Submission

Senate Legal & Constitutional Affairs Committee

Medical Services (Dying with Dignity) Bill 2014

Dr David van Gend, MBBS (Qld), FRACGP, DipPallMed (Melb)

Senior Lecturer in Palliative Medicine, University of Queensland
Member, Queensland Health working group on paediatric palliative care
Medical Advisory Committee, Toowoomba Regional Hospice

(Views are my own and do not purport to speak for the above organisations)

20th August 2014

Outline of Submission

1. General faults in the present Bill

The doctor as healer, not killer

This Bill contrives to portray euthanasia as a 'medical service' under s.51 of the Constitution. The medical profession disagrees: the intentional taking of a patient's life is not a medical service.

Euthanasia and the 'duty to die'

This Bill fosters injustice: it asserts the rights of only certain individuals and fails to consider the 'big-picture' consequences of euthanasia for the most vulnerable members of society.

2. Correct understanding of 'euthanasia' and 'assisted suicide'

What euthanasia is and is not

What physician-assisted suicide is and is not

3. Specific faults in the present Bill

1. **The crucial contradiction at the heart of this Bill.**
2. **This Bill is radically subjective in its medical justifications.**
3. **This Bill offends against standards of legislative clarity.**
4. **A new offence of attempting to prevent homicide?**
5. **And one more curiosity…**

4. Conclusion

Euthanasia brings increased 'rights' to some, but predictable oppression to others. This Bill would corrupt the relationship between the state and its most vulnerable citizens and between doctors and their most vulnerable patients. Any law which fails to protect the most vulnerable is bad law. Any law which attempts to equate medical killing with a 'medical service' is misguided law.

The Bill before the Committee should be rejected.

1. General faults in the present Bill

The doctor as healer, not killer

This Bill attempts to bypass the authority of the States concerning euthanasia and other forms of intentional killing and put it under the Federal Government via a contrived reading of s.51 (xxiiiA) of the Constitution. The validity of such an attempt depends on euthanasia being considered a valid 'medical service'. It is not. The providers of medical services – doctors – through their peak associations will not have a bar of such an abuse of terminology.

Euthanasia / assisted suicide is not a 'medical service'.

At the time of the Northern Territory euthanasia debate the Australian Medical Association (AMA) voted 88 to 1 to uphold the World Medical Association statement against euthanasia (defined as "the act of deliberately ending the life of a patient").[i] And in its submission to the most recent Senate Inquiry into euthanasia (the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*) the AMA wrote:

> The AMA strongly reiterates that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life. We cannot confuse the role of the medical practitioner as someone who supports life with someone who takes life.[ii]

Doctors know the difference between caring for a patient and making a patient die. Further, as a palliative care practitioner I provide the 'medical service' of giving 'dignity in dying', but that is through my care, not by giving my patient a lethal drug. The twisting of the honourable terms 'medical service' and 'dignity in dying' by Senator Di Natale into the antithesis of good medical practie is truly offensive.

Power corrupts, and the profound power of taking another human life is going to corrupt profoundly. Doctors have no illusions about the capacity for corrupt behaviour amongst their members if they are given the power to take life.

Official evidence from the Dutch Government's own confidential surveys show that, year after year, doctors euthanase around a thousand patients without any valid consent – even where, on the doctors' own admission, many of those patients were competent to give or withhold consent if asked.[iii]

Senator Bob Brown asked me at the Senate Committee hearing into his *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* whether there had been a reduction in what he called these "illegal killings" since the Dutch officially legalised euthanasia in 2002.[iv] Prior to 2002 euthanasia had been illegal but tolerated if certain guidelines were adhered to.

I assume Senator Brown thought that "bringing euthanasia out into the open" by legalising and regulating it would reduce these underground practices. Not at all. The 2007 official Dutch report on euthanasia shows no statistically significant reduction in cases of these "illegal killings" since legalisation.[v] And why would we expect a reduction in such unscrupulous behaviour? Doctors who were prepared to break the rules on mercy killing when it was strictly illegal would be even more complacent about breaking the rules on mercy killing once it is socially approved.

But even where they do not directly kill patients without consent, unscrupulous doctors can influence a patient's decision in a way that makes a mockery of the patient's "autonomy".

Brisbane professors of psychiatry, Frank Varghese and Brian Kelly, warn of the impossibility of protecting patients from such doctors once these authority figures are allowed to be involved in a patient's suicide: [vi]

> Much of the debate about euthanasia and physician-assisted suicide has as its underlying assumption that doctors will always act in the interests of their patients. This assumption fails to take into account the doctor's unconscious and indeed sometimes conscious wishes for the patient to die and thereby to relieve everyone, including the doctor, of distress.
>
> Legislation to enable assisted suicide has been designed to provide a safeguard, through psychiatric assessment, that protects patients from themselves. What these laws do not do and cannot do is protect the patient against unconscious factors in the doctor.

And it gets worse. Even the contention that euthanasia laws "provide a safeguard, through psychiatric assessment, that protects patients from themselves" – that is, by detecting and treating any depression that might be marring their judgement – is shown to be a false contention, on the available evidence from the US State of Oregon and the Northern Territory.

Of the 49 patients who died by physician-assisted suicide in Oregon in one year not a single patient was referred for psychiatric assessment prior to their lethal injection.[vii]

And why would we expect them to be? In Oregon most cases of assisted suicide are carried out by a handful of doctors overtly committed to the euthanasia cause. Their goal is to help their patients obtain assisted suicide and strike a blow for the 'right to die' – not, as with all other doctors, to identify depression and prevent suicide. Likewise, in the Northern Territory during the brief era of legalised euthanasia / assisted suicide, all the patients died under the one doctor, euthanasia activist Dr Philip Nitschke.

We have detailed knowledge of the clinical circumstances of Dr Nitschke's patients, as he co-authored an article in the *Lancet* journal entitled 'Seven Deaths in Darwin', along with psychiatrist and palliative care specialist Professor David Kissane.[viii]

Of the so-called "safeguard" of compulsory psychiatric assessment in the Northern Territory legislation, Kissane told the 2008 Senate Inquiry:

> This was the part of the certification schedule most feared by patients and Nitschke reported that all seven described patients saw this step as a hurdle to be overcome… Indeed, four of the 'Seven deaths in Darwin' revealed prominent features of depression, highlighting its strong role in decision-making by those seeking euthanasia. Alarmingly, these patients went untreated by a system preoccupied with meeting the requirements of the Act's schedules rather than delivering competent medical care to depressed patients.[ix]

Of the cases described, the most pitiful was an isolated English migrant with cancer who appeared very ambivalent about suicide. The required psychiatry assessment was not carried out until the very day the patient had selected to be put to death. And the specialist assessment was done in under twenty minutes, according to Dr Nitschke's testimony to the 2008 Senate Committee hearing in Darwin.[x] That, in my view, is a mockery of psychological assessment of a suicidal and socially isolated man who was suffering, in Dr Kissane's estimation, "a demoralised mental state". One Senator asked Dr Nitschke if he believed such a brief assessment was "adequate and proper". Dr

Nitschke replied. “I do… I had no concerns about it. In a sense we were going through the requirements of the legislation”.

There is a troubling passage from Professor Kissane’s submission, describing Dr Nitschke taking this lonely man home after the psychiatry assessment:

> From the psychiatrist’s office, he was taken home to a musty house that had been shut up for several weeks. Nitschke had to hunt for sheets to cover the bare mattress. It rained heavily in Darwin that summer afternoon, and in administering euthanasia Nitschke felt sadness over the man’s loneliness and isolation.[xi]

As I told the Senate Committee hearing in Darwin:

> Does that not cry out to all of us that this man needed company? He needed social work intervention. He needed church groups to go and involve him in this society where he was so isolated. He needed anything else but a lethal injection.[xii]

*

Doctors must not be asked to be our patients’ killers as well as healers. We cannot stay uncorrupted by that sort of power, and patients cannot be protected from our abuse of that power.

How then can doctors best respond to the sort of patients who presented to Dr Nitschke asking for a lethal injection?

When we look after such patients well, thoughts of euthanasia often fade. Then, as with one woman who had asked me for euthanasia only the day before, but was now pain-free, “It’s a different world”.

But I would not use the argument against euthanasia that “palliative care can ease all suffering”. As someone who works and teaches in this field, I know that we cannot ease all suffering in dying any more than we can ease all suffering in childbirth. But I do know that ours is the first generation in history which can reasonably expect a tolerable dying, unlike the raw pain and wretchedness of all past generations. As the National Hospice and Palliative Care Organization in the US stated in 2007:

> When symptoms or circumstances become intolerable to a patient, effective therapies are now available to assure relief from almost all forms of distress during the terminal phase of an illness without purposefully hastening death as a means to that end.[xiii]

For those distressed people who ask us for euthanasia, we must explain that we cannot “make them die”; we can only accompany them in their dying and ease it in every way possible.

Palliative care is a community movement that starts with the political will to fund the best possible facilities and training; it involves ongoing medical education and research to perfect the relief of distressing symptoms, and a huge grassroots contribution from volunteers. It is a remarkable movement blending powerful science, wise counselling, and rich community connectedness.

But rejection of euthanasia is not dependent on perfecting palliative care for all patients. Its rejection stands on the rock-solid ground of justice, on the “one unifying principle” referred to by the Hon Kevin Andrews on presenting his *Euthanasia Laws Bill 1996*: “The people who are most at risk are the most vulnerable, and a law which fails to protect vulnerable people will always be a bad law”.[xiv]

Euthanasia and the 'duty to die'

This Bill fosters injustice: it only asserts the rights of the individual and fails to consider the 'big-picture' consequences of euthanasia on the most vulnerable members of society.

By contrast, the Federal Parliament's broad focus in 1997 was on the big-picture issue of justice - whether laws permitting euthanasia (i.e. intentional killing of patients by doctors) are intrinsically unjust and corrupting of social relationships.

The shallow thinking of this Greens' Bill is evident when we look to the central conclusions on euthanasia by the Australian Parliament in 1997, as well as other major world enquiries into euthanasia. Always these reports *balance* the deeply felt concern for the terminal suffering of our loved ones, with the serious issues of corruption of law and social relationships that would result from legislators setting up the social machinery of mercy killing.

May I illustrate this with reference to two comments of the majority report of the *Legal and Constitutional Affairs Committee* in its enquiry into the *Euthanasia Laws Bill 1996*.[xv]

(i) LegCon Committee 1996: "The choice may well become a perceived duty"

The moment that, for many of us, crystallised this corruption in social relationships, this sense that laws purporting to support the "right to die" were really going to bring about an oppressive "duty to die", was referred to by the majority of Senators in your Committee's 1996 Report:

> **The potential for 'guilt feelings' for being a burden… may become such that they perceive a subtle duty on them to exercise the euthanasia option. The choice may well become a perceived duty. This is so especially when considered in the context of comments by those such as former Governor General, Hon Bill Hayden, that "There is a point when succeeding generations deserve to be disencumbered - to coin a clumsy word - of some unproductive burdens".**

As Governor General, Mr Hayden was speaking to the Royal Australian College of Physicians about his views on death and dying.[xvi] He identified himself as one of those "who, denied the choice of medically administered, painless, voluntary euthanasia, would wish to exercise the death option themselves."

But the main significance of this address by our Head of State was his suggestion that voluntary euthanasia is not merely a matter of choice but, more nobly, a positive obligation to society.

Mr Hayden reminded us of past cultures where the elderly would take poison or wander off into the forests when their usefulness to society was done. In the absence of forests, "the Inuits left their aged to float away on the ice". Elderly ancient Japanese "retreated to a mountaintop"; in fact the practice was for the elderly (defined as such by the loss of all teeth) to jump from the rim of a volcano for the greater good.

The question for Mr Hayden and other admirers of these practices is this: did the elderly Japanese jump or were they pushed? More subtly, did they indeed "choose" to jump but only because of an irresistible cultural push? How much autonomy were the abandoned Inuit's exercising? And is such a state of human relations admirable or degenerate?

Returning to the present, the Governor-General made the connection to our own elderly who, after "a full and satisfying lifetime" can become "unproductive burdens". He declared, as quoted by the Senators: "there is a point when the succeeding generations deserve to be disencumbered - to coin a clumsy word - of some unproductive burdens".

Within a day this newly articulated duty of the burdensome to do the right thing by society was given extra gravitas by another ex-Governor, the late Sir Mark Oliphant. Speaking on ABC Radio he praised Mr Hayden's views, and referred to an aged colleague in Canberra who "should be dead", who is a burden to his family but "likes being looked after". When the interviewer laughed and said "that's his right too", the blank response was that it was not, and that he was cluttering up the world when he shouldn't be.[xvii]

These are the sentiments, not of neo-Nazis snarling about "useless eaters", but of thoughtful citizens, respected Governors, shapers of social attitudes. They seriously propose that we develop a culture, like those described by Mr Hayden, where "unproductive burdens" will act for the greater good of society. These lonely and sick old people, already suffering low self-esteem and the sense of being a burden, would know when they had outstayed their welcome, and when to accept society's offer of assistance to die.

This is not an enlargement of “rights” and “choice” for these people. Given the psychological vulnerability of the average sick old person, the sense they already have of being "unproductive burdens", and the power of insensitive family or medical staff to reinforce this sense, such a decision will be made from a position of humiliation and weakness.

Professor Robert Manne of Monash University gave a clear exposition of this central concern:[xviii]

> Even the most elementary knowledge of human nature will tell us that while some families will treat older parents afflicted by terrible illness with love and respect, others will find the pain of their elderly parents merely ugly and their obligation of endless hospital visits over weeks or months distinctly tiresome. In such circumstances is it not at least possible that in the family discussions concerning the future, pressure will be applied which will suggest to someone who is terminally ill that no good can come from their purposeless clinging to life, that they have become a mere burden, and that they owe it to their suffering family to request an officially sanctioned death?
>
> Will it not be the case even among those of the afflicted who are genuinely loved that some, in the depths of depression and fear, will imagine falsely that it is their death that their families most desire? And is it not precisely because of the recognition that, in a situation of legalised euthanasia, we cannot protect all of the terminally ill from insidious pressure of this kind that thus far no legislature in the world - other than that of the Northern Territory - has passed such a law?

Because the influx of this new coercive culture would be subtle and insidious, the prospect has less emotive impact on legislators than the vivid scene of terminal suffering. The urgent claims of mercy for the dying hold the attention better than the long-term concern of protecting the weak, the unwanted and the vulnerable from forms of oppression. But the gradual demoralisation of old people is a form of suffering. The social-suggesting of an "unproductive burden" towards suicide, when that person would never otherwise have chosen suicide, is a form of oppression, however indirect.

At present the frail old "unproductive burdens" in our hospitals or nursing homes are not troubled by such demoralising messages from the State. They accept our care as unquestioningly as we give it. But anyone who knows the psychological vulnerability of sick old people, their low self-esteem and loneliness, knows how readily they would internalise this sort of message within a culture of euthanasia.

That is an oppression of the frail, and a profound corruption of the doctor-patient relationship, that we must not allow. We can only redouble our efforts to care, without killing.

(ii) LegCon Committee 1996: "The cornerstone of law and of social relationships"

The majority of Senators reviewing the *Euthanasia Laws Bill 1996* affirmed the central concerns of other international enquiries:

> **We share the views expressed by members of the House of Lords Select Committee, the Canadian Special Select Committee and the New York State Task Force that laws relating to euthanasia are unwise and dangerous public policy. Such laws pose profound risks to many individuals who are ill and vulnerable. In particular we share the view of the House of Lords Select Committee on Medical Ethics which held that: 'The prohibition of intentional killing is the cornerstone of law and of social relationships. It protects each one of us impartially… We do not wish that protection to be diminished.'**

Of these reports, the most illuminating remains the United Kingdom House of Lords enquiry in 1993 (and notably, the more recent vote in the House of Lords against euthanasia supports the earlier 1993 enquiry).[xix]

It is highly significant that the majority of the House of Lords Select Committee's members were previously on the record as favouring legalised euthanasia, including the Chairman, Lord Walton of Detchant, a neurologist who had been Medical Consultant to the Voluntary Euthanasia Society. The Committee's reflections on this question of the dying or debilitated patient showed their personal sympathy for the plight of such people:

> Many of us have had experience of relatives or friends whose dying days or weeks were less than peaceful or uplifting. Or whose final states of life were so disfigured that the loved one seemed already lost to us. Our thinking must inevitably be coloured by such experience. The accounts we received from individual members of the public about such experiences were particularly moving, as were the letters from those themselves who longed for the release of an early death. Our thinking must also be coloured by the wish of every individual for a peaceful and easy death, without prolonged suffering, and by a reluctance to contemplate the possibility of severe dementia or dependence.

It is remarkable that a Committee which was predisposed to support mercy killing, concluded, after extensive research and public discussion, and a visit to Holland, by strongly opposing any such move. Dr Luke Gormally Director of the Linacre Centre for Health Care Ethics in London saw in this transformation evidence of the Committee's impartiality:

> This seems to me to mark a difference between true statesmen and short-sighted politicians, that the Committee was unwilling to allow such personal and emotive experiences to control public policy. It is not that they were without compassion, but they were convinced that we need to look for creative responses to illness, suffering and dying and be loathe to embrace destructive ones.[xx]

The UK Committee stressed the prime importance of creative responses to illness:

> There is good evidence that, through the outstanding achievements of those who work in the field of palliative care, the pain and distress of terminal illness can be adequately relieved in the vast majority of cases. With the necessary political will, such care could be made available to all who could benefit from it.

We can note from the House of Lords conclusions that even people with a predisposition to support euthanasia can come to accept that the wiser and more humanly creative path to take is to strive for more effective and more holistic palliative care.

But what were the "big-picture" considerations which brought about such a significant change of heart and mind? The Select Committee's central concern was about an injustice inherent in the social establishment of euthanasia. In short, they perceived a new and subtle form of oppression:

> **It would be next to impossible to ensure that all acts of euthanasia were truly voluntary. We are concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death. We believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.**

That is the heart of the matter - this insidious pressure on the vulnerable to comply with social expectations of euthanasia. This subtle and unavoidable oppression of the elderly, lonely, sick or distressed is the corruption we did not need to have.

The UK Committee was able (unlike the present Bill) to weigh the claims of individual claims against the bigger picture of the corruption of basic law and our relationships with the ‘unbeautiful’ people amongst us:

> Ultimately we concluded that none of the arguments we heard were sufficient to weaken society’s prohibition of intentional killing, which is the cornerstone of law and social relationships. Individual cases cannot establish the foundation of a policy which would have such serious and widespread repercussions.

Other enquiries mentioned in your Committee’s 1996 Report came to the same judgment. The New York State Task Force 1993:

> No matter how carefully any guidelines are framed, assisted suicide will be practised through the prism of social inequality. The practices will pose the greatest risks to those who are poor, elderly, members of minority groups, or without access to good medical care.

Subsequent to the Federal debate of 1997, the Parliament of Tasmania held its own enquiry and its Committee came to the same conclusion:

> The Committee 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.

That was a compelling argument in 1993, 1997, and 1998, and it has not changed. The Bill before your Committee would bring in an unnecessary injustice and subtle corruption of our relationships with the elderly and frail.

2. Correct understanding of 'euthanasia' and 'assisted suicide'

Before Senators can consider the consequences of any Bill permitting euthanasia, it is important to achieve clarity on what 'euthanasia' and 'assisted suicide' mean.

What euthanasia is and is not:

Many people still think that turning off futile life support in a dying patient, or giving adequate doses of morphine to relieve pain in terminal cancer amounts to 'bumping off Granny'. It does not. If such an action did amount to euthanasia, then we should all support euthanasia. But it does not.

Euthanasia is best understood by the image of a lethal injection. Euthanasia is where a doctor makes a patient die, in order to end their suffering. If there is an intention to 'mercy-kill', that is euthanasia. If there is no intention to kill, that is not euthanasia.

Now there is *no intention to kill* when a doctor gives adequate morphine to relieve pain, and therefore that is not euthanasia. Sometimes morphine appears to hasten death; sometimes morphine appears to postpone death by relieving the patient's physical stress. As doctors we can not know and frankly we do not care: we have no interest in either hastening death or postponing death. We intend only to ease a dying patient's suffering, whatever that takes.

There is *no intention to kill* in those extreme cases when a doctor can only relieve suffering by inducing a form of deep anaesthesia called 'terminal sedation' – a necessary but very rare intervention that ignorant people slur as 'slow euthanasia'. The intention is only to relieve suffering "whatever it takes", not to make the patient die.

There is *no intention to kill* when a dying person is taken off life support; there is merely an acceptance of inevitable dying, and the provision of all supportive care while the person dies.

The essential test for whether this is an act of euthanasia is to ask: *what would you do if the person keeps living after this action?*

- If the person lives on after life-support is ceased, then you would sit with the person and give all care, for however long she has yet to live. You are not trying to make her die, so that is not euthanasia.
- If a person rouses from 'terminal sedation' with reduced distress, as one of my patients did, you would let her remain awake unless she feels her symptoms are unbearable again. You are not trying to 'slowly' kill her.
- Likewise, if after an adequate dose of morphine the person – as expected - lives on, free from pain, then you would continue caring for the person until pain returns and a further dose is needed. There is never an intention to kill, only to relieve pain.

With euthanasia, by contrast, if you give a lethal injection to a patient and she keeps living, you give another and another until she is dead. Euthanasia is intentional killing.

What physician-assisted suicide is and is not:

This differs from euthanasia in that the doctor does not kill the patient, but helps the patient kill herself. It has nothing to do with the patient refusing medical treatment: if a patient refuses any medical assistance for any reason, even knowing they will die as a result, that is entirely within their rights. Consider the following World Medical Association declaration, which has been confirmed by the Australian Medical Association:

World Medical Association Statement on Physician-Assisted Suicide:

> 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.

3. Specific faults in the present Bill

This Bill, as with all euthanasia Bills, should be rejected on the broad principles of justice outlined above, of the corruption of the relationship between the state and its most vulnerable citizens and between doctors and their most vulnerable patients. So it is almost redundant to point to the muddy drafting and conceptual curiosities in the present Bill. I willl make only brief notes on a selected few, in order not to distract attention from the ‘big-picture’ issues by which any euthanasia / assisted suicide Bill should be rejected.

1. There is a crucial contradiction at the heart of this Bill.

The Objects state at the outset that the Bill only applies to those who are “suffering intolerably”. However, that emotive gesture is set aside at s.13 (4), where the patient can obtain euthanasia *even when her suffering has been relieved*. That section envisages a patient’s suffering being fully addressed by palliative care – i.e. she is no longer “suffering intolerably” - but still provides for the patient to direct the doctor to end her life! This incoherence is highlighted below in bold italics:

s.3 (a)

> The objects of this Act are:
>
> to recognise the right of a mentally competent adult ***who is suffering intolerably from a terminal illness*** to request a medical practitioner to provide medical services that allows the person to end his or her life peacefully, humanely and with dignity; and

s.13 (4)

> If a person:

> (a) requests a medical practitioner to provide dying with dignity medical services to the person; and
>
> (b) ***subsequently receives palliative care that brings about the remission of the person's pain or suffering;***
>
> the medical practitioner must not provide dying with dignity medical services to the person ***unless the person indicates to the medical practitioner the person's wish to proceed with the request.***

2. This Bill is radically subjective in its medical justification for euthanasia / assisted suicide.

The Schedule 1 'Request for dying with dignity medical services' specifies that a patient can direct a doctor to take her life wherever "there is no medical treatment that is acceptable to me in the circumstances". There might be excellent palliative treatment that (as per s.13 (4) above) "brings about the remission of the person's pain or suffering" and which one would expect to nullify the request for euthanasia. But not under this Bill: the patient need only say that they don't want the palliative team's help. There might be proven psychological therapies which have satisfied other people in a similar clinical situation – but no, the discretion is entirely with the patient finding such options "acceptable". That makes a mockery of the objective 'intolerable suffering' in the Objects.

Further, the loose definition in the Schedule of "an illness that will ultimately result in my death" is hopelessly broad. It would include many common conditions – for example diabetes, which can cause people suffering (nerve pain, visual loss, 'hypos') and will (if untreated) ultimately result in a patient's death. Of course, diabetes can be treated – but this Bill allows for a patient to reject medical treatment as not being "acceptable to me in the circumstances" and request a lethal injection.

This aspect of the Bill reveals the unbalanced philosophical emphasis on the criterion of 'autonomy', without consideration for wider social justice implications, that underlies the death-on-demand movement and underlies this legislation.

3. This Bill offends against standards of legislative clarity.

Statutes should be precise instruments using precise language, not an exercise in euphemism and obfuscation. Language is mangled by the euphemism at the heart of this Bill ('dying with dignity medical services' instead of 'ending the patient's life'). As a palliative care practitioner, my services are always directed to helping a patient 'die with dignity', but that means attending to distressing symptoms to achieve a gentle death, not *making* the patient die.

Any proposal to legalise a previously criminal act should at least dare to speak its name clearly and unflinchingly, not commit the offense of 'euphemasia'…

4. A new offence of attempting to prevent a homicide?

Should a daughter plead with a doctor not to kill her mother, and exercise her free speech by saying "I think you are doing a terrible thing and I will tell all my friends not to go near you", will she have breached s.21 (ii) and risk a jail sentence?

> A person commits an offence if:

> (a) the person causes, or *threatens to cause, any disadvantage to a medical practitioner*; and
> (b) the person does so with the intention of influencing the medical practitioner to provide, *or not provide, a dying with dignity medical service.*
> Penalty: Imprisonment for 5 years.

It is also a strange law where the 5 year penalty for ‘threatening to cause disadvantage to a medical practitioner’ is greater than the mere 2 year penalty where a doctor puts a patient to death without having even met the requirements of the Act! In other words where it is homicide. Under s.23 the doctor can fail to fulfil the most vital requirements of this legislation required at s.19, including the record of the patient’s valid consent and the record of duly obtained second medical opinions – in other words the whole thing can be a sham – and he is up for a mere 2 years for unlawful killing.

5. And one more curiosity…

This Greens Bill is admirably ‘socialist’ in that killling a patient *must* be Bulk-Billed to the Government, without even the possibility of a private $7 co-payment!

> **18 Commonwealth payment is full payment**
>
> If a medical practitioner agrees to provide dying with dignity medical services to a person, the medical practitioner is taken to have agreed that the Commonwealth will pay for the services in accordance with this Part in full satisfaction of any amount that would otherwise be owed by the person to the medical practitioner.

4. Conclusion

These specific faults in this unsafe, medically ill-informed Bill are not the main game. The main game is always the big-picture issue of injustice outlined earlier: the new and inevitable demoralisation of the most vulnerable amongst us and the dangerous corruption of the doctor-patient relationship.

“A law which fails to protect vulnerable people will always be a bad law”. Therefore the Bill before the Committee should be rejected.

Thank you.

*

I am available to provide further clarification and information before the Committee, if there is to be a public hearing.

Dr David van Gend
Toowoomba

ENDNOTES

---

[i] World Medical Association Declaration on Euthanasia, Madrid, 1987.

[ii] AMA submission to Senate Legal and Constitutional Affairs Committee Inquiry, 2008 at: http://www.aph.gov.au/Senate/committee/legcon_ctte/terminally_ill/submisssions/sub375.pdf

[iii] Onwuteaka-Phillipson B, van der Heide A, et al, Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995 and 2001, *Lancet* 2003; 362: 395-99.

[iv] Senate Legal and Constitutional Committee, Darwin Hearing 14th April 2008, transcript: http://www.aph.gov.au/hansard/senate/commttee/S10740.pdf L&CA12.

[v] van der Heide A. et al, End-of-Life Practices in the Netherlands under the Euthanasia Act, NEJM Volume 356:1957-1965 May 10, 2007 No. 19 at http://content.nejm.org/cgi/content/full/356/19/1957

[vi] Varghese F, Kelly B, Physician-assisted suicide, Psychiatric Services, April 1999, Vol. 50 No.4

[vii] Oregon data on referrals to psychiatrist at http://www.oregon.gov/DHS/ph/pas/docs/yr10-tbl-1.pdf

[viii] Kissane DW, Street A, Nitschke P. Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. Lancet 1998; 352: 1097-1102.

[ix] Kissane DW submission to Senate Legal and Constitutional Affairs Committee Inquiry, 2008, p 16: http://www.aph.gov.au/Senate/committee/legcon_ctte/terminally_ill/submisssions/sub589.pdf

[x] Nitschke, Senate Legal and Constitutional Affairs Committee, Darwin Hearing 14th April 2008, transcript: http://www.aph.gov.au/hansard/senate/commttee/S10740.pdf L&CA29.

[xi] Kissane DW, submission op cit, p.12.

[xii] van Gend, Senate Legal and Constitutional Affairs Committee, Darwin Hearing 14th April 2008, transcript: http://www.aph.gov.au/hansard/senate/commttee/S10740.pdf L&CA15.

[xiii] US National Hospice and Palliative Care Organisation http://www.nhpco.org/templates/1/homepage.cfm

[xiv] Andrews K, second reading speech, Euthanasia Laws Bill 1996, House Hansard 28/10/06 p.5904: http://parlinfoweb.aph.gov.au/piweb//view_document.aspx?TABLE=HANSARDR&ID=59170

[xv] Senate Legal and Constitutional Affairs Committee, The Parliament of the Commonwealth of Australia. Consideration of the Legislation Referred to the Committee: Euthanasia Laws Bill 1996. Canberra: Government Printer, 1997.

[xvi] The Hon Bill Hayden, Governor General, Address to the Royal Australian College of Physicians, 21/6/95, reported Courier Mail 26 June 1995.

[xvii] Sir Mark Oliphant, ABC Radio A.M., 22/6/95.

[xviii] Robert Manne, Quadrant editorial July 1995

[xix] House of Lords, Report of the Select Committee on Medical Ethics, 1994 HMSO.

[xx] Mr Luke Gormally, "The British House of Lords - why it Rejected Euthanasia", address to the John Plunkett Centre, Sydney, November 10 1995