



**Submission to the
Joint Standing Committee on Community Development
Inquiry into the Dying with Dignity Bill 2009**

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Executive Summary

The Australian Christian Lobby (ACL) is opposed to the Dying with Dignity Bill 2009 (the Bill). The effect of the Bill would be to introduce legalised voluntary euthanasia in the state, which would put at risk the lives of Tasmania's most vulnerable citizens – those who are elderly, lonely, sick and depressed. Legislation that fails to protect the most vulnerable members of society is bad law.

Euthanasia puts at risk the lives of vulnerable patients because it transmits the overt message that some lives are not worth living. It encourages patients to seek death when a truly compassionate society would provide care and support to a person who is frail and in need. ACL empathises with those who are suffering a terminal illness, but believes the right response to their suffering is to alleviate their pain through appropriate medical care and emotional support.

Euthanasia infringes the inviolable right to life, as provided for in accepted international human rights instruments. It changes the relationship of the State to its most vulnerable citizens, relinquishing its responsibility to equally protect the lives of all its members. It forever alters the trusted relationship between medical practitioner and patient. Patients would no longer be assured that their doctor is always acting to protect their life.

There is no way to ensure that all cases of euthanasia are truly voluntary, and there is sufficient evidence to show that legalised voluntary euthanasia paves the way for the practice of involuntary euthanasia. Supposed safeguards in euthanasia legislation, which are designed to protect vulnerable lives, have been clearly shown not to work. Of the seven patients who made formal use of the Northern Territory euthanasia law, three were 'socially isolated', and symptoms of depression were common.¹

Legalised euthanasia can too easily become the 'quick fix' method of addressing complex end of life care issues. The swift termination of life is, however, neither the solution of families wishing to be spared the grief of suffering, nor the administrative answer to problems of ageing demographics and budgetary constraints. It would be dangerous to determine matters of life and death by subjective judgements about the quality of life.

The appropriate first step in compassionately addressing complex end of life issues is to recognise the intrinsic value and worth of somebody who is suffering and dying. Society is educated and encouraged to value such lives when governments are committed to funding the provision of well-resourced and equitable palliative care services.

Every major published inquiry in the world into the legalisation of euthanasia has independently concluded that such a law could never be made safe. When the Tasmanian parliament examined euthanasia in 1998, it found that:

the legalisation of voluntary euthanasia would pose a serious threat to the more vulnerable members of society and that the obligation of the state to protect all its members equally outweighs the individual's freedom to choose voluntary euthanasia.

Euthanasia is an appealing ideal for supposedly well-informed and empowered individuals who would like to exercise complete autonomy over their lives and deaths. But it is dangerous to people who are vulnerable due to disease, depression, or those who feel they

¹ Kissane, D.W., Street, A., & Nitschke, P. (1998). Seven deaths in Darwin: Case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. *The Lancet*, 352, 1097-1102

are a burden to others. Legalised euthanasia fails the objective of the law to primarily protect the weak and powerless. The supposed 'right to die' becomes the 'duty to die', as governments and families seek to become disencumbered of the financial cost and emotional burden of care.

This submission outlines ACL's general opposition to voluntary euthanasia, and specifically details the flaws of the proposed Tasmanian legislation. In particular, the definitions in the Bill are far too subjective to be a firm basis upon which to deliver the consistency of interpretation required for end of life decision-making.

Terminology

For the purposes of this submission, ACL intends the term 'euthanasia' to mean, 'active euthanasia', which according to the Australian Medical Association (AMA), is: "giving a patient a treatment or action that directly and deliberately results in their death". ACL likewise agrees with the AMA's interpretation of other types of end of life treatment:

*The AMA believes . . . that if a medical practitioner acts in accordance with good medical practice, the following forms of management at the end of life **do not** constitute euthanasia or physician assisted suicide:*

- *not initiating life-prolonging measures;*
- *not continuing life-prolonging measures;*
- *the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.²*

General objections to euthanasia

The foundation of Christian objection to euthanasia is the fundamental belief that all people are made in the image of God. This important theological concept, called *Imago Dei*, is central to understanding the inherent dignity and worth of all human life, regardless of one's physical wellbeing or mental state. It is why Christians conscientiously work to preserve the sanctity of life.

Implicit in the practice of euthanasia is the underlying concept that certain lives can be terminated because they are not of optimum quality, and hence, are of less value than others. ACL opposes euthanasia due to this notion, which rejects the fundamental idea that all human life is inherently valuable.

ACL also opposes euthanasia because its availability and incidence can be neither confined nor controlled, regardless of apparent 'safeguards'. Euthanasia has a range of alarming

² AMA (2007). *Position Statement on the Role of the Medical Practitioner in End of Life Care*, p. 2.

consequences, such as the inevitability of involuntary euthanasia, a forever changed doctor-patient relationship, and the acceptance of euthanasia as a cost-effective treatment option.

The human rights case against euthanasia

The long title of the Bill outlines its intention “to confirm the right of a person enduring a terminal illness with profound suffering to request assistance from a medically qualified person to voluntarily end his or her life . . .” This, the so-called ‘right to die’, has been invented by euthanasia advocates. The notion, and this Bill, are incompatible with accepted human rights standards as articulated by the United Nations and assented to by Australia.

All human beings, including those suffering from a terminal illness, have the right to life³ and to legal protection against violation of this fundamental human right.⁴ People have the right to medical care and social services.⁵ They also have the right to effective remedy against violations of these rights, “notwithstanding that the violation has been committed by persons acting in an official capacity”.⁶

People are subject to limitations on their human rights by law, but only for the purpose of “securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and general welfare in a democratic society”.⁷

Whilst a small percentage of the population may request euthanasia or persistently lobby for it, there is no right to it. The law rightly rejects the alleged ‘right to die’, upholding the right to life as the foundation of a civilised society. This is the only way to protect the rights and freedoms of all people, especially vulnerable sick and elderly patients whose lives would be placed at risk by legalised euthanasia.

Impact on the doctor-patient relationship

The Bill effectively gives doctors the ability to kill their patients with legal protection. The decision to preserve or terminate a patient’s life essentially rests with the medical profession. Giving doctors the power of life or death would severely restrict the autonomy of patients in their care, notwithstanding the intent of the Bill that any euthanasia is administered at the patient’s request.

Since the earliest days of medicine, doctors have been trained to heal their patients. Actively participating in the death of a patient contradicts the mandate of doctors to care for their patients, and to do no harm. The Hippocratic Oath states that “I will neither give a deadly

³ Article 3, *Universal Declaration of Human Rights 1948*, United Nations; Article 6, *International Covenant on Civil and Political Rights*, United Nations, 1966

⁴ Article 7, *Universal Declaration of Human Rights 1948*, United Nations

⁵ Article 25, *Universal Declaration of Human Rights 1948*, United Nations

⁶ Article 2, *International Covenant on Civil and Political Rights*, United Nations, 1966

⁷ Article 29, *Universal Declaration of Human Rights 1948*, United Nations

drug to anybody if asked for it, nor will I make a suggestion to this effect.” After millennia of medicine as care, euthanasia would, according to Professor John Wyatt, a specialist in neonatal paediatrics at University College: “toss away, almost in a casual way, two thousand years of a tradition that doctors would only be dedicated to healing”.⁸

Euthanasia would erode trust between doctors and patients. Patients would be subject to any medical determination to shift from trying to heal and comfort to trying to procure death. Uninformed vulnerable patients would be particularly at risk. Where there is legal euthanasia a patient can never be sure whether their doctor is, as the British Medical Association suggests, wearing the white coat of the healer or the black hood of the executioner.⁹

Legalised euthanasia represents such a departure from accepted medical ethical standards that the Australian Medical Association is opposed to the practice, declaring that: “medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life”.¹⁰

Inevitability of involuntary euthanasia

Patients can rightly feel wary of their doctors when the culture of the medical profession changes from preserving life to causing death. Legalised euthanasia in other countries has given doctors the capacity to take the lives of patients who have not requested death because the changed culture supports the taking of life. It gives rise to a culture that devalues human life and turns a blind eye to involuntary euthanasia.

The example of the Netherlands shows the disturbing consequences of allowing medical practitioners to terminate the lives of their patients. The Netherlands officially legalised euthanasia in 2002, but the practice has been permitted since the mid-1980s.

Three reputable surveys conducted over a ten-year period show that medical practitioners in the Netherlands kill approximately 1000 patients a year against their wishes or without their consent. The first report, published in 1991, showed that physicians administered a drug in 1000 cases with the explicit purpose of hastening death where there was no explicit request from the patient. These significant findings were confirmed in 1996 and again in 2001, when 1000 patients were still being killed each year against their will.¹¹

⁸ ‘Views of doctors on assisted dying’, Care Not Killing Alliance, UK

⁹ ‘Statement on End of Life Decisions,’ British Medical Association, 2000

¹⁰ AMA, op cit. p. 6.

¹¹ Van der Maas PJ et al (1991). Euthanasia and other medical decisions concerning the end of life. *Lancet*, 338, 669-674.

Van der Maas PJ et al (1996). Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995. *New England Journal of Medicine*, 335, 1699-705.

Onwuteaka-Philipsen BJ et al (2003). Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995, and 2001. *Lancet online*, <http://image.thelancet.com/extras/03art3297web.pdf>

Failure of intended safeguards

Proponents of euthanasia, including the sponsor of the Bill, claim that safeguards will prevent the involuntary killing of patients. However, despite similar safeguards, the Northern Territory's short experience of legalised euthanasia found the safeguards to be ineffectual. Reviewing the only Australian experiment with legalised euthanasia, the University of Adelaide's Professor Robert Goldney noted:

[E]ven with ostensibly strict guidelines embodying most issues considered by proponents of euthanasia to be important, as a result of the clinical details provided there exist reservations about what occurred with two of the four persons who died under the Northern Territory legislation. This is hardly a reassuring record for examples of euthanasia.¹²

Safeguards are unable to work because they are incapable of encapsulating the full extent of circumstances likely to be covered by the legislation. Legislative safeguards assume an even power relationship between the patient and the medical practitioner, and that the doctor has disclosed all pertinent information to his or her patient. Yet the treating physician possesses greater power in the process, controlling the flow of information to the patient before death, and perhaps the only person to hold all details after death.

Although doctors are medical experts who must adhere to defined ethical standards, they are prone to the same character flaws and temptations as other people. One temptation would be for the doctor to choose the easy option of euthanasia rather than working hard to ensure a higher quality of life for the patient. A doctor can also overestimate their own skill, believing a patient's condition to be 'unrelievable' because they have been unable to ease the suffering.

Doctors are not immune from unethical practices, and it is unlikely any amount of intended legislative safeguards will prevent a physician who is determined to act unscrupulously from doing so. Once euthanasia has been carried out, it is too late to intervene on the patient's behalf. Perhaps the only other witness to the unsanctioned killing is now dead, and the doctor-killer controls the evidence.

Even with the permission of the state to kill patients, Dutch doctors have been found to falsify records to protect themselves. I.J. Keown, a healthcare lawyer, writes that in the Netherlands the "vast majority of deaths from euthanasia are illegally and incorrectly reported as natural deaths [which] itself casts doubt on the lawfulness of much of the euthanasia which is being carried out."¹³

Dr Brian Pollard, an Australian palliative care specialist, made a similar observation in an article referring to the Dutch Advocate General's comments that:

The medical profession is in all likelihood the only academically trained group of professionals, who by virtue of their profession, are guilty of making false statements in writing with great regularity when, after a euthanasia procedure, they make inaccurate death declarations which conceal the unnatural death case.¹⁴

¹² Goldney, R. (2001). Euthanasia: The Australian experience, in D. De Leo, (Ed.) *Suicide and Euthanasia in Older Adults: A Transcultural Journey*. Seattle: Hogrefe & Huber, pp. 172-179.

¹³ Keown, I. J. (1992). The Law and Practice of Euthanasia in The Netherlands. *The Law Quarterly Review*, January, 67-68.

¹⁴ Pollard B. (1991). Medical aspects of euthanasia. *Medical Journal of Australia*, 154:9, 613-616.

Death as treatment

In a terrible perversion of medicine, euthanasia turns death into a form of treatment. Rather than kill the pain, doctors are given license to kill the patient. The risk to the vulnerable is heightened further as society learns that euthanasia is a cost-effective healthcare strategy. Euthanasia cheapens the value of human life, and inevitably introduces utilitarian considerations about the costs of medical treatment.

Dying from a terminal illness is emotionally and financially expensive, for the patient and their family, and for governments and broader society. The care of professionally trained doctors and nurses, hospital stays, treatment and drugs cost thousands of dollars per patient. A society which values the intrinsic worth of human life is happy to bear this cost.

However, a society that permits the legally sanctioned killing of certain people based on subjective judgements about the quality of their life will not so readily accept the outlay of such financial costs. It will begin to question ongoing expensive medical care, especially when this will fail to save the life of a terminally ill patient. Why bother paying for expensive palliative care and support when euthanasia is so cheap and painless?

And why discriminate against other patients who might otherwise 'benefit' from euthanasia? Why limit access to this new treatment to only those with terminal conditions? Once legalised, death becomes an acceptable treatment for an ever-increasing catalogue of treatable, non-terminal conditions such as depression or for those whose quality of life is judged to be too poor to make caring for them worthwhile or financially justifiable.

'Mercy killing' of those who are not terminally ill

Given the way in which euthanasia devalues the sanctity of human life, it is unsurprising yet horrifying that the lives of innocent and vulnerable newborn babies are also at risk from euthanasia.

Belgium legalised euthanasia for 'competent' adults in 2002. Though it remains illegal to kill babies, by 2005 seven percent of deaths of newborn babies were due to lethal injection. A staggering 75 percent of all neonatal physicians were prepared to euthanize newborn babies.¹⁵ In the Netherlands, nine percent of deaths of newborn babies occurred following the administration of drugs designed to hasten death. Nearly three percent of deaths of Dutch children between the ages of one and 17 are from euthanasia.¹⁶

There can be no doubt that euthanasia places at risk the lives of society's most vulnerable members, whose lives are judged by others to be of little quality. This in turn places enormous pressure on the vulnerable to opt for euthanasia in order to keep faith with society's expectations.

¹⁵ Provoost V et al (2005). Medical end of life decisions in neonates and infants in Flanders. *Lancet*, 365, 1315-1320.

¹⁶ Vrakking A et al (2005). Medical end-of-life decisions made for neonates and infants in the Netherlands, 1995–2001. *Lancet*, 365, 1329-1331

Vrakking A et al (2005). Medical end-of-life decisions for children in the Netherlands. *Archives of Pediatrics & Adolescent Medicine*, 159, 802-809.

'Unproductive burdens'

Legalised euthanasia sends society the not-so-subtle message that some lives are worth more than others. Instead of valuing life intrinsically, life is subjectively valued according to its perceived quality. This places enormous pressure on those who believe they have become a burden to their family or society. In an age of spiralling health costs and complex care needs it is all too easy for some patients to feel they are simply an economic and emotional drain on their families, and that the best solution is to end their life.

Euthanasia increases the pressure and expectation of the sick and frail to relieve their families of their burden. The US state of Oregon legalised euthanasia in 1997. As physician assisted suicide was increasingly accepted, the percentage of patients whose reasons for requesting death included feeling like a burden to others climbed from 12 percent in 1998 to 63 percent in 2000.¹⁷

The so-called 'right to die' inevitably becomes the 'duty to die' as economic pressures and deference to other people's convenience begin to dominate end of life decision-making. If this Bill were passed many vulnerable people – those who are elderly, lonely, depressed, disabled or distressed – will feel pressure, whether real or imagined, to request an early death in order to avoid being a burden to others.

Parliament has a responsibility to continue to protect the lives of society's most vulnerable members. It should not pass laws that will pressure people to die or create an environment where the vulnerable can be coerced to 'choose' death.

Euthanasia in Tasmania

The debate about euthanasia in Tasmania certainly has some important contextual history that the present Committee should recognise and reflect upon. This section of the submission will briefly comment on the 1998 report of the Community Development Committee on the "Need for Legislation on Voluntary Euthanasia".

The 1998 inquiry

Following the 'lead' of the Northern Territory towards voluntary legislation, the Tasmanian parliament decided in 1998 that it should investigate whether the state should also allow the legally sanctioned killing of patients by their doctors. It unequivocally, however, followed the example of every major parliamentary investigation into euthanasia around the world and soundly rejected the 'need for voluntary euthanasia', even though some Committee members were known to previously support the practice.

Based on a staggering 1162 submissions and numerous public consultations, the Committee came to the following unambiguous conclusions, among others, that:

¹⁷ Sullivan A D et al (2001). Legalised physician assisted suicide in Oregon, 1998-2000. *New England Journal of Medicine*, 344, 605-607

- *whilst individual cases may present a strong case for reform the obligation of the state to protect the right to life of all individuals equally could not be delivered by legislation that is based on subjective principles;*
- *the codification of voluntary euthanasia legislation could not adequately provide the necessary safeguards against abuse; and,*
- *the legalisation of voluntary euthanasia would pose a serious threat to the more vulnerable members of society and that the obligation of the state to protect all its members equally outweighs the individual's freedom to choose voluntary euthanasia.*

These same findings remain especially pertinent today one decade after the original inquiry. Very little has changed in the euthanasia debate since this time to contemplate rejecting the Committee's findings. The mandate of the state to equally protect human life remains strong. In fact, the imperative to protect vulnerable lives has become stronger in the last decade due to increasing pressures on health budgets and a trend towards devaluing human life.

The only substantive change in the euthanasia debate since 1998 is that palliative care is even better now than it was at that time, which weakens the case for euthanasia. Of course euthanasia advocates will point to greater levels of public support for the practice, as shown by opinion polls, but a simple show of hands is no way to legitimise complex social policy. No new safeguards have been developed that would ensure that the lives of vulnerable people are not put at risk.

The legalisation of voluntary euthanasia was soundly rejected by the Tasmanian parliament in 1998, and it should be rejected for the same reasons now.

The present Bill before parliament

Proposed euthanasia legislation relies on subjectivity, invented human rights and imprecise definitions in order to overturn laws which objectively and equally preserve human life. Such proposed laws present opportunities to endanger the lives of patients who do not want their lives ended, and go to great lengths to protect doctors from existing criminal law. The euthanasia bill presently before the Tasmanian parliament follows this trend.

There are a number of flaws with the Bill which will now be examined in detail (arranged by reference to the relevant section of the Bill).¹⁸

Section 3 – Interpretation

- Definition of 'assist':

To kill somebody is not to 'assist' that person.

- Definition of 'intolerable suffering' (*a profound level of pain and/or distress, that the sufferer finds intolerable*):

This definition is far too subjective to be the basis for law that allows the taking of human life. There is no objective measure of pain, and its cause is not always physical. The

¹⁸ ACL acknowledges Dr Brian Pollard for his analysis of the Bill.

'intolerability' of pain is an entirely subjective judgement that is able to be claimed, but is impossible to objectively test.

- Definition of 'mentally competent' ((b) *a capacity of the sufferer to make a decision freely, voluntarily . . .*):

It is almost impossible to know that somebody is entirely 'mentally competent' to make a decision for death, as coercion from family, friends and doctors is often subtle and hidden. The terminally ill routinely experience duress and depression. Former Human Rights Commissioner Brian Burdekin observed that the sick and mentally ill are already "the most systematically abused and the most likely to be coerced".¹⁹

- Definition of 'sufferer':

It is tragic that this Bill reduces the worth, and devalues the life, of somebody experiencing a terminal illness by labelling them a 'sufferer'. We should reaffirm for such people that their identity and worth is not to be judged solely on their mental state or physical health. The provision of professional palliative is the appropriate response, whereby a 'sufferers' pain is relieved through care, not death.

- Definition of 'terminal illness' (*an illness which, in reasonable medical judgment, will in the normal course, without the application of **extraordinary measures** or of treatment **unacceptable to the sufferer, result in the death of the sufferer***):

This definition is especially weak for a number of reasons. Firstly, an illness that will "result in the death of the sufferer" could potentially include not only terminal conditions where death is imminent, but also common chronic illnesses for which there is no cure but will result in death, perhaps after many years. According to this definition, death could potentially be requested and obtained by a patient assured of a reasonable quality of life. There is also no precise definition of the key phrase 'extraordinary measures'. The acceptability of treatment to the patient again introduces another subjective test, based on personal perception alone, that is no firm basis for legal consistency or protection against the taking of human life.

Section 8(1)(c)(iv)

This section outlines the role of the qualified psychiatrist in the euthanasia process is to determine whether the patient is mentally competent to make an informed decision to end his or her life. This is a terrible distortion of the proper response of psychiatrists to requests of death. A sustained wish to die is psychologically abnormal, and depression is commonly associated with the desire to die. The appropriate response to such requests is clinical care, not death, as the Australian Medical Association outlines:

Patient requests for euthanasia or physician-assisted suicide should be fully explored by the medical practitioner in order to determine the basis for such a request. Such requests may be associated with conditions such as a depressive or other mental disorder, dementia, reduced decision-making capacity, and/or poorly controlled clinical symptoms such as pain. Understanding and addressing the reasons for such a request

¹⁹ Burdekin, B. (1993). Cited in *The Sydney Morning Herald*.

*will allow the medical practitioner to adjust the patient's clinical management accordingly or seek specialist assistance.*²⁰

Section 10 – Palliative Care

*(1) A medical practitioner must not assist a sufferer under this Act if . . . there are palliative care options reasonably available to the sufferer to alleviate the sufferer's pain and suffering to levels **acceptable to the sufferer**.*

The utility and efficacy of discussed palliative care options is here to be determined solely by the subjective judgement of acceptability to the patient. Basing the decision to end life on the opinions of vulnerable and emotionally strained patients is an inconsistent test and an inadequate safeguard against the taking of life.

Section 15 – Certification of Death

(2) A death as the result of assistance given under this Act must not . . . be taken to be unexpected, unnatural or violent, or of having occurred during an anaesthetic, for the purposes of any coronial inquiry.

This section insists that, for the purposes of a coronial inquiry, euthanasia is not an unnatural cause of death, when death by lethal substance is clearly not natural.

Section 16 – Medical record to be sent to Coroner

This section places medical practitioners in a compromising position. As the sole survivor of the euthanasia process, and sole author of the report to the Coroner, potential exists for a physician to be open to the accusation of withholding relevant information from the Coroner.

Section 22 – Immunities

This section seeks to protect the doctor from civil or criminal action or from disciplinary action by a medical organisation as a result of actions taken under the legislation. These immunities contradict the intent of the criminal law, which is especially designed to protect people in positions of powerlessness or weakness. This section, however, defends the doctor, who is in the position of power, rather than the vulnerable patient.

The intentional taking of human life is against medical ethical standards. The Bill opens the way for doctors to participate in the unethical practice of euthanasia, which does not have the consent of the profession. The section rejects sound medical practice by placing the protection of physicians who choose to act unethically above considerations about public safety and the welfare of disempowered patients.

²⁰ AMA, op cit. p. 6.

Section 24 – Act to prevail

In the event of any inconsistency between this Act and any other Act, including the Criminal Code Act 1924, commenced before or after the commencement of this Act, this Act prevails to the extent of the inconsistency unless a contrary intention is stated in the subsequent Acts.

This section presumes that the newly legislated license to kill patients should always prevail over the collective legal wisdom that it is morally wrong to intentionally take a life, as articulated in the *Criminal Code Act* and other parliamentary law. Any protection of life that might otherwise be available in Tasmanian law, including the fundamental legal standards of the Criminal Code, is set aside where there is inconsistency with this Bill. This represents a serious threat to the preservation of vulnerable lives.

Recommendations

ACL recommends that the Committee:

1. Reject the bill in its entirety because it represents a weakening of essential protections of human life and would threaten the lives of vulnerable Tasmanians, and place doctors in unaccountable and compromising positions;
2. Reaffirm the findings and recommendations of the 1998 report of the Community Development Committee on the Need for Legislation on Voluntary Euthanasia;
3. Commit to the further expansion of palliative care services; and,
4. Recognise the link between untreated depression and repeated requests of death – committing to appropriate funding of mental health services.²¹

²¹ Chochinov H M et al (1995). Desire for death in the terminally ill. *American Journal of Psychiatry*, 152, 1185-1191.

This study found that nearly 60 percent of terminally ill patients who expressed a desire to die were depressed, whereas depression was only found in 8 percent of those without a desire to die. The authors conclude their study by saying: “The desire for death in terminally ill patients is closely associated with clinical depression.”

Conclusion

Legalised euthanasia represents a serious weakening of the fundamental responsibility of the state to equally protect all human life. It destroys the long-standing commitment of doctors to heal and to do no harm. Legalised euthanasia legalises the exception rather than the rule. Whilst there are some tragic and sad cases of horrific suffering and hardship, using these few cases as a basis for legislation creates an inconsistent and ineffective law that will threaten the lives of society's most vulnerable members. Any law that puts at risk the lives of vulnerable citizens is bad law.

Euthanasia sends a horrifying message to sick and elderly people that their lives have less value than others due to their reduced mental or physical capacity. It pressures vulnerable patients to desire not to be a burden on society, and their loved ones in particular. Contrary to accepted human rights standards, it judges life to only be valuable when it has utility.

Evidence from overseas clearly demonstrates that supposed safeguards against involuntary euthanasia fail to work in practice. The only example of Australia's own very brief experiment with euthanasia shows that the safeguards are easily side-stepped by medical practitioners all too willing to meet the request of the patient to die rather than professionally assessing and treating his or her physical and emotional ailments.

Every major published inquiry in the world into the legalisation of euthanasia has independently concluded that such law could never be made safe. It is impossible to prevent or detect all types of coercion, and no euthanasia law is capable of ensuring that vulnerable lives will not be lost. Legalised euthanasia quickly makes the 'right to die' a 'duty to die'. Involuntary euthanasia becomes involuntary euthanasia.

ACL empathises with those who are suffering a terminal illness, and strongly believes that the appropriate caring response to their pain is professional palliative care.

The Dying with Dignity Bill 2009 and any attempts to legalise euthanasia should be rejected.

Nick Overton

ACL Tasmania Director

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