Euthanasia
20 July 1995

Mrs PENFOLD (Flinders): A considerable amount of material has been given to me by the opponents and proponents of euthanasia and I have read all of it with interest. Many people have spoken to me personally. Nevertheless, I will vote against the Bill. Arguments in favour of the Bill have tended to play on sympathy and compassion, along with the assurance that the laws framed by this legislation would never be misused. That has been done, I believe, with the best of intentions.

The English writer and wit Ben Johnson is credited with saying that the road to hell is paved with good intentions. Good intentions are simply not enough to prevent so-called voluntary euthanasia from becoming a road to hell, no matter how the laws are drafted.

In the Netherlands, where euthanasia has been quasi legal for some time, a high proportion of people have had their lives terminated without their consent. Those who support and those who oppose voluntary euthanasia agree with that statement. The Netherlands' safeguards have been unable to prevent this, yet I understand that the safeguards in the Quirke Bill, which this House is now considering, are less than are required in the Netherlands.

My daughter Katrina, who is 20 years of age, was horrified when I told her that I would be voting against the Bill as I had previously indicated sympathy for such provisions. However, she undertook an assignment on the subject for her university course and I handed over some of my information for her confidential perusal. On the completion of her assignment I asked how she would vote and she admitted that she would not vote for the Bill.

If everyone had the information available to them that I have, I believe that it is unlikely that a majority would vote for euthanasia. I read Katrina's paper with interest and she had obviously read and researched the subject very widely, including the practice in Japan. euthanasia was legalised in Japan in 1962, but only when `death is imminent and the patient is in unbearable pain and requests it'. Writing in her paper on euthanasia, Katrina cited the case of a Japanese doctor who was reportedly charged with murder in 1992 when he terminated the life of a patient not upon the patient's request but upon a request from the family. Katrina observed:

Even if the lethal injection was given in the best interest of the patient it justifies people's fears that by legalising euthanasia it will allow for more people to be killed without their permission and not in their own best interests.

I have become aware of a great fear among the elderly, that is those over 60, that this Bill will be passed because they are in the age bracket to which euthanasia would most likely be applied. A constituent wrote:

If passed, many elderly and very ill people will feel obliged to sign their lives away and `get out of the way' for the sake of their relatives.

Another constituent put it this way:

The elderly people I work with are frightened that if this Bill is passed `doctors may give them a pill'. Why put our doctors, elderly and sick through this unnecessary worry?

The passing of this Bill would put unwarranted and unnecessary pressure on people in that age bracket to choose euthanasia, especially if they felt they were a burden or were unwanted. All people, regardless of their age or condition, have the right to live without unnecessary pressure and fear. Let us not add to the paving on the road to hell.

Most people are unaware of what is possible under existing legislation and medical ethics—and certainly under the Medical Treatment and Palliative Care Act—to help dying patients. Dr John Emery of the South Australian Branch of the Australian Medical Association stated:

It is our experience that patients do not want a painful death and this is what they fear. Many patients also have the misunderstanding that their doctors will not under any circumstances administer a dose of analgesia that may be lethal. This is not so. Under current legislation and ethical guidelines, doctors can, do and should use sufficient analgesia to relieve pain if requested by a patient (or their legal attorney). If this dose happens to cause death this does not pose legal or ethical problems, as long as the primary intent was pain relief and not to cause death.

It is worth noting that the Consent to Medical Treatment and Palliative Care Act absolves doctors and nurses from prosecution when treatments administered with the intention to relieve pain or alleviate suffering (but not death) do in fact cause death. Individuals vary greatly in their tolerance not only to pain but to drugs. Therefore, what is a lethal dose for one person is merely a pain reliever dose for another. Administering analgesia to relieve pain is therefore in a different category from deliberately ending a life by that means.

High quality palliative care is available in South Australia now and continuing medical and public education will enhance and reinforce that appropriate care. Katrina, whom I quoted earlier, has said:

Many fear a `slippery slope' which allows euthanasia to become a widely accepted practice in circumstances other than those originally set. For example, a Dutch woman was assisted to die by her psychiatrist because she was depressed, an act now acceptable in Holland.

The Quirke Bill states that the request for euthanasia must be made in the presence of a medical practitioner and another adult witness who attest that the person appeared of sound mind, appeared to understand the nature and implications of their euthanasia request, and were not apparently under duress.

There are so many unspoken prejudices against people, particularly in the lower socio-economic groups, that all those three points could be attested to and yet the person may have agreed to euthanasia because they felt that that was what was expected of them rather than what they really wanted. That is supported by this conclusion of the New York Task Force on Life and Law in 1994:

The risks (of euthanasia and assisted suicide) would extend to all individuals who are ill. They would be most severe for those whose autonomy and wellbeing are already compromised by poverty, lack of access to good medical care, or membership in a stigmatised social group.

Someone in those categories can be easily intimidated by others whom they perceive as having more knowledge than themselves and certainly more authority. It can be easily accepted that agreeing to euthanasia is what they should do, whether or not they want to. The non-voluntary intentional killing of weak and disabled patients is a small step from the introduction of euthanasia.

I believe that the case against euthanasia has been put exceptionally well by Dr Robert Pollnitz, Chairman of the Lutheran Church's Commission on Social and Bioethical Questions, as follows:

While the notion of personal freedom to choose a time to die may be superficially appealing, the United Nations declares that the right to life is inalienable, a right of which I cannot be deprived and of which I cannot deprive myself. The reason why the State cannot permit me to give up my right to life by giving legal recognition to euthanasia is that it would threaten the right to life of other less fortunate, weak and vulnerable members of the community. As always, our personal rights have to be balanced against our responsibilities to other members of our society.

There is also the matter of a person being declared terminally ill with not long to live but who recovers. A constituent wrote to me about the following instance, as follows:

My sister at the age of 36, with a tumour in her spinal cord, was given a few weeks to live. The doctors thought there was no hope as it was inoperable. Miraculously she has lived to see her five children grow up. If euthanasia had been legalised then she may not have been lucky enough to celebrate her 60th birthday this year.

I have several letters with similar stories to that. Suicide is committed at a higher rate in Australia than anywhere else in the world. The rate of suicide among young adult males (that is, aged about 18 to 35) in rural areas is of particular concern. Being a member who represents rural communities makes me very aware of that. Voluntary euthanasia blurs into assisted suicide too readily. We have more positive and productive ways to help those contemplating suicide than simply assisting them to do the job.

I have a constituent who, as a quadriplegic, has attended university, become a university lecturer, was ordained, has travelled overseas as a guest speaker at international conferences and has achieved international renown as a painter. Some of those who support voluntary euthanasia do so for the incurably ill and terminally incapacitated. That may sound noble, until you begin to relate it to the people you know, such as the quadriplegic mentioned. Again, good intentions turn into hell. The issue of euthanasia—voluntary or otherwise—has been a private concern to me over the past 18 months because of personal experiences. Therefore, I speak from the point of view of someone who has faced the type of decisions that would be required.