Euthanasia – Senate Speech 3 March 2016

Senator DAY (South Australia) (10:23): Like any piece of legislation, the sensible place to start is with the facts, the definitions. What is euthanasia? What is not euthanasia? Herein, I believe, lies great confusion in the community, particularly when asked to consider opinion polls. Before considering what euthanasia is, let us begin with defining what euthanasia is not. The Australian Medical Association policy on euthanasia spells out what euthanasia is not. None of the following is euthanasia: not initiating life-prolonging measures, for example, using a heart defibrillator; not continuing life-support measures, such as turning off life-support equipment; not offering futile care, such as ceasing prescription medication; the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death, commonly known as the doctrine of double effect, such as the administration of strong morphine dosage.

Almost every Australian knows of a usually elderly relative, or perhaps even a close relative, who has died and the difficulty in seeing them die. That most likely informs their view on euthanasia. But no poll seeks to explain to them properly what euthanasia is and is not. People who are polled are also dismissive because they are not faced, at that moment, with an end-of-life decision. Lawyers tell me that, when preparing what are now known as 'advanced care directives', clients are, before proper advice, quite dismissive about their care options. 'Just flick the switch', they say. But when they or a loved one are faced with a situation it is not that simple.

The poll we so often hear is that 70 or 80 per cent of people support dying with dignity. Yet I wonder what the result would be if a different question were asked. For example, faced with a terminal illness, should we care for the patient, or kill the patient? I wonder what the result of that question would be? Progress can never be achieved if you are travelling down the wrong road. If this bill is successful, the nation will begin the long march. We will be moving forward but away from the truth. We will be moving into deeper error with every step.

Euthanasia is presented in many shapes and forms, but it is united in a single idea: the intentional, premature ending of life. Over the years this has been cloaked with many euphemisms—the 'right to die', 'mercy killing', 'dying with dignity', 'aid in dying' and so on. Yet behind this curtain is an increasing appeal to self-determination and autonomy. Around the world more and more people are asserting their libertarian freedom: 'I am the captain of my own ship and master of my own destiny', and 'If you have a right to life, then you have a right to determine when to end that life.' Although all euthanasia laws are introduced with supposedly rigorous safeguards, the reason they never hold is that, eventually, those safeguards are considered unfair, restrictive and even paternalistic.

Terminally ill people are overwhelmed, often depressed, easily influenced and extremely vulnerable. In truth, they have far less autonomy during this time than at any other time in their lives. It is very likely that they will require their families and friends to routinely assist in their care. Tending to the needs of sick loved ones and sticking with them to the end is a dignified display of love and selflessness. Most importantly, it is a witness to outsiders of sacrificial love and familial obligation. For those who do the caring it forges a character of resilience, enabling them to persevere in times of trial. For those who do the dying opportunities develop to reconsider past hurts and biases and for reconciliation and making peace. End-of-life moments can be the most powerful healing moments for the dying person and their loved ones.

Assisted dying offers an alternative—of evasion and abandonment. Family and friends cannot face the emotional investment or the painful reality of suffering. Even in the most loving of families, there are requests for doctors to refrain from dragging things out. It is often not the dying person but the family member who wants the suffering to end. In worst cases, there are ulterior motives for wanting the death of a relative. We are only beginning to understand the extent of elder abuse. We have to realise that in some cases what began as a well-intentioned exercise in being a carer for another person can become such a burden that dark thoughts and schemes develop, particularly where money is involved—be it real estate, funds, or the proceeds of a life insurance policy or policies. No matter how many safeguards, checks or balances you have, the hunger for power, revenge or money can steer its way around many hurdles.

Perseverance and patience have become scarce in our culture of rights. The emerging moral vacuum favours permissiveness before forbearance. Burdens are now felt as intolerable intrusions into one's life and happiness. Worldwide, doctors are feeling the pressure to conform to these new expectations. They are placed in an impossible situation, forced to reconcile their Hippocratic oath with a new-found directive to euthanise. Their great skill, developed over years of effort towards treatment, is now twisted by assisting death—or, more properly, killing.

As with many other emerging rights, conscience exemptions are reluctantly granted or refused altogether. A few years ago, the Royal Dutch Medical Association declared it a professional duty to euthanise by killing those who legally qualify or by referring them to another physician who will. Theo Boer, a Dutch professor of healthcare ethics, recently admitted that his country had got it wrong. He said:

Whereas assisted dying in the beginning was the odd exception, accepted by many — including myself — as a last resort … Public opinion has shifted dramatically toward considering assisted dying a patient's right and a physician's duty. … Pressure on doctors to conform to patients' or relatives' wishes can be intense.

Your complicity or your career. Enough is never ever enough. Perhaps that is why to date medical professional bodies' policies have been hesitant to endorse euthanasia. Why breach centuries of medical ethics?

There are alternatives to prematurely ending a patient's life, such as improving our already excellent palliative care. In fact, a greater presence of such care may have made the Northern Territory euthanasia bill of 1995 unnecessary. During an inquiry in 2009, Professor Ray Lowenthal said:

It is no coincidence that the previous Northern Territory euthanasia legislation was set up at a time the NT had no palliative care services whatever. The instigator of that legislation, Mr

Marshall Perron, has even been quoted as admitting that when he introduced the legislation into the parliament he had never heard of palliative care.

Now that such care is widely available, the former act should stay where it is—dead and buried.

But it is too late for victims elsewhere. Both Belgium and the Netherlands started with compassionate intentions and supposedly rigorous safeguards when crafting their euthanasia laws. Like all nations travelling the wrong path, these assurances were proven all but false. Gradually, they have gone off the rails. In the modern and regrettable climate of censorship, it is virtually forbidden to raise concerns about slippery slopes. Following ideas to their logical conclusion is dismissed as fearmongering, exaggeration or cheap scare tactics. But we are not dealing with hypotheticals here. The gate has flung open and all of the so-called safeguards have been trampled under the weight of progress. Belgium has recently approved a request to die from a 24-year-old woman with mental health problems. Known only as 'Laura', her suicidal thoughts led her to declare: 'Life; that's not for me.' Despite all of the unknowns of the future, a negative prognosis has been given to her remaining decades. Hopelessness has been given the green light.

How does euthanasia interface with preventing suicide? If legislatures say it is acceptable for one person whose life has become unbearable to end their life, how does the suicidal person respond? In Oregon in the USA, where euthanasia is legal, the suicide rate has risen. And here is the great paradox in our community. On the one hand, we all applaud suicide prevention programs. Now, we applaud and facilitate assisted suicide. So at what age does a person no longer qualify for the suicide prevention program and enter into the suicide facilitation program? At what age? How do we define a person?

When does a person qualify or no longer qualify for support and assistance with suicide prevention and then get shunted off into the suicide facilitation program?

It is a perversion of the word 'treatment' to 'cure' a young woman's suicidal thoughts by ending her life. Since when was killing treatment? No matter how qualified, assisted death is now a state endorsed remedy for emotional and psychological hardship. And this is far from an isolated case. I quote once again Professor Boer:

Whereas in the first years after 2002 hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now sharply on the rise. Cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted in being aged, lonely or bereaved.

They were the symptoms that they suffered from: they suffered from being old, they suffered from being lonely and they suffered from bereavement. Are these the people who no longer qualify for suicide prevention program assistance? Are these the people we now move into the suicide facilitation program?

'Laura' is just one of the five people killed each day under Belgium's assisted dying laws. Further studies have revealed cracks appearing around consent safeguards. Professor

Cohen-Almagor of Hull University discovered that life-ending drugs were administered to 30 Belgians in 2013 without—I repeat, without—explicit consent. Involuntary euthanasia appears to be emerging, despite strict provisions that were supposed to guarantee voluntary euthanasia. Tragically, even children are becoming caught up in cultures transformed by these laws. The Netherlands, for example, permits children as young as 12 to be killed, and there is public support growing to include those under the age of 11. Belgium has no age restrictions whatsoever.

The writing is on the wall: so-called 'safeguards' have not prevented a comprehensive weakening of medical and legal standards. What was intended for the elderly has now become available to all ages, including children. What was intended for physical illness is now for mental illness. What was intended for terminal illness is now for serious illness. What was intended to be consensual is now nonconsensual. Soon, euthanasia will be available for good reason, bad reason or no reason at all.

The weight of evidence is an embarrassing rebuke to advocates of so-called 'safeguards'. There are none. No safeguards are safe, nor are they guards; they have more holes than a Swiss cheese. The law will not stand still for very long. Once people have adjusted to a so-called 'new normal' the safeguards will be continually reviewed and seen as intolerant, dispassionate and cruel, and as something that should also be removed. We do not have to turn to other nations to see this in action. It has happened in our own country. Some of the people euthanised under the Northern Territory bill from 1995 were not even terminally ill. That is a shambles, considering there were only four in total.

I pause for a moment when speaking of the Northern Territory, to highlight its higher percentage of Aboriginal people—many of whom do not live near hospitals. The Aboriginal population is not fond of euthanasia at all, and legislating it will create an environment where they are disinclined to seek health treatment for fear of involuntary euthanasia. Many people believe in supernatural healing. For some, euthanasia is sorcery and against customary law. Submissions from Aboriginal people to the Northern Territory Select Committee on Euthanasia were overwhelmingly against euthanasia. One submission from a Yolngu woman stated:

We were and are nomads, hunters, food gatherers, ceremonial and cultural people who just, and will give, comfort and tender loving care to our terminally ill relatives.

I will say that again, 'We will give comfort and tender loving care to our terminally ill relatives.' She continues:

Because our terminally ill relatives know that they are dying they usually always want songs to be sung, they want to hear the last sound of their traditional songs and the sound of the didgeridoo and clapsticks.

In conclusion, euthanasia is more likely to reduce health improvements in the Northern Territory Aboriginal communities as they stay away from a euthanasia environment.

It is fashionable, I know, to talk of a dignified death. But death itself is a wholly undignified and tragic reality. It is a very personal reality, one that cannot be resolved by its acceleration. To burden our doctors — agents of healing and life — by forcing them to participate in premature death, in killing, is a distortion of their vocation. Worse still, forcing them to do so against their conscience is a dangerous path indeed.

The law is a teacher. Returning Australia to assisted suicide will only serve to dull our collective conscience. Australia is not a special case. We are not immune from dehumanising cultural forces.

Far from trivialising the existence of pain and suffering, our institutions and laws need to be united in an affirmation of life. This affirmation is a powerful force for good; preserved by the sacred, immutable truth of human dignity. To conclude with the words of G K Chesterton,

"Think of all those ages through which men have had the courage to die, and then remember that we have actually fallen to talking about having the courage to live."