Submission to
Senate Legal and Constitutional Affairs Committee

Inquiry into the

Australian Capital Territory (Self-Government) Amendment (Disallowance and Amendment Power of the Commonwealth) Bill 2010

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Euthanasia and Senator Brown's enabling Bills

The first legislation in the world allowing euthanasia was the *Rights of the Terminally Act 1995* [ROTI Act] which was passed by the Northern Territory and which became law on 1 July 1996. It was repealed by the Commonwealth *Euthanasia Laws Act 1997* which came into effect on 25 March 1997. Since then Senator Brown has tried to facilitate legislation enabling euthanasia in the Australian Territories by a number of Bills with variations on this theme. The *Australian Territories Rights of the Terminally Ill Bill 2007* included the right of a terminally ill person to request a doctor's assistance to die; it extended to all Australian Territories including the external Territories. The *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* applied this facility only to the ACT, the Northern Territory (NT) and Norfolk Island (N Is) and sought to repeal the *Euthanasia Laws Act 1997*; moreover it sought to restore the provisions of the ROTI Act (NT) to have effect as if the *Euthanasia Laws Act 1997* had not repealed that Act.

Senator Brown's persistence in bringing forward these Bills provides an interesting window into his purposes. The most frequently invoked mantra in defence of his proposals is that he wishes to restore the right of Territories to legislate as they see fit. However, his 2007 Bill legislated for euthanasia in so far as the Commonwealth could validly do so; his 2008 Bill aimed at restoring the provisions of the ROTI Act (NT), notably without consultation of the then NT Government. Senator Brown's *Restoring Territory Rights (Voluntary Euthanasia) Bill 2010* has its purpose granting to the NT, the ACT and NI the right to make laws on euthanasia.

Senator Brown's latest Bill in respect of Territory rights, the *Australian Capital Territory (Self-Government) Amendment (Disallowance and Amendment Power of the Commonwealth) Bill 2010,* has as its purpose removing the Governor-General's power under the *Australian Capital Territory (Self-Government) Act 1988* to disallow or amend any enactment of the ACT Legislative Assembly Territory. Surprisingly the Bill as presented exhibited no concern for similar rights for the NT nor for N Is.

One has to ask the reason for this extraordinary omission as Senator Brown has so frequently expressed concern for the rights of these Territories. His belated move to correct this oversight by indicating his intention to move amendments in committee of the whole to include parallel freedom from executive action for the NT and N Is only serves to highlight his substantial purpose in moving passage of the *Restoring Territory Rights (Voluntary Euthanasia) Bill 2010* and the *Australian Capital Territory (Self-Government) Amendment (Disallowance and Amendment Power of the Commonwealth) Bill 2010.* These two Bills together clearly demonstrate Senator Brown's haste to clear the way for passage of euthanasia laws in the jurisdiction most likely to pass legislation approving euthanasia, that is, the ACT. If both Bills were to be passed by the Parliament there would promptly follow proposed legislation in the ACT legislative Assembly to approve euthanasia.

Euthanasia and the Australian Capital Territory

This is not idle speculation. Since 2008 the ACT Legislative Assembly has consisted of seven Labor, six Liberal and four Green Members. On 'progressive' issues of social 'reform' the Stanhope Government and the Greens Party form a virtual coalition. The national policy of the Greens Party approves euthanasia and on 13 January 2011 the ACT Greens leader, Meredith Edwards, expressed her view that the 'three-party System' was at a crossroads for an electorate which looks for renewal in areas such transport, energy, health and social cohesion. The innocuous term 'health' is fleshed out by the proposal of ACT Greens MLA, Amanda Bresnan: a legislative model involving a voluntary euthanasia board, and assessments by doctors (*Canberra Times* [CT], 7 February 2011).

Further, the policy platform of the ACT Branch of the Australian Labor Party includes support for euthanasia:

> EUTHANASIA
> 1. Retain legislation that allows for interventionist medical treatment to be refused by a patient.
> 2. Allow the same rights for a patient who has become incompetent but did, whilst competent, execute an 'advance directive' or an enduring power of attorney providing for such withholding of treatment.
> 3. Support voluntary euthanasia legislation that provides that if a patient who has been counselled consistently requests assistance to die and two doctors are of the view that there is little or no prospect of substantial improvement of the patient's condition, then it should not be an offence for a doctor to assist the patient to die.
> 4. Require that if the patient has become incompetent and two doctors consider there is little or no prospect that the patient will regain competence, it should not be an offence for a doctor to cause the patient to die if:
>   a) the patient did, whilst competent, make an 'advance directive' that makes it clear that in circumstances such as prevail, the patient should be caused to die.
>   b) the patient did whilst competent enact an enduring power of attorney which makes it clear that in circumstances such as prevail, the attorney may and should, on the patient's behalf, authorise a doctor to cause the patient to die.
> 5. Continue to support a conscience vote on euthanasia for ALP Public Office Holders.
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> **Australian Labor party -ACT Branch 2008-09 Policy Platform - Human Rights Section at page 78**

It should be noted also that the policy platform of the NT Branch of the Labor Party is reconsidering the matter of euthanasia.

> EUTHANASIA
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> 39. Expand the provision of palliative care services and reconsider voluntary euthanasia.
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> **Australian Labor Party - Northern Territory Branch 2005 Policy Platform - Health and Community Services**

Over the past few years there has been a steady stream of articles appearing in the *Canberra Times* in support of euthanasia, for example: an article titled, *Euthanasia: debate that must not be silenced* by Bettina Arndt (CT 29 September, 2009 page 13); another, *Pro-life 'threat' to rights of territory* (sic) (CT 5 November, 2010); another, *Right to die should be my own* by David Swanton (CT 31 January 2011, page 9); and another,

We need a calm and factual debate on euthanasia by Amanda Bresnan, Greens Member of the ACT Legislative Assembly (CT 7 February 2011, page 11). All these articles express approval of legalised euthanasia. The article by David Swanton argued that persons, particularly politicians, with any religious convictions should be excluded from the debate on this topic.

Euthanasia and the *Rights of the Terminally Ill Act 1995* (NT)

These correspondents have lately been joined by Dr Philip Nitschke in the *Letters* page of the *Canberra Times* where he puts forward a self-serving history of the euthanasia deaths under the ROTI Act (NT), claiming those correspondents who referred to seven deaths in the NT in connection with the ROTI Act were wrong and that only four deaths were involved. This semantic distinction serves doubtless to imply that strict criteria for access to legalised euthanasia can be effectively met (CT February 4 2011, page10). This implication is misleading to say the least. An article in the British medical journal, *The Lancet*, co-authored by Nitschke, reports that seven persons who applied to be killed under the legislation were all approved: two died after passage of the Act but before its commencement date; four died while the provisions were in effect; and one died after the Act was repealed. The paper notes the "clear limitations of the gate-keeping roles of the medical specialist and psychiatrist in the ROTI legislation". [1]

The 1998 the *Lancet* paper revealed disturbing facts about the practice of euthanasia in the Northern Territory in 1996 and 1997, that is, during the short life of the ROTI Act. For example:

> Depression was a major factor in the Northern Territory's experiment with euthanasia …… Of seven cases studied, Case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management. [2]

Though the authors admit that fatigue, frailty, depression and other symptoms contributed more to the suffering of the patients than any pain arising from their condition, these persons met the requirements of the then Northern Territory euthanasia law.

Such an approach stands in stark contrast to the benign view of ethical medical practice that the depressed, the physically or mentally ill, and the dying should be given every assistance to overcome their problems without deliberate intervention causing death Suicidal people need help - not a recipe on how to end their lives.

Overall, depression is a significant risk factor for suicides and its operation in persons seeking euthanasia should not be underestimated. Legalising assisted suicide will not promote understanding, nor improve the management of depressed persons.

Euthanasia clinics – where?

The enactment of such socially and morally significant provisions in any of these small Territories would not be in the best interests for the practice of medicine in those regions. Inevitably 'specialist' outlets would develop where the 'business' would not be expert

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[1] Kissane, D, Street, A, Nitschke, P (1998), Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. *The Lancet*, Vol 352, pp1097-1102.

[2] ibid.

diagnosis of their condition nor referral to palliative care facilities, but death delivered as requested. Nor would it enhance the reputation of these Territories to become some sort of euthanasia havens for those interstate patients who are experiencing difficulty in the management of their illness.

Philip Nitschke has announced plans for his first euthanasia clinic to be established in Hobart or Adelaide as soon as the appropriate legislation is passed (T*he Australian* 8 March 2011, page 7). It is puzzling why he did not mention the far greater likelihood, even the certainty, of the ACT's legislature being first to approve euthanasia. The new Labor Premier of Tasmania has said that she and the Tasmanian Greens leader "will continue to progress [legalising euthanasia] as private members. At this stage, it is too early to say whether clinics like those proposed by Dr Philip Nitschke would be appropriate in a Tasmanian context" (*The Australian* 8 March 2011 page 7).

One would have to ask why these death clinics would not be 'appropriate' for Tasmania. Perhaps the 'progressive' ACT could be more willing to carry the opprobrium of being a centre for 'death tourism'. Certainly it is more easily accessed from major centres of population. Perhaps Nitschke, having thrown in his support for euthanasia in the ACT, strives obligingly to divert attention from this obvious site for a death clinic. While such a projection has been dismissed as 'scaremongering' by a member of Exit (CT 21 February 2011), scant attention is paid to the fact that the majority of those seeking to be killed under the repealed ROTI Act (NT) were not residents of that Territory. Further, the suggestion by pro-euthanasia advocates that this scenario could be avoided by restricting access to euthanasia to long-term residents of the ACT presents legal problems. Section 117 of the Commonwealth Constitution has been found generally by the High Court to prevent restricting access by non-residents to some 'right' available to residents in a particular State/Territory. I respectfully ask the Committee to seek advice on this issue.

Vulnerable people and legal euthanasia

In Australia more than 2200 people commit suicide each year.[3] That is more than the annual road toll of over 1500 deaths per year that we see regularly reported on the television news.[4] A study by the World Health Organisation (WHO) found that, despite there being almost one million suicides every year, suicide is a largely preventable public health problem if the right policies and interventions are in place.[5]

Unfortunately, however, a significant pool of young people considers suicide or self-harm. and some 7%-14% of adolescents will self harm at some time in their life, and 20%-45% of older adolescents report having had suicidal thoughts at some time. Certainly there is a very high association between suicide in adolescents and depression. .Psychological post-mortem studies of suicides show that a psychiatric disorder (usually depression, rarely psychosis) is present at the time of death in most adolescents who die by suicide.[6]

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[3] Australian Bureau of Statistics (2004), *Suicides: recent trends, Australia*. 15 December. Catalogue 3309.0.55.001.

[4] Australian Transport Safety Bureau (2005), Road Deaths Australia: Monthly Bulletin January.

[5] Suicide huge but preventable public health problem, says WHO.. Media release for World Suicide Prevention Day - 10 September. World Health Organisation. Issued 8 September 2004.

[6] Hawton, K and James, A (2005) Suicide and deliberate self harm in young people. *British Medical Journal*, Vol. 330, pp 891-894.

Such vulnerable young people could be pushed over the edge to their death by individuals or groups promoting suicide. If doctors can be involved in assisting patients to kill themselves, as Senator Brown once advocated in his 2007 and 2008 Bills relevant to this issue, then another barrier to the acceptability of suicide would be removed.

Significant risk factors overall for suicides are major depression, substance abuse, severe personality disorders, male gender, older age, living alone, physical illness, and previous suicide attempts. For terminally ill patients with cancer and AIDS, several additional risk factors are also present.[7]

Given the high association between depression, a treatable condition, and being suicidal, it is important that depression is always considered when suicide is discussed. Depression is often missed or not treated properly.[8]

Despite the importance of depression in contributing to suicidal behaviour, Dr Philip Nitschke Exit International's director is reported to have refused to seek expert opinion on whether those who approach him are suffering from depression. Dr Nitschke said:

> I would say common sense is a good enough indicator. It's not that hard to work out whether you are dealing with a person who is able to make rational decisions or not.[9]

The law should not compound the suffering of victims of depressive illness and of their families by encouraging suicide rather than providing the help they obviously need.

If it becomes routine to ask for assistance to die then this acceptance becomes a pressure on people to end their lives with the self-justification that they will ease the burden on family while ending their own physical and psychological pain. Fear of dependency and reluctance to burden family members are influential factors in making a decision to commit suicide.[10]

Euthanasia is not a solution to illness, pain or depression. There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care. Clinically depressed persons may wrongly see themselves as terminally ill. To allow such persons to agree to be killed undermines the protection of the law for vulnerable suicidal people. It says that sometimes people's lives are no longer of value and can rationally be extinguished with assistance - a dangerous notion. It is of relevance that Nitschke and Senator Brown have had a long association in support of euthanasia and that Nitschke has expressed support for the legalising of euthanasia in the ACT.

Euthanasia and appropriate limits to autonomy

It is often asserted by pro-euthanasia that to restrict assisted suicide is to restrict a person's autonomy to take charge of their own lives. Autonomy of the individual is not an absolute right. What may appear like an exercise of choice in choosing assisted death is that these persons may be suffering depression which can foment suicidal thoughts.

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[7] New York State Taskforce on Life and the Law (1994), page 12.

[8] Hitchcock Noel, P et al (2004), Depression and comorbid illness in elderly primary care patients: impact on multiple domains of health status and well-being. *Annals of Family Medicine*, Vol 2(6), pp 555-562.

[9] Pelly, M, A better option: the wait for a way out. *The Sydney Morning Herald*, March 19 2005.

[10] Johnson, T (2003), Book review: Suicide and euthanasia in older adults: a transcultural journey. *Psychiatric Services*, Vol 54, pp 261.

The exercise of one's person's autonomy, especially as approved by law, will increase pressure on the depressed, the frail, the elderly, and the confused to request euthanasia. People in those circumstances often feel they are a burden on relatives and consuming too much of society's resources. A law allowing euthanasia or assisted suicide, by legitimatising that option, removes the bulwark which should protect such persons from themselves and from those who might out of self-interest exploit their weakness.

During the debate on the Lord Joffe's 2006 UK euthanasia provisions Jane Campbell, a Disability Rights commissioner, explained how she suffers from a severe form of spinal muscular atrophy. "Many people who do not know me," she commented, "believe I would be 'better off dead.'" This sort of view is based mainly on ignorance, or even prejudice, argued Campbell. Lord Joffe's Bill failed to get the endorsement of a single organization of disabled people. Groups representing the terminally ill and disabled, frightened by what the bill seeks to achieve, formed a coalition, *Not Dead Yet*, to fight the proposal.[11]

Palliative care is advancing very rapidly, both in relieving suffering experienced by those with a terminal illness, as well as in providing support for their families. Politicians should take steps to ensure adequate training is given to doctors and nurses to adequately treat such patients; they should also fund the establishment of centres of specialist palliative care. They should ensure that the law continues to affirm the principle that life is precious especially in its most challenged, vulnerable moments.

The euthanasia movement - a slippery slope?

It is too easy to disparage as a 'slippery slope' argument reasonable predictions of the consequences of certain laws and/or practices. Legal permission for doctors to directly kill patients with their permission has led to an extension of the concept of voluntariness. It is too readily argued that, if the competent are to exercise choice to relieve their distress, then why should the same freedom be denied to the incompetent? If distress or loss of will to live is appropriate for those who are elderly or afflicted with a terminal illness, why should relief be denied to the young and those suffering the burden of mental illness?

In 2001 Dr Nitschke told US *National Review* that he chose to restrict himself to helping the group of "terminally ill adults who are articulate, lucid and not suffering from clinically treatable depression". However he signalled a shift of intention in the course of the same interview:

> Someone needs to provide this knowledge [of suicide methods], training or recourse necessary to anyone who wants (death), including the depressed, the elderly bereaved, [and] the troubled teen.[12]

In his letter to the *Canberra Times* Nitschke asserted that he had "never supported euthanasia – voluntary or involuntary – for 'troubled teens' (CT 4 February 2011, page 10). This progression in the potential reach of euthanasia revealed in the thinking of a prominent advocate of assisted suicide is significant. Attempts by me to correct the record on the latter point have been denied publication twice by the *Canberra Times*; I

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11 *The Guardian* 9 May 2006.

12 Lopez, K J (2001), Euthanasia sets sail. *National Review Online*, 5 June. http://www.nationalreview.com/interrogatory/interrogatoryprint060501.html

have complained to the Australian Press Council about the overall bias of that Press and await a reply.

During the period of operation of the NT *ROTI Act* Dr Nitschke was involved with highly publicised cases of people who were not terminally ill. It began with Nancy Crick. After her suicide it emerged that Crick was not terminally ill - a fact Nitschke had not publicly revealed. Crick was what the international euthanasia movement calls "hopelessly ill", a new catch-all category to include those who don't fit the definition of terminal illness.

This was a significant and frightening new step in the Australian euthanasia debate. Later the NT suicides of Lisette Nigot, a woman called Ruth, and Syd and Marjorie Croft, all in relatively good health, helped the euthanasia lobby take things even further. Terminal, even "hopeless" illnesses were no longer needed as justification for suicide or euthanasia. These actions were portrayed as rational suicides.

The concept of rational suicide greatly expands the range of people at risk from euthanasia activists. It could include those living in social isolation, those with physical disabilities or even business people who go bankrupt. One person's sad and desperate cry for help is another person's rational suicide. Death is all such groups have to offer. The cause of physical, mental or spiritual hurting will not be addressed. The difficult question of how to help suicidal people avoid a self-destructive course will be left unanswered.

Experience in countries where euthanasia is legal

Experience with legalised euthanasia in Holland shows that significant numbers of persons are killed without their consent. While euthanasia had been openly practiced for two decades in Holland, it was only formalized in statute law in 2002. This law allows the killing of patients down to the age of 16; it has been proposed by a collection of 35 bioethics centres and institutions that that age be lowered to 12 years. One in every 32 deaths in Holland is the result of legal or illegal euthanasia. As well, Dutch pro-euthanasia groups have campaigned to extend grounds for assisted suicide, for example, to people with dementia.

Three official Reports since 1990 (Remmelink, Van der Maas and Onwuteaka-Philipsen Reports) provide detailed data about the practice of euthanasia in Holland. The overall finding is that physicians kill approximately 1000 patients each year without their request or consent, representing between 0.7-0.8 percent of all deaths in Holland. In almost half of these cases, the patient had not discussed euthanasia with the physician nor expressed a wish to be relieved of suffering. Significantly, in 79 percent of these cases the patient was mentally incompetent. A further 5000 patients annually were administered terminal sedation without explicit request.

Legislative attempts to ensure that patients freely consent to be killed have had little effect on these statistics. Academic and medical analysts are concerned that no distinction is made between mental and physical pain. The current legislation governing access to euthanasia includes no requirement that the patient's condition be diagnosed nor that information be provided about available treatments which might bring relief.

In December 2004 a Dutch hospital adopted a policy allowing the killing of severely handicapped newborn infants. In 2005 the Royal Dutch Medical Association asked the

government to propose new rules to facilitate the killing of disabled children, the severely mentally retarded, and patients in irreversible comas.

Data from the more recent practice of euthanasia in Belgium reveals disturbing parallels with the Dutch experience including consideration of euthanising children without parental consent. Appeals have been made to the European Union to protect the basic human rights of children and newborns, where consent is not possible. [13]

The estimate of euthanasia deaths with or without patient consent is considered to be very conservative, as under-reporting of euthanasia by participating doctors is considered by experts to be around one-half of all such deaths in both countries.[14]

Lausanne University has announced that it will allow doctors and nurses, in that hospital, to kill patients. The hospital's legal director, Elberto Cresbo, stated "We are not trying to encourage suicide but, at the same time as a hospital, we have to respect the wishes of someone who wants to die (*The Guardian* 19 December 2006). The erosion of medical ethics seems to follow swiftly the legalisation of killing by doctors. The practice too easily spreads from requiring a person's permission to be killed to that 'choice' being assumed in the case of those unable to make it for themselves.

Rejection of euthanasia by major countries

The overwhelming evidence accepted by parliamentary inquiries into euthanasia conducted in countries across the world is that it is dangerous to give someone the power to kill another person.

In May 2006 moves to approve an assisted suicide proposal in Britain were strenuously opposed by the *Care Not Killing Alliance* which was formed by medical groups, organizations representing disabled people, and churches. Leaders of various faith groups wrote an open letter to all members of Parliament and the House of Lords. The groups, which included Buddhists, Christians, Hindus, Jews, Muslims and Sikhs, expressed their concern at the attempt to change the law, adding that they held all human life to be sacred and worthy of the utmost respect.

Just prior to the parliamentary debate Catholic, Anglican and Jewish national leaders wrote to MPs urging them to take steps to ensure adequate training be given to doctors and nurses to enable them to provide proper treatment to such patients. They also requested that more centres of specialist palliative care be established. They noted that in countries

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[13] LifeIssues Newsletter 2 221 April 2006. www.lifeisues.net

[14] Detailed studies can be found at: Allen, Mason L, "Crossing The Rubicon: The Netherlands' Steady March Towards Involuntary Euthanasia", *Brook Journal of International Law*, 2006, 31:2, pp 535-575; www.brooklaw.edu/students/journals/bjil/bjil31ii_allen.pdf ; and van der Heide, A *et al.* "End-of-Life Practices in the Netherlands under the Euthanasia Act"**,** *New England Journal of Medicine*, Vol 356:1957-1965, 10 May 2007; http://content.nejm.org/cgi/content/full/356/19/1957

"Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey" by a study by Chambaere et al. in the *Canadian Medical Association Journal*, May 17, 2010 reveals disturbing parallels in the more recent practice of euthanasia in Belgium (*see* http://www.cmaj.ca/cgi/reprint/182/9/895)

where assisted suicide or euthanasia is legalized there are serious concerns over how it is applied.[15]

The Lords voted 148-100 to postpone the debate and the measure has since been defeated. The British Medical Association continues to oppose assisted suicide or voluntary euthanasia. Canadian Bill C-384, the private members bill that would have legalized euthanasia and assisted suicide was strongly defeated by a vote of 228 to 59 in April 2010. In the last two years legalised euthanasia has been rejected also in Scotland and France

Suicide and the law

Legislators have a responsibility to protect the community, for the common good of all, even if this involves some interference in the interests of some members of the public. It is important to ensure that those who are vulnerable to influence do not have unrestricted access to advice or materials that would encourage or assist them to end their life rather than seeking help. The community has a responsibility to protect vulnerable people and to provide the best medical and social care.

A number of organisations and individuals argue that, given suicide is no longer a crime, providing information to assist suicide and actively assisting persons to commit suicide should be lawful. But just because suicide is not a crime does not mean it is a public good that should be promoted or facilitated. Suicide was decriminalised because there was little value in prosecuting someone who was dead or who had attempted suicide. Suicidal people need help, not prosecution. But there is great value in protecting the general public from people who assist suicide.

The law also has an educative dimension. It is for this reason that aiding or abetting a suicide is illegal in every State and Territory in Australia. If the principle that every human life is valuable is abandoned then society may be less willing to provide special care to those who are vulnerable.

Euthanasia and public health policy

In considering the provisions of the *Criminal Code Amendment (Suicide Related Material Offences) Act* 2005 the Senate Legal and Constitutional Affairs Committee called for the implementation of additional broader research, strategies, resourcing and policy initiatives by the Federal Government and State/Territory governments in order to address jointly and consistently issues relating to suicide in Australia (Recommendation 4). With access to the promotion of suicide through the internet now restricted by the provisions of that legislation, it would be contradictory for the Federal Parliament to assist facilitation of assisted suicide as promoted by this Bill. To do so would be poor public policy and undermine the ethical foundations of Australia's health services.

Pro-euthanasia groups cannot dissociate themselves from the activities of Dr Nitschke's high-profile advocacy of euthanasia and suicide of Philip Nitschke, the chief architect of, and practitioner approving deaths under the repealed ROTI Act (NT). His 2005 book *Killing Me Softly: Voluntary Euthanasia and the Road to the Peaceful Pill* (Penguin, 2005) is an activist's manifesto, not averse to dealing with the economics of euthanasia. Noting that end-of-life care is expensive, Nitschke observed that if voluntary euthanasia

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15 *The Times* 12 May 12 2006.

lopped a mere six months off the lives of ailing elderly, immense savings would result. Therefore he concluded euthanasia would be a good way to trim fat from government budgets:

> One can but wonder when a government will have the guts to stop digging the fiscal black hole that is their ever-deepening legacy for future generations. While the enabling of end-of-life choices will not fix the economic woes of the next 40 years, it would not hurt, given half a chance. So the next time you hear a government minister trying to argue why this or that payment or welfare program for single mothers or war veterans must be cut, counter their argument with their fiscal irresponsibility on end-of-life choices.

Nitschke also included prisoners among the potential beneficiaries, mooting voluntary euthanasia as "the last frontier in prison reform".

Nitschke's activities stand in contrast to our national strategy to reduce the suicide rate. Preventing suicide is a very complex issue which requires further significant study and long term investment. The Australian Government provides more than $10 million per year for the National Suicide Prevention Strategy.[16]

Nitschke's appearance this year in the *Letters* pages of the *Canberra Times* together with the many articles supporting euthanasia and editorial support of 'territorial rights' should persuade the Federal Parliament to reject the two Brown Bills here discussed.

Euthanasia in Australia

If both Brown's amended *Australian Capital Territory (Self-Government) Amendment (Disallowance and Amendment Power of the Commonwealth) Bill 2010* together with his *Restoring Territory Rights (Voluntary Euthanasia) Bill 2010* were both to succeed, the outcome would not be in the best interests of the Australian community as a whole. The populations of the Territories are small and their local governing bodies are correspondingly constituted by small numbers of parliamentary representatives. Settlement of such a vital issue as euthanasia, that is medically assisted suicide, is likely to be decided by one or two votes within their respective legislatures. Passage of the Bill would fuel demands by euthanasia advocates/publicists that the rest of Australia follow with matching legislation. This would be an example of the tail wagging the dog.

Governance in the Australian Capital Territory

The ACT Legislative Assembly has seventeen Members, Ministers typically hold multiple portfolios, and the capacity of the ACT Government to hold a wide-ranging, expert Inquiry, such as the legalisation of assisted suicide, is limited.

Prior to 1988 ACT possessed fully elected bodies which advised the federal Department of the Capital Territory on government of the Territory. In 1978 a referendum on self-government had been defeated, with 68 per cent of voters recording a 'No' vote. What was preferred was a municipal form of government without power to make laws in respect of all criminal and civil matters.

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[16] New National Advisory Council on Suicide Prevention. Media Release from the Hon Trish Worth MP, Parliamentary Secretary for Health, 29 March 2004.

Nevertheless, despite the result of the referendum, the Hawke Labor government set up a Self-Government Task Force in 1986 to report on the government of the ACT. The *Australian Capital Territory (Self-government) Act 1988* provided for a fully elected legislature to make statutory law for the ACT, for an executive, and for the independent court system subsequently created under the *ACT Supreme Court Transfer Act 1992*.

The experience of self-government in the ACT has overall been disappointing. Access to and from the new northern suburbs of Gungahlin is still difficult; the fiasco of long delays in building the Gungahlin Drive Extension was due to numerous court-issued injunctions sought by Greens activists (including Senator Brown); when finally built it boasted a single lane each way for large stretches and on bridges, an expensive, foreseeable error which is now being corrected at great cost and continued inconvenience to residents of those expanding northern suburbs.

The highly destructive outcome of the bush fires in 2002, which destroyed 550 houses and large tracts of forest area, was exacerbated by failure to undertake adequate clearing of bush fuel and keep clear fire-fighting trails. The ACT has the longest waiting lists in Australia for surgery in the public hospitals. Extravagant expenditure on public art and a $45m arboretum by the Stanhope Government is indefensible when major street trees, a prime element in Canberra's attractive appearance, were left to die through lack of watering during a prolonged drought. It could be fairly said that the ACT Assembly fails as an efficient 'Town Council', while at the same time striving for plenary powers of a State, the better to fulfil its hubristic aspirations to be first to effect major social change

Conclusion

Brown's *Australian Capital Territory (Self-Government) Amendment (Disallowance and Amendment Power of the Commonwealth) Bill 2010* in respect of territory rights would mean that the Territories would have virtually plenary powers such as are proper to States. If this Bill were to be successful, a Territory might hold the Federal Constitution in contempt: raise a militia (contra the defence power s.51(vi)); conduct its own postal service (contra postal services power s.51(v)), put up customs barriers (contra free trade between States s 92) etc - and the options open to the Commonwealth, having lost the executive power to curb such action, would be solely to quash such encroachments by an Act of Parliament.

This option is time-consuming, distracting from the business of the Federal Parliament and, most importantly, likely to be blocked by Greens numbers in the Senate. Of course, given the inconsistency, not to say hypocrisy, of Senator Brown's stance over the years, only those Territory laws which pleased the 'progressive' agenda of the Greens would be spared quashing. The Greens did not oppose intervention by the Commonwealth in the Tasmanian Dams case nor the removal of Tasmanian sodomy laws on the grounds of their incompatibility with international convention in the one case, and with alleged breach sexual equality principles in the other.

As a last resort the Commonwealth might attempt to challenge a Territory's usurpation of its exclusive powers in the High Court. It is, however, problematic whether the Court would take such a case in a situation where the Commonwealth had moved to exercise its powers under section 122 of the Constitution but had failed to secure its Bill through both

Houses of Parliament. The Court would be reluctant to enter into a political joust. Consequently a Territory could occupy a more favourable position than a State in respect of the Commonwealth's ability to challenge an encroachment on its powers, given that the Court would always accept a challenge from the Commonwealth to a State law which it judged encroached on Commonwealth exclusive powers and conflicted with exercise of that power. A citizens' challenge would be hampered by difficulty in obtaining standing for such a challenge and deterred by the substantial cost of such an action.

Senator Brown's *Australian Capital Territory (Self-Government) Amendment (Disallowance and Amendment Power of the Commonwealth) Bill 2010* is fraught with legal and constitutional difficulties, and should not be approved by the Committee. In combination with his *Restoring Territory Rights (Voluntary Euthanasia) Bill 2010* it attempts to advance a particular social agenda at the cost of upsetting the balance in the Federal system.

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I am president of the ACT Right to Life Association Inc. However this submission is made by me as an individual, containing as it does argument in addition to the matter of euthanasia which clearly is disapproved by the Constitution of the Association.