

Submission to: *Inquiry into
aged care, end-of-life and
palliative care and voluntary
assisted dying in Queensland*

AUSTRALIAN CHRISTIAN LOBBY

About Australian Christian Lobby

Australian Christian Lobby's vision is to see Christian principles and ethics influencing the way we are governed, do business, and relate to each other as a community. ACL seeks to see a compassionate, just and moral society through having the public contributions of the Christian faith reflected in the political life of the nation.

With more than 125,000 supporters, ACL facilitates professional engagement and dialogue between the Christian constituency and government, allowing the voice of Christians to be heard in the public square. ACL is neither party-partisan nor denominationally aligned. ACL representatives bring a Christian perspective to policy makers in Federal, State and Territory Parliaments.

acl.org.au | Like us on [facebook.com/ACLobby](https://www.facebook.com/ACLobby) | Follow us on twitter.com/ACLobby



Australian Christian Lobby

4 Campion Street
Deakin ACT 2600

t 02 6175 0200

e natoffice@acl.org.au

abn 40 075120 517

acl.org.au

Qld Parliamentary Health, Communities, Disability Services
and Domestic and Family Violence Prevention Committee
Queensland Parliament

15 April 2019

Dear Committee

Re: Submission to the Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying.

The Australian Christian Lobby (ACL) welcomes the opportunity to provide a submission to the Committee considering end of life choices in Queensland.

The ACL has endeavoured to respond to the questions raised by the Issues Paper which discussed Aged Care, Palliative Care and Voluntary Assisted Dying. We are concerned primarily with ensuring the dignity of the human person is preserved in all aspects of health care and were troubled by the simultaneous discussion of end of life care and assisted suicide. This alone, is an issue of serious concern.

The ACL has outlined its views on these matters to the Committee in the attached submission.

Please feel free to contact me if I can be of further assistance in the consideration of this matter. I would be pleased to meet to discuss our submission or any other aspect in respect to this review and would appreciate an opportunity to present to the committee if appropriate.

A handwritten signature in black ink that reads 'W Francis'.

Wendy Francis

Director | QLD & NT

Contents

Introduction	2
Recommendations.....	3
AGED CARE.....	4
PALLIATIVE CARE	8
VOLUNTARY ASSISTED DYING	12
Euthanasia versus “assisted dying: notes on the use of language	12
Elevated vulnerability of Aboriginals and Torres Strait Islanders	13
Poor aged and palliative care creates vulnerability.....	15
The mere availability of euthanasia as a choice produces pressure.....	15
Direct pressure.....	16
Indirect pressure.....	17
The elderly are already vulnerable and their risk is increased.....	18
How do we treat existential suffering?.....	20
Euthanasia effects the disabled disproportionately.....	22
Euthanasia for children and “mature minors”	23
Freedom of conscience for medical practioners.....	23
Conclusion	24

Introduction

The ACL commends the Queensland government for giving careful consideration to the care needs of older citizens. The prioritisation of the needs of the vulnerable is a hallmark of every compassionate society and, since aging is inevitable for those who are blessed with long life, it concerns every Queenslander to ensure that the needs of the elderly have been anticipated and provided for.

The ACL is deeply concerned, however, to find that the legalisation of euthanasia forms any part of such a conversation. Euthanasia is fundamentally irreconcilable with a recognition of inherent human dignity. Acceptance of state-sanctioned killing, even if for ostensibly compassionate motives, requires more than a simple change to the law: it represents a paradigm shift from an ethical and legal framework that declares the deliberate taking of life by private citizens (including medical professionals) as morally insupportable in absolute terms to one which allows relative and circumstantial evaluations to be made about different lives on a case-by-case basis. Euthanasia can only be contemplated by putting aside the current legal recognition of the unique and infinite value of the human person, to instead embrace the acknowledgment that some lives are not worth living. This submission will elaborate on several reasons why the legalisation of euthanasia is at variance with the Queensland Government's declared aims to promote an "age-friendly community" in the state.¹

There are currently numerous serious problems in both aged care and palliative care in Queensland. Previous under-commitment by the government has been exposed in recent public statements of Queensland's health care professionals who point to:

- lack of palliative care specialists. (For example, Rockhampton ought to have eight palliative care specialists; they have one);
- the fact that aged care facilities have no trained palliative care nurses;
- inadequate financial support for aged care facilities;
- insufficient funding for home care packages (so that patients often die before they receive these);
- critically deficient numbers of nurses working in remote communities.²

Until these deficiencies are comprehensively addressed, the dangers that inevitably attend the legalisation of euthanasia can only be magnified. The vulnerability created for the elderly is self-evident: given sufficiently deplorable conditions, anyone might be persuaded to look on suicide as a blessing.

¹ <https://www.communities.qld.gov.au/seniors/queensland-age-friendly-community>

² Marszalek, Jessica, "Euthanasia cannot be legalised in QLD until palliative care improved".

<http://online.isentialink.com/couriermail.com.au/2019/04/05/0a18efc2-8301-4181-9c51-fa861bd4c57f.html> (Accessed 8 April 2019).

It is therefore unfortunate that, when the need for remedial attention to correct serious deficiencies in palliative care and aged-care is so apparent, this Issues Paper not only raises the possibility of legalising euthanasia but appears to give this disproportionate weighting. The swathe of suggestions on possible implementations of euthanasia together with a table of countries which practice euthanasia and a summary of their practices, contrasts strikingly with a complete absence of recommendations about the implementation and/or improvement to the aged care or palliative care sectors. Perhaps an Inquiry that was serious about aged care and palliative care might have provided a similar comparison of how such care is practiced in other countries to enable an assessment of best practice and suggestions for the improvement of existing arrangements. The absence of this discussion is therefore concerning; it could be taken as an indication of the government's pre-established determination to legalise euthanasia in spite of the particularly unsafe environment. The ACL hopes, however, that this unfortunate impression does not reflect that true case.

Even those who advocate for euthanasia in other circumstances (the ACL does not share the view that euthanasia can ever be legalised safely) might query the timing of this Inquiry. Not only is the environment particularly unsafe in Queensland, but the results of the Federal Royal Commission into Aged Care are still pending. After the two initial rounds of hearings, it is already clear that the Royal Commission will uncover serious deficiencies in the provision of aged care.

Recommendations for serious reform can be confidently anticipated. Since any findings of this Queensland Inquiry at variance with the recommendations of the Royal Commission can be expected to be superseded within such a short time frame, the efforts of the government would perhaps be better directed to monitoring and improving the quality of existing aged care, rather than running a soon-to-be-redundant inquiry in parallel with the Royal Commission.

RECOMMENDATIONS

1. Improve aged care
2. Ensure best practice palliative care is available throughout Queensland
3. Implement holistic care for Indigenous Australians.

The ACL submits that, if the above are implemented, there will be no need for euthanasia.

AGED CARE

The Inquiry addresses some questions to the public that would benefit from targeted expert examination. Question 10, for example, about the cost of hospital stays compared to the cost of residential aged care could be answered with reference to Queensland Health data. Further questions relating to the availability of aged care, staffing levels, disability care, indigenous care, rural and regional availability, increased demands due to an aging population require an analysis of hard data and comparison with international best practice. The responses provided below are necessarily brief and indicative and do not represent the detailed quantitative and qualitative study this subject rightly deserves.

1. Is the aged care system meeting the current needs of older Queenslanders, including those people with special needs? Why or why not?

The ACL submits that current standards of aged care in Queensland are inadequate. Staffing levels are low and staff training is inadequate. In combination, these conditions breed the further problems of poor morale and high rates of staff turnover as staff become disillusioned with the reality of aged care. An assistant nurse in an aged care facility made the following observation about her colleagues:

What I see is that people who take on this job to make a positive difference in people's lives don't last. Fresh ideas and a positive view on ageing are not supported by management. It is no wonder that the aged care sector faces high turnover. Despite the need for thousands of new assistants-in-nursing (AINs), people leave constantly for other jobs where they are not forced to turn a blind eye to people's basic needs.³

And in relation to the care provided, she notes:

The facility I work at, which is probably typical of others, is more like a sweatshop or factory line than a residential care facility for Australia's elderly. We simply do not have the time to provide holistic care. On some days, even providing the basics of daily life, like brushing teeth, showering and toileting are a challenge.⁴

³ Anonymous. "Diary of an assistant nurse: People go without showers so others are not left in their faeces." https://www.theguardian.com/commentisfree/2019/apr/05/diary-of-an-assistant-nurse-people-go-without-showers-so-others-are-not-left-in-their-faeces?CMP=share_btn_link (Accessed 6 April 2019).

⁴ Ibid.

3. Do the standards of residential aged care, home care and other aged care services provided in Queensland meet clients' and the community's expectations? Can you give examples?

There are clear examples where standards are below expectation. One assistant nurse in aged care comments that there are frequent staff shortages which result in serious lack of care. She says:

On those days, if residents request a shower we have to decline because the priority may be to change another resident's incontinence pad so they do not continue to lay in their own faeces.⁵

4. How will demand for aged care services change in Queensland as the population increases and ages, and what changes to the aged care system will be needed to meet future demands for aged care?

There will be greater demand for both aged care facilities and in-home care, but the political will to provide for this is not in evidence. The focus on euthanasia in these circumstances is concerning.

5. Are there enough residential aged care places (beds) available in aged care facilities, in areas and at the levels of care that are required?

Again, deficiencies are apparent. There is a great need for palliative care nurses in aged care facilities, which would ease the burden on hospitalisation of people at end of life.⁶

In addition, there is a shortage of all staff in all areas of aged care, from qualified nurses to assistant nurses and personal carers.⁷

6. Are adequate numbers of home care packages available in areas at the levels required?

There are insufficient home care packages available. Some patients die before home care packages are implemented.⁸

⁵ Ibid.

⁶ Marszalek, Jessica, "Euthanasia cannot be legalised in QLD until palliative care improved". <http://online.isentialink.com/couriermail.com.au/2019/04/05/0a18efc2-8301-4181-9c51-fa861bd4c57f.html> (Accessed 8 April 2019)

⁷ Op cit. Anonymous.

⁸ Op.Cit. Marszalek.

7. Are there sufficient staff in the aged care sector to meet current and future workloads?

There are not sufficient staff at present so it is difficult to see how future needs may be met without urgent and extensive planning. The Royal Commission will no doubt provide recommendations on this subject, or Queensland could look to international best practice to correct the current deficiency.

8. Is the mix of staff appropriate for different settings within the aged care sector?

There is a serious shortage of trained palliative care nurses in Aged Care facilities. There is a need for staffing ratios to ensure adequate care is provided for the residents.⁹

9. Do aged care staff receive training that is appropriate and adequate to prepare them for the work?

The evidence available and the testimony of staff in aged care facilities and the experience of the families of the aged, suggests that current levels of training are deficient.

10. What are the costs to the public health system of caring for elderly people in hospitals whilst they are waiting for residential aged care places to become available?

This information should be available from Queensland Health.

11. Are suitable health care services being provided within residential aged care settings and/or aged care providers?

Unfortunately, anecdotal evidence of the provision of sub-standard care in nursing homes abounds. The ACL knows of specific cases where elderly relatives have to be taken to other professionals, e.g. podiatrists, because those who visit the centre are not sensitive to patients' needs or provide a poor service and where the dietary requirements for diabetics are not well attended to, resulting in poor health outcomes. It is also too frequently the case that those unable to feed themselves are neglected.¹⁰

⁹ Op. cit. Anonymous

¹⁰ Ibid.

13. How can the delivery of aged care services in Queensland be improved?

Again, this question would best be answered by a detailed expert study. In broad terms, it seems clear that areas for improvement include;

- Improved staff ratios
- More qualified nurses in facilities
- Nurses trained in palliative care
- Commitment to retaining quality staff through better pay and conditions.

16. What are the key priorities for the future?

The priority must be to ensure best outcomes for the aged and their families – to ensure that:

- the elderly and their families are fully supported in caring for their loved ones as they reach the end of their lives;
- those who do not have family support are fully provided for;
- wholistic care is available, taking into account more than just the physical body but the social, emotional, spiritual needs of each patient;
- staff caring for the elderly are highly motivated, properly supported, fully trained;
- regional Queensland is adequately resourced so that distance from the city does not result in reduced levels of care;
- in-home care is available to those who want it.¹¹

¹¹ Op.Cit. Marszalek.
Australian Christian Lobby

PALLIATIVE CARE

The Issues paper raises eight questions relating to palliative care which, even taken together, cannot do justice to such a complex and specialist field of medicine. Palliative care involves a wholistic approach to patient care. As well as attending to pain relief, palliative care encompasses the patient's spiritual, psychological and relational needs. A palliative care practitioner will assess which aspect of life is causing suffering and address those issues which may not be about physical pain, but which might concern fear or hopelessness. The palliative care practitioner also includes attention to the well-being of family members. This wholistic approach to end of life care is apparently not well understood by the community. The Cancer Council both acknowledges and responds to this community confusion about palliative care on its website, seeing the need to clarify, for example, the distinction between euthanasia and palliative care.¹²

Palliative care seeks neither to hasten or postpone death.¹³ Indeed, the Specialist Palliative Care Practitioners oppose the discussion of euthanasia when there is inadequate provision of palliative care. When euthanasia becomes "one of the options" that must be offered to the patient, this is antithetical to the aims of palliative care and serves to complicate already difficult and emotionally intense family situations.

17. What are the palliative care services offered in Queensland?

I have personal experience of Queensland's palliative care services as two of my sisters have died from cancer and they were cared for in their last days by palliative care medical staff. I will always be very grateful for the care they received. However, medical experts in the field refer to the standard of services offered in Queensland as appallingly inadequate to cater for the level of need and seriously under-resourced. (See comments for question 18 below.)

18. Are palliative care and end-of-life care services meeting the current needs of Queenslanders? Why or why not?

These services are acknowledged to be inadequate. According to Dr Greg Parker, head of Queensland Specialist Palliative Care Services Directors the following issues are of concern:

- Patients requesting at-home care packages were often dead before they were delivered.
- Regional Queensland has had one palliative care specialist for the past 12 years but should have 8.

¹² <https://www.cancerCouncil.com.au/cancer-information/advanced-cancer/palliative-care/key-questions/is-palliative-care-the-same-as-euthanasia/> (Accessed 2 April 2019).

¹³ Goiran, Nick; Minority Report for the Joint Select Committee on End of Life Choices submitted under Legislative Assembly Standing Order 274, Parliament of Western Australia, August 2018, 3.

- Rockhampton boasts a “level five” cancer and palliative care service but has no palliative care physician.
- Pain-relief procedures that are standard in NSW hospitals are not available in Queensland.
- Many at-home packages do not include a nurse.
- Nurses in aged care homes have no palliative care training so patients have to be sent to hospital emergency departments.
- Figures are not kept on staff shortfalls.¹⁴

19. Do the standards of palliative care and end-of-life care provided in Queensland meet clients’ and the community’s expectations?

They do not. In the context of inadequate resourcing for palliative care, any consideration of euthanasia exposes the Queensland government to the regrettable appearance of using the suffering of the dying to promote a pre-existing ideological commitment to euthanasia.

No responsible government can afford to disregard its budget and the costs of palliative care are obviously considerable. In Canada, the benefits to the national budget of assisting suicide have already been grimly quantified in a 2016 report published in the *Canadian Medical Association Journal*. Doctor-hastened death, including life-ending drugs, can cost as little as \$25 per “patient”. By comparison, particularly in the final month of life, the medical costs of caring for the dying can increase dramatically. This report points out that physician-assisted dying has the advantage of enabling patients to “forgo this resource intensive period.” Even as the authors of this study protest that “neither patients nor physicians should consider costs when making the very personal decision to request, or provide, this intervention,” they announce the results of their gruesome calculations; assisted dying could save the Canadian government as much as \$139 million annually.¹⁵

In the same month this journal published articles on the following subjects:

- “Medical error and medical assistance in dying”;
- “Seniors and self-harm factor in the opioid crisis”;
- “Canada needs twice as many palliative specialists”.

It does not take a cynic to see how these issues are connected. Palliative care is expensive, provision is inadequate, seniors are self-harming under these circumstances and the inexpensive solution – delivering marvellous benefits to the incumbent government whose financial management will surely be applauded by a grateful electorate – is to facilitate euthanasia. It costs less than helping people.

¹⁴ Op.Cit. Marszalek.

¹⁵ Sharon Kelly, “Doctor-assisted suicide could save Canada up to \$139 million each year, Alberta study suggests”, *National Post*, 23 January 2017. Available at: <http://nationalpost.com/news/0124-na-assisted-dying>; Aaron J. Trachtenberg and Braden Manns, “Cost analysis of medical assistance in dying in Canada”, *Canadian medical Association Journal*, 23 January 2017, p. 189 (doi:10.1503/cmaj.160650)

While financial self-interest, rather than sincere care for the elderly, appears to be driving the pro-euthanasia policy of the Canadian government, it would be regrettable if the Queensland government were to expose itself to suspicion of acting on similar motivation. The parlous state of palliative care provides fertile soil for the unwelcome speculation that this is not entirely disconnected from the advancement of policies that allow for euthanasia.

20. How will demand for palliative and end-of-life services change in Queensland as the population increases and ages, and what changes to the delivery of these services will be needed to meet future demands?

Future needs require a greater availability of palliative care services. It will be necessary to provide for current needs before expanding to future requirements. Evidently there will be a need for more trained palliative care specialists and the placement of palliative care trained nurses in aged care facilities as well as being available to in home aged care services.

21. How can the delivery of palliative care and end-of-life care services in Queensland be improved?

These can be improved by making up the current shortfalls and then continuing to improve availability especially in regional and rural areas.

- Provide home care packages to patients when required and especially before they die.
- Ensure that Regional Queensland has the recommended 8 palliative care specialists rather than the present ONE.
- Ensure that “level five” cancer and palliative care services have a palliative care physician.
- Provide a high standard of pain-relief procedures that are available in NSW hospitals but not available in Queensland.
- Ensure that at-home palliative care packages include a nurse.
- Provide palliative care training to nurses in aged care homes that have no palliative care training so patients do not have to be sent to emergency departments.
- Figures are not currently kept on staff short falls but they should be.¹⁶

22. What are the particular challenges of delivering palliative and end of life care in regional, rural and remote Queensland?

Availability of palliative care specialists – doctors and nurses – these are severely under resourced or not available at all.

¹⁶ Ibid. These improvements are extrapolated from the deficits outlined by Dr Greg Parker in his submission to this inquiry.

23. What are the particular challenges of delivering palliative and end of life care for Aboriginal and Torres Strait Islander communities?

The United Nations Declaration on the Rights of Indigenous Peoples, article 24.2 states:

Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.¹⁷

A critical problem is the poor health care options available to Aboriginal and Torres Strait Islander communities with inferior health outcomes throughout their entire lifecycle. A higher percentage of Aboriginal and Torres Strait Islander babies are of extremely low birthweight, there are more maternal deaths, and Aboriginal and Torres Strait Islanders have a significantly lower life expectation than non-indigenous Australians. They are more likely to develop diabetes and kidney disease than other Australians and much of this can be linked back to lower standards of living and inappropriate diet.¹⁸ This data would suggest that palliative care options need to be available at earlier stages, but there also needs to be a commitment to better whole of life care for indigenous Australians.

Perhaps there are still many lessons to be learned from the death of Gurrumul Yunupingu and the difficulties faced by indigenous people in the health system.¹⁹ For many Indigenous people, treatment requires that they travel large distances and are thereby separated from their communities and support networks. Palliative care nurses should be available to remote communities.

24. What are the key priorities for the future?

Best practice palliative care to be delivered across the entire state.

¹⁷ As quoted in:

http://www.patrickdodson.com.au/15_08_2018bills_restoring_territory_rights_assisted_suicide_legislation_bill_2015_second_reading (Accessed 8 April 2019).

¹⁸ <https://healthinonet.ecu.edu.au/learn/health-facts/overview-aboriginal-torres-strait-islander-health-status/36501/?title=Overview%20of%20Aboriginal%20and%20Torres%20Strait%20Islander%20health%20status%2C%202018> (accessed 8 April 2019).

¹⁹ <https://www.abc.net.au/news/2017-07-27/yunupingu-chose-to-leave-dialysis-knowing-he-would-die:-doctor/8749750> (accessed 8 April 2019).

VOLUNTARY ASSISTED DYING

The Issues Paper raises many questions that cannot be answered without implicitly accepting the premise that euthanasia can be legalised “safely”. The ACL contends that some deaths through nefarious intervention, lack of good options, indirect or direct pressure, will inevitably result from legalised euthanasia and international examples bear this out. The correct question therefore is not whether euthanasia can be made safe, but rather how many deaths of elderly people are considered acceptable in order to offer the “choice” of euthanasia to those among the wealthy, white, worried well, who, having the privilege of genuine choice, typically lobby for the legalisation of euthanasia out of concern regarding loss of agency in old age.²⁰ Rather than addressing the specific questions therefore, the remainder of this submission will point to defects in the premise that euthanasia can ever be safely legalised.

EUTHANASIA VERSUS “ASSISTED DYING: NOTES ON THE USE OF LANGUAGE

The Issues Paper, whether intentionally or not, adopts the lexicon of pro-euthanasia lobbyists in describing the activity in prospect as “physician assisted suicide” or “voluntary assisted dying”. The use of language is significant, particularly where it is recognised that “political speech and writing are largely the defence of the indefensible.”²¹

An ancient but evergreen practice with controversial political and ethical issues is to manipulate ideas and language, spinning them to serve one's ends... The advocates for physician-assisted suicide make use of a favorite method from the spin tool box, that of obfuscation, defined in dictionaries as an effort to render something unclear, evasive, or confusing. I believe that in recent years, many (though hardly all) advocates of euthanasia and physician-assisted suicide have used organized obfuscation as a political tactic...²²

Since linguistic clarity is important to the preservation of distinctions, it is worth noting that euthanasia refers the practice on intentionally acting to kill a person by the administration of drugs.²³ Although it is argued that this is only undertaken a person's voluntary and competent request, internationally, public concern in growing at the numbers of people who are now being euthanised without ever having made such a request.²⁴

²⁰ Rachel Aviv, “The Death Treatment: when should people with a non-terminal illness be helped to die?”, *The New Yorker*, 22 June 2015. (<https://www.newyorker.com/magazine/2015/06/22/the-death-treatment>).

²¹ George Orwell, “Politics and the English Language”, London, 1946. http://www.orwell.ru/library/essays/politics/english/e_polit/ (Accessed 11/04/19).

²² Callahan, Daniel. “Organized Obfuscation: Advocacy for Physician-Assisted Suicide”, *Hastings Center Report*, pp. 30–33. (<http://mtw160.198.ippl.jhu.edu/article/250758/pdf> – accessed 8 April 2019).

²³ https://www.eapcnet.eu/Portals/0/PDFs/PM2015_Euthanasia%281%29.pdf

²⁴ See, for example, Kenneth Chambaere, Johan Bilsen, Joachim Cohen, Bregje D. Onwuteaka-Philipsen, Freddy Mortier and Luc Deliens, “Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey”, *Canadian Medical*

Assisted Suicide (used by anti-euthanasia advocates) or **Assisted Dying** (favoured by pro-euthanasia advocates) refers to situation where a doctor or person “helps a person to terminate their life by providing drugs for self-administration, at that person’s voluntary and competent request.”²⁵

What is being contemplated in Queensland appears to be euthanasia, rather than assisted dying or assisted suicide. The Belgians, who have been practicing euthanasia for years do not attempt to disguise it with inaccurate nomenclature – their report on euthanasia deaths in 2018 is clearly identified as *EUTHANASIE – Chiffres de l’année 2018*.²⁶

The argument has been made, for example by the Victorian Premier Daniel Andrews²⁷, that physician assisted suicide is already happening in Australia and that the legalisation of euthanasia will assist governments to ensure this practice is properly regulated. If the testimony of Lord Laverne, addressing the House of Lords, is to be believed then Andrews is right as to the first point. Laverne claimed that:

“in Australia, where euthanasia is illegal, the proportion of deaths without consent ...[is] 3.5 per cent.”²⁸

However, if Australia already has a problem regulating “unofficial” euthanasia, the argument that relaxing the law to allow for greater scrutiny of this practice, is self-defeating. If current legal safeguards are already failing to protect the vulnerable from being killed against their will in hospitals and hospices – if doctors are already making moral, rather than medical, judgements about the value of different lives – this should signal an environment in which further relaxation of protective legalisation could only increase the dangers for patients.

Euthanasia and assisted suicide are NOT the following things: turning off life support, ‘do not resuscitate’ requests, stopping treatment, refusing treatment, palliative care. These are all already legally sanctioned and available and do not involve the active and intentional ending of a life.

ELEVATED VULNERABILITY OF ABORIGINALS AND TORRES STRAIT ISLANDERS

Modern, western humanism contends that death must ultimately be a matter for individual freedom of choice. Where people are unable, through incapacity, to complete their own suicide, this gives rise to demands that the state facilitate death. The policies now contemplated are a

Association Journal, May 17, 2010. (https://euthanasiadebate.org.nz/wp-content/uploads/2012/10/cmaj.091876.full_.pdf - accessed 15/04/19).

²⁵ Ibid.

²⁶ Press Release, Commission fédérale de Contrôle et d’Évaluation de l’Euthanasie – CFCEE, Belgium; *EUTHANASIE – Chiffres de l’année 2018*; <https://organesdeconcertation.sante.belgique.be/fr/documents/euthanasie-chiffres-de-lannee-2018> (Accessed 2 April 2019).

²⁷ Legislative Assembly Hansard, Victorian Parliament, 17 October 2017.

²⁸ House of Lords Hansard, UK Parliament, 6 May 1998, Column 713. Available here:

<https://publications.parliament.uk/pa/ld199798/ldhansrd/vo980506/text/80506-12.htm>

consequence of flawed philosophical foundations that will compel others, including medical professionals who see healing and care as their primary objective, to act against their consciences.

There is another way; a way that entails community and interdependence. It is a way that is understood by our Indigenous communities and which was movingly articulated by Senator Pat Dodson in his opposition to the Restoring Territory Rights Bill on 15 August 2018. To quote from his speech:

In Yawuru we have three concepts that guide our experience of life. They shape our ways of knowing and understanding and are the collective approach to our existence on this earth and, to that extent, any afterlife that may come. They are: mabu ngarrungu(nil), a strong community—the wellbeing of all is paramount; mabu buru, a strong place and a good country—human behaviour and needs must be balanced in their demands and needs of what creation provides; and mabu liyan, a healthy spirit and good feeling. Individual wellbeing and that of our society not only have to be balanced but be at peace with each other within the context of our existence and experience.

This concept of interconnectedness is one that transcends across many First Nations groups. It is grounded in our understanding that human resilience is based on our relationships with each other and our connectedness with the world around us. The quality of life for individuals and for our communities are intertwined, not limited to the wellbeing of an individual. We are fundamentally responsible for honouring our fellow human beings. We are called to carry responsibilities, to exercise duties and to honour those who are in need, who are ill, who are elderly, who are dependent and those of the next generation to value life with love, respect and responsibility. This is true of family members and unknown individuals. Moving away from such principles and values begins to reshape the value of human beings and our civil society, in my view.

We exist not as solitary individuals; we exist within a family, a community, our cultures and ethos, and in the kinship landscape. I'm a great admirer of those who have cared for loved ones and made personal sacrifices to do so. Not everyone is able to do this, I know, and I do not condemn them for the choices that they make. In the broad sense, we are part of a common humanity. If we give one person the right to make that decision—that is, to assist in committing suicide—we as a whole are affected. If we give one family that right, we as a whole are affected. If we give one state or territory that right, we as a country are affected. If we give one nation the right to determine life, our common humanity is affected. I cannot support this legislation.²⁹

It is our Indigenous peoples who, when requiring medical treatment, are likely to be far from their people and their community. This exacerbates pre-existing vulnerabilities relating to depression and despondency and is likely to influence them towards different choices to those they would

²⁹ Dodson, Senator Pat;

http://www.patrickdodson.com.au/15_08_2018bills_restoring_territory_rights_assisted_suicide_legislation_bill_2015_second_reading (Accessed 9 April 2019).

make if palliative care were available in their communities. The opposition to euthanasia expressed by Senator Dodson is cultural.

This way is not foreign to western civilisation, just in danger of being forgotten. It was a former Labor Prime Minister who remembered it and articulated it as:

[Euthanasia] constitutes an unacceptable departure in our approach to human existence and the irrevocable sanctity that should govern our understanding of what it means to be human ... What matters is the core intention of the law. What matters is the ethical threshold being crossed. What matters is that under Victorian law there will be people whose lives we honour and those we believe are better off dead.

In both practical and moral terms, it is misleading to think allowing people to terminate their life is without consequence for the entire society. Too much of the Victorian debate has been about the details and conditions under which people can be terminated and too little about the golden principles that would be abandoned by our legislature.³⁰

Many Indigenous communities are in regional and rural areas of Queensland. Language and literacy problems already contribute to a distrust of healthcare and a reluctance to accept care if it means absence from their communities and support networks. The move towards providing euthanasia is likely

POOR AGED AND PALLIATIVE CARE CREATES VULNERABILITY

The current poor standards in the provision of aged care and palliative care are factors leading to requests for euthanasia due to the pain and demoralisation experienced by the elderly and the terminally ill.

A dying person and their family are extremely vulnerable. In the absence of complete information, particularly information about the possibilities of good palliative care, they make decisions based on the limited options that the Queensland Health Care system makes available to them. In poorly resourced circumstances, families seeing their loved ones going through unnecessary suffering could be forgiven for forming the conclusion that euthanasia is a better option.

THE MERE AVAILABILITY OF EUTHANASIA AS A CHOICE PRODUCES PRESSURE

³⁰ Keating, Paul; <https://www.smh.com.au/opinion/paul-keating-voluntary-euthanasia-is-a-threshold-moment-for-australia-and-one-we-should-not-cross-20171019-gz412h.html> (Accessed 10 April 2019).

Another objection to euthanasia concerns the impossibility of ever entirely comprehending another person's motivation. Advocates for euthanasia argue for the importance of giving effect to 'free choice'. (Presumably, no one who advocates for euthanasia would do so if it meant ending a person's life against their will, in circumstances where their free choice is compromised by other considerations, or where this decision is taken in response to pressure). Free choice can only be said to exist if all other possible motivations to hasten death can be absolutely ruled out. Since no one can fathom the internal processes of another soul, and since this choice cannot be clinically isolated from other complicating considerations which may cloud the purity of that choice and thus compromise the freedom with which it is made, the necessary conditions for purely free decision-making are never achievable in practice.

Pressure to end one's life may be direct or indirect.

Direct pressure

Legislated safeguards offer the vulnerable imperfect protection against overt, direct pressure. Governments can legislate narrow circumstances in which euthanasia is allowable, they can stipulate multiple medical opinions, cooling off periods and guidelines for counselling of the patient, etc. However, even with the best safeguards in an ideal world, no system of protections will ever be entirely impregnable to individuals of ill-will who are motivated to circumvent them. Family and doctors are trusted to act entirely in the best interests of their patients and loved ones. On the other hand, it is well-known that most abuse of the elderly occurs at the hands of family members, typically adult children, and that doctors, however well-meaning, may be subjected to pressure. A 2011 survey of 800 family doctors in the Netherlands found that nearly half had "felt pressured by patients or their relatives" to use euthanasia.³¹

An example of such pressure can be found in the Dutch case referred to by Lord Ashbourne in the House of Lords euthanasia debates, in which an old man was dying of lung cancer:

His symptoms were controlled, and he asked if he could die at home. When his children were told about his wish, they would not agree to take care of him. Even after repeated discussion, they refused. Instead, they pointed to their father's suffering and the need to finish things quickly in the name of humanity. When the doctor refused, they threatened to sue him. As the patient insisted on going home, a social worker went to investigate. She discovered that the patient's house was empty, and every piece of furniture had been stripped out by the family.³²

Laws must anticipate human failing. They cannot assume all families, however apparently loving, are entirely free of ulterior motives in hastening the end of elderly relatives. "Inheritance impatience" is a recognised motivating factor for some adult children of older parents in wishing to hasten their death, as is the wish to avoid the expense and burden of caring for them. Whether

³¹ "One third of doctors have refused a euthanasia request", 7 DutchNews.nl, 29 July, 2011. Available at: http://www.dutchnews.nl/news/archives/2011/07/one_third_of_doctors_have_refu/ (Accessed 9 April 2019)

³² House of Lords Hansard, UK Parliament, 6 May 1998, Column 723

through nefarious activity or undue pressure to hasten death, the risk of 'involuntary euthanasia' for vulnerable individuals is unavoidably greater where voluntary euthanasia is accepted practice.³³

These risks cannot be entirely eradicated even by very careful legislation. In 1994, the UK's House of Lords Select Committee on Medical Ethics concluded that it would be:

virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law ... could not be abused. We were also concerned that vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, whether real or imagined, to request early death.³⁴

More recently, in *Haas v. Switzerland*, the European Court of Human Rights considered that

“the risk of abuse inherent in a system which facilitated assisted suicide could not be underestimated.”³⁵

Were it possible to devise perfect legislative safeguards, it would still be impossible to ensure that the letter of the law would be observed in all cases and that no one would feel pressured to end their lives prematurely. Risk, even from direct pressure, cannot be legislated away.

Indirect pressure

Any discussion of the possibility of pressure being applied for the elderly or terminally-ill to end their lives prematurely must acknowledge the operation of indirect pressure, which occurs merely because euthanasia is an available end-of-life choice. To imagine that the ability to choose death does not impose pressure on the vulnerable is to believe in a world where every individual operates in complete autonomy and can be trusted to make entirely selfish choices, without any consideration for the effects of these decisions on others. Such a world does not exist.

The first principles of social psychology address the fact that we live in community, we make decisions with reference to the common good and for the benefit of those around us all the time. Reduced autonomy is an unavoidable corollary of aging, where dependence on others necessarily increases. If governments could ensure no friend, relative or doctor of an elderly person would ever whisper to them privately that they should consider suicide (and they clearly cannot ensure this), even that would not ensure that the elderly were free from pressure (even if this exists only in their own perceptions) to consider suicide simply because this choice would remove the burden of caring for them from those they love.

³³ F. Norwood, G. Kimsma, and M. Battin, “Vulnerability and the ‘Slippery Slope’ at the End-of-life: a qualitative Study of Euthanasia, General Practice and Home Death in the Netherlands”, *Family Practice*, vol. 26, p. 472. 33 Select Committee on Medical Ethics. Report. London: HMSO, 1994. (House of Lords paper 21-I).

³⁴ Select Committee on Medical Ethics. Report. London: HMSO, 1994. (House of Lords paper 21-I).

³⁵ Press Release: “Switzerland Cannot be Criticised for Not Having Assisted a Suicide”, European Court of Human Rights, Press Release issued by the Registrar of the Court, no. 040, 20th January 2011. <https://hudoc.echr.coe.int/eng-press> Registrar of the European Court of Human Rights, 2011: 3. (Accessed 2 April 2019).

In the moment that end-of-life choices includes euthanasia, those aspects of care that are perceived as the 'indignities of aging' and the inevitable burden that caring for the aged entails are changed from being inevitable and necessary to being avoidable and the product of 'choice'. The old person who could choose death is now a burden for others through their own selfish choice to stay alive. Such a choice may well be resented by those required to care for them or pay for their care. Circumstances are not difficult to envisage in which such old people come to regard killing themselves as 'the right thing to do'.³⁶ In 2012 in Oregon, 57% of those requesting death reported 'burden to family and friends' as an end-of-life concern.³⁷

If laws are changed to allow voluntary euthanasia, indirect pressure is the inevitable result. No government can legislate safeguards against it. The elderly and terminally ill are only protected from indirect or perceived pressure to choose euthanasia by firm legislation prohibiting assisted dying and by the powers of the government arrayed to prosecute any who break this law. The law cannot be changed to accommodate the wishes of the few without exposing the many to pressure to choose euthanasia.

The risks that legal euthanasia poses to the vulnerable thus come in different forms which include direct pressure and indirect pressure to choose death for the benefit of others or for lack of other good options. The end result of both circumstances is that someone dies when they otherwise would live and the State has contributed to their death by failing to offer sufficient protections. Since death is irreversible, there is no opportunity for injustice to be appealed or victims to be compensated. In such matters of life and death governments must exercise the highest duty of care for all citizens by not enacting legislation that would increase the vulnerability of society's most vulnerable.

There are many groups who are particularly vulnerable to being euthanised. These include the elderly, the disabled and the clinically depressed.

THE ELDERLY ARE ALREADY VULNERABLE AND THEIR RISK IS INCREASED

It is hoped that the Royal Commission into Aged Care will identify ways of improving the welfare of the elderly and examine why, for many, their lives are terrible and what could be done to make them less so. Meanwhile, advocates for the elderly affirm that many elderly people wish for death as a means to escape from abusive situations. Advocacy groups for the elderly have termed these

³⁶ Hannah Graham and Jeremy Prichard (October 2013), 'Voluntary Euthanasia and 'Assisted Dying' in Tasmania: A Response to Giddings & McKim', October 2013.

<http://www.bestcare.com.au/documents/reports/VoluntaryEuthanasia-and-Assisted-Dying-in-Tasmania-A-Response-to-Giddings-and-McKim-Oct2013.pdf> 14.

³⁷ Oregon Public Health Division, Oregon's Death With Dignity Act 2012 [Annual Report Year 15] Oregon Public Health, 2013, Salem, 5. <http://www.livinganddyingwell.org.uk/sites/default/files/LDW%20-%20Research%20%20Oregon%20Year%2015.pdf> (Accessed 2 April 2019).

“the suicides we choose to ignore”. An Australian study investigating patterns of suicide among the elderly (the largest study of its type in the world) was published recently in the *International Journal of Geriatric Psychiatry*. The study found that, of suicides in the 65+ age bracket:

nearly 70% ... were male, 66% had a diagnosis of depression and nearly 80% were experiencing one or more major life stresses, such as health deterioration. Around 43% were experiencing isolation and loneliness, and nearly 30% had trouble adjusting to life in a nursing home.³⁸

This information should prompt further questions: why are men more susceptible? How can we support men better? What contributes to depression and what can we do about it? How can we help the elderly cope with major life stresses? How can we alleviate isolation and loneliness? While the conversation revolves around euthanasia, even when the answers to some of these questions are known, they still go unaddressed.

The authors of this study also note that 50% of residents in aged care facilities show signs of depression, compared with just 10%–15% of those living in the community. This figure alone contradicts the view that depression is “a natural part of the aging process”.³⁹ Living alone, rather than mental illness, has been found to be a significant predictor of suicide for the elderly.⁴⁰ Investigations into the deaths of older people in the Oakden care facility in South Australia revealed conditions which might reasonably cause depression and suicidal ideation in anyone.⁴¹ Why is it then, that every effort is made to avert suicide for those aged 15–29 years, but the same rigor is not applied to alleviating the difficulties that might lead to suicidal ideation for the elderly? The answer can only be discrimination – perhaps unconscious discrimination – against the elderly.⁴²

In practice, motivations for choosing to die may be complex. A 2015 survey of patients requesting euthanasia in Oregon revealed the three most significant reasons for this choice concerned a reduction in ability to engage in those activities that made life enjoyable (96%); loss of autonomy (92%) and loss of dignity (75%). By contrast, only 28.7% said they were suffering from ‘inadequate

³⁸ Briony J. Murphy, Lyndal C. Bugeja, Jennifer L. Pilgrim, Joseph E. Ibrahim, “Suicide among nursing home residents in Australia: A national population-based retrospective analysis of medico-legal death investigation information”, *International Journal of Geriatric Psychiatry*, 5 March 2018. <https://doi.org/10.1002/gps.4862> (Accessed 2 April 2019).

³⁹ Briony Murphy and Joseph Ibrahim, “Too many Australians living in nursing homes take their own lives”, *The Conversation*, 6 March 2018. <https://theconversation.com/too-many-australians-living-in-nursinghomes-take-their-own-lives-92112> (Accessed 2 April 2019).

⁴⁰ Paul Donoghue, “Why are elderly Australians taking their own lives?: searching for answers to ‘the suicides we ignore’”, *ABC News*, 4 October 2016. <http://www.abc.net.au/news/2015-10-08/mental-health-depression-elderlysuicide/6808998> (Accessed 2 April 2019).

⁴¹ Nick Harmsen, “SA Premier ‘deeply sorry’ after Oakden ICAC reports five individuals for maladministration”, *ABC News*, 28 February 2018. <http://www.abc.net.au/news/2018-02-28/icac-report-on-oakden-aged-care-homereleased/9492008> (Accessed 2 April 2019).

⁴² Brian Draper, “Elderly men have the highest suicide rate – and ageism stops us from doing something about it”, *The Conversation*, 3 September 2015. <https://theconversation.com/elderly-men-have-the-highest-suiciderate-and-ageism-stops-us-from-doing-something-about-it-46923> (Accessed 2 April 2019).

pain control or concern about it'.⁴³ In jurisdictions that have legalised euthanasia, the State's inability to provide for vulnerable individuals is certainly a contributing factor to the decision in favour of death. Wim Distelmans, Chairman of the Federal Control and Evaluation Commission and staunch proponent of euthanasia, described how doctors in Belgium have adopted increasingly loose interpretations of disease:

We at the commission are confronted more and more with patients who are tired of dealing with a sum of small ailments—they are what we call “tired of life.” Although their suffering derives from social concerns as well as from medical ones, Distelmans said that he still considers their pain to be incurable. “If you ask for euthanasia because you are alone, and you are alone because you don't have family to take care of you, we cannot create family.”⁴⁴

Clearly social causes of unhappiness are at least as difficult to treat as medical ones. As it would be repugnant to offer euthanasia in place of medical help, it ought to be repugnant to offer euthanasia in place of social support. A more humane social policy would be directed to alleviating loneliness, rather than simply killing the lonely. Far from being a reason to introduce euthanasia, suicide among the elderly indicates a significant failure in existing levels of support. Until all other possible motivations for choosing death are removed, the choice to suicide cannot be assumed to be the expression of autonomy, or unrestricted free choice. A choice is only a free choice when there are at least two good options.

HOW DO WE TREAT EXISTENTIAL SUFFERING?

As we have seen above, depression is a reality for a large percentage of our elderly. Depression can be treated yet, most jurisdictions which have adopted euthanasia have no mandatory requirements for psychological assessments. Indeed, some of them allow euthanasia *for* depression. In Oregon, depression is supposed to be screened, however, in 2016 less than one in 25 (3.75%) who died under Oregon's euthanasia law were referred by a prescribing doctor for a psychiatric evaluation before the doctor prescribed a lethal substance.⁴⁵ It is doubtful that a single visit to a psychologist is sufficient to adequately assess whether a patient requesting assisted suicide was suffering from a condition which impaired their judgement. Only half the psychologists surveyed in a study conducted in Oregon felt they could be confident of an

⁴³ *Oregon Death with Dignity Act: 2015 Data Summary*, Oregon Health Authority, 4th February 2016, 6. <http://www.worldtrd.net/sites/default/files/newsfiles/Oregon%20report%202015.pdf> (Accessed 2 April 2019).

⁴⁴ Rachel Aviv, “The Death Treatment: when should people with a non-terminal illness be helped to die?”, *The New Yorker*, 22 June 2015. <https://www.newyorker.com/magazine/2015/06/22/the-death-treatment> (Accessed 2 April 2019).

⁴⁵ Oregon Public Health Division, *Oregon Death with Dignity act: Data Summary 2016*. Table 1, ‘Characteristics of end-of-life-care of 1,127 DWDA patients who have died from ingesting a lethal dose of medication as of January, 23, 2016 [sic 2017], by year, Oregon, 1998-2016’ 9. <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf> (Accessed 10 April 2019).

assessment after only one visit.⁴⁶ A similar experience is found in the Netherlands where referral for a psychiatric assessment is optional. The rates of psychiatric assessment plummeted from 25% in 1998 to 0% in 2010.⁴⁷ Not surprisingly studies show that 50% of patients euthanised in the Netherlands were suffering from depression.⁴⁸

It is obvious to conclude from this that many people are being euthanised while depressed without any efforts to alleviate the depression which may result in reversing the request for assisted suicide.

Typically, where euthanasia is legalised, it is limited only to situations of terminal illnesses. The State of Victoria, for example, requires a diagnosis that the person is likely to die within 6 months. Experience shows, however, that the criteria are invariably expanded over time. The Netherlands, for example, has seen a sharp increase in the number of people choosing to end their own lives due to mental health problems including depression, Borderline Personality Disorder, and trauma caused by sexual abuse. Whereas just two people had themselves euthanised in the country in 2010 due to an "insufferable" mental illness, by 2015 this figure had risen to 56 people. This trend has sparked concern among ethicists.⁴⁹

In January 2018, Aurelia Brouwers, a young Dutch woman, drank poison supplied by a doctor and lay down to die. Euthanasia and doctor-assisted suicide are legal in the Netherlands, so hers was a death sanctioned by the state. But Aurelia Brouwers was not terminally ill - she was allowed to end her life on account of her psychiatric illness.⁵⁰ Aurelia had a diagnosis of Borderline Personality Disorder.

Even without legislative permission for euthanasia in Australia, we have seen one case of a 45-year-old man who was not terminally ill, but suffering from depression, suiciding in Australia with the assistance of pro-euthanasia activist Phillip Nitschke.⁵¹ Reducing the legal protections to the vulnerable clearly only increases the risk and directly contradicts all the efforts and messages of suicide prevention groups.

⁴⁶ Ganzini, L. and Fenn, "Attitudes of Oregon Psychologists Toward Physician-Assisted Suicide and the Oregon Death with Dignity Act." World Federation of Right to Die Associations. <https://www.worldrtd.net/attitudes-oregon-psychologists-toward-physician-assisted-suicide-and-oregon-death-dignity-act>

⁴⁷ Leiva, RA, "Death Suffering and Euthanasia", *Canadian Family Physician* 56(6), 528-10. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2902937/> (Accessed 10 April 2019).

⁴⁸ White, H. "Dutch Study Shows Patients Requesting Euthanasia Likely Depressed" <http://www.euthanasia.com/depression.html> (Accessed 10 April 2019)

⁴⁹ "Netherlands sees a sharp increase in people choosing euthanasia" *Daily Telegraph*, UK; 11 May 2016. <https://www.telegraph.co.uk/news/2016/05/11/netherlands-sees-sharp-increase-in-people-choosing-euthanasia-du/> (Accessed 10 April 2019)

⁵⁰ "The troubled 29-year-old helped to die by Dutch doctors" <https://www.bbc.com/news/stories-45117163> (Accessed 10 April 2019)

⁵¹ <https://www.abc.net.au/news/2014-07-03/nitschke-criticised-over-45yo-mans-suicide/5570162> (Accessed 10 April 2019)

EUTHANASIA EFFECTS THE DISABLED DISPROPORTIONATELY

In her address to the Victorian Parliament, disability rights advocate, Liz Carr pointed out how legalising euthanasia increases the vulnerability of the disabled:

If there was a non-disabled person at a railway bridge about to jump, what do we do? Do we go up to them and go 'you know what, in the name of autonomy and self-determination, you do this. If this is your choice, you do it.' I don't think we do that usually. We usually stop them ... We question their mental health. We would see it as a tragedy if it had occurred.

Now, if that person was ... disabled ... would we act the same? ... My betting is a lot of people would not act the same. They would go 'If that person wants to end their life, I understand why because if I was like that, I'd feel the same.' ... So then we start to call it about choice ... For me, if you even see those two people as different, and those two situations as different, that suggests we do have an unconscious bias and discrimination. So legislation is unsafe already because not everyone starts out as having equal value under the law or in the medical profession or in public perception.⁵²

Unavoidably, legalised euthanasia gives the support of law to the proposition that some lives are not worth living.

The Oregon experience at least suggests that suicide as a culturally accepted "value" and legislation permitting "assisted suicide" go together. The culture of suicide, given its imprimatur by the state, confounds the efforts of parents and caregivers. There's something patently contradictory in a state's provision of, on the one hand, a suicide hotline and, on the other, assisted suicide. The depressed and disabled need our care and encouragement.⁵³

Agitation to change laws to permit assisted suicide is often motivated by the wealthy, white, worried well and the younger generation, who derive comfort from the knowledge that they can control the end of their lives, and that the process of aging and dying need involve no loss of dignity. A confronting response to this argument has been articulated by the disability rights group Not Dead Yet, when they state what should be obvious, but has somehow been overlooked: "we don't need to die to have dignity". They explain:

In a society that prizes physical ability and stigmatizes impairments, it's no surprise that previously able-bodied people may tend to equate disability with loss of dignity. This reflects the prevalent but insulting societal judgment that people who deal with incontinence and other losses in bodily function are lacking dignity. People with disabilities

⁵² Liz Carr, Disability advocate, Address to Victorian

Parliament.http://www.no euthanasia.org.au/liz_carr_address_to_victorian_parliament_on_assisted_suicide (Accessed 9 April 2019).

⁵³ Arthur Goldberg and Shimon Cowen, "The Contagion of Euthanasia and the Corruption of Compassion", Public Discourse, The Witherspoon Institute, 11 September 2017. <http://www.thepublicdiscourse.com/2017/09/19983/>

are concerned that these psycho-social disability-related factors have become widely accepted as sufficient justification for assisted suicide.⁵⁴

EUTHANASIA FOR CHILDREN AND “MATURE MINORS”

The issues paper questions the age at which euthanasia might be administered and suggests an age of 18 years. Overseas experience has demonstrated that euthanasia might be administered to children who are terminally ill.

Belgium amended legislation in 2014 to allow minors with terminal illnesses to qualify for euthanasia. Since that time there have been three cases of euthanasia administered to children. The eldest of these was 17. In the Netherlands it is permissible to administer euthanasia to children over the age of 12.⁵⁵

Canada which only legalised euthanasia in 2016 is already considering extending it to children and also to mature minors, who might be able to access euthanasia and have the parents informed after the event has occurred.⁵⁶ Or, as Wesley J Smith points out, once euthanasia is available, there is no limit to its application:

Here’s the problem: Once a society widely supports eliminating suffering by eliminating the sufferer and redefines as a “medical treatment” the act whereby doctors kill seriously ill patients, there is no logical argument for limiting euthanasia to adults with legal decision-making capacity. After all, children suffer too, so how can they be logically refused “medical aid in dying” — or MAID, the current euphemism for euthanasia and assisted suicide — only because of their age?⁵⁷

FREEDOM OF CONSCIENCE FOR MEDICAL PRACTITIONERS

Conscientious objection is essential to the exercise of freedom of speech and freedom of conscience. Australia is a diverse community and its medical practitioners reflect that diversity. Society and medical practitioners draw on a variety of respected ethical traditions which do not necessarily have the same applications and outcomes. It is important not to narrow the parameters of autonomy of medical practitioners by limiting their free speech and potentially prescribing the manner in which they exercise their professional competence. There are many areas of medicine in which there is no single generally accepted view. Euthanasia is one of them.

⁵⁴ Not Dead Yet, <http://notdeadyet.org/disability-rights-toolkit-for-advocacy-against-legalization-of-assisted-suicide> (accessed 10 April 2019)

⁵⁵ https://www.washingtonpost.com/opinions/children-are-being-euthanized-in-belgium/2018/08/06/9473bac2-9988-11e8-b60b-1c897f17e185_story.html?utm_term=.22bb0ab5514d (accessed 10 April 2019)

⁵⁶ <https://www.redstate.com/alexparkers/2018/10/19/canada-euthanasia-children-parental-consent/> (accessed 10 April 2019)

⁵⁷ Smith, WJ; <https://www.nationalreview.com/2018/11/canada-euthanasia-assisted-suicide-children/> (accessed 10 April 2019)

The community trusts that doctors will operate within an ethical framework for the best interests of the patient. Mandatory compliance with euthanasia will challenge that relationship by removing the ethical judgment from the doctor and potentially lead to a mechanistic response to the provision of health care.

Importantly, a doctor with a conscientious objection to euthanasia should not be required to refer a patient to a practitioner who does not hold a conscientious objection to euthanasia. In many ethical systems this is considered to be co-operation with an unethical action and therefore a person may not be a conduit to this unethical action occurring. In the case of euthanasia, the objector is opposing the direct killing of another human being (murder) or assisting them to kill themselves (suicide). This can never be condoned.

CONCLUSION

This submission hopes to have identified the dangers that exist in legislating for euthanasia. It shows that, historically, those jurisdictions that have legislated for assisted suicide assure that the most stringent safeguards will be enacted, but inevitably through creeping practice and further liberalisation, those safeguards are subject to continual erosion.

If anything, this only affirms the importance of adhering to the first dictate of the Hypocritic Oath – “first, do no harm” – in considering end-of-life choices. Until positive interventions have been explored, funded and implemented; until an impregnable bulwark against the expansion of euthanasia laws by future governments can be established; until direct pressure and indirect pressure can be absolutely ruled out as motivation for suicide; until we can decide categorically which lives are worth living and which are not; until blue sky can be established between suicide for the terminally ill who want it and suicide for those who think they want it because of illness (even terminal illness), depression or both; until the economic savings of suicide can be shown to play no part in the thinking of governments or families; until palliative care is adequately funded and the benefits fully understood by all Queensland residents; until fear of loss of dignity can be removed as a motivating factor for suicide.

ACL submits that any form of euthanasia, assisted dying, assisted suicide not be introduced in Queensland.