realise the value of life as he shared with us his faith in God, fostered a caring family relationship, and gave dignity to living until natural death. He shared with us as family that life has meaning to the last breath.

Respectfully submitted, March 24th, 1995:

Joy D Wurst Norman W Wurst

REFERENCES

1 Statement by the Commission on Social Questions of the Lutheran Church of Australia - adopted by the General Synod 1981 Convention.

2 From an unpublished paper entitled Human Rights - Bioethical and Public Policy Perspectives based upon the 'Consensus Gentium' by John I Fleming, July 3, 1992.

3 Fr. Paul Marx, O.S.B., Ph.D 'And Now ... Euthanasia' Human Life International, 418 C Street, N.E. Washington, D.C. 20002, 202/546-2257 Second revised edition (p 68)

4 Fr. Paul Marx, O.S.B., Ph.D 'And Now ... Euthanasia' Human Life International, 41 C Street, N.E. Washington, D.C. 20002, 202/546-2257 Second revised edition (p 81).

Richard Fenigsen, M.D., Ph.D. 'The Report of the Dutch Governmental Committee on Euthanasia' Human Life International, 7845 Airpark Road, Suit E, Gaithersburg, MD 20879-4124, 301/670-7884, 1992.

SUBMISSION 884 1

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27 - 03 - 1995

The Chairperson

Select Committee on Euthanasia.

Dear Sir/Madam,

I have long supported Euthanasia having over the years seen the suffering of elderly people who no longer had any quality of life left. I believe that new technologies mean a rethinking of what constitutes "living", as many people who in previous eras would have died, are kept alive by artificial means.

Certainly, palliative care as an option to be considered, but there are many instances where it is known to have been inadequate for the needs of people with terminal illness.

And for myself (at present a healthy 52 years) I want euthanasia available to me as an option should I require it. I feel incensed that someone who does not know me, can make the decision that I must live on when I, and my family, have come to the stage of acceptance of death.

Please support the Marshall Perron Bill on Euthanasia.

Yours sincerely,

Jean Stanton

19A Kisham Rd

Applecross W.A. 6153.

SUBMISSION 885 1

The Secretary

Ms Pat Hancock

Legislative Assembly

GPO Box 3721

DARWIN NT 0801

27 March 1995

D.S.S. SydneySmith

22 Quandong Cres.

Nightcliff 0801.

We are writing to express our opposition to the Euthanasia bill.

We believe that to allow killing is against the principle of sanctity of life. Also, when we legalise killing suffering patients, it means our society has stopped caring. We need to support and love the sick, doing everything we can to allow them to die without pain and suffering, but in peace and dignity. Ending a life prematurely simply removes the problem, making it easy not to care. Lets solve the problem of good care, not remove the person.

Euthanasia also has the potential to become out of hand, for instance, in the Netherlands though euthanasia is not legal, more than half of the people who are killed under so called 'euthanasia' are killed without their knowledge or consent.

The medical profession is supposed to be there to care for patients not to kill them. If doctors are allowed to kill people, how are we to trust them, once you are dead it is a little late to change your mind or say that actually you did not consent. The potential for human error is enormous.

Finally some people have made the comparison between the putting down of animals, and ending the suffering of people. People are not animals, and are able to understand illness, unlike dogs. They are able to come to a place where they can deal with their death, and help their relatives to come to terms with it. Allow the early death of patients and the potential for this healing is gone.

Thank you for taking the time to consider our views.

Yours sincerely,

DAVID and SUSAN SYDNEYSMITH.

SUBMISSION 886 1

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11 Lamberten Street

Greenwood. 6024

28th March 1995

The Chairperson

Select Committee on Euthanasia

Parliament of the Northern Territory.

Dear Chairperson,

I wish to express my support for the Marshall Perron Bill. I believe euthanasia to be a most humane act and its legalisation should no longer be impeded by beliefs of a minority.

Euthanasia is an intelligent solution to needless suffering and although I have never been personally involved, should the need arise I pray that such necessary action would have been made legal.

I congratulate the Parliament of the Northern Territory for debating such an important issue. Hopefully the Northern Territory may be the first in Australia to legalise euthanasia, setting an example for the other States.

Yours sincerely,

(Mrs) J.L. Dodd

Member of WAVES

SUBMISSION 887 1

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6 Grange St

Claremont 6010

W.A.

28th March.

The Chairperson

Select Committee on Euthanasia

Parliament of Northern Territory

Darwin.

Dear Sir,

I would like to state my whole hearted support for your Bill. I am a member of WAVES and believe a person has a right to preserve their dignity by choosing to finish their life when they are no longer capable of doing this either through illness or disability or incapability.

Thanking you

Eve Perrin.

SUBMISSION 888 1

The Committee,

It was with great relief that we heard of the farsighted, humane approach of The Chief Minister of the Northern Territory, in his proposal for a bill allowing for voluntary euthanasia for the terminally ill.

It is of great concern to us that society allows us to show greater compassion towards ailing family pets than family members. It is high time that individuals are given a similar choice when faced with death, living a life without purpose and dignity, full of pain and suffering.

A bill allowing people this dignity of choice, puts control of one's life, and impending death, within reach. Surely when there is little left for a terminally ill person, they should be allowed to choose how and when they should die, if that is what they wish.

It is the argument of those who support the "Right to Life Movement" that no person has the right to take the life of another. A life full of pain and suffering, with no future, to us is not a life, and we feel a bill allowing voluntary euthanasia gives us the hope that we would not have to spend the last of our lives in misery, a lesser person than we would wish, a burden to our families and the community.

We have no desire to impose our beliefs and desires upon others, just as we do not want the beliefs of others imposed on us. We do, however, desire the right to be allowed to make our own choice if ever faced with a terminal illness.

We congratulate The Chief Minister on his move to introduce this bill, and wish to have our support recognised.

Jim Core. Jennie Core.

34 Curlew Cir.,

Wulagi,

NT.

29/3/95.

SUBMISSION 889 1

G.P.O. Box 3152

Darwin N.T. 0801

30th March 1995.

Dear Ms. Hancock.

I wish to make it know that in no way do I support the voluntary euthanasia bill.

Palliative care doctors will tell you that in almost all cases (90%) it is easy to make a dying patient comfortable, lucid, and to reduce any pain. In another 5% it is possible, although a bit harder and in only 5% of patients is it quite difficult, although not impossible, to keep the pain to an acceptable level.

Palliative care doctors will also tell you that almost no patient asks to be killed. Some will ask for their medication to cease so that they can die, but that is not euthanasia. The killing of a patient by injecting them with a lethal drug, is.

The step from voluntary euthanasia to involuntary euthanasia for those who are not capable of giving their consent, is extremely small. The concentration camps of the Third Reich did not start with the Nazis. They started ;the

century before when some people were considered "unworthy of life". Once the idea of legalized killing (which began with abortion) has been accepted, the slide to other forms of killing is not hard.

Many old people, whether or not they are in serious pain, may consider themselves a burden on their children or on society., Although they would not choose to die, they may go along that path in order to cease being a problem imagined or otherwise to those near to them. This is actually involuntary euthanasia. Of course, I realize that it's a cheaper solution than increased palliative care or nursing homes!

Rather than having people killed, I would like to see more palliative care services in the Northern Territory.

I am asking you to oppose the bill.

Yours faithfully,

(Mrs) WENDY McCLENAGHAN

SUBMISSION 890 1

ELIZABETH BUTCHER

PO BOX 201

WYNDHAM WA 6740

29-3-95

Dear Sir, Madam,

I read the Darwin NT Times from the 25 March and in the letters to the Editor was a letter from M Robson of Wanguri about the NT Euthanasia Bill.

As you can see from my address I live in the top half of WA and I would class Darwin as my nearest city 900 klms compared with Perth of over 3,000 klms so I don't class my self as a southerner. I shop in Darwin, Pistol Shoot in Darwin and go scuba diving there as well.

I am all for and I will stress the "all for" this Bill to pass at least Mr Perron has the guts to do something about it.

I saw my father die from cancer and I hope that I don't have to go through the same as I get older.

Yours sincerely

Elizabeth Butcher.

SUBMISSION 891 1

21.2.1995

Daryl & Claire Catt

17 Spencer St.

Alice Springs, 0870

Dear Richard,

As you are aware, we attended last Friday's Open Forum on the proposed legislation on Euthanasia, organised and chaired by you.

As was pointed out many times during the session, this proposed legislation is meant for a very small number of carefully described patients fitting very tight criteria.

It is precisely this aspect of the legislation which concerns us. It proposes to not only decriminalise but legalise assisted suicide for a very select group of patients. Thus by implication, AND PARTICULARLY BY CREATING A LAW ON THE ISSUE, it makes it 'more illegal' to assist patients who do not fit this strict criteria. However, this issue comes up in many situations, often less clear-cut than those described by the proposed legislation.

We believe whilst the present situation is far from ideal, there may be a strong case for leaving it this way, if we consider the best interests of ALL patients, not just a few.

There is inherent danger and difficulty in making laws so specific which impinge upon moral and religious attitudes in a varied and free society.

As was mentioned during last Friday's discussion, RIGHTS really need to apply to all. Unless a society is prepared to say every adult has the right to end his or her life if he or she chooses, it may be wiser to leave voluntary death out of the law books.

More often laws are made to cater for small minorities which potentially may exclude other minorities or even a majority. This we consider a major factor in our society causing us to make forever more laws, further complicating issues and creating more problems.

Before a Bill like this is considered, there should be the appropriate palliative care and hospice facilities available. Assisted suicide should only be considered as the ultimate fall back position.

We believe this proposed legislation may have the potential to create more problems than it will solve.

Kind regards,

Daryl & Claire Catt.

SUBMISSION 892 1

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25 March 1995

Select Committee on Euthanasia

Parliament to the Northern Territory

P 0 Box 3721

DARWIN

NT 0801

Dear Madam/Sir

My submission is as a result of forty years of working within many areas of the health service and in a variety of positions as a nurse and health educator.

I can only commend Marshall Perron for courageously taking this step of introducing a bill into the Parliament of the Northern Territory - namely 'Rights of the Terminally Ill Act 1995'. For too long men, women and children have had to struggle, when suffering a terminal illness, to die in peace and with dignity. I admire him and those who support the bill for their compassion, empathy and foresight.

Euthanasia has been practised for many years in Australia. I was a young graduate nurse in the early forties when a leading surgeon asked me to give his patient a days' dose of the morphia he had ordered in one shot. His patient

was a woman, skin and bone, yellow all over and dying painfully of cancer. She would look at me with pain-filled, begging eyes when she surfaced between shots. I had to examine my deeply-held principles and beliefs, then carried out the doctor's orders and recorded only the normal dose given. She died quickly and peacefully. I had grown up in the country and would not have allowed an animal to go through such agony.

Since those days I have witnessed death in a wide variety of miseries; some persons getting help; some going to the line with every step an agony. I would say each of us wants to have courage when we face death as the last stage of living.

We now have many heroic means of preserving life and the dying process is getting longer and longer. One of my old friends lived to be one hundred and seven and for the last years was tired of living. He would say to his doctor 'enough doctor; I've lived enough; I want to die'. His daughter and two grandsons were proud of this man when he was finally helped and had his 'living will' carried out. Nevertheless this doctor could face a criminal charge. There are thousands and thousands of similar stories carried out in Australia each year; all illegal!

A most important aspect of the euthanasia question is the ever-rising cost of the dying process. Currently 95% of the health budget is spent on the dying process. Most of the diseases resulting in hospitalisation and eventually causing death are behavioural based.

Where are governments going to obtain funds to enlighten future generations that it is each and everyone's responsibility to adopt a healthy life-style, emotionally, nutritionally and physically, to enable each of them to plan and experience a healthy future? On average governments spend only 5% of their health budgets on such primary health care.

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Without bills such as Marshall Perron's Rights of the Terminally Ill Act 1995 there is plenty of evidence that more and more people in dire straits will endeavour to end their lives in unassisted suicide, often in lonely and drastic circumstances - not to mention the botched up, messy and failed attempts.

I wish the bill every success and hope that it will be passed.

Noeline Hartley

22 Marian Street

Innaloo

W A 6018

SUBMISSION 893 1

P.M.B. 132,

Daly Water,

N.T. 0852.

24th March '95.

The Chairman on Euthanasia,

Mr Eric Poole M.L.A.,

P.O. Box 3721,

Darwin. 0801.

Dear Sir,

Being in favour of euthanasia I would appreciate having my name added to Mr Hatton's list of approvals.

Too many poor souls have to suffer pain and mental distress by being kept alive by drugs or machines. To me, it is unthinkable no matter the age of the person.

Yours faithfully,

Mollie G. Hartig (Mrs).

SUBMISSION 894 1

Susan Shotton,

PMB 105,

WINNELLIE,

N.T., 0822

Eric Poole MLA,

Chairman,

Committee on Euthanasia,

NT Legislative Assembly,

PO BOX 3721, Darwin, 0801.

Dear Mr Poole,

I would like to voice my concerns regarding the proposed Euthanasia Bill.

Firstly I think it allows a "well" terminally ill patient to end their life if they so wish. I have nursed many people who have been diagnosed to die within a time frame and that person has lived a great deal longer. Only those people who are able to write for assistance are eligible, this again indicates a "well" terminally ill patient.

I am not totally against Euthanasia, however I feel that this option should be only a last resort to put an end to the terrible suffering a patient may have when close to death.

Secondly, only adults are covered under this proposed bill. Do children not suffer as much as adults when coming to the end of a terminal disease?

Thirdly, and perhaps the most frightening. If this bill is to pass parliament, what will prevent terminally ill patients from interstate moving to the Northern Territory to take advantage of this law. This will add to the burden of our hospitals, our health system in general as well as increasing the risk of spreading some diseases like AIDS which would have devastating effects on our Aboriginal Communities.

Perhaps some time frame for residency in the Northern Territory for eligibility might overcome this or at least alleviate it.

I personally would not like this bill to come into effect as it is drafted at present as I feel it has too many loopholes and can allow people whom have been informed they have a terminal disease to opt for legal suicide when they are going through a time of denial about their disease.

Some legislation for Euthanasia for terminally ill patients, both adults and children, in the last month of their life to end their final suffering should be considered.

Thank you for taking the time to read this letter.

Yours sincerely.

Susan Shotton.

SUBMISSION 895 1

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21 Banksia St

Nightcliff 0810

25-3-95

Submission

Select Committee on Euthanasia.

Sir,

I strongly support the proposed enactment of legislation legalising voluntary euthanasia.

Yours faithfully,

D. KANE (Dr.)

SUBMISSION 896 1

SUBMISSION

TO

SELECT COMMITTEE ON EUTHANASIA

NORTHERN TERRITORY

22nd MARCH 1995

Queensland

Right to Life

INGHAM BRANCH

C/- MRS M.C. HART

13 ATKINSON ST.

LUCINDA 4850

PH (077) 778108

2

Queensland

Right to Life

INGHAM BRANCH

The suggested Bill has no respect for human life, is completely negative and the author appears to have no confidence in the kindness of others.

If people could stay in their own homes during their last illness they would be spared much loneliness and depression, and surely palliative care has advanced enough to make life tolerable, their carers, of course, would need to receive every medical and financial support.

Euthanasia is too similar to the work of Doctors in Nazi prison camps.

How can a patient in a Nursing Home rest easy, especially when they feel themselves becoming more helpless and more trouble for the staff. They would perhaps wonder if they are expected to request that their life be terminated.

Let's have hope not despair, and life not death.

M.C. Hart.

SUBMISSION 897 1

Draper Rd.,

Howard Sps.

N.T. 0835.

22-3-95.

The Secretary,

Misses Pat Hancock,

Legislative Assembly,

G.P.O. Box 3721,

Darwin 0801.

Dear Mrs Hancock,

Regarding 'Lifes Sake'.

I am definitely not in favour of euthanasia, and those that are trying to 'Play God'.

Yes we certainly are in need of a home and a special care facility for the terminally ill.

But they should be allowed to die in dignity should they become affected and any other illness, they should not be treated with drugs of any kind, to heal that particular infection, nor should they be put on a life support of any kind. Just let nature take it's course, and give only pain relief drugs, to the strength enough to alleviate all pain.

If distressed, to the point of pulling out oxygen tubes, sedation, can be ministered, but they definitely must not be restrained, but allowed to die in peace and with dignity.

I remain

Yours faithfully,

Misses L. McKee.

SUBMISSION 898 1

Select Committee on Euthanasia

Parliament of the Northern Territory

20th March 1995

I am a 55 year old Australian born female

I have nursed my Father who died of Lung Cancer age 47 years

I have nursed my Husbands Cousin who died of Bowel Cancer age 39 years

I have nursed my Mother who died of Bowel Cancer age 82 years

ALL THREE WANTED TO DIE WITH DIGNITY BUT WERE REFUSED AND ALL THREE HAD LINGERING DEATHS!!!!

LEGAL VOLUNTARY EUTHANASIA MUST BE AVAILABLE FOR ANY AUSTRALIAN WHO REQUEST IT!!!

Mrs Anne Button

45 Isaac Street

PEAKHURST 2210

N S W

(02) 535452

SUBMISSION 899 1

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3 Somerville Street,

Coburg. Victoria 3058.

24th March, 1995.

The Secretary,

Ms Pat Hancock,

Legislative Assembly,

GPO Box 3721,

Darwin. NT 0801.

Dear Ms Hancock,

I am writing to you to express my alarm at the Chief Minister Marshall Perron's euthanasia bill. The Northern Territory has no medical oncologist, very limited radio therapy services, not a single palliative care specialist, an adequately resourced domiciliary palliative care program and not a single hospice. Marshall Perron should not be giving doctorfs a licence to kill. Our elected representatives should be providing the above services n to euthanasia.

Yours sincerely,

Ms Anna Mastrippolito.

SUBMISSION 900 1

61/29 The Crescent.

Manly

2095.

Dear Sir,

I am writing to support your bill it make V.E. in specific circumstances legal.

I am 65 y.o. and I am praying that if my quality of life and health are such that I widsh to legally end it - my doctor in consultation with others can do so.

My support and good wishes are with you -

(Mrs) A. Souter

SUBMISSION 901 1

Northern Territory Council of Churches

Submission to the Select

Committee on Euthanasia

Legislative Assembly of the

Northern Territory

Submission dated: *23rd March, 1995*

Introduction.

The following submission has been prepared by the Executive of the Northern Territory Council of Churches.

The Northern Territory Council of Churches represents the following Christian Churches: - Anglican, Catholic, Church of Christ, Greek Orthodox, Lutheran, Salvation Army and Uniting. The Baptist Church has observer status. These churches represent approximately 90% of all practicing Christians in the Northern Territory.

A Christian Perspective.

We are well aware that the religious concerns relating to this bill have been well canvassed in the community and to members of the committee.

It is the purpose of this submission to raise some practical concerns that the Council has about the proposed legislation rather than present detailed religious objections.

The Christian reaction to the proposed legislation was well stated in the letter of Bishop Richard Appleby to all members of the Legislative Assembly when he stated:

"Our strong objection to "voluntary euthanasia" arises from the fact that we have a fundamental belief that all life is God-given and that no-one has the authority to take the life of any innocent human being, either with or without

their consent ..... should we ever permit life to be terminated (even in limited and strictly controlled circumstances) this will result, in due course, in a change of attitude in society towards the value of human life. Human life will be seen to be expendable." - letter dated 7th February, 1995.

Some practical concerns

1 Definitions

Although the Bill gives certain interpretations of words used, clause (2), no attempt is made to define the meaning of such concepts as "severe pain"; "suffering"; "distress"; "reasonable grounds" or "competent".

All these concepts present a huge difficulty in the interpretation of the Bill.

Is it possible to assess these concepts in a meaningful way that safe guards continued human life.

Degrees of suffering and the perception of suffering will vary considerably from person to person and situation to situation.

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2 Additional pressure to the sick and dying

One of the unseen consequences of this Bill could be to place pressure on those who are aged or dying to seek for "voluntary euthanasia" so that they do not become a "burden" on society.

Once a society moves in the direction of voluntary euthanasia there may grow a lessening of compassion, concern and support for those in the final stages of their life.

3 The role of the medical practitioner

This Bill places a great deal of responsibility with the medical practitioner and there will be obvious problems for those who find that "voluntary euthanasia" is in conflict with their ethical point of view.

There is a danger that those who do not agree morally with the Bill may be placed in a situation of making compromises that may have an effect not only on them but also their patients.

It is to be hoped that the position of the medical profession on this issue will be carefully listen to.

4 Why twelve months?

How sure can any medical practitioner be that a patient will die within a period of 12 months? There are many examples of cases where people have made recoveries or lived for years after being diagnosed as going to die within a certain period.

Can we really place this sort of burden and responsibility on the medical profession?

5 The disadvantaged

This proposed Bill moves our society into new areas regarding our basic care of the dying in our community.

Will those who are poor be placed in the position of opting for "voluntary euthanasia" because they are unable to afford long term or costly medical treatment that may prolong life?

Will those who are educationally disadvantaged be able to fully understand the implications proposed by this Bill?

There is also the whole question of the attitudes of Aboriginal people to questions of life and death.

6 Confusion over the meaning of Euthanasia

There does seem to be a reasonable amount of confusion in the minds of many about the difference between the right to a dignified death and an active intervention to terminate life.

Christian churches, in general, have no objection to the right of people to refuse treatment which may only prolong life to no good purpose.

There is a right to die with dignity.

This may also involve the use of pain killing drugs which, as a consequence of their use, may shorten a persons life. In this situation it is clear that the use of such pain killing drugs is intended to relieve pain and not terminate life.

This is not Euthanasia.

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7 Unacceptable risks

The area of suffering, death and dying in our society is an emotional one. There is a danger in this Bill that the precious gift of life may be endangered by a focus on the right of the individual as against a balanced approached to the needs society as a whole.

No matter how the legislation is worded or whatever safe guards are added there will always be the possibility of abuse - an abuse in this case which can lead to the death of an individual.

8 Consequences to Society

For many in the churches the introduction of this Bill seems to indicate a change in the nature and the purpose of our society and the responsibility of government.

It would be assumed that, in accordance with the Universal Declaration on Human Rights, the role of government is to protect the basic rights of its citizens which includes the right to life.

Any government that acts to intervene in the right to life of its citizens may well be exposing them to unacceptable risk and undermining the very principles on which that society is built.

Conclusion

We hope that the issues raised in this submission will be of assistance to the Select Committee as it makes its deliberations.

Ms. Kate Ross

The Very Revd Michael Chiplin

for the Northern Territory Council of Churches

C/- Christ Church Cathedral

2 Smith Street

Darwin NT 0800

Phone: 81 9099 Fax: 81 9039

SUBMISSION 902 1

World Federation of Doctors who Respect Human Life

President Dr Michael Christie MB BS FRACGP

Secretary Dr Philomena Joshua MB BS MRACGP

PO Box 232., Box Hill 3128

VICTORIAN DIVISION Phone/Fax 03 890 6856

Dear Ms. Braham

Our organization would like to submit our view on the proposed Rights of the Terminally Ill Bill. We are a group of concerned Doctors in Victoria, affiliated with the World Federation of Doctors who Respect Human Life, an organization with thousands of doctor members world wide. We are concerned that the proposed Act would "prepare the ground" for Euthanasia Australia wide.

We object to the deliberate killing of sick people called by some, euthanasia, per se. But we would like to draw your attention to a number of specific points about the proposed legislation:-

1. The involvement of doctors in the deliberate killing of their patients is completely anathema to all the noble traditions of Medicine. If this law is passed, the Legislative Assembly is not just affecting the lives of terminally ill people, it is affecting normal medical practice. How can patients go to the doctors with confidence in the future if they are not sure if the doctor will heal them or kill them? The role of executioner is not a doctor's role at all.

If the N.T. insists on euthanasia for some patients, it should find another profession to do the killing. Doctors should not be involved.

2. To legalise Euthanasia would reduce the impetus to improve the care of terminally ill patients. Palliative Care Medicine has made remarkable progress in the last twenty years and would continue to do so to improve the care of terminally ill people.

If this law is passed, the need for research would be reduced - patients with difficult palliative care problems can be simply killed. There would be little need to look at new approaches, new drugs for pain management and improvements to care.

3. Perhaps more insidiously, we feel that by legalising Euthanasia there will be an increase in subtle pressure on the elderly and infirm to consider euthanasia to solve others' problems not their own. Distressed relatives may pressure the terminally ill to look at euthanasia as an option when the terminally ill do not wish it themselves. Those who are sick and deemed to be of "no economic use to society" may be pressured to also look at Euthanasia to save money for the State. the Economic Advisory Council Report of 1994 has looked at this very issue already.

For all sorts of reasons the sick and infirm may feel it is their "duty" to be euthanased. The sick and elderly can be discarded when of no use anymore.

By legalising euthanasia - not only would palliative care of the sick be affected, medicine as well would never be the same again and society at large would be the poorer when sick people can simply be killed off.

Thank you for receiving our submission.

Yours sincerely

Dr. Michael Christie

MB BS FRACGP

SUBMISSION 903 1

World Federation of Doctors who Respect Human Life

President: Dr Michael Christie MB BS FRACGP

Secretary: Dr Philomene Joshua MB BS MRACGP

VICTORIAN DIVISION

Phone/Fax 03 890 6856

Members of the Select Committee

Rights of The Terminally Ill Bill

Dear Members,

We would be grateful for you to accept our submission regarding the "Rights of the Terminally Ill" Bill. We are a group of concerned Doctors in Victoria who are affiliated with the World Federation of Doctors who Respect Human Life, a group of Doctors representing many thousands of Doctors world-wide. We are very much concerned with the implications of the proposed bill.

We thank you for accepting our submission,

Yours sincerely,

Dr Michael Christie MB BS FRACGP

World Federation of Doctors who Respect Human Life

President: Dr Michael Christie MB BS FRACGP

Secretary: Dr Philomene Joshua MB BS MRACGP

VICTORIAN DIVISION

Phone/Fax 03 890 6856

Statement On Euthanasia

There is a growing push in our society to legalise Euthanasia - the deliberate killing of terminally ill patients. We, as members of the World Federation of Doctors Who Respect Human Life wish to object to these moves.

The deliberate killing of patients is completely anathema to all the noble traditions of Medicine. The Hippocratic Oath, the World Medical Association Declaration of Geneva and more recently the Australian Medical Association Code of Ethics, all forbid deliberate killing of patients.

Doctors have a dual responsibility to preserve life and relieve suffering. In situations of illness where death is inevitable or the treatment excessively burdensome the imperative to preserve life becomes secondary to that of relief of suffering. If in the relief of this suffering, a patient's life is unavoidably shortened this is morally and ethically permissible. This is the principle of Double Effect.

However it is quite another thing for a doctor to take deliberate, active steps to end their patients' life. This is

murder.

If Euthanasia by physicians legalised, there would a number of consequences:

(a) The delicate doctor-patient relationship would be forever changed. How can patients trust their doctor if they could not be sure if they will cure or kill them?

(b) The proponents of Voluntary Euthanasia say that it would be done only in cases where the patient requests it and has a terminal illness. Superficially this appears attractive to some people. However the reality would be quite different. There will be inevitable imperative to extend the "benefits" of Euthanasia to non-competent people with a terminal illness, then to people who are suffering from a non-terminal illness etc. etc.

The result would be that inexorably Involuntary Euthanasia would become a reality. This has already occurred in Holland where Euthanasia has been liberalised.

(c) If Euthanasia is allowed the need for research and improvement in Palliative Care is reduced. Why should one bother trying new drugs or techniques to relieve suffering when the patient can simply be killed off.?

(d) By legalising Euthanasia, Society is saying to sick and elderly people that there are lives that are not worth living and should be euthanased. Seriously ill people in the future would be worried that their doctor would kill them if they became too much of a burden. This has also occurred in Holland as a result of their laws.

Medical treatment would never be the same again.

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Euthanasia is morally, and ethically wrong and is fraught with practical, inevitable and disastrous consequences. Our legislators should not go down that path.

If society insists on Euthanasia, it will need to find another profession to do it. Doctors should not be involved.

SUBMISSION 904 1

7/44 Lyndavale Dr

Alice Springs 0870

26.3.95.

The Secretary

Ms Pat Hancock

Legislative Assembly

Darwin N.T. 0801

Dear Ms Hancock

I am writing to protest against Chief Minister Marshall Perron's euthanasia Bill. We all experience the suffering of one or more of our loved ones from a terminal disease. But I do not agree to such a Bill as Mr Perron is presenting. Allowing such a Bill to be passed would only open a "Pandora's Box" of which we could not imagine the outcome years from now.

I am very much against such a Bill and I ask you consider my opposition to it.

Yours sincerely,

Maureen Park

SUBMISSION 905 1

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80 Lockheed Rd.,

Katherine N.T. 0850

21st March, 1995.

Dear Dr. Richard Soon Huat Lim,

I am writing to you to express my alarm and concern about the introduction of euthanasia in the Northern Territory.

If this bill is passed, patient killing will spread to the rest of Australia.

The solution is the provision of adequate palliative care. I mean specialists and care programs, and some hospices.

As our elected representative should you not be providing the above services. A bill that allows killing of human beings is against the principle of the sanctity of life - It is against God's law.

Yours sincerely,

N.M. DAVIS.

SUBMISSION 906 1

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12 Wallis St.

Alice Springs. 0870.

Dr. R. Lim.

Dear Sir

I wish to register my protest re the Euthanasia Bill. I think the whole concept is outrageous.

Yours faithfully,

Ernest Williams.

SUBMISSION 907 1

K. & S. Hollingworth

P.O. Box 8264

Alice Springs

14 Glass Crt.

Dr Richard Lim

P.O. Box 3269

Alice Springs.

Dear Dr Lim,

I'm writing to you to express my alarm at the Chief Minister Marshall Perron's euthanasia bill. The Northern Territory has no medical oncologist, limited radio therapy services, and not one single palliative care specialist, an adequately resourced domiciliary palliative care program and not a single hospice, either Marshall Perron should not be giving Doctors a licence to kill. As our elected representatives the people should be provided with the above services not euthanasia.

Yours sincerely,

Sue Hollingworth

SUBMISSION 908 1

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23 Lackman Tce.

ALICE SPRINGS. N.T. 0871

23rd March, 1995.

The Chairman,

The Select Committee on Euthanasia,

G.P.0. Box 8721,

DARWIN. N.T. 0801.

Dear Sir,

Re: "Rights of Terminally Ill Bill"

I wish to advise your committee that I oppose the passing of this bill.

I feel that once passed, amendments will be made to take away the controls as has happened with the Abortion legislation, so that we now have Abortion on demand.

As an alternative to this Bill I suggest the need for palliative care become a priority for the N.T.

In the late 1960's I nursed my uncle, for the last three months of his life. As a cancer patient at the Peter McCallum Clinic in Melbourne, he fought this disease to the end. His courage sustained the family and he died peacefully at home. I feel as he accepted revolutionary treatment he contributed to helping find a cure for others.

I ask that you consider my opposition to this bill in your deliberations.

Yours faithfully,

Maree Miller.

SUBMISSION 909 1

Mrs Bridget Maskell

PO Box 28

Alice Springs NT 0871

23 March 1995

The Chair

Select Committee on Euthanasia

GPO Box 3721

DARWIN NT 0801

Dear Sir,

I understand that a Select Committee has been set up to report to Parliament on the Euthanasia bill.

I have read the newspaper articles and the facts they purport to contain, and watched the program shown on television "Death on Request". I have also been subjected to the views of the Catholic Church on this issue as my daughter attends the local Catholic school, and they urge us to say "no".

I would be very VERY disappointed if this bill was not passed. I am just an ordinary working Australian, who like most, puts up with decisions made for us in the belief that they are for the good of the community as a whole. This issue has the potential to show that the beliefs of some can be forced on all.

I believe that the issue is one of 'choice'. Those whose beliefs prohibit such action as euthanasia would not be placed in a situation where they were forced to have it, but they see fit to also prevent those who may find this the most acceptable alternative, under predetermined circumstances, having this option.

When I read that certain groups in the community want the bill stopped I feel outraged, do they believe that they are 'protecting' the rest of us from ourselves? I want the option to make these decisions for myself. Should I become terminally ill and very sick, beyond home care etc I want the option of euthanasia. I hope that I will never be faced with the need to make this kind of decision, but at least give us this option.

In closing I will again stress that I believe that this is an issue of 'choice'. Respect the right of individuals to make their own choices and not have the beliefs and misguided morals of others preventing us from doing so.

Yours faithfully,

B. Maskell.

SUBMISSION 910 1

To Whom It May Concern:

I am writing as a Territorian concerned about the future of myself and my children should you choose to legalize euthanasia in the NT. So often the decisions we make in anticipation of easing suffering or helping the next generation deal with such "tough" issues as the deliberate termination of life actually impair our judgment as Christians and human beings. As an elected official, I am sure you are reminded on a daily basis that you must bear the consequences of your decisions for the rest of your life. Therefore, please consider the ramifications of your actions for what may be the beginning of a tragic chain of events.

The fundamental principle of euthanasia "an act or an omission which causes death to eliminate suffering" violates an individual's basic human rights. People with a serious illness or incapacity have as much right to live as those who are well. We have to continue to care for and feed the disabled, the demented, the abandoned and the unwanted who are not dying. All humans have the right to live with serious illness or incapacity. No one has a right to be killed, just as we have no right to maim ourselves or be robbed.

Please understand that I truly believe that we should ease suffering of our fellow human beings, if possible, and come to the aid of those incapable of taking care of themselves. How can death be the "final solution" for

suffering? When we marry, the presiding official often quotes "what God has joined let no man put asunder." So too, what God has created let no man destroy. The final justice for these actions will be given at our final judgment but can you not know that your actions may endanger many helpless people, incapable of making a rational decision about their own lives?

Your attention to my petition is greatly appreciated.

Sincerely,

Dan Rust.

SUBMISSION 911 1

The Chairman,

Select Committee on Euthanasia,

GPO Box 3721,

Darwin, NT 0801

Nicolaas VAN ECK,

16 Leichhardt Crescent,

Fannie Bay, NT 0820.

Tel: (089) 81 5537

22-3-'95.

The Rights of the Terminally Ill Bill

Herewith I wish to express my support for the Euthanasia Bill currently before your Committee.

During World War II I became a Prisoner of War of the Japanese and worked on the Birma Death Railroad, where many of my compatriots died under the most appalling circumstances. Many diseases took their toll, while towards the latter part of the war we were very often bombarded by allied planes, whose pilots were apparently not aware that they were victimising their own people. Many of us were wounded, often very badly to such an extent that they died within days or weeks, most often in terrible pains. We had no doctors, no medication, nothing and in my own little group of friends we agreed to 'help one another out' if the pain became too terrible with no chance of recovery in sight.

Not long after the end of the war (1948), I saw my father die of the after effects of his time in P.O.W. camps in Java (Netherlands East Indies at that time) in much pain and without chance of recovery. He begged to be released of his misery, but that was legally not possible. Did he suffer ....

Now recently my mother died at the age of 93. She had always been a very active person, but physically she had deteriorated so much that she could not at all look after herself anymore which for someone like her was an unbearable suffering. Mentally she deteriorated so much too, that she was barely conscious most of the time and did not recognise my sister nor me. Twice I heard her say (in Dutch: "Voor my hoeft het niet meer.") : 'As far as I am concerned it is finished.' Mum was completely unconscious for several weeks before her body finally gave up.

All these experiences have made me a firm believer in the right to Euthanasia and the bill has my full support.

Yours faithfully,

Nicolaas Van Eck.

SUBMISSION 912 1

THE UNITING CHURCH IN AUSTRALIA

NORTHERN SYNOD

Telephone: (089) 81 8444 GPO Box 717

Facsimile: (089) 81 3285 Darwin NT 0801

March 24, 1995

The Chairman

Select Committee on Euthanasia

GPO Box 3721

DARWIN NT 0801

Dear Select Committee Members

Please find attached a copy of some of my concerns about the Rights of the Terminally Ill Bill 1995.

Yours sincerely

Rev. A.G. Hall

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THE RIGHTS OF THE TERMINALLY ILL BILL - A CONCERNED RESPONSE

There are a number of concerns relating to the Rights of the Terminally Ill Bill. Most of these relate to the fallibility of human nature.

1. This Bill will increase the fear of hospital and medical professionals that already exists in the minds of many people in the Territory. Evidence coming out of Holland indicates that older people are beginning to resist going to hospital and for medical treatment because of the numbers of involuntary Euthanasia life terminations that are taking place.

Our aboriginal communities contain many people who have had poor experiences of hospitals and medical treatment. They are often unable to comprehend the relationship between the treatment and their illnesses. Many do not have the ability to understand the intricacies of even this Bill. The Bill will be seen as giving doctors the right to kill. 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. When twenty five percent of the Territory's population are aboriginal, it can be argued that this will have a negative affect on the life expectancy of a large proportion of the Northern Territory's population.

2. The competence of a person to decide life and death issues when people are ill is very debatable. There is a real danger that feelings of being a nuisance or even temporary bouts of depression, will lead to a person saying things and agreeing to actions which would not be said or agreed to under different conditions.

3. The Bill puts medical practitioners in the situation that they can be requested to do something that is unacceptable to them from a ethical point of view. Even to suggest that they can refer patients to other medical

practitioners is an unsatisfactory solution.

4. The Bill allows for "voluntary Euthanasia" where a person may live for twelve months. There are enormous numbers of stories of people being told they only had 3 months to live who have lived much longer than that. No doctor can say with certainty that a person who may live for 11 months may not live considerably longer.

5. There is already evidence from practices documented in at least one other state of Australia and from Holland, that there is what has been termed a slippery slope between "Voluntary Euthanasia" and "involuntary Euthanasia". While the Bill is designed to allow only voluntary Euthanasia, the data would indicate that this will soon be widened.

6. The Bill, if passed, will mean an end to the sort of society that we, in Australia , have enjoyed. If the State is not prepared to guarantee life it cannot be expected to guarantee any of the freedoms that flow from such a guarantee. The Bill is a negation of the Universal Declaration of Human Rights.

SUBMISSION 913 1

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21 March 1995

PO BOX 456

KENSINGTON NSW 2033

Chairperson

Select Committee on Euthanasia

Parliament of the Northern Territory

PO BOX 3721

DARWIN N.T. 0801

Dear Chairperson and the Honourable Members of the Committee,

I am writing to express my support for the proposed legislation before the chamber of the Northern Territory in regard to voluntary euthanasia. Although I do not reside in the Territory, I would like my views to be taken as indicative of a more or less substantive segment of Australian society, as found in numerous opinion surveys.

I strongly support the basic individual human rights upon which our democratic and secular society is founded. Not to mention the various international covenants which have reaffirmed these rights on a global scale.

As for the future, it is quite clear that the direction in which our society is moving is undeniably towards greater personal freedom based on mature, rational and non-violent thought. Despite some rear-guard actions by conservatives (in a moral sense), a fair segment of society have supported this liberalism and most have accepted that such changes, when adopted, have not destroyed the 'fabric of our society' but have indeed enhanced it.

Therefore it is an evolutionary process that the basic right of living with dignity, in good health and with adequate opportunity, should be respected in its entirety. A right to choose not to live without these basic fundamentals must become another facet of our liberal society. This is with respect primarily in the case of the terminally ill who have, with sound and rational mind, decided that their current or future conditions warrant a contravention of their basic rights.

From a personal perspective, fortunately, to my knowledge, I have not had a relative who has suffered as such. Though, despite my lack of personal cognition, I do not deny this right to other people who may wish it. I know that my grandfather after a proud and healthy life working on the land, had all his dignity stripped from him by

eight years of degradation after suffering a stroke. I know that he would not have preferred such a state should he have had the opportunity to decide. Though, voluntary euthanasia would not have helped in this situation as he did not require artificial means to be kept alive. Nevertheless, I know the burden which this situation placed on his family. I therefore cannot imagine the burden placed on a family whose loved-one found themselves in a condition requiring artificial life sustention. The burden of pain, grief and finance would be heartbreaking. Should anyone be given the opportunity to avoid this for their family I am sure most. would choose to.

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Finally, with respect to the opponents of the proposed legislation, there is without doubt always the right not to choose to apply these rights. The right not to, should and must, always to be respected in addition to the right to accede.

I thank the members of the committee for their time and hope that their report is made on the basis of rationality with respect primarily for the unfortunate people who may be in a position to be helped by this legislation.

Yours sincerely,

CRAIG DALY

SUBMISSION 914 1

Grace Sivell

Box 391

Nightcliff, NT 0810

22 March 1995

The Chairman

Select Committee on Euthanasia

GPO Box 3721

DARWIN, NT 0801

Written Submission on Euthanasia

Dear Sir,

I wish to express my support for the RIGHTS OF THE TERMINALLY ILL BILL 1995.

My stand on this position is based on logic, not emotions, and on the following incidents:-

1. An elderly woman was bedridden with cancer for a period of over 2 years. She told me that the chemotherapy appeared to have affected her mind and she was no longer able to carry thought processes - ie unable to watch TV because she could not follow the story, unable to read, because she could no longer comprehend the thoughts in the reading material, unable to talk long with people, because she couldn't remember what they said - her mind just wouldn't work properly. She felt retarded, with no hope of mental process recovery. She was extremely ill, in constant pain, and lay for over 2 years hoping every day to die, FOR A RELEASE FROM THE PAIN AND MENTAL ANGUISH. She had a strong belief in a "hereafter" and just wanted to end this life and go on to whatever comes next.

2. My grandmother had a leg amputated at the age of 89, and 2 weeks later another section was amputated from the

same leg. She was very frail and lived on intravenous and pain killers, and just kept saying "I have lived my life. I have known my children and my grandchildren. Dad is waiting for me, I just want to go to him." again a strong belief in a "hereafter", and a freedom from the human body.

3. My aunt had a number of strokes, was bedridden in a nursing home, became barely able to speak, lost bodily function control (extremely embarrassing to have someone have to clean you all the time), and continually said to me "Why won't they just let me go to sleep and not wake up. Its what I want!"

4. Another elderly lady was bedridden at home, with members of the family taking turns sitting with her. She was gasping for air constantly, was on high pain-killing injections and required 24-hour care. At her funeral, when I looked at her very old husband - I knew - and he knew that I knew - and he said to me with tears in his eyes "I could not watch her suffer any more; I put my hands around her neck until she stopped breathing". HIS PAIN in having to stop her suffering in that way is something that just shouldn't have to happen! - and it does! - probably more often than we care to think.

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5. In a recent death in Alice Springs, the elderly lady suffered from lung cancer becoming progressively worse over the past year, until finally being hospitalised for a period of about 4 weeks. She could not breath without terrible pain and was put onto morphine every 34 hours, she lost control of body functions, she developed a blood clot in a leg, the body basically shut down, and she kept crying to go home. But there was no-one to give her the 24hour care she needed at home, and so she was forced to remain in hospital. Her husband felt her pain and the helplessness of being unable to comfort her, and sat home crying in his emotional pain. She was brought home on a weekend and died with her daughter holding her hand. And her death brought everyone the relief of the end of her suffering.

How anyone can say to make the CARE better for these people, really defies logic. Perhaps someday they may be in that situation themselves, and it will be too late to undo the damage they are creating now.

It is MY body; it should be MY choice. If I choose not to want to suffer needlessly, no-one should have the right to force me to do so, based on their beliefs, not mine.

I believe that my body is the vehicle I get around in, and, like the car crashed at the side of the road, there is no use sitting in it if its not going to go again. I would much rather be free to go on to WHATEVER may be next. Can anyone really believe that the human body is the ultimate in the universe?

Churches say that they believe in an afterlife, a "heaven" in some form, and are yet prepared to prevent people from going on, when the people themselves chose to go. I am writing personally to the churches asking them to consider that factor.

Thank you for the opportunity of making this submission. I hope that the personal examples shown will be of some support in this cause.

Sincerely,

Grace Sivell

SUBMISSION 915 1

ST MARY'S CATHEDRAL PARISH

G.P.O. BOX 229, DARWIN N.T. 0801. TELEPHONE: 81 2863.

23rd. March '95.

The Chairman,

Select Committee on Euthanasia,

GPO BOX 3721

DARWIN NT 0801

Dear Sir,

I am aware that since the introduction to Parliament in the Northern Territory of the Chief Minister's private members Bill of the Rights Of The Terminally Ill, much debate has followed. I believe much of the public debate, especially as seen in such place as Letters To The Editor in the N.T. News and in a number of the reports as aired on television, indicates a genuine lack of understanding of the issues by many people and a lack of anticipation of the possible repercussions of the passing of such a Bill.

I therefore respectfully request, that my summary of the issue at hand, be presented for consideration by the Select Committee.

If any action ought to be undertaken by the Northern Territory Parliament in support of the terminally ill, I suggest that surely the provision of a palliative care hospital or a unit within the Royal Darwin Hospital, would be the more appropriate way to move, rather than to provide for the easy but dangerous option, of euthanasia.

Yours sincerely,

Fr. Frank Perry M.S.C.

Administrator.

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ST MARY'S CATHEDRAL PARISH

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EUTHANASIA

The Chief Minister has introduced a Private Member's Bill into Parliament dealing with the issue of euthanasia under the Title of: Rights of the Terminally Ill Act 1995

This Bill is a cause of serious concern to me. I would like to outline my objections to the Bill and question the necessity for such a Bill.

Euthanasia is a difficult subject because the term 'euthanasia' means different things to different people. However, most understand euthanasia to be: The deliberate, rapid and painless termination of the life of someone afflicted with an incurable and progressive illness. With that person's consent it is called voluntary euthanasia, otherwise, non-voluntary. In either case, a person suffering and who is terminally ill is not allowed to die a natural death, rather his or her life is prematurely terminated.

In public discussions, we hear it said that it seems undignified to stand by and watch some poor soul suffering, when we know and they know, that it is only a matter of time and yet the pain and discomfort goes on. Wouldn't it be more charitable, they argue, to offer them an easy exit from this life. A quick, merciful, pain-free death?

To situate euthanasia into its rightful perspective, we need to distinguish between such differences as;

(1) withholding or discontinuing life-prolonging treatments,

(2) control of pain and other symptoms and

(3) actual euthanasia.

If in the course of an illness, a time comes when it is no longer possible to restore health and no longer possible to reverse the dying process, Catholic Church teaching acknowledges that prolonging life at all costs, especially at the cost of continued suffering, is NOT required from a moral point of view.

When should we allow the dying to die? Patients are allowed to die according to the moral law of the Catholic Church, when the only treatment that could prolong life, causes more suffering than benefit. To withdraw futile medical treatment, is morally acceptable. That is very different from euthanasia. Euthanasia is the deliberate act of ending a life.

Patients are not obliged to undergo treatments that are futile. A patient suffering a grave illness, severe levels of pain, or extreme physical or mental anguish, is perfectly entitled to be treated with medication which alleviates pain, even though this may cause, as a secondary effect, a semi-conscious state. The patient eventually die earlier than may have been the case.

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Nevertheless the medication was administered WITH THE INTENTION OF alleviating pain, not of hastening death and this is a distinctly different case from that of active euthanasia, as promoted by the Chief Minister's Bill

With the level of palliative care (the medical care of the dying) in this country being as highly developed as it is, no one need die a slow or miserable death. Catholic teaching says that we are not morally obliged to have recourse to extra-ordinary means of prolonging life. However, we are always bound to make reasonable provision under the circumstances for palliative care, including food, liquids and comfort. If we have access to efficient palliative care, why is there a need for euthanasia?

Humans are more than animals. Each has a unique dignity, a right to respect from others, whether we are sick or well, old or young, rich or poor, physically perfect or handicapped. We all have the right to live. The taking of one's own life or that of another is morally unacceptable.

God is the Creator of life and the only Lord of life. We have no direct dominion over our own lives nor over the lives of any other human being, irrespective of the condition of health or the stage of the life cycle, either before birth nor at any time after birth.

A law in Australia permitting euthanasia could easily assume proportions as indiscriminate as figures reveal in the Netherlands today. Of the total number of deaths in the Netherlands in 1990, more than 36,000 were physician-assisted deaths. More than 11,000 of these lives were terminated, WITHOUT any patient request or consent. Do we want a similar practice for Australia?

There is a need for each of us to have our belief of the sanctity of life maintained. A need to oppose a law that would allow for the termination of human life.

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