

**CONSENT TO MEDICAL TREATMENT AND PALLIATIVE CARE (END OF LIFE
ARRANGEMENTS) AMENDMENT BILL**

Wednesday, November 10th, 2010

The Hon. D.G.E. HOOD (17:10): I rise to indicate my position on this bill that has been proposed by the Greens, and I think members will not be shocked to hear that I am strongly opposing the bill. I am aware of the time so I will get straight to it.

There are a number of things I want to address in this bill and the first thing I would like to say for members' information is that next week we will be tabling a petition with over 5,000 signatures against this bill and, to be honest, I think we could have got 10,000, so that is something for members to be aware of.

Also there are a few things I would like to clear up that I perceive might be misconceptions about this bill. We often hear with respect to the debate on euthanasia that some 80 per cent of the population favours it. I have even heard people quote figures of 85 per cent. I strongly reject those figures. I think the Hon. Mr Finnigan made some very lucid comments in his contribution to the last euthanasia debate which outlined very succinctly that there is good reason to think that the numbers are substantially less than that. In fact there was an *Advertiser* poll about three or four weeks ago that showed that it was, in that poll anyway, about 51:49. In fact I have never believed a result of 80 per cent, although that is the figure that keeps getting bandied around.

The Hon. M. Parnell: I'll send it to you.

The Hon. D.G.E. HOOD: I look forward to that and to ascertaining the reliability of it. In Oregon we know that 51 per cent of the respondents favoured euthanasia. In Washington it was 46 per cent and in California, 46 per cent. These figures show in Oregon slightly more than a majority but in the other states certainly less. There is an *Advertiser* poll right at the moment, I just noticed as I was walking up to my office, and I note that that is running at about 60:40 in favour. So, I think the figure of 80 per cent should be disputed, and I certainly do not accept it.

We have seen political parties or smaller groups that have tried to stand on euthanasia platforms, and I think of Philip Nitschke himself who stood back in 2002 and who received around 10,000 votes, as I recall. So there is the claim that this is such a pressing issue and then, when the public actually had a chance to vote for somebody who is probably the single most known advocate of euthanasia, in fact he got the grand total of about 10,000 votes. I think that is a clear rejection of the argument that this is such a burning issue in the public's mind.

In fact, we had two groups standing in the last state election advocating euthanasia and those groups each received something like 0.3 per cent of the vote, if I recall correctly—0.2 and 0.5 of 1 per cent. Here was the chance for the public to stand up and make a big charge for euthanasia and, in fact, that is what actually happened. I think that is a more accurate reflection of the extent to which the people of South Australia view this as a priority.

Just for members' information, as I am sure they would be aware, of course the most recent vote in Australia with respect to euthanasia occurred in the Western Australian parliament just a few weeks ago in the upper house and the bill was defeated by a margin of about two to one. I reiterate that Family First opposes this bill, which is an attempt yet again to legalise doctor-assisted suicide and active euthanasia in South Australia.

Over the years in this place there have been various proposals to legalise the practice of voluntary euthanasia and all have failed when subjected to parliamentary scrutiny. This proposal before us today is certainly a very broad bill proposing far-reaching changes to the way medicine is practised in South Australia and going beyond what many of those past bills have proposed. Most particularly the bill proposes that a person does not need to be terminally ill in order to qualify to be put to death under this bill. Indeed this bill will allow doctors to kill people who are not even dying. I find that aspect particularly troubling and indeed absolutely unacceptable.

I begin by acknowledging, as I did during the past debate, that euthanasia is indeed a truly difficult issue for many people. There are sincere proponents on either side of the debate. On the one hand, there are those who say very sincerely that people who are suffering should have the option to have a 'dignified death', which means to them that a doctor should be able to administer a drug to kill them if certain preconditions are met. On the other hand, proponents of euthanasia should admit that there are those with just as sincere reservations about euthanasia, the message being that in some circumstances the active deliberate killing of a citizen of this state may be permissible should this bill pass.

Proponents of voluntary euthanasia should also admit one other fact: there may very well be strong proponents of euthanasia in this chamber who may nevertheless be profoundly dissatisfied with the model found in this bill. The reality is not voting on euthanasia. This is not a referendum on euthanasia: this is a vote on a particular model of euthanasia. There are certainly some who I have spoken to who may be somewhat in favour of the concept of active euthanasia but who, I think, are predisposed not to support any bill at any cost. If they are to support the concept of euthanasia, these members—certainly, it has been suggested to me—demand better safeguards and consultation.

Let us remember, this particular bill, which seeks to make far-reaching changes to the way medicine operates in this state with respect to palliative care, has not been through a consultation process, as one might expect for such a serious change. Those steps may not be required when we are dealing with comparatively simple bills, but I think that people may legitimately expect that that would happen in cases of literal life and death type decisions. Certainly, the life and death implications associated with this bill are quite profound, as we are dealing with situations where people do not even need to be terminally ill in order to qualify for euthanasia under this bill.

Now, as members are aware, there were some errors, or at least one error, in the previous version of the bill, and I think the honourable member who introduced the bill has admitted that. During the committee stage on the previous bill, it was discovered that there was some wording that actually allowed dentists to perform euthanasia in that bill. Now that wording has been amended in that version and it does not appear in this bill, which is obviously an improvement, but it does make one wonder what mistakes happen when you are drafting a bill about such serious matters.

I believe it is useful to begin by pointing out what this bill is not. This bill is not a bill to legalise the withdrawal of life support from a terminally ill person. That is already legal in most circumstances, and doctors have no duty to prolong life needlessly, and neither would I support that. Nor is there a duty to treat someone who does not want treatment. Doctors are already allowed under law to not treat people who refuse treatment. There is no problem with that under our current law. Jehovah's Witnesses, for example, routinely refuse blood transfusion. Some die as a result, but doctors do not interfere with that wish.

In the same way, many elderly patients make directives that they not be resuscitated in the event, for example, that their heart stops beating. These requests are already routinely respected in our society. There is a clear difference between allowing someone to die and intentional killing. Ethicist Daniel Callahan provides this distinction, and I quote:

A lethal injection will kill both a healthy person and a sick person. A physician's omitted treatment will have no effect on a healthy person...It will only, in contrast, bring the life of a sick person to an end because of an underlying fatal disease. ...the doctor who, at the patient's request, omits or terminates unwanted treatment does not kill at all. Her underlying disease, not his action, is the physical cause of the death...

Nor is this bill about giving terminal patients high doses of pain relief, knowing that the administration of pain relief may end their life. Under the so-called doctrine of double effect, if a high dose of pain relief is required by a patient then it is quite permissible for a doctor to administer it, even if the doctor knows, or strongly suspects, that the pain relief may end that patient's life. This already occurs every day in our hospitals, and I offer for the chamber's consideration it as an appropriate and indeed valuable option for doctors and families. Ethicists John and Paul Feinberg explain the principle as follows, and again I quote:

We are obligated both to preserve life and to relieve pain. Sometimes it may be impossible to do both. If it is impossible to preserve the life of the terminally ill, we are not immoral if we do not. Of course, there is still the obligation to relieve pain and suffering. If we do what we can to relieve pain and in the process hasten death, there is still no moral blame, since we could not preserve life.

I do not believe it when the polls show support for euthanasia at 80 per cent, as I said a moment ago. I believe that many of the people surveyed have those types of passive actions in mind, that is, the withdrawal of treatment or the administration of pain relief with a double effect. None of these things are considered to fall under the category of active euthanasia. Certainly, I feel convinced that nothing like 80 per cent of the population would support the deliberate intention to kill a patient who may not even be terminally ill, as permitted by this bill.

So, let us be crystal clear on what this bill actually does. This bill extends those doctrines to allow medical practitioners to actively kill patients who may, in fact, not be dying or terminally ill in any way whatsoever. The argument is made that this proposal, and others like it, contain 'numerous safeguards', but I wholly reject that submission. I reject the fact that the regime set up in this bill contains anything like the safeguards that most members of the South Australian public would expect.

For example, this bill sets up a voluntary euthanasia board. Some proponents talk of the board as if it has vast powers to oversee this new euthanasia regime, and yet the bill specifically notes, in inserted section 27:

It is not a function of the Board to approve or otherwise authorise each request for voluntary euthanasia.

So, if the board is not there to look at each request—that is, approve it or not—what is it constituted for?

The inserted section 41 describes a very small class of people who may apply to the board for a determination (most particularly the doctors involved in the procedure themselves) and then lists a limited set of decisions the board can make. In essence, this is a body constituted to provide doctors with legal immunity in some of the more difficult or, you might say, morally questionable, cases.

It is the sort of body I would want if I were Dr Philip Nitschke or the like. Third parties, parents or children of the patient, family GPs or medical specialists who are not part of the euthanasia process have no standing to bring any application to the board whatsoever so the board is nothing more than the illusion of a safeguard, I submit.

Much is also made of the fact that psychiatrists will play a key part in determining whether people seeking euthanasia are of sound mind. Again, this is simply bluster and an illusion. The language of the inserted section 35(3)(d) specifies that a referral to a psychiatrist is only required if the practitioners suspect—which, of course, is an entirely subjective element—that the person requesting death is not of sound mind or is under duress; therefore, referral to a psychiatrist is completely discretionary.

Oregon's Death with Dignity Act has a similar discretionary referral clause and, of the 59 people who sought euthanasia in that state in 2009, how many do you think were referred to a psychiatrist? The answer, of course, is not one. One would have thought that a bill with genuine safeguards would contain a mandatory referral to a psychiatrist as an absolute bare minimum, rather than a referral at the discretion of the doctors involved at the very least. I ask members of this chamber how many referrals would Dr Nitschke make if it were entirely at his discretion?

I have already made mention of the fact that this particular model of euthanasia does not even require a patient to be dying. The inserted section 35 certainly allows people who are in the terminal phase of a terminal illness to request euthanasia. This is where many proposals to allow euthanasia draw the line. But the bill takes the concept one huge leap further: the inserted section 35(1)(b) also allows any adult person who is suffering from irreversible illness, injury or medical condition to request euthanasia, provided only that that person subjectively believes that their life has become intolerable.

During debate on the last bill before parliament, which contained similar language, about this time last year, I raised some troubling scenarios that will result from this radical concept. In our mind, we often have pictures of sick and old people requesting euthanasia, but, in fact, the Dignitas Clinic in Switzerland has routinely killed people who are young and comparatively healthy.

Similar to this bill, Dignitas will accept people who are not terminally ill. One *Daily Mail* report from the UK, which I can supply to members if they wish, raised concerns with the active euthanasia of 23-year-old Daniel James, a young rugby player from Worcester in the United Kingdom.

Daniel was paralysed after being crushed in a rugby scrum during training and was confined to a wheelchair. He was not terminally ill; he was not dying. He simply believed that being confined to a wheelchair was intolerable and so he was killed at the Dignitas Clinic. Under the wording of this section, the same 23 year old will be also permitted to request euthanasia and I find that wholly unacceptable.

Others have raised the hypothetical case of a concert pianist who gets arthritis. Their life may now be intolerable to them. Again, remember, this is a totally, completely subjective description and they would therefore be able to request euthanasia. One could also imagine the case of an artist who loses his or her sight, for example. Under the wording of inserted section 35(1)(b), all they would have to say is that they believe their life is intolerable with their new disability and the preconditions for being euthanased would be met. Their life would soon be ended.

The honourable mover may argue that the voluntary euthanasia board can intervene in such cases but, again, I see no actual section in the bill that would enable them to intervene unless the registrar knew of the case or one of the doctors involved in the euthanasia expressed a concern with the board and sought a determination. They simply would not know in most cases. I remind members again of the provisions contained in the inserted section 27:

It is not a function of the Board to approve or otherwise authorise each request for voluntary euthanasia.

I submit that this bill has a number of serious flaws. The mover of this bill has criticised the need for additional safeguards, calling additional safeguards hurdles put up in the way of people who are suffering. With all due respect to the honourable member, I believe it is appropriate for there to be numerous safeguards and numerous hurdles in the way of deliberately assisted suicide along these lines. It should not be a quick and easy process, and obviously it should not be entered into lightly.

There are other serious concerns which do not relate to the actual provision of euthanasia, but I believe again it demonstrates cause for concern and pause for members in considering their position on this bill. One of those concerns relates to insurance, and it is a very serious matter indeed. The inserted section 55 provides that an insurance company is not entitled to refuse to pay life insurance on the ground that a person's death resulted from voluntary euthanasia. Further, people requesting to buy life insurance are not required to tell the insurance company that they have requested euthanasia. That rule is spelt out in subsection (3).

Potentially, we could have people walking into the euthanasia clinic, buying life insurance over the phone on the way, and then being given a lethal injection. I do not mean to be trivial about this but that is a conceivable scenario, and it is hardly fair on the insurance companies or, for that matter, other purchasers of life insurance as their premiums will inevitably rise. How is that fair? However, that will be allowed and, in fact, will be legal under this bill. In fact, the bill specifically bans insurance companies from blocking such attempts. We will see a dramatic rise in life insurance premiums.

I approached the Financial Services Council, the peak body representing life insurance companies in Australia, regarding this provision in section 55. They replied to me in writing, and I will read that out in a moment, but it indicates their concern regarding the section. I quote from their communication with me in full so as to be fair:

In providing the following comments on the Bill, we wish to emphasise that the interaction of State legislation concerning life insurance with federal legislation such as the Life Insurance Act 1995, and the Insurance Contracts Act 1984, is potentially a complex matter requiring careful legal analysis—not least because of the provision in the federal Constitution that provides that where there is a conflict between State and federal laws, that federal law will prevail.

As such, we suggest that the insurance provisions be removed until such time as Members of the South Australian Parliament have had an opportunity to consider the complex legal details of the proposals for insurance in this Bill. We make the following brief comments on proposed section 55 of the Bill being considered.

I read them word for word, as follows:

□ we raise the jurisdictional application of South Australian legislation in the area of life insurance—we understand that most life insurance contracts are actually issued out of NSW, Qld and Victoria;

□ the proposed protection for the consumer under the proposed section 55 contradicts current disclosure obligations under the Insurance Contracts Act 1984 (Cth);

□ the proposed section 55 also creates a risk for anti-selection for the insurer—which ultimately results in an adverse cost impact for other policyholders with that insurer (anti-selection within a risk pool will increase the cost of insurance for all those in that pool);

□ it is not clear whether section 55 will have a retrospective effect. If it does, this will have a negative and disruptive impact for insurers in terms of the pricing of insurance contracts, reinsurance arrangements, reserving and capital management (noting that capital/prudential standards for insurers in Australia are set and supervised by the Australian Prudential Regulation Authority (APRA). As such, APRA may be interested in the potential impact of these provisions);

□ overall, the proposed section 55 creates significant uncertainty as to its intention and scope, for example, in relation to suicide exclusions, and where an existing life insurance policy has exclusions for pre-existing conditions.

I think it is fair to say that the insurance industry has very serious concerns about this matter. These are serious issues, and the wording may in fact encourage and legalise what is in effect insurance fraud.

Further, the bill, in inserted section 54, calls for the corruption of public records. The inserted section states that the death of a person shall be recorded as being due to their underlying illness rather than due to the administration of voluntary euthanasia. In cases where a person is suffering from a terminal illness, the inserted section makes some sense—for instance, if they have cancer. However, we have to remember that under this bill terminal illness is not required.

I have raised the hypothetical scenario of a concert pianist suffering from arthritis being able to request euthanasia because to them their life has become subjectively intolerable. Under the strict wording of this section, the cause of death on that person's death certificate would be listed as arthritis, which, of course, is nonsensical. Certainly, the entire wording of this section is very difficult to understand, when we are dealing with cases where the underlying illness is not life threatening.

Further, in the inserted section 45(2)(b), there is a reference to medical practitioners supplying drugs for self-administration. There is a clear delineation in the medical field in our country between those who can prescribe drugs, that is, doctors, and those who can supply them, that is, pharmacists. This section, which has doctors supplying drugs to patients, puts the onus on doctors to perform the role of a pharmacist.

To be fair to the honourable member, it may be that that was not his intention, but certainly the advice I have had from the people I have had look at the bill suggests that that is the case. So, what you would have is the doctor performing the role of a pharmacist, sourcing the drugs, presumably selling that drug to the patient, as would normally be the function of a pharmacist, and then properly disposing of drugs that are partly used or out of date, and, of course, this is contrary to federal law as it stands.

Further, this bill appears to have conflicting elements. One clear example is the inserted section 37, which requires any medical practitioner to forward an active or advance request to the registrar of the euthanasia board. There is no scope for conscientious objection in that regard; however, in very recent discussions I have been made aware that the honourable member is removing the advance request provisions from this bill, so, to be fair, that will be removed. The fact is that, if a doctor who may object ethically to euthanasia refuses to forward the form to the registrar (there are provisions for ethical objections in the bill, I acknowledge), then that doctor will face imprisonment for 10 years.

This provision is disturbing in that many good doctors who may sincerely oppose the practice of euthanasia will potentially face imprisonment. Whether or not a court would put them there, of course, is another matter but, nonetheless, they will potentially face imprisonment if they refuse to participate to that degree, and yet the inserted section 56 provides that medical practitioners may decline to participate in the administration of voluntary euthanasia and should face no penalty. 'Hear, hear!', I

say to that. Mind you, doctors and hospitals that refuse to participate in the practice of euthanasia are required, under this bill, to advertise, or to supply, the name of another doctor or institution that does.

I was at a seminar today, which members would be aware of, that we organised with Mr Tom Kenyon MP from the other place, and there were a number of clinicians there, including a cancer specialist at the Royal Adelaide Hospital; he treats cancer every day, and he said quite categorically, 'I would absolutely refuse to do that. I don't care what the law says about it; I just wouldn't do it.' This is going to create very serious problems in practice.

I will read onto the record some comments that I have received regarding this bill. In particular, I sought some comment from some palliative care specialists regarding provisions in this bill. Mrs Marion Seal, writing on behalf of the Respecting Patients' Choices program, notes that the current laws work exceptionally well, compared to other jurisdictions in Australia under the consent act framework, in conjunction with the Guardianship and Administration Act 1993, giving rise to policy which has enabled the provisions under our law for refusal and advance request of medical treatment under statute (section 7 of the consent act) and common law (affirmed section 13 of the consent act) to be brought into effect.

From this perspective, it would be judicious to allow the consent act, that is, the current law, to remain. On the phone she has explained that the wording of this bill would make their advance directive process unworkable. Dr Bethany Russell, who works in palliative medicine through the Royal Australasian College of Physicians and is now based at Daw House Hospice, who have I spoken to at the Repatriation General Hospital in Daw Park, has made the following submission to me that I believe is important for the record. Again, I am quoting in full. To be fair, these are not edited comments: they are the full comments. This is a doctor working in palliative care, and I quote directly from her communication:

It's easy for the media to focus on the suffering of an individual and their right to autonomy. I have personally witnessed many protracted deaths of both my patients and indeed of family and friends. I agree that these situations are distressing and frustrating, particularly where severe pain or gradual loss of neurological function is involved. However a sober review of the implications for society on a broader level may be difficult to present on television, but is the duty of parliament.

She goes on:

Firstly, euthanasia and physician assisted suicide erode trust between doctors and patients. The Netherlands experience has shown frail elderly people become reluctant to seek medical attention—refusing to take pain medications, and refusing hospital and nursing home admission for fear they may be killed by their doctor. Establishing rapport with a person 40 or 50 years my senior with a language barrier or cognitive impairment is difficult enough without the added complexity of them doubting my intentions. Despite poorly controlled symptoms, many patients young and old sadly refuse to see our palliative care team due to the misconception that we will somehow hasten their death, even though it is illegal. Without our absolute rejection of intentional killing, even more patients will be deterred from accessing the help they need.

She goes on:

Secondly, euthanasia and physician assisted suicide sends mixed messages to the community that suicide is acceptable. People with depression—youth in particular, are vulnerable to these influences. We need to be clear that premature death is a tragic and unacceptable response to life's struggles when effective and compassionate services are (or should be) available. Also...this bill outlines that mental illness would need to be excluded before euthanasia can be approved. Unfortunately depression, anxiety and other mental illnesses are extremely common in the setting of chronic or terminal illness, making this judgement fraught with difficulty. Research also shows that patients frequently change their minds about end-of-life decisions as death draws near, so, forward planning regarding this issue is also fraught with difficulty.

She continues:

Thirdly, euthanasia and physician assisted suicide will cause serious psychological trauma to medical and nursing staff. 'First do no harm' is such a fundamental principle by which we guide our ships through daily medical and ethical storms. Giving a treatment with intent to kill is very different from either giving a treatment with intent to alleviate symptoms whilst accepting the side effect of sedation or withholding life-prolonging treatments within the setting of terminal illness. Blurring this distinction will lead to sloppiness for some, guilt and anxiety for others. It is hard to imagine teaching medical students how to resuscitate patients in one class and how to kill them in the next.

She goes on:

And finally, euthanasia and physician assisted suicide will have deep ramifications on the psyche of our society. It stems from a line thought that life is expendable; that when a human is no longer productive/active/happy they should be disposed of in the cheapest and quickest manner. In an increasingly consumerist society it is simpler to press the abort button than to provide appropriate care for a seriously ill patient. Again, the Netherlands experience has proved there is a 'slippery slope' of legislation with children as young as 12 and babies with disabilities (as per the Groningen Protocol) now being euthanased, as well as approximately 500 unconsented people per year. Dutch parliament is currently considering the inclusion of people over 70 years of age who are simply 'tired of life'. These laws are wide open for abuse and do not protect the sacred nature of human life—we must stand against similar changes in Australia.

She concludes with these words:

I direct your attention also to the position statement of the Australian and New Zealand Society of Palliative Medicine, of which I am a member...These experienced physicians are not strangers to suffering and yet firmly oppose the practice of euthanasia and physician assisted suicide. On Thursday 16 September [this year], during a national conference held in Adelaide, 66 of these physicians were moved to protest this new bill on the steps of the South Australian parliament.

It is a long letter, but I think well worth reading onto the record. The truth is that, as a member of the palliative care society of Australia and New Zealand, she has firmly rejected active euthanasia, as has her society. This is not just her personal opinion: the Society of Palliative Care's official position rejects active euthanasia in legislation.

I make just a brief note on the seminar that we held today. I think that it was a success, it is fair to say. At the seminar we had four key speakers. There was a cancer specialist from the Royal Adelaide Hospital. He is a recipient of the Douglas Hardy Research Prize, the NEMO Prize, the Albert Baikie Memorial Medal, the Pfizer Award and the Haematology and Oncology Targeted Therapies Award. He said to me that, because of the nature of his profession, almost all his patients are dying or facing that situation.

He said publicly that he strongly opposes this measure because—and he said the literature supports this—about 6 per cent of people who are actually given up as having no hope (that is, they are in fact terminally ill) actually can completely recover. He told a story of how he had a patient just a few weeks ago who completely recovered, although he had actually given up on that person and considered that they would certainly die. He made the point that none of us knows the future and that in about 6 per cent of cases that appear to have no hope, that is to be hopeless, in fact they do go on to live, and live for many years quite a happy and healthy life in many cases.

He also made the point that none of the major medical bodies— none of them—has a position in favour of euthanasia, including the AMA, the Palliative Care Association, the Australian Anaesthetists Association, and on and on it goes. So, he challenged anyone to find a medical body that supported euthanasia.

Another speaker was a registered nurse and a former director of the Mary Potter Hospice Foundation and a current board member of the Palliative Care Council. She concurred with the comments of the cancer specialist from the RAH, but she told a very personal story that she was actually offered quiet euthanasia, if you like, three times. She was told three times that she was expected to die, that she would not live and that it was hopeless. And yet there she is today, in relatively good health.

We also had an Emeritus Professor of Palliative Care at Flinders University and a palliative care consultant and founder of the Daw House Hospice, who spoke of his objection to this bill. Finally, we had the director of the Southern Cross Bioethics Institute, who gave some very sound reasons to oppose the bill as well.

During the debate on the last euthanasia bill, I read onto the record the formal position of several organisations, including churches, regarding euthanasia. At that stage I did not yet have a response from the Presbyterian Church in South Australia. I am grateful for the submission from their committee for investigating social, moral and ethical issues, which reads:

The Church and Nation Committee of the Presbyterian Church of South Australia urges all representatives of the people in parliament to have another look at sections 7 and 17 of the Consent to Medical Treatment of Palliative Care Act 1995 and realise that all that needs to be legalised is already in place. The Presbyterian Church of South Australia recognises the good intentions of those promoting the legalisation of voluntary euthanasia, that is to relieve pain or duress of those

with medically incurable untreatable diseases by consciously ending that life. However, we respectfully believe that this purpose does not justify the means proposed to be used, namely the deliberate administering of drugs with the aim of death.

I read that onto the record because it has been suggested by some members that the Presbyterian Church in some way supports euthanasia. It is quite clear that they do not. In fact, I have further documentation to support that.

I also now have correspondence from the Catholic Church. It has been suggested by some that the Catholics are ambivalent about this, but that is clearly not the case. I have a very long letter here concerning which, in the interests of time if members are looking to move on, I will not read out every word, but I will give members the gist of this letter, if I may. I think it is quite clear that their position is unequivocal. If you will bear with me for a moment, I will get to the crux of it. The church states:

Euthanasia puts enormous pressure on the frail aged to do away with themselves in order to lessen the distress they believe they are causing their family. Euthanasia puts enormous stress on medical and nursing staff not to continue their great care for those in high dependency. People come to aged care homes in order to be cared for, not have their lives terminated before time.

It goes on; they unequivocally oppose euthanasia, and I have that letter for members who wish to access it. Lastly, and I think this is one of the most important points that I will make, I also received the following very powerful correspondence from a person who was at one stage profoundly disabled and who would likely have availed himself of a euthanasia option, according to his own admission, if given the chance.

I believe it's important to hear the voice of someone on the other side of the debate, that is someone who may have been euthanased if such a regime existed here. This person has agreed to their name being used publicly, so I will do that with some reservation. The letter, written to me, says:

Dear member of parliament,

While euthanasia on compassionate grounds seems a good thing on the surface, put yourself in the position of the elderly, disabled or unwanted person. I do not have to put myself in such a place, I am already in such a place. I was born totally blind and in fact was a vegetable for the first couple of years of my life, suffering from cerebral palsy. Through the persistent and loving work of my mother, I learned how to sit up, hold objects, eventually eat without assistance and live a normal life albeit totally blind. The doctors said I'd never live a normal life.

In spite of me overcoming the first hurdle of my life, there have been many times I've been made to feel unwanted, a burden on society and that I should not live. My grandmother and brother consistently made me feel like I really should do everyone a favour and die. There have been times when I've felt such a burden to society that I have considered dying. Of course, at these times, rather than being encouraged to do so, GOOD friends have helped me through and helped me see my value in society. I'm now married with seven children, [have] an excellent job, and helping hundreds of thousands of blind people around the world through the technology I have developed to aid blind people use computers.

Aiding those blind people includes my own mother, who is using the technology this person developed in order for her to learn how to use a computer. The letter continues:

Euthanasia and assisted suicide are both extremely dangerous and outrightly wrong. People who are already vulnerable can be manipulated, as I was, to feel like ending my life. In such circumstances we need to be encouraged to live and given hope, not encouragement to die. My life has turned out far more successful in every possible way than my brother who made me feel I should die, and my grandmother, who consistently made me feel worthless. This is not about the rights of the disabled or elderly to choose to end their life; this is about protecting such people from the ill motives or prejudices of others.

DO NOT allow the legalisation of euthanasia or assisted suicide. Just remember: it may be you who someone convinces to die when you're at your lowest point. Rather, you could be given hope, love and worth, which all humans deserve, regardless of disability or age. It is not up to others to assess the quality or span of another's life.

I will not name that person, but if members are interested I have those details.

In closing, I note that the Netherlands has allowed euthanasia since 1973 and has formally allowed so-called mercy killings by doctors since 2002. The range of conditions has expanded gradually, as it would here, I suspect. This year more than 100,000 Dutch citizens signed petitions calling on parliament to pass laws allowing people who are over 70 years and simply tired of life to be euthanased. Hundreds in the Netherlands every year are euthanased without their specific consent, including babies born with disabilities or terminal conditions.

This is very telling: it is little wonder that Els Borst, who was health minister in the Netherlands at the time euthanasia was legalised, now says that she thinks it was the wrong move and that the country should have focused instead on palliative medicine. That was recently reported in *LifeSite News* in December 2009. There we have the minister responsible for bringing it in now wishing they had not, very publicly and clearly.

In short, there are many serious question marks regarding the drafting of this bill and practical problems such as those outlined by the Insurance Council. I am asking members who are predisposed to supporting the concept of euthanasia not to support any bill for euthanasia and certainly not this bill. It will allow people who are not even terminally ill to be killed, as I have outlined at length. Family First will strongly oppose this bill.

Debate adjourned on motion of Hon. I.K. Hunter.