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9 April 2008

 **ILS**
INSTITUTE OF
LEGAL STUDIES 

Mr Peter Hallahan
Secretary
Standing Committee On Legal And Constitutional Affairs
Parliament House
Canberra

legcon.sen@aph.gov.au

Dear Mr Hallahan

Thank you for your letter of 17 March 2008 inviting me to make a submission to the Inquiry into the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*. Please consider this letter and the two attachments as such a submission.

I would like to draw to the attention of the Committee the observation I made when the original *Euthanasia Laws Bill* was being considered by the Commonwealth Parliament. In my submission of 10 December 1996 (Submission 7399, p. 11 (19664)) I said: "The Commonwealth Parliament may not have the power to overrule a State law legalising the administration of requested lethal injections. It does have the power to overrule a Territory law. Should it ever exercise that power? Only in very rare circumstances: where no State has similarly legislated; where the Territory law is a grave departure from the law in all equivalent countries; where the Territory law impacts on the national social fabric outside the Territory; and where the Territory law has been enacted without sufficient regard for the risks and added burdens to its own more vulnerable citizens, especially Aborigines. This is such a circumstance. National legislation for matters of national interest has often been considered by the Senate as in the cases of the Franklin Dam and the *Human Rights (Sexual Conduct) Act 1994*. National protection of Aboriginal interests in the Northern Territory is still maintained with the *Aboriginal Land Rights (Northern Territory) Act 1976* and national policy has often been imposed on the Northern Territory as with restrictions on uranium mining."

Nothing material has changed since then, except the composition of the Commonwealth Parliament. No State in Australia has legislated on euthanasia since 1997. There has been no further Supreme Court litigation on the matter in the US since that Court ruled that there was no due process or equal protection argument supportive of the right to physician assisted suicide. Oregon remains the only state in the US with a law permitting physician assisted suicide. There has been considerable agitation of the issue in the UK. Lord Joffe's *Assisted Dying for the Terminally Ill Bill* was defeated in the House of Lords. The British Medical Association poll on 29 June 2006 resulted in a reversal of its previously neutral stance on proposed euthanasia legislation. At its annual meeting, the members voted:

That this Meeting:

(i) believes that the ongoing improvement in palliative care allows patients to die with dignity;
84% for, 16% against

(ii) insists that physician-assisted suicide should not be made legal in the UK;
65% for, 35% against

(iii) insists that voluntary euthanasia should not be made legal in the UK;
65% for, 35% against

(vi) insists that non-voluntary euthanasia should not be made legal in the UK;
94% for, 6% against

(v) insists that if euthanasia were legalised there should be a clear demarcation between those doctors who would be involved in it and those who would not;
82% for, 18% against

(vi) requests that all members of the BMA be balloted on this issue. (Needed a two-thirds majority to be passed due to cost involved):
43% for, 57% against

In May 2007, members of the Royal College of General Practitioners voted against a change in the UK law to allow assisted dying, by 73%. Meanwhile here in Australia the AMA in response to this present inquiry has reaffirmed unequivocally its belief "that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life."

So there has been no change to the law and practice in equivalent jurisdictions since 1997 which would warrant a revisiting of the special case for the Commonwealth Parliament's overriding the Northern Territory *Rights of the Terminally Ill Act 1995*. Furthermore, I am not aware of any sustained clamour from the Parliament or citizens of the Northern Territory for the repeal of this Commonwealth measure. Perhaps this explains the use of the constitutionally suspect clause (Schedule 1, s.2) purporting to resurrect the operation of the *Rights of the Terminally Ill Act 1995* without the need for further legislative action by the Legislative Assembly of the Northern Territory. Members of the committee will recall that when the Northern Territory Legislature itself voted 14-11 on a conscience vote not to repeal the Territory law, it did so in circumstances where two of the majority (Messrs Palmer and Hatton) made clear their long held opposition to euthanasia. Once the issue of federal intervention is removed, there is no basis for believing that a fresh vote on the substantive issue in the NT Parliament would result in a re-enacted euthanasia law. The cause's chief protagonist has long departed the NT Legislature.

There are grounds for thinking the introduction of this bill without a formal request from the government or parliament of the Northern Territory, with the addition of a constitutionally suspect "legal resurrection clause", is simply a device

for pro-euthanasia advocates to re-agitate their case nationally, as is their prerogative. But they have not adduced any fresh grounds for reversing the Commonwealth Parliament's consideration of either the substance of the law on euthanasia and physician assisted suicide or the federal override of the Territory law. The introduction of physician assisted suicide in the Northern Territory would of course do nothing to assist in the national commitment "to close the appalling 17- year life gap between Indigenous and non- Indigenous in overall life expectancy". (K. Rudd, 2008 CPD (HofR) 171; 13 February 2008)

I will not repeat the detail of my original 1996 submission or the evidence I gave to the committee on 14 February 1997 (L&C 299-309). For ease of reference, I attach that original submission and my 1997 evidence as part of this submission. I would be happy to give evidence again on this issue if asked. I have no objection to the publication of this submission (with attachments) on your website.

Yours sincerely

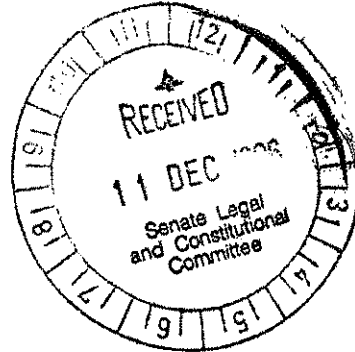
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(Fr) Frank Brennan SJ AO

Encl:

10 December 1996

Senator Chris Ellison
Chairman
Senate Legal and Constitutional Committee
Parliament House
Canberra
ACT 2600



Dear Senator Ellison,

Re: *Euthanasia Laws Bill 1996.*

Thank you for your letter inviting me to make a submission to your Committee on the *Euthanasia Laws Bill 1996*. The proposed bill overriding the *Rights of the Terminally Ill Act 1995 (NT)* raises questions about law, morality and federal/state relations - topics on which there is always a difference of viewpoints, across and within party lines.

Australian federalism is providing new opportunities for social experimentation and new challenges for our politicians. While the ACT was prepared to trial legalised heroin only if the States agreed, the Northern Territory has gone it alone trialing legalised euthanasia. As Mr Leo McLeay said, "On an issue such as this I believe there should be a broad national consensus. When we have that legislature that represents the second smallest group of Australians passing a law that can have an effect on all Australians, there is not consensus. The ACT parliament sought consensus and, when it could not get it on its heroin trials, it dropped the trials. Surely euthanasia ranks as important as trialing heroin."¹ Some of our political leaders such as Premier Jeff Kennett favour such out-of-town try outs, but Prime Minister John Howard is concerned by the adverse effects on the national social fabric. I share the Prime Minister's concern.

The Northern Territory's *Rights of the Terminally Ill Act 1995* has legalised voluntary euthanasia for the first time. Similar legislation was rejected by the South Australian Parliament last year. There has been talk in recent years about similar legislation being introduced in Queensland and Victoria. The New South Wales AIDS Council has drafted a bill for consideration by the New South Wales Parliament whose members by an

¹Hansard, 28 October 1996, p 5911

overwhelming majority have spoken against legalised euthanasia. The decision of the Northern Territory Parliament has been opposed by the AMA and Northern Territory church leaders, including the respected Aboriginal leader, Djiniyini Gondarra.

Having failed to hold the numbers on the floor of the Territory Parliament, these community leaders have now turned to the courts and the Commonwealth Parliament seeking to override the legislation, claiming it is beyond the scope of the Northern Territory's legislative power. In times of such change, all parties need to accept some ground rules about democracy, law, morality and federalism. Let me state three of them.

First, democracy in a pluralistic, developed society is not only the will of fifty percent plus one; individual rights and the public interest matter. Second, just because something is wrong or thought to be wrong does not mean there should be a law against it. Third, state and territory rights are not necessarily trumps at the federal card table when an issue affects the national ethos.

Many Australians continue to believe that physician assisted suicide is wrong. While prepared to see a machine turned off, they are opposed to the administration of a lethal injection. I am one such Australian. These persons would never seek euthanasia for themselves. As health professionals they would never provide such assistance. Others are worried by the possible abuses, fearing that a lethal injection could be administered during a down period in a person's life, which need not necessarily be the end. But should there be a law against the administration of the injection given that many other Australians believe individuals should have a right to choose? Opponents of active euthanasia have to admit that the Northern Territory law makes the procedure available only in rare circumstances - where an able minded adult is facing sure death as the result of incurable disease. Respect for individual choice and self-determination are always to be accorded high priority in setting down public policies about medical decisions.

While NT church leaders and doctors hope the courts will strike down the NT legislature's attempt to extend the freedom of the individual to end life, Americans are preparing for Supreme Court challenges aimed at striking down state attempts to limit the freedom. In 1994, a US Federal District Court judge for the first time struck down a state law prohibiting assisted suicide. She relied upon the claim by three Supreme Court Justices in a recent abortion case that "matters involving the most intimate and personal choices a person may make in a lifetime are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, or meaning, of the universe, and of the mystery of human life."

This was part of the Supreme Court's new rationale for a woman's right to choose abortion. The trial judge thought it pointed to a right of a competent dying person to take their own life with state authorised assistance. This decision was affirmed by the Ninth Circuit of the United States Court of Appeals in March 1996 (Compassion in Dying v State of Washington²). It remains to be seen whether the Supreme Court judges this the opportune case to consider the constitutional right to die with state authorised assistance. Professor Ronald Dworkin has recently published *Freedom's Law: The Moral Reading of the American Constitution* claiming that "Making someone die in a way others approve, but he believes contradicts his own dignity, is a serious, unjustified, unnecessary form of tyranny." Dworkin gave evidence to the House of Lords Select Committee on Medical Ethics in 1993 saying, "I am in favour of choice because people disagree about what kind of death is meaningful for them. I, myself, believe that what sort of death is right for a particular person and gives the best meaning to that person's life, largely depends on how that life has been lived, and that the person who has lived it is in the best position to make that decision."³ The British Medical Association conceded that denial of a right to euthanasia ran counter to the concepts of autonomy and self-determination but argued that "granting the desires of some entails an unacceptable cost for others and therefore is contrary to other ethical imperatives such as the concept of justice."⁴ The Committee concluded:

Our thinking must also be coloured by the wish of every individual for a peaceful and easy death, without prolonged suffering, and by a reluctance to contemplate the possibility of severe dementia or dependence. We gave much thought too to Professor Dworkin's opinion that, for those without religious belief, the individual is best able to decide what manner of death is fitting to the life which has been lived.

Ultimately, however, we do not believe that these arguments are sufficient reason to weaken society's prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. Moreover dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.

One reason for this conclusion is that we do not think it possible to set secure limits on voluntary euthanasia. Some witnesses told us that to legalise voluntary euthanasia was a discrete step which need have no other consequences. But as

²79 F. 3d 790 Also the Second Circuit has reached a similar conclusion in Quill v Vacco, 80 F. 3d 716.

³House of Lords, *Report of the Select Committee on Medical Ethics*, Session 1993-4, Volume 1, p.23

⁴*Ibid* 24

we said in our introduction, issues of life and death do not lend themselves to clear definition, and without that it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused. Moreover to create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence, or by the human tendency to test the limits of any regulation. These dangers are such that we believe that any decriminalisation of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address. Fear of what some witnesses referred to as a "slippery slope" could in itself be damaging.

We are also concerned that vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, whether real or imagined, to request early death. We accept that, for the most part, request resulting from such pressure or from remedial depressive illness would be identified as such by doctors and managed appropriately. Nevertheless 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.

The House of Lords Committee reached the same conclusion as the New York State Task Force on Life and the Law, the most comprehensive report on the public policy of euthanasia. True to the US constitutional tradition, the New York Task Force was anxious to justify any burden which may be placed on individuals like Mr Dent "who make an informed, competent choice to have their lives artificially shortened, and who cannot do so without another person's aid"⁵. Finding that "very few individuals fall into this group", the Task Force was unanimous in its view:⁶

... laws barring suicide assistance and euthanasia serve valuable societal goals: they protect vulnerable individuals who might otherwise seek suicide assistance or euthanasia in response to treatable depression, coercion, or pain; they encourage the active care and treatment of the terminally ill; and they guard against the killing of patients who are incapable of providing knowing consent. In this regard, prohibitions on assisted suicide and euthanasia are distinct from earlier statutes that barred suicide committed without another person's aid. While unassisted suicide is essentially a private, independent act, assisted suicide and euthanasia possess a uniquely *social* dimension, as they involve one individual participating directly in another person's decision to die. Such participation carries far-reaching risks of mistake and abuse. While proponents of legalized assisted suicide and euthanasia suggest that safeguards could be established to minimize these dangers, the essential prerequisites for such safeguards — an attentive and caring physician-patient relationship, skilled pain management and comfort care, and universal access to effective psychiatric services — represent an idealized version of medical care that society has thus far failed to achieve. Given this reality, any effort to carve out exceptions to the prohibitions on assisted suicide or euthanasia would seriously undermine the state's interest in preventing suicide in the vast majority of cases in which patients seek this option because of pressure, undiagnosed or untreated depression, or improperly managed

⁵New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, Health Education Services, New York, 1994, p.72

⁶*Ibid* 73-4

pain. The state's interest in protecting these patients outweighs any burden on individual autonomy that prohibitions on assisted suicide and euthanasia might entail.

The New York Task Force of 24 members held different views about the ethical acceptability of assisted suicide and euthanasia but they were unanimous in their recommendation that the "existing law should not be changed to permit these practices".⁷ They fell into three groups: those who thought euthanasia inherently wrong; those concerned that euthanasia would violate values fundamental to the patient-physician relationship; and those who did not see euthanasia as unethical or incompatible with medical practice. But even this third group thought that legalisation would be "unwise and dangerous public policy".⁸ These members regarded "the number of cases when assisted suicide or euthanasia are medically and ethically appropriate as extremely rare. They do not believe that the benefits incurred for this small number of patients can justify a major shift in public policy or the serious risks that legalising the practice would entail."⁹ These members believed that in appropriate circumstances, euthanasia "would manifest a physician's commitment and duty to his or her patient" but they still believed it would be unwise and dangerous public policy. They reported:¹⁰

Several facts played a critical role in the judgment reached by these members. They recognize that in extreme cases when assistance to commit suicide is most compelling, patients may now find a physician willing to provide medication and information. It is highly unlikely that physicians who are thoughtful and responsible in providing this assistance will face criminal sanctions; given the sympathies of juries and the difficulties of proving intention in the private interaction between doctor and patient, prosecutors have not been eager to bring these cases.

Although the law barring assisted suicide and euthanasia is rarely enforced, these Task Force members believe that this legal prohibition serves important purposes. In addition to regulating and restraining behavior, our laws also serve a highly symbolic function. These members regard the consequences of quietly tolerating assisted suicide as a private act of agreement between two individuals in extreme cases as profoundly different from the consequences of legalizing the practice. The legal prohibition, while not uniformly honored, preserves the gravity of conduct to assist suicide. It demands caution and reflection. It maintains the decision by both patient and physician as a solemn, private act and prevents abuse. It also requires a deep commitment by health care professionals who must violate the law to offer this assistance to patients.

These Task Force members acknowledge the inherent tension and discomfort of a position that prohibits actions they believe are ethically justifiable. They recognize the problems of a policy that renders relief for patients, albeit in rare cases, contingent on the moral courage of health care professionals and on their

⁷Ibid, p. xii

⁸Ibid, p. xiii

⁹Ibid, 134-5

¹⁰Ibid 140-1

willingness to violate the law. Significant too is the fact that some physicians now provide suicide assistance without the benefit of guidelines that would be established if the state and the medical profession sanctioned and regulated the practice. Finally, they recognize the shortcomings of a policy that leaves physicians who act responsibly and with the best of motives subject to possible criminal or professional sanctions for conduct that is legally proscribed but caring and appropriate.

On balance, even considering these reasons to legalize assisted suicide, these members unanimously concluded that the prohibition against assisted suicide should not be changed. While not a tidy or perfect resolution, it serves the interests of patients far better than legalizing the practice. By curtailing the autonomy of patients in a very small number of cases when assisted suicide is a compelling and justifiable response, it preserves the autonomy and well-being of many others. It also prevents the widespread abuses that would be likely to occur if assisted suicide were legalized.

The Task force members were unanimous in their recommendation that the existing law should not be changed:¹¹

Legalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable. The Task Force members concluded that the potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved.

The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantages, would be extraordinary.

For purposes of public debate, one can posit "ideal" cases in which all the recommended safeguards would be satisfied: patients would be screened for depression and offered treatment, effective pain medication would be available, and all patients would have a supportive, committed family and doctor. Yet the reality of existing medical practice in doctors' offices and hospitals across the state generally cannot match these expectations, however any guidelines or safeguards might be framed. These realities render legislation to legalize assisted suicide and euthanasia vulnerable to error and abuse for all members of society, not only for those who are disadvantaged.

As in the United States and the United Kingdom, church leaders in Australia, the AMA and many others are concerned to maintain the integrity of the doctor-patient healing relationship and the relationship between the dying person and relatives whom they do not wish to burden. They want to limit the options available to the dying person so that all dying persons, doctors and relatives at the time of death may be spared the burden of choice. They want to limit the option for the few so that the many who are vulnerable will not be exposed

¹¹Ibid 120

to risk or greater pressure. Legalised active euthanasia requires every dying person to consider questions like, "Should I end my life now so my estate can educate the grandchildren rather than providing me with nursing care?"

These issues are more acute in the Northern Territory which is notoriously under-resourced in the provision of palliative care. Also many Aborigines from remote communities with traditional belief systems and fear of "white fella" medicine will be even more afraid and confused by doctors and hospitals when the foreign medical technology is known to be used not just for sustaining life but also for imposing death. There can be no doubt about the widespread Aboriginal opposition to the Northern Territory law. I urge you to consider the Aboriginal perspective when you come to vote.

There have been three Aboriginal members who have participated in debate on this topic in the Northern Territory Legislative Assembly. On 24 May 1995, Mr Maurice Rioli (ALP, Arafura), told the Legislative Assembly:

- I have received nothing but indications of overwhelming opposition to this bill from constituents in my electorate of Arafura which contains 8 major Aboriginal communities and many outstations. Most of these communities have written and spoken to me about their concerns in relation to the bill.
- Nearly all Aboriginal people have had difficulty in understanding the details of the bill, as have many other people we have heard from in the course of the committee's travels.
- However, even if Aboriginal people fully understood the bill, through all the appropriate cultural means of communication, I believe they would still oppose the principle of euthanasia.
- Such a situation might result in the possibility of payback or some other form of family feuding.
- I still do not fully understand the complexities surrounding legislating to permit voluntary euthanasia.
- I understand my stance here today will be seen to be against the rights of individuals, but I cannot walk away from my beliefs or those of my electorate.

Mr John Ah Kit (ALP, Arnhem) spoke in the debate for the repeal of the legislation on 21 August 1996. He said:

- I do have a problem with Aboriginal people in my constituency. I have a problem with the way the government has not handled the educational and awareness campaign properly.
- I have had contact with many Aboriginal leaders who are resident outside my electorate of Arnhem. In my discussions with them, the majority have been dead set against this. They feel that they have been neglected again, because the so-called consultation process has never really occurred. Later, there was a mad rush to get consultation on the road, but in my book the horse had bolted.
- Why, with just over 1% of the population in this country, do we have to have this legislation? We have all the headaches in front of us: challenges in the courts, political manoeuvrings in Canberra. I think we need to seriously consider what we really want the Territory to become. I will certainly be supporting the repeal bill.

Even the late Wesley Lanhupuy (ALP, Arnhem) who voted for the legislation said in the original debate:

- If this legislation is passed, I wonder whether that suspicion will be held forever by the family because of the powers given to a doctor by this bill.
- The people at every Aboriginal outstation that I visited told me to 'give it away'

The Northern Territory Government has set up an education program about the euthanasia law for Aboriginal communities. So far, three reports have been presented to the Aboriginal Reference Group. The report for 28 June 1996 notes:

- The level of fear of and hostility to the legislation is far more widespread than originally envisaged.
- People are extremely angry that they were not consulted about the legislation in the first place.

- As expected, there has been considerable interest in Palliative Care, which has been seen by all as “the Aboriginal way”.
- There is a continuing philosophical problem apparent throughout this process, and that is related to widespread Aboriginal beliefs about cause of death, that is, that there is no such thing as natural death and that deaths are caused by external agencies such as sorcery, payback, transgression of the Law etc. This has the real potential of setting back the work of Territory Health Services and health centres in gaining confidence and trust of their clients by years.

The Report of 9 July 1996 notes:

- ... the current damage being done is difficult to estimate, but potentially dangerous especially given the general problems and politics of Aboriginal health in the Northern Territory.

The Report of 23 July 1996 notes:

- The greatest fear and reluctance about the legislation would appear to be coming from Aboriginal Health Workers themselves. They are concerned that their position within their own communities has been or might be irreparably damaged by the existence of the legislation ...
- The “problem” is the Territory Health Services’ successes in developing a more holistic approach ...is compromised by a “package” that now includes euthanasia, with all its differing interpretations.

Even those Senators committed to respect for individual choice and self determination and who otherwise would be supportive of tightly regulated euthanasia ought support the *Euthanasia Laws Bill 1996* so that Aborigines in the Northern Territory may have greater faith in the health system and may be spared needless anxiety at times of death. In these cross-cultural situations, consent is never simple nor what it seems. A generation ago, many Aboriginal women had their fallopian tubes tied. No doubt all doctors and nurses would swear the procedure was always performed with informed consent. The present "Stolen Children" Inquiry relates to Aborigines who in hindsight have no doubt that they were taken without consent. Some public servants and missionaries at the time were convinced they

were acting not only with parental consent but in the best interests of the child. As the Royal Commission into Aboriginal Deaths in Custody heard, "It is likely that those who administered the white law did so with the assurance that they were helping to assimilate these children into the dominant community." A casual visitor to the Darwin hospital at Casuarina sees Aboriginal patients recuperating outdoors, tentative strangers to the stainless steel and ether behind the air conditioned concrete walls. Many will now stay away rather than visit a place of death administered by white hands. The harm to the vulnerable far outweighs the benefit to the few like Mr Dent who want to choose a timely death with physician assistance and state authorisation.

Some advocates for euthanasia argue that the law should simply be expanded within the tight restrictions of the Northern Territory law to authorise existing practices, withdrawing the uncertainty that doctors acting in good faith may be prosecuted for activity which few regard as criminal. For example, Mr Gareth Evans argued in the debate in the House of Representatives that "voluntary euthanasia is already an omnipresent reality in our society, with doctors constantly being put in the position of being asked to take steps to hasten the inevitable and to help people escape an existence that has become simply intolerable, but without having any legal basis to do so and being put in a very difficult position, very often, as a result."¹²

Two points should be noted. First, just because some drivers can drive perfectly safely at 120km/h in a 110km/h zone with virtual assurance that they will not be apprehended by the police, this is no argument for raising the legal limit to 120. The very same drivers will then drive at 130 increasing the risk to the motoring public. Incremental legislation of this sort has to draw a line in the sand. By purporting to cover the grey area, the legislator will inevitably cast another shadow of uncertainty.

Second, once the law crosses the moral Rubicon of state authorisation of administered death, there is no moral or ethical bar to expansion of that authorisation in the future. If the patient is no longer competent, why shouldn't the relatives be able to make the decision? Then, if there are no relatives, why shouldn't the state be able to make the decision? If the patient is poor and the state under-resourced, why shouldn't the state be able to provide better, cheaper euthanasia services and spend less on palliative care procedures - rendering the "choice" of voluntary euthanasia more attractive to the poor? As Mr Leo McLeay has observed, "As legislators we all know it is harder to argue for programs for which there are cheaper alternatives. This would surely be with case with euthanasia versus palliative care."¹³ Why

¹²Hansard 21 November 1996, p. 7232

¹³Hansard, 28 October 1996, p. 5911

should the patient have to be in the terminal stages of a life threatening disease? Why shouldn't the 25 year old just diagnosed with full blown AIDS have the option of a peaceful, dignified death now rather than enduring the years of suffering and uncertainty he has witnessed in the deaths of so many of his friends? Why shouldn't the person who is simply sick of life also have the benefit of state authorisation and assistance for the suicide?

A taxi driver who drives from Broken Hill to Darwin seeking euthanasia is not a person incapable of taking his own life. He is seeking more than medical assistance. He wants the company and social support without which he is existentially unable to close the book of life. Why should this social benefit be granted only to those in the terminal stages of a life threatening disease? Mr L. Tanner was right when he told the House of Representatives, "I am troubled by euthanasia because I think it is virtually impossible to draw safe boundaries, because I think it is virtually impossible to prevent abuses and mistakes and because I think it is virtually impossible to justify offering the option of assisted suicide to one category of people when you deny it to others. That is the necessary implication of the Territory legislation."¹⁴

The Commonwealth Parliament may not have the power to overrule a State law legalising the administration of requested lethal injections. It does have the power to overrule a Territory law. Should it ever exercise that power? Only in very rare circumstances: where no State has similarly legislated; where the Territory law is a grave departure from the law in all equivalent countries; where the Territory law impacts on the national social fabric outside the Territory; and where the Territory law has been enacted without sufficient regard for the risks and added burdens to its own more vulnerable citizens, especially Aborigines. This is such a circumstance. National legislation for matters of national interest has often been considered by the Senate as in the cases of the Franklin Dam and the *Human Rights (Sexual Conduct) Act 1994*. National protection of Aboriginal interests in the Northern Territory is still maintained with the *Aboriginal Land Rights (Northern Territory) Act 1976* and national policy has often been imposed on the Northern Territory as with restrictions on uranium mining.

In this instance, the freedom for the few should remain restricted because it is not possible to protect others, especially the most vulnerable in society, from the risk of abuse. Once the legislature abandons the distinction between passive and active euthanasia, there is no remaining and equally compelling distinction to protect the most vulnerable in society from laws which provide for state sanctioned killing available on demand. In this case, expanding the right to choose will increase both the risk that a citizen might think that there is no option

¹⁴Hansard, 28 October 1996, p. 5917

but to die and the risk that a citizen could be chosen by others to die. Our Commonwealth parliamentarians should override the Northern Territory law and fetter the legislative competence of the Territories for the good of all Australians, thereby maximising freedom, choice and security for all Australians at the time of death.

I am happy to give evidence to the Committee at any time.

Yours sincerely,

A thick black horizontal bar redacting the signature of Frank Brennan.

Frank Brennan SJ AO