THE JOINT STANDING COMMITTEE ON COMMUNITY DEVELOPMENT MET AT HENTY HOUSE, LAUNCESTON, ON MONDAY 10 AUGUST 2009.

DYING WITH DIGNITY INQUIRY

Mr RENE HIDDING MP WAS CALLED AND EXAMINED.

CHAIR (Mr Finch) - Thank you, Rene, for being here today to give evidence.

Mr HIDDING - Thank you for the opportunity to make a presentation to this committee that is looking into physician-assisted suicide public policy to exist here in Tasmania. I sought to come before you because I wanted to share some experiences from my 1997-98 inquiry into euthanasia. I still see it as one of the most important periods of my 11 years in this job. That was the one chaired by Judy Jackson.

I would ask each member of this committee to understand that the proposition before you is to consider whether Tasmanian laws should be amended to set aside any charge of murder, or versions of it, that could be made against Tasmanian medical practitioners where they have either provided the means for or carried out the early termination of life of a patient.

With the indulgence of the committee, and with respect, I would like to lead you through the issue from a professional legislator's point of view, much as I did in 1997-98. I have kept a very interested eye on developments on this matter around the world ever since.

Step one is to understand what we're talking about. Euthanasia is a legal environment which would allow a citizen to take or assist in the taking of another life. There are many forms but in this legislation before you the version of euthanasia is known as PAS - physician-assisted suicide - as a form of voluntary euthanasia. That appears to be the intention of this legislation, although it could be argued that the life-taking exercise could be carried out by others. Euthanasia physician-assisted suicide always requires a deliberate perpetrator other than the sick individual. This legislation is all about protection for that perpetrator against charges of murder, manslaughter, wrongful death, malpractice, negligence et cetera.

Euthanasia is not about the switching off of treatment or of life-saving devices or forgoing futile treatment or allowing such a person to die peacefully. That is good and proper medical practice and what happens now in Tasmania. Neither can that practice be termed 'non-voluntary' euthanasia, as the Greens have accused doctors in Tasmania of practising in a document they have circulated in the community recently. Euthanasia is also not doctors treating patients against their wishes. To do so is quite wrong and illegal. A patient's right to refuse all or any treatment is supreme in Tasmania and Australia. It is also not the use of adequate pharmacological methods of pain relief which may or may not contribute to a person dying, and it is also not suicide, which is the same result but is clearly a unilateral action.

Where euthanasia laws exist - the first evidence of legislated or permitted euthanasia appeared in Germany in the 1930s, but I don't intend to go into what that may or may not have led to in the 1940s. The Netherlands, the country of my birth - which is some embarrassment for me in this matter - operated for many years a legal environment where court findings had acquitted doctors who had carried out euthanasia. Eventually, just a few years ago the Netherlands passed legislation to formalise that environment. Supporters of the practice in the Netherlands talk it up as being enlightened and the Government even has an advertising campaign currently running which promotes that the request to die is brave, wise and progressive. Opponents in the Netherlands tell me - and I have spoken to my relatives and friends there - that they are embarrassed, just as they are with the marijuana cafes and their disgusting red light areas in some Dutch cities, to be seen as a country which stands almost alone with these kinds of laws. They point to hung parliaments and deals to stay in power as the political environment in which many of these laws happen.

Switzerland has very broad laws which go further than physician-assisted suicide. Just last week a leading health professional labelled suicide as a 'marvellous possibility', evidently to manage his country's health portfolio challenges. You can't argue that euthanasia frees up hospital beds.

In Belgium, where they have broad euthanasia laws, they have distinguished themselves as leading the world in the killing of neonatal babies with problems. Presumably, in due course, Belgium will have the world's best disability outcomes. In Washington State in the USA, as in neighbouring Oregon, these laws came into being as a result of one of their citizens-initiated referenda carried out in their non-compulsory voting system, and so should not be seen as a considered act of a body of professional legislators, as we all are in this place today. Other CIR highlights include the State of California, which has been technically bankrupt since its citizens voted to reduce income tax on themselves.

Currently, other than in Tasmania, there is the persistent tabling of a bill in the British Parliament by Lord Joffe. I draw your attention to an outstanding document which evaluates Lord Joffe's Assisted Dying for the Terminally Ill Bill by Professor John Keown. There is also a celebrated case before the courts in the UK called the Purdy case, where I believe the courts have ruled that a husband was wrong to take his wife to Switzerland to terminate her life. It is accepted that whatever the finding, common law around the world will be affected. This could affect Australia with interstate relocations to access Tasmania's unique laws should this bill clear both Houses of Parliament. It is likely that a challenge to the Tasmanian residency under freedom of movement between States would succeed in Tasmania would have a whole new industry called 'death tourism', as Switzerland now does.

Where Euthanasia has been rejected: Throughout the 1980s and 1990s there was a strong push for euthanasia laws throughout most developed countries, resulting in parliamentary inquiries by the House of Lords in the UK, the Canadian Parliament, the United States and in various parts of Australia. These reports are all good reading and essentially found the same outcome, that a professional legislator would not be able to provide laws to allow for the early death of a patient in extreme circumstances without substantially risking the interests of a huge section of the community which could be labelled 'weak and vulnerable'. I commend these reports to you as a committee so that you do not need to reinvent the wheel; the list of inquiries is there for you to look at.

The 1998 Tasmanian inquiry - In particular, because of its relevance, the report of the 1998 inquiry is a very comprehensive report based on the input of some 1 100 submissions, 200 personal appearances and some very diligent work by all members of that inquiry, which included a member of the Tasmanian Greens and two each from the two major parties. It was a House of Assembly inquiry so it missed the input of the upper House, sadly.

My notes of proceedings show that at a certain point during that inquiry the chairperson said, 'You have a strong belief all your life about a matter and then when the evidence is placed before you, you are forced to change your opinion'. In essence the report of that inquiry came down very similar to parliamentary inquiries elsewhere in the free world, in particular point 12 of the findings where it said:

> 'The committee recognises that in a small percentage cases palliative care is ineffective in relieving all pain, however whilst regrettable this is not sufficient cause to legalise voluntary euthanasia.'

Mr Chairman, there are five boxes in the Parliamentary Library of all the submissions and the transcripts of the 1997-98 inquiry. I went through them recently and I commend them to you for your research.

Hospice care/palliative care - Mid last century the hospice care movement was the first evidence of a medical and social welfare community's acknowledgment that more needed to be done to manage end-of-life situations. These societies still exist and have a proud record in developing the palliative care public policy now in place in developed countries.

As professional legislators the first question you must ask yourself is this, as with any bill: Safe for all Tasmanians? Flowing from this, the question is do you recognise the duty of the State to treat all citizens equally, as expressed in most human right charters in existence around the world? If you can identify some questions over safety for all in this legislation, the question for you is: do you believe you can make it safe? This question is the magic pudding question that all the inquiries around the world into euthanasia have not been able to positively resolve. I submit to you that this legislation, while trying very hard to build in safeguards, because of the autonomy it grants to individuals to override all safeguards at every point, simply cannot pass the principal safety test that should apply to all legislation. On this basis, this bill condemns itself as unsafe and should be rejected as such.

The second question is precisely what mischief this bill seeks to address. There is simply no evidence of a large number of 'unmanageable' end-of-life experiences and Tasmanian doctors report that the current operating environment for them is about as good as it could be. The claim that there is some groundswell of public opinion for euthanasia laws is simply not substantiated. A poll of 1 000 people seeking their reaction to a one-sided question simply does not represent any latent need for policy change in this area in Tasmania.

I would like to now lead you through seven key philosophical concepts. The first main philosophical concept you should consider is the concept of autonomy for all versus the obligated citizen. Autonomy is a seductive proposition where every human being should be able to be in charge of his or her own destiny from a day-to-day point of view over all matters relating to one's existence. The opposite, where a State would seek to overly control matters of physical treatment of an individual, clearly is not attractive to anyone. All legislators, however, understand that where a person seeks to manage their own affairs to a point where they want to take their own life then it is the duty of the State to prevent that, even the planning for it.

I would commend to the committee the writings of Anne Manne who is an Australian writer and social commentator who has written widely on feminism, motherhood, child care and family policy. She has written about current society as having two very different moral values, autonomy and obligation. She describes it like this:

> 'A clash between the ideal of a sovereign autonomous self, which is expressive of the individual's right to freedom, choice and self-determination, and (versus) an ideal of an obligated self, which emphasises interdependence, connectiveness and limits the freedom where actions are constrained by the consequences for others.'

That bears thinking about.

The second philosophical concept here is the sanctity of life. I have spoken about it as being a simple and mysterious force which sees strangers dive into rivers to save struggling swimmers. It is understood and embraced by all countries of the free world by many human rights charters but particularly the universal declaration of human rights which the free world developed after the appalling atrocities of the Second World War.

The human rights agenda contemplates no basis for the taking nor the giving of life before its natural course is over.

At the base of the sanctity of life principle is the equality of value of every human being on earth with a particular leaning towards protection for the weak and vulnerable. In the context of the legislation before you, every person who is suffering from an illness which will eventually terminate their lives must be considered as a weak and vulnerable person by definition.

The sanctity of life principle is a mainstay of the Judeo-Christian faith as one of the Ten Commandments. It is also a key principle of most other faith systems in the world. Australia has a distinct Christian heritage encapsulated in the Union Jack in the corner of our national flag made up of symbols of three Christian saints, Saint George, Saint Andrew and Saint Patrick.

While it may not be fashionable to raise Christian, religion or church matters in our Parliament, this inquiry must carefully consider the plain English request from the churches of Tasmania that this legislation simply not be proceeded with. To ignore the churches simply because it is fashionable to do so in our society these days ignores the reality that as of 2001, 68 per cent of your fellow citizens still bothered to identify themselves with the teachings of those churches. For the churches those people identify with, that euthanasia as a simple proposition: it's wrong because God forbids it.

Of course while the sanctity of life principle may have been first expressed in Christian teachings, it has become a centrepiece of all secular creeds in the world dealing with human rights including, as I said, the universal declaration of human rights.

The third one is a slippery-slope or slippage of public policy. This is a longstanding argument against euthanasia laws as there have been demonstrable movements in practice, common law and legislation in the understanding of just who can access euthanasia practices and under which circumstances they can do so.

There is constant discussion in those countries where euthanasia exists whether Alzheimer's should now be seen as a terminal illness and levels of disability are constantly under discussion as well.

In summary, the obvious move downhill on the slippery-slope is moving from voluntary euthanasia through to non-voluntary euthanasia, through to goodness knows whatever is next. Non-voluntary euthanasia is already in common practice in those three European countries that started out with voluntary euthanasia. In the Netherlands, just recently, it was announced that laws were to be relaxed this year but a legislator was quoted as saying, 'The time for full mercy killing is not here yet', demonstrating that they are not yet at that point on the slippery-slope but they are certainly going there.

This legislation hijacks the meaning of the word 'dignity' by using it in the title of the bill and claiming that to lose your life at the hands of another is somehow to die with dignity. I will speak more about that later.

Medical professional issues - While doctors are no longer required to take a Hippocratic oath, the concepts of that oath are embodied in most laws and operating principles for both doctors and nurses. Doctors will provide evidence to this inquiry that euthanasia laws destroy the medical mandate of a doctor originally expressed in the Hippocratic oath as to do no harm.

Of course there are a large number of people in the medical profession and it is obvious that there will always be a percentage who are frustrated by the lack of legal ability to carry out a patient's wishes and therefore state a preference for euthanasia laws to be in place. In discussions with them, their answer to my questions about the weak and vulnerable is invariably along the lines of, 'But surely you can build in those protections?'. They seek to transfer that problem to us as legislators. The evidence around the world shows that we simply cannot do so.

On the question of the issue of pain, I will leave that until later. There is a question about the status of the bill and what the Greens' bill is.

Ms O'CONNOR - Excuse, Mr Hidding, can I correct you, it is not a Green's bill, it is a private member's bill.

Mr HIDDING - Sorry, of course it is, it is Mr McKim's bill. However, some material such as the advice regarding submissions is from the Tasmanian Greens.

Mr HIDDING - The 1998 inquiry into palliative care found that while there was a need for greater resources to expand and improve the quality of palliative care services, the evidence presented showed that in the majority of cases, palliative care was able to provide optimum care for suffering patients. It also found that there was a demonstrated need for increased education through the health system to improve the delivery and efficacy of palliative care in Tasmania.

While, on a political level, it could be argued that not enough is being done on these findings in the intervening period, it simply cannot be argued that palliative care is not available, at least to some degree, in all Tasmanian hospitals including country hospitals or in the home by experienced mobile palliative care nurses.

I do make a formal request to this committee that it takes the time to visit the Whittle Ward as an example of hospice care and also to question the Government on its development of its 'hospice without walls' concept elsewhere in Tasmania.

It could be argued that under the proposed legislation a patient may more easily make the judgment that the palliative care services available in Smithton, without a Whittle Ward, are not acceptable, and therefore move through that safeguard as proposed in the bill. This highlights some regional inequity inherent in the bill which tends to afford a human being in Smithton as having less practical value than someone in Hobart.

In summary, palliative care is just not good enough or available easily enough in Tasmania, but that is the challenge of political will, not a reason to kill those who feel it is not good enough, as this bill proposes. Brian Pollard, a retired anaesthetist and palliative care specialist for 20 years, says in a submission forwarded to me and which was too late to bring before this inquiry, that -

> 'While it is now more than twenty years since the discipline of palliative care was introduced into Australia, far too many patients are still left in unnecessary degrees of pain and other distressing symptoms. This is doubly disgraceful because of the result in human suffering and also because such suffering is largely responsible for the recurrent call of legalised euthanasia.'

Safeguards can be seen as the tests which a patient and medical practitioner needs to pass before taking a human life can take place without the charge of murder being made. In essence, step one for the patient is to make the statement that their pain is intolerable or severe. A minimum seven-day period for consultation with other doctors then is in force, after which a formal request needs to be signed. After a minimum of 48 hours, following that signing, subject to a few achievable tests, the doctor can kill his patient.

I submit that you should strip those 29 tests down to real-life situations, as I did, and find that the hurdles to having one's life taken are really quite low and that the patient is always able to move around the hurdles by steadfast maintenance of the intolerable pain or severe suffering mantra.

For a brief walk through the bill itself, as fellow professional legislators I would like to provide you with my view on the following: the title, 'Dying with Dignity' - this is sheer sophistry. No-one could argue that the taking of a human life conveys dignity. The word 'dignity', as explained in various dictionaries, should not be in the title at all. The title of a bill should always accurately convey the content. So I would suggest, 'A Bill to

Permit a Person to be Killed with a Lethal Substance On Request', would be a more appropriate title.

In more sophistry, the introduction to the bill commences with, 'An Act to confirm the right of a person to… to request assistance to … to end his or her life …'. It is simply impossible to confirm a right that does not appear in any recognised list of human rights, it is not regarded as existing and, in any event, for which no argument is offered. What would be more honest would be to replace the word 'confirm' with the word 'establish'.

In clause 3, 'Interpretation', the word 'assist' is more sophistry. This interpretation is not confined to assistance but includes the administration of a substance by another person, which is clearly not assistance.

Intolerable suffering - just at this point, Chair, I will point out a matter of great concern which is that the bill on the parliamentary web site is not the bill that the Greens intend to progress in Parliament. I have had that confirmed today.

Ms O'CONNOR - It is a private member's bill.

Mr HIDDING - Yes, again I'm sorry. Mr McKim's bill is not the bill that is on the parliamentary web site, and that has led to quite some concern because the words 'intolerable suffering' are not the words used in that bill. I understand it is 'severe pain or suffering' which has really changed a number of things, and I know many people have made submissions on the basis of the words, 'intolerable suffering'. That is a bit of a shambles.

As stated earlier, there is no objective measurement for pain or comparing it with the pain of anyone else. It is a totally subjective experience. The same is true of the word 'suffering' for which many causes exist, including many that are related to social factors and are existential in nature. Therefore, any suffering present in a person with a certain medical condition may not be as a result of that medical condition. Intolerability, or severity of suffering, has only to be in play to commence the process of euthanasia without it being able to be tested or contested.

As legislators, framing a law governing the taking of an innocent human life dependent on such subjective criteria makes a mockery of legal standards of proof.

The term 'mentally competent' refers to the sufferer's capacity to choose freely and voluntarily - that is, to be free from coercion. Doctors tell me it is beyond the ability of any observer to know whether the sufferer is under coercion from any source of which the doctor may not be aware.

Regarding the term 'terminal illness', for the purposes of this legislation, this would include a large number of chronic common illnesses for which there is no cure and which would result in death, perhaps after many years. This bill would entitle all those sufferers to eligibility for induced death, including some who are simply tired of life. Under this interpretation is also the term 'extraordinary measures'. It is so indefinite that it should receive precise definition in here, but it receives none at all.

'Treatment unacceptable to the sufferer' is another interpretation. While the sufferer has a right to accept or refuse any medical process, their views on acceptability have nothing to do with the defining illness and it would be improper to give them any power at law about intentionally taking innocent life.

Clause 8(1)(c)(iv) refers to a qualified psychiatrist having to assess the sufferer's mental competence under various headings. I am advised by medical specialists that this is a serious misreading of the responsibility of a psychiatrist in relation to a person who wishes to be killed. Other than the understandable wish from time to time to not have to undergo treatment, a sustained wish to be dead is psychologically abnormal, and this is true whether it is suicide or euthanasia at issue. This wish is known by specialists to be most often accompanied by the persistence of unrelieved distressing symptoms, including those that could be relieved but are not, and/or for a previous history of depression or existing psychological disturbance. In fact Dr Kay Jamison, a visiting expert on mental illness, said during a television interview that between 90 and 95 per cent of suicides are associated with major psychiatric illness.

The main body of the bill relates to some 29 tests, processes and hurdles which need to be cleared within the minimum nine-day period from the first expression of intolerable pain or severity through to the legally protected act of somebody administering a lethal injection to the patient. Nine days is less than the change-of-mind provision in the retail industry for the return of goods.

Generally, these clauses appear to be of a patchwork nature with a number of different tests, for instance related to palliative care, not logically presented. Further, clause 9 lapses from the defined words 'medical practitioner' into the undefined words of 'the treating doctor' which would appear to allow a veterinarian or a naturopath the ability to take someone's life.

Clause 15 is quite disturbing. This clause provides for a coroner to find certain findings regardless of what the truth is. Firstly, that the doctor who assists or causes the sufferer's death must be regarded as the one who cared for the sufferer prior to death, even if this was not so. Secondly, the evidently unnatural cause of death, namely by a lethal substance, must not be taken to be 'unnatural' which would then trigger a coroner's wish to inquire into the death. These two clauses of this section can only be seen as devious and deceitful precautions that have to be taken in order to smooth the passage for the bill which would likely not proceed if the plain truth were to be told in these two clauses. Just how a coroner would feel in being bound to find certain things regardless of the facts remains untold here and should be probed by this inquiry.

Section 16, medical records to be sent to the coroner: this is a recipe for deceit by the doctor if deceit were wanted. The doctor will be the one who makes the final decision to proceed with the killing without having to provide his or her reasons for doing so. He or she will also be the sole survivor and the sole author of the report to the coroner. Under these arrangements there is zero likelihood a doctor would reveal anything that he or she did not want the coroner to know.

The immunity is there. I will leave that there for you to read. That is the AMA's position, that doctors should not be involved in interventions that have as a primary goal the ending of a person's life.

'Summary: the moral basis for this bill is bad. It seeks to set aside the charge of murder, the most heinous and criminal act in our society. Therefore it is likely to be the most serious bill you will ever have before you in your political life. Euthanasia has been discredited as immoral and unnecessary by most of the free world's parliaments. This bill has no strong demonstrated public need or wish for implementation. It is being pushed by people who are well, afraid of the dying process, who believe it is better to be dead than in pain or in an undignified situation.

This latest euthanasia proposal is no different from all the others. It proposes special rules for the educated, articulate and in-control individual and ignores the inherent threats to the less educated, less articulate and less in control persons in our community who can only be described as in a weak and vulnerable position.

The bill is badly drawn up, clearly a cut and paste of various bits of legislation and needs redrafting by professionals. In fact it is an appalling proposition that Parliament is being asked to relax murder laws by way of a bill that is being proposed by a minority party, by an individual, with no access to parliamentary legislative draftspeople and no input as to consequences to Tasmania's body of legislation from all relevant agencies which would normally be represented in the Cabinet process, which this bill otherwise would have gone through. As an example, the problem we have now of which bill we are actually working with is an example of the problems here.

Further, it presumably is proposed that this bill would be fully debated and voted upon in the House of Assembly in one, two or three 75-minute private members' session times. I submit that this alone should give rise to serious concerns for this committee.

My colleagues would like you to send this message to all Tasmanians. It is by Dame Cecily Saunders, the founder of St Christopher's Hospice, a forerunner of the hospice care movement in every country. Her statement is this:

> 'You matter until the last moment of life and we will do all we can, not only to help you die peacefully, but to live until you die'.

I submit, Mr Chairman, that it is your duty as objective legislators to send such a message.

CHAIR - Mr Hidding, thank you very much for your submission.

If I could ask a question of our secretary. Mr Hidding did mention that a submission was too late and if that is the case, are we still able to accept submissions or is our cut-off date operating?

SECRETARY - The committee had agreed to Friday 31 July as the cut-off point.

Mr HIDDING - I have that submission and I will circulate it privately if you wish.

CHAIR - Okay, thanks very much.

Mr HIDDING - I am happy to take questions.

Mr BEST - When you referred to the magic pudding question, that is safety, and being the entry-level question, I am just wondering if you could define what you see as the important issue around safety. You talk around it in your submission. I think I know what you mean but I was wondering if you could explain exactly what you mean.

Mr HIDDING - Could I table the submission guide - the parliamentary committee of inquiry into the Dying with Dignity Bill, which talks about Nick McKim's bill, the Green's Leader. Every page has along the bottom 'The Greens', so I could be forgiven for calling it a Green bill. I understand that that is a private member's bill and I don't seek to argue on that.

Ms O'CONNOR - It's a matter of the Greens putting forward a bill as a private member.

Mr HIDDING - We are getting a little semantic now.

I am proposing to you as a professional legislator that one of the very first things we look at when a bill gets dropped on the table, whether it be public transport or the whole raft of things we get, is whether the bill is going to kill any Tasmanians. We would normally set that bill aside, throw it in the bin or look forward to voting against it when it comes before us. We would simply say, 'I'm really not going to waste my time working on this or having an inquiry into it because it actually kills people. If you look at this bill and ask whether or not it will protect the ongoing life of an individual in Tasmania, I would say the bill fails at that point. I would say that this bill has inherent safety issues. It's not a question of whether people won't be killed, it's a question of whether they will be charged with murder. That is the issue. It is not a safety provision here; what we're talking about here is somebody not going to prison for killing someone.

Mr BEST - I know you are philosophically opposed to the whole situation here that is being proposed -

Mr HIDDING - Both as a practising Christian and also as a practical professional legislator.

Mr BEST - I'm not commenting in that regard. When we talk about safety, you are of the view then that there is a different emotional state, obviously, when someone is terminally ill as opposed to when they are well.

Mr HIDDING - I think the dichotomy here is that we are talking about educated, articulate people who are well, worried about their dignity when they become unwell and the safety issue needs to be tested for the people who are weak and vulnerable. We shouldn't consider somebody who is educated and articulate and sick as not being weak and vulnerable. Of course they are. I believe anybody that has an illness that could lead to their death automatically goes straight into the weak and vulnerable situation. There are plenty of writings from psychologists and medical specialists to say that the minute you are advised that you have an illness that will lead to your eventual death, it is just commonsense that you find yourself in a weak and vulnerable area, at which point you don't necessarily make as many brilliant decisions as you might have done if you weren't in that situation. It is a terrible place to be to be making decisions about whether you live or die, about your own life. So the weak and vulnerable are the ones that need protection and therefore it is, I believe, a very large section of the community as compared to a small section of articulate, intelligent people who are well and worried about what might happen if they become unwell.

Mr BEST - It is conceivable then that somebody, if they are healthy, could be of a balanced mind in regard to making future decisions, even though philosophically you are opposed -

Mr HIDDING - No, as my submission said, from my interaction with medical specialists and a professional psychiatrist and many writings on this matter, it is the strong feeling of those in the psychiatric specialist area of medicine that any person who wants to take their own life is psychologically abnormal; that is a psychologically abnormal position to be in. People just aren't wired to want to take their own life. They must, by any definition of a normal human being, find themselves in the weak and vulnerable category and be dealt with specially, carefully, as someone who has a condition. Despite the fact that they are educated and articulate, the fact that they want to take their life because, say, they have Crohn's disease or MS at a very early age or somebody believes they have early onset Alzheimer's and they don't want to go on because it's undignified, which is what, before long, this gets to, their wish to die early can and should be seen as psychologically abnormal - and that is treatable.

Mr BEST - I certainly have some issues with the legislation as to the statement it makes to the community but I am looking at the quote that you have in here from the 1998 inquiry when you 'recognise that in a small percentage of cases palliative care is ineffective in relieving all pain, however whilst regrettable this is not sufficient cause to legalise voluntary euthanasia'. Every now and then, of course, we see in the media the case where the loving husband or wife has assisted. They go to criminal trial and there seems to be a pattern in most cases where they receive a good behaviour bond. Do you think there could be, moving away from this legislation, perhaps some consideration of decriminalisation of certain cases?

Mr HIDDING - That is exactly where those European nations have gone now and that is exactly where they started, going to courts and saying, 'Come on, Your Honour, surely it wasn't that bad' and His Honour finds, 'Well, what else could you do?', but where are they now? They are killing neonatal babies with difficulties, whereas in this country we live with them and give them lovely lives. That is where that goes. So, no I don't, but thank you for raising that point because what the committee found back in 1998 was that while there were a few cases which may present a case for - I did not believe they presented a case for but that was the finding of the committee - that was back in 1998. Palliative care is 10 years better already. Pain management is 10 years better. We went to a pain clinic in South Australia, the best in Australia, and under questioning from us on oath this doctor said, 'It's really only bone cancer in some that I could really say that we have a real trouble with', but there are new drugs coming on the market, made with stuff grown in Tasmania, paradoxically, which will allow us to manage that. That is 10 years ago and so you would need to make your own investigations from the doctors, but I am of the view that things have changed in that 10 years. That was in any event a tiny few and in any event not even a number of them would allow us to consider threatening all the weak and vulnerable for those few cases.

CHAIR - On the subject of the 1998 report, there were quite a lot of recommendations in respect to palliative care. Over that time do you think progress has been made and that we have seen more of an advancement and development in that area?

Mr HIDDING - I will forgo the political opportunity to criticise the Government on its role in palliative care because I do not think that even the chairman of that committee would be happy even with the good palliative care we have. I would have to say it is much better. There is a much higher understanding of it; most nurses have some training now in palliative care. Palliative care is available in the St Mary's hospital, the Circular Head facility and anywhere. These things are available to a better degree than they were. There are still lots of arguments about this hospice-without-walls situation that they talk about on the north-west coast. The Whittle Ward in Hobart is wonderful but we do not have a Whittle ward here. We have Calvary Hospital where my Mum died, and it is good. There is not one on the north-west coast, but they have something else. I do not believe in any event, whether it is good, bad or indifferent, the response to that should be anything other than let us find a way to make it better, not to reduce the demand on it by euthanasia.

I have had submissions from people in Tasmania writing and saying, 'Mr Hidding, do you understand that palliative care is not good enough in Tasmania, so we need to have euthanasia laws?'. A scary prospect. It is the political will of whether we want to improve it or not.

Ms O'CONNOR - Going to page 3 of your submission, it states in Washington and neighbouring Oregon these laws came about as a result of a citizen-initiated referenda, and EMRS polling shows that 75 per cent to 80 per cent of the Tasmanian population supports voluntary euthanasia, the right of people to choose. Are you saying that legislators know better than the community in terms of this, because clearly this is the will of the people?

Mr HIDDING - In Washington and Oregon it wasn't; it was the will of the majority of a percentage -

Ms O'CONNOR - Of the majority.

Mr HIDDING - Of the majority of the people who voted. It is not compulsory voting. I guess you could argue that the questions on the two polls here reflect the outcome here. Over there it is not compulsory. The poll you refer to was only 1 000 people.

Ms O'CONNOR - Again I didn't do the poll.

Mr HIDDING - Sorry.

Ms O'CONNOR - Do you believe the community broadly and a majority of community members support voluntary euthanasia or their own right to choose?

Mr HIDDING - I choose to answer the first question. Do I believe that we are smarter than the broader community? As legislators, we must be, we have to be, because we have to take every view into consideration. After the atrocity of Port Arthur, if we had done a poll of 1 000 people and said, 'Should there be the death penalty in Tasmania?', a lot would have come and said 'Yes'. Then we would have said that the people of Tasmania want it so we would now have the death penalty in Tasmania. I stood out there at Agfest shortly after that atrocity. There were thousands of people coming up to me arguing the death penalty and said, 'No, this is a barbaric concept and we will not be part of it', and because it is my job as a legislator to do this on your behalf and to take everyone's view into consideration. If you ring somebody up and ask, 'Should you be able to choose?'. 'Yes, I like choice, choice is good'. If you were to say, 'What about the weak and vulnerable?', they would reply, 'What is that all about?'. They have not had the opportunity to read, to consider; that is your job. It is not the job of the general population out there. If you can leave all of that to the general population, then you can replace all of us with computers, punch in a result every day and you would not need a parliament. You did not need a parliament in Oregon or in Washington state to come up with euthanasia laws. You came up with broad public opinion in a non-compulsory vote.

Ms O'CONNOR - I am wondering if you have had a look at the way the Oregon laws have operated in the past 11 years. Some 341 people have gone through them and a lot of your argument is based on understandable concern for the weak and vulnerable. We have a Parliamentary Library research paper here which says that in 92.1 per cent of the cases people who accessed the scheme in Oregon had at least a high school degree, with 64.2 per cent having at least some college education. So, in terms of the risks that you propose to the weak and vulnerable and to the uneducated, how do you verify that in terms of the evidence from overseas and the fact that the bill makes it very explicit that the person has to be fully informed of palliative care options and of their rights under the law?

Mr HIDDING - I see Oregon, operating for 10 years, as pretty young in its euthanasia.

Ms O'CONNOR - First in the world.

Mr HIDDING - No, euthanasia has been going on in the Netherlands since the early 1990s - not under legislation but in the court room. It was the hottest subject in 1997-98. The Netherlands was going gangbusters on euthanasia. It quietened down after legislation. So it has been going for quite some time already and they did the slippery slope. They went down all that. Oregon, to a degree, is yet to go there, but there are discussions in Oregon about slippage, about the need to look at this and that. So I firmly believe they will go exactly where the Netherlands went because, after all, they are same sort of societies. Concerning the very matter you raised, it is those people, the educated and articulate, who are accessing the scheme. But is there any test in there about danger to the weak and vulnerable? How many of the 341 were genuinely terminally ill? How many could have benefited by treatment?

Ms O'CONNOR - The statistics are available, they published them a few weeks ago.

The commission of inquiry into the medical practice concerning euthanasia was established by the Dutch Government in 1990. They found 1 000 cases where a doctor had deliberately ended the life of a patient without a clear and explicit request from the patient - non-voluntary euthanasia. Do you accept that in palliative care in Australia today there are situations where people who are terminally ill, on death's door, are involuntarily euthanased because their doctor believes that it is the most compassionate response to their situation; they ramp up the morphine until they die?

Mr HIDDING - I reject that completely. I think it's an outrageous slur on doctors to say that today in Tasmania there is non-voluntary euthanasia taking place. In 1998 there was a power of work done on this. There are findings that show that the practice in 1998, which is still a practice now, is that where a physician chooses to medicate a person for the purposes of pain management, if it has some effect on that person's length of life, that is absolutely a side issue. The intention was to manage the pain of that person at that time. That was perfectly acceptable, and for you now to raise and for the proponent of this bill to call that non-voluntary euthanasia is a slur on all doctors.

Ms O'CONNOR - I think you will find here has been research published to show that in Australia one in 50 deaths are attributed to non-voluntary euthanasia.

Mr HIDDING - That's what you call it, but the medical profession sees it, and it had the complete blessing of the 1997-98 inquiry and every inquiry since, as good medical practice. This bill before us today proposes that good medical practice is injecting morphine or phenobarbital for the purposes of killing them. What you are trying to link that to is the medication of a patient to assist their living, which may or may not have some minor effect on the length of their life as a side issue. To call that euthanasia of any description is wrong and offensive.

Ms O'CONNOR - On page 6 of your submission you say 'that this legislation while trying very hard to build in safeguards, because of the autonomy of individuals to override all safeguards at any point' - do you also acknowledge that the legislation gives the individual sufferer the right to opt out at any point, that it is always at every stage of the process the individual's right to ask and to opt out, and there's no coercion at any point in the bill?

Mr HIDDING - The reverse of that would be most peculiar if there was no opt-out clause. You'd say, 'No, no, don't do it'!

Ms O'CONNOR - I just want some clarification on what you mean by 'overriding of safeguards'.

Mr HIDDING - I sat around with a group of friends, some of whom are professionals in health and the law and other things, and we created a scenario in our minds of a normal Tasmanian environment, in a country hospital, and we looked at how hard these 29 tests were and whenever it got a little sticky, it was the patient, by using the right word, which we thought was 'intolerable' but now we're told it's some other word.

Ms O'CONNOR - I think we need to clarify this.

Mr HIDDING - It goes like this. The bill on the parliamentary web site uses the term 'intolerable pain'.

Ms O'CONNOR - So does this copy we have been given today. I'm not having an argument with you, I actually want to know.

Mr HIDDING - What does it say in there?

Ms O'CONNOR - It says 'the right of a person enduring a terminal illness with profound suffering', and then when it goes to the definition it talks about 'intolerable suffering'. So I don't know if we've got the wrong copy of the bill too.

CHAIR - That is off the web site.

Mr HIDDING - I think it's wrong. We were advised on Friday by your senior adviser that the copy of the bill using the words 'intolerable pain' is not the right copy, not the one Nick McKim will be presenting. In clause 8(d), 'the illness is causing the sufferer intolerable pain or suffering'. I was advised on Friday that the words now are to read 'severe pain or suffering'.

Mr WHITELEY - We need to clarify that sooner rather than later.

CHAIR - Thanks very much, Mr Hidding.

THE WITNESS WITHDREW

The Most Rev. ADRIAN DOYLE, **Fr MARK FREEMAN** AND **Dr GERARD McGUSHIN** WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Finch) - Welcome, gentlemen, and thank you very much for making yourselves available to our inquiry.

Archbishop DOYLE - Thank you very much for the invitation to appear at this hearing. Mark Freeman is the Vicar-General of the archdiocese. Dr Gerard McGushin is well-known to many people as a very committed general practitioner on the west coast for many years and a very significant contributor to the community over there. He has since transferred to Hobart and is at Calvary.

In light of what has been said already, I don't think there is any need for me to remind you of the importance of this discussion, the responsibility that you and your parliamentary colleagues have about this matter. It really is about life and death and I'm sure that you are aware of it. Even as I come here to speak to you I am very conscious of those implications from the discussions and contributions about this most important issue. Hopefully they can be done with conviction and clarity but also with compassion.

In another capacity I attended the meeting of the previous committee on 22 July 1997. In fact I got my photo in the paper that day, as the carer of Archbishop D'Arcy who came in a wheelchair after an accident a couple of weeks earlier. I know that he made a very significant contribution at that time and I wish I had some of his clarity of thinking with me today. Nonetheless I now am his successor as the representative of the Catholic community here in Tasmania. It is a responsibility that I take very seriously, as I think you all know. I believe that the Catholic community here in Tasmania makes a very significant contribution to society in various ways, through education, hospitals and aged care and welfare services and I think it has an important contribution to make to this discussion. It is true that the Catholic Church and other churches are religious organisations but that doesn't preclude us from having a contribution to make to this discussion. I don't believe we have the possibility of imposing our views on this process. You are the ones who in the end have to make that decision. We have the opportunity, and I think the responsibility, to come and put our position, along with other people who have contributed in a written form or who will also be meeting with you.

I am aware that quite a number of Catholic bodies and organisations have made a written submission. I know that one has come from Cardinal George Pell, the Chair of the Bishops Commission for Doctrine and Morals. I know there is another one from Calvary Health Care. There is also one from the Catholic Women's League, and I would like to pay tribute to those ladies who for many years have attempted to make a very significant contribution to all these issues of discussion and have given an enormous amount of their time to do this.

I think also that you would be aware, as I indeed am, that a change in legislation would not only be of significance for our own State of Tasmania but for the whole of the nation. What happens in one State has an enormous implication in other States as well.

I must admit that I, too, find it hard to refer to this bill by the title of Dying with Dignity, as if it implies that there are other forms of death that are without dignity. From visiting people in palliative care facilities including Calvary HealthCare facilities in Launceston and in Hobart and in the Whittle Ward, I think people who are terminally ill in those facilities are treated with enormous dignity. One can only admire and commend the people who work there with such dedication in situations where so much love and care is applied.

When I have been questioned about this issue, as inevitably one is from time to time, I have said that the direct intervention of a person to bring about a termination of a life of another is morally wrong and totally unacceptable. That is the basic position I will continue to hold.

There are a number of foundational premises to that position and they are: that all persons are equal in worth and dignity; that every person has a right to life especially understood as a right not to be unjustly killed; that there is no such thing as a person whose life is worthless; that there is no requirement according to medical ethics or the Christian tradition for maximal prolonging of life to be the principal goal of medical treatment; that man and woman of full age and sound understanding may choose to reject medical advice, medical or surgical treatment either partial or in its entirety, even if this is foreseen as likely to lead to a premature death; and that no person or section of the community ought to be absolved from legal responsibilities for their actions.

There are, I think, other things that might follow from the discussion. My colleagues are here wanting to back up what I have to say but I would be prepared to speak to the submission and to enter into discussion without going on too long by way of initial presentation.

CHAIR - Thanks, Archbishop. I think we might hear from your colleagues before we start the questioning.

Fr FREEMAN- Obviously I concur with what the Archbishop said but there are a couple of things more from experience of being involved with people that I think are important to put before a group such as yourselves. You have the responsibility of making the laws of our State in particular but also, as you know, you are expressing what is the good of the whole community. The concern that we would share is that this particular piece of legislation rather than enhancing the good of the whole community in fact takes away from the good of the community mainly in terms of the things that have been expressed by the Archbishop.

One particular concern that I have is what this says to the whole community, and most especially the great concern I have is the reality that we find ourselves in. We work very hard and we are appalled at the rate of suicides, for example, in our society among young people. My concern and a concern about this legislation is that it almost suggests that the ending of life and the choosing to end life is an option for people. I believe it gives a very contrary call to a person who is, no doubt, suffering who might be contemplating suicide. You might argue that that is drawing a long bow in all of this but regarding any person that I have worked with or listened to or tried to support who is struggling with suicidal tendencies or wanting to attempt suicide or who believes that it is the only option I would say and argue very strongly that they are suffering severe and almost intolerable suffering, which are the sorts of terms that are used in this legislation about the end of life and saying that there is no hope. My concern about this legislation, and I believe the concern of people that I work with and care for and support, is that you are really saying that when there is no hope or the presumption that there is no hope then it is okay to end life either by you choosing to do it or by seeking assistance and allowing people to help you to do that. I believe that it is totally unacceptable and I think that it gives a very, very poor message to the wider community and especially to the young. I think it is such an irony that we put so much energy and effort into trying to address the problem of suicide in our society and then we are proposing legislation to do, in a sense, almost exactly that but in another circumstance.

I have worked very closely with people who have been dying and suffering. Perhaps the most telling experience for me in terms of this sort of legislation is the experience of my own brother-in-law who died of cancer about six years ago. The important thing to point out to you is that my brother-in-law did not share any of the beliefs about life and hope and the fullness of life and the Christian faith that I have. We were great mates but he did not share any of those things. I would say he suffered intolerably at times but he also was the recipient of wonderful palliative care. His children think I am a bit crazy because of my beliefs but none of them or any of our family wanted his life to end any earlier than it did, and it ended very naturally with very good palliative care. He was suffering and he was in pain at times but that was eased and soothed because of that good care. I believe I can say to you and that they would argue that despite his horrible illness he died with great dignity. Despite the good intentions of the legislation and the polling of people to ask them whether people should have the right to do this or should they have the choice, I can understand how people say, 'Yes, we should have the choice and it is awful how people suffer', but I don't believe that in the long run it is ultimately for the good of the whole community'. I use those examples as experiential things to back up what I am saying.

We could argue until we are blue in the face as to whether that is a valid argument or has a basis but I believe it is true and my belief comes from having experiences over and over again. There are two cases about the suicide issue - trying to support and work with people who are in danger of taking their life because of their great suffering and also working very closely with people who have an incurable illness, a terminal illness and great sickness but seeing for the person, their families and the wider society a great deal of dignity. I believe that that sort of thing is at risk with this proposed legislation.

CHAIR - Thanks very much, Father.

Dr McGUSHIN - You might have to excuse me because I might be a bit fragile. I've just done night shift at Calvary Hospital and didn't knock off until 8 a.m. so I have had two hours' sleep.

Ms FORREST - Did you drive up then?

Dr McGUSHIN - No.

Mr WHITELEY - Chauffeur?

Dr McGUSHIN - Yes.

I come to you on the basis of a doctor who is a practising Catholic so I agree with everything that Father Mark and Archbishop Adrian have said about the ethos with death and dying, but I am also familiar with death, respects death and has dealt with death and looked after a lot of people who are dying and in need of terminal care. I did that for 19 years in Queenstown where I was the person responsible for looking after them while they were dying.

In my current role at Calvary, I work in accident and emergency but I also work at St Johns Hospital three days a fortnight and some of my work is involved with people dying with cancer. So I do have ongoing care for people who are dying. As a practising Catholic I serve as commissioner for the Tasmanian Catholic Justice and Peace Commission and I am also a member of AMA.

I agree that the name 'Dying with Dignity' bill is probably a misnomer. The bill should be called 'The Physician-Assisted Suicide' bill because that is what it is. It is a voluntary physician-assisted suicide bill. I agree that the term 'dying with dignity' implies that other means of death is undignified. I would say here that we live in probably the richest country in the world. We have the best medical systems in the world, even though we are moaning and groaning about having to wait two hours in an accident and emergency department. That is the situation and no-one dies a lonely, dirty, disgusting death in Tasmanian hospitals. That just does not happen. The bill seems to be coming from people who are frightened of death and my response to them would be, 'You are educated and articulate, why are you so frightened of death?' The bill suggests that you are going to die while you are well and truly in control of your faculties and do not want to come to that final passage of death, which we all realise is a process of life. So I disagree with the title of the bill.

As for the claim that one in 50 people are euthanased anyway, that is completely wrong. I have never given anything on the basis that I would end a person's life. It is extremely rare and I do not know any doctors who do. Sure, it probably does happen. In England, Harold Shipman killed 250 of his patients by doing exactly that. I do not think there are too many serial killers who are Australian doctors, killing patients. I disagree with the suggestion that it is happening anyway, so why don't we legislate and make it all kosher? It is not happening.

I do not propose to speak for the AMA, but I can give you the AMA position. The Australian Medical Association made a position statement on the role of the medical practitioner and end-of-life care in 2007. One of the statements was that the AMA recognises that there are divergent views regarding euthanasia and physician-assisted suicide, but the AMA believes that medical practitioners should not be involved in interventions that have the primary intention to end a person's life. This does not include the discontinuation of treatments. If a medical practitioner acts in accordance with good medical practice, the following forms of management at the end of life do not constitute euthanasia or physician-assisted suicide: that is, not initiating life-prolonging measures, not continuing life-prolonging measures and the administration of treatment intended to relieve symptoms which may have a secondary consequence of hastening death.

I have been in the position many times of providing palliative care relief of symptoms where I know for a fact that by ramping up the morphine and rendering the patient either comatose or semi-comatose, I am going to hasten that person's death, but we are talking about only a few hours, days- it's not months. I have never had any problem with that. The doctors in Tasmania do not have a problem with that. That is just good palliative care. The idea that we see our role as prolonging someone's life no matter what is wrong. It does not happen. It is not what most doctors are about.

I also believe that if the bill is passed it would undermine the trust that people have in the nursing and the medical profession. Currently people trust doctors and nurses and the basis of that is that people perceive that nurses and doctors look after their interests ahead of other people's interests. If you say, 'We're now going to pass this bill because it has all these checks and measures that prevent any sort of coercion', there are all kinds of subtle coercion. People might say, 'Maybe this is my best option if I'm suffering from intolerable pain'. What is pain? Is it physical or is it mental? 'If I'm suffering from intolerable mental pain and my continuing to live is putting all this undue pressure on my relatives. It's terrible to see them crying, so I'll sign this bill and end my life.' Then maybe the doctor has suggested it might be the way to go. Who is the doctor acting for? Is the doctor acting for the patient or for the State or does he just want to get rid of the patient because they are a nuisance? I just don't think it is the way to go. If you introduce this legislation it will undermine people's trust in doctors and nurses.

We are a rich country with first-class health services and we will be judged on how we look after the weak and vulnerable in our society. When people are dying they are at a very vulnerable stage in their lives, as are the relatives, but people sometimes find it an extremely enriching experience. Not necessarily the person going through the death but the relatives getting together and saying goodbye and dealing with all the family differences they have had for years. To deprive people of that full experience by saying, 'This is an option you can take' and then they say, 'Let's take this option because it seems to be the right thing to do', I don't think that does anything for society.

Ms FORREST - I would like to ask a couple of questions. You talked about doctors giving extra morphine or other drugs in the course of palliative care which could hasten death. Would you please clarify how you see that as being completely different from giving a cocktail of drugs designed to end a person's life?

Dr McGUSHIN - It is different because the primary intention is not to end a person's life. The primary intention is to provide relief. That's the difference. You say, 'Maybe that's just semantics' but that is a big gap to go over. It is crossing the Rubicon to go to that line of thinking; 'I'm going to end this person's life by injecting a lethal cocktail of drugs'.

Ms FORREST - I've talked to a lot of health professionals and when I asked them about this particular issue and how they would respond to a question such as asked in the MRS survey, many of them said that they understood the question to include that treatment you were talking about. Given that response, do you think that might be the way it could be interpreted? In that case, are we not really talking about the same issue when we say that 85 per cent of people support the view that voluntary euthanasia or the choice to end their life at a time that is right, as they see it, is a choice they should have.

Dr McGUSHIN - I'm not sure what you are getting at. People might say, 'This is not such a bad idea' but the fact is that doctors don't want to do -

Ms FORREST - A lot of them said that to me as well, that they don't want to do it themselves.

Dr McGUSHIN - But would you put in a cannula and give the illegal cocktail of drugs? They say no. That is a pretty grey area.

Ms FORREST - When the question was asked in a survey - a medical professional was asked that question - they could see it including increasing morphine, for example, or withdrawing ventilator support from a patient. Do you think that could include that or do you think they all see the difference?

Dr McGUSHIN - That is not euthanasia, that is just withdrawal of treatment with the idea of not prolonging that person's life. That is just allowing nature, if you like, to take its course.

Ms FORREST - I appreciate that. Do you think though that when that question was asked broadly in the community that people could equate that sort of treatment or withdrawal of treatment or whatever it is, with actively taking someone's life in the same -

Dr McGUSHIN - Are you talking about the general public?

Ms FORREST - Yes.

Dr McGUSHIN - I think that's entirely right. I don't think people understand, when they tick the box in favour of voluntary euthanasia, what they're talking about. They perceive that's a possibility.

Fr FREEMAN - On that very point, I think what you seem to be getting at is exactly true. For example, after mass on a Sunday, the bishop had sent a letter inviting people to think seriously about this issue and to have a look at the legislation and make their own responses and so on. I was amazed at the number of people that came out and said, 'Are we saying that we don't believe in palliative care?'.

Ms FORREST - Or withdrawing treatment.

Fr FREEMAN - Yes, withdrawing treatment, and I was very interested in that. I was surprised that people weren't clear about it. If they were asked about it in a survey, what are they answering? That was a concern certainly for me. I was quite surprised at the number of people who took me to task about why are we against this sort of thing. I am thinking, 'Where are we going here?'. It was about this very issue because they were saying they believed the church was saying, in opposing a bill like this or opposing euthanasia, that we didn't believe that you couldn't give proper palliative care or that you could withdraw extraordinary means to maintain life.

Archbishop DOYLE - The irony is that, at the time when we seem to have such wonderful opportunities for palliative care, we're getting into this debate at all. We should be in a position where we have so many other options available to us that this particular direction ought not to be in our purview at all.

Ms FORREST - Gerard, I understand you oppose the principle of the bill, however I just want you to look at it in a fairly broad sense. If the bill was passed and you were working on the west coast and were not a Catholic doctor who had opposition to it, but rather a doctor who had to work under the law here, do you think that people on the west coast could access euthanasia under this bill, because of all the steps and boundaries they have to go through?

Dr McGUSHIN - Yes.

Ms FORREST - How would they access the palliative care specialist and the psychiatrist required?

Dr McGUSHIN - It would be difficult. They would have to travel to go through that process. I can't see a psychiatrist and palliative care specialist coming to Queenstown to see one person.

Ms FORREST - And they may need to see them a number of times.

Dr McGUSHIN - Yes, though I'm sure that west coast people could access it. A similar issue is what do you do about abortion. I don't refer people for abortions, but I don't actively try to stop them from going to another doctor. If this is passed I wouldn't actively encourage my patients to participate, obviously. But if they said to me, 'I'm going to go and see the doctor down the road and have this done', I'd say, 'That is your choice'.

Ms FORREST - There's some contention that, because of the number of requirements that are in the bill that someone has to go through, people from anywhere on the north-west coast -

Dr McGUSHIN - Yes, you are right. People in isolated areas are handicapped with lack of medical services; they don't exist or are limited, so you're right. It would be much more difficult for people in remote areas to go through this process.

Ms FORREST - So could it be discriminatory in that sense?

Dr McGUSHIN - You could look upon it in that regard, yes, but a lot of medical services are discriminatory for remote people.

Mr BEST - We are equally concerned about the message the legislation portrays to the community. In the media we read stories that a loving husband or a loving wife in a very genuine circumstance has reached the point where they can no longer cope with the pain. These are the ones, I suppose, who fall through the cracks. They are charged, go to court for either murder or manslaughter or whatever the case may be. Do you think those people should be charged? I know it is a very general question and I have not presented a particular case, but do you think those people should be charged in that situation?

Archbishop DOYLE - Obviously those situations are ones that cause considerable pain and anxiety for all. I think we have to provide them with as much support and care as we possibly can and if there are shortcomings we have to try to do that. I think there are some other elements to it all. Lawyers would say that hard cases don't make good laws;

you can't legislate in the light of exceptions. As Dr McGushin has already said, the very important thing for me is that this legislation is calling upon someone else to kill; that is what it boils down to.

I know that the situation mentioned comes up and it is a pity for them.

Mr BEST - An extreme example.

Archbishop DOYLE - I think we have to set out as a caring community to try to find another way to help those people in those circumstances.

Ms O'CONNOR - Going to your understanding of the bill, do you accept that it does not compel anybody to request the physician's assistance and it does not compel any general practitioner to accept that request; there is no element of compulsion in this bill in terms of the implications for the vulnerable?

Archbishop DOYLE - As I said a few moments ago, whether people do not feel compelled or are compelled, I cannot accept that one human being is called upon to pursue an action that will directly bring about the death of another person. That is really at the heart of what I personally am struggling with about this bill. In the context of an organisation like mine, it may be that in the Calvary facility you have a person who wants it and maybe even a staff member who is prepared to do it, but we can't accept and allow that to happen in our facility. That really is an enormous worry for me as the leader of this big organisation.

Ms O'CONNOR - I guess the flip side of your concern is that it makes medical professionals complicit, if you like, in the death of another person, is that the individual sufferer, if they don't have access to a regulated and controlled regime, may take the option of taking their own life. To some people who are suffering severely and who are heading down the short terrible tunnel of death, suicide may be the only option that they can see. Can you see why it might be preferable for there to be a regulated, controlled system for people who are suffering and for whom palliative care offers limited or no relief, that this may be preferable to leaving them in the community to exercise the worst possible option of a lonely suicide or making another member of their family complicit, like in the Godfrey case where the son helped his mother to die at her request and ended up in court?

Archbishop DOYLE - I couldn't bring myself to say it is preferable in any event because it is involving the intention or decision of one person to intervene in the death of another. That is a non-negotiable condition that I would not move away from at all.

Ms O'CONNOR - Fr Freeman, I just want to talk about your brother-in-law. Did he at any point express a desire to end his own life or to have immediate relief of his terrible suffering?

Fr FREEMAN - Not specifically, and in fact he expressed certainly a desire to keep living as long as he possibly could.

Ms O'CONNOR - So there was no 'Put me out of my misery' plea?

Fr FREEMAN - Not specifically, but when he came towards the end of his life he was given the option by his oncologist of having ongoing treatment or palliative care and he made the option to have palliative care because he did not want to continue the regime of treatment that would probably, I suppose, have extended his suffering. He actually wanted to die with dignity, ironically, in terms of this sort of discussion, and he died with enormous dignity. It was an enormous privilege for us as his close family to accompany him in that. It was very painful and very difficult but I think that perhaps the most moving experience was when my sister-in-law and niece-in-law who are nursing sisters, and actually sisters - but it is Tasmania after all - were caring for him.

Laughter.

Fr FREEMAN - Sometimes they needed my brother and me to help them move him and bathe him and I consider it was an enormous privilege to be able to do that for him; it was a wonderful experience of dignity, as have been so many of the experiences that I have had. I know I am a Catholic priest so I am going to be in those sort of circumstances but I suppose my objection to the bill is that I am wanting to plead with our society to not miss out on these opportunities by neatly packaging an option and putting that into the legislation. A person may choose to commit suicide because they cannot stand their suffering any longer but they ought to make that choice themselves, not impose it on our society or another human being to have to intervene to cause their death in the sorts of terms the bishop is saying.

Ms O'CONNOR - Do you accept that because committing suicide is not a crime under the current law here that it actually discriminates against people who are physically disabled, because if you are physically disabled and suffering from a terminal illness and wish to take your own life to end your suffering you cannot do it?

Fr FREEMAN - I think that I would just have to say no, I do not think it discriminates.

Ms O'CONNOR - Dr McGushin, at one point in your testimony we you were talking about how medical practitioners administer palliation to the terminally ill and the proposition that I put to Mr Hidding earlier that there are situations where out of compassion and only out of compassion medical practitioners may increase the dosage of a palliative drug, knowing that relief will be provided but also that death will be hastened. Do you accept that that does happen?

Dr McGUSHIN - Yes, I accept that that happens and I do it all the time and so do other doctors. But that is not what we are actually talking about because the primary intention is not to end that person's life, it is to relieve their symptoms.

Ms O'CONNOR - But in administering the elevated level of that drug you are doing so in the full knowledge that it is likely to hasten the sufferer's death.

Dr McGUSHIN - I have no problem with that at all, it is good palliative care.

Mrs BUTLER - I am interested, Your Grace, in your reaction to Ms O'Connor who was talking about the fact that in Oregon there is quite a high percentage of people who were well educated who had made the choice to euthanase. I wonder whether there is some element of fear or lack of control. I would like a response from you in regard to that.

Archbishop DOYLE - I have no way of verifying it, but it is being said that it's a part of the attractiveness, perhaps, for some people because it will allow them to exercise some control about how things unfold for them at the end of their life, but I wouldn't for a moment try to anticipate what their thinking might be. It is what one hears but I have no way of verifying it. We come from a particular point of view where we see death in a particular way and we see it as them moving on to something greater, but not everybody shares that view. It can be hard for us sometimes to put ourselves in the mind of somebody who sees it differently. I heard Mr Hidding say that people would be more highly educated but I'm not in the position to confirm that.

Mrs BUTLER - Dr McGushin, could you expand a bit on times when there is hope and reconciliation with death? That is certainly my experience in working with the dying.

Dr McGUSHIN - I'm probably not the person to elaborate on it. I was recently at a talk with Dr Paul Dunne, who is a palliative care specialist in Hobart, and he made this very point, that with all his experience he has found it quite a positive experience for the relatives involved being with the person who is dying. He was castigated in the *Mercury* in the Letters to the Editor, 'What would he know about death? He's only a palliative care specialist'.

Laughter.

Dr McGUSHIN - From my own personal experiences in dealing with it, sometimes it is terrible. I remember a lady in Queenstown who was dying with renal cancer and her two adult daughters would come and wail by her bedside every day. One day she rang the bell and I went to her and she said, 'Can you get rid of these people?' They were making her experience a bad thing. Then you have a discussion with the family, 'This is not the way to go' and in the end she died a very nice death and the relatives came a bit more to grips with what was going on. If you say, 'I don't want to go down that path because it's too difficult, it's going to be too difficult for me and for my relatives', I think you deprive some people of an extremely positive experience.

CHAIR - While on the subject of palliative care, in the 1998 report there was a reference to a lack of training for medical professionals in respect of palliative care. I think there was a reference to something like nine hours of training in all the training that a doctor will do. Has the scenario changed? Is there more concentration on palliative care and the training of doctors these days?

Dr McGUSHIN - Much more so. We have to deal with an ageing population so that will mean a lot more palliative care, looking after people as they're getting older and dying. I would say the training is much better, the services are much better also. Doctors' and nurses' understanding has increased significantly over the last decade.

Mr WHITELEY - Dr McGushin, in your experience, and going down the same route as Mr Hidding - and this is not a political witch-hunt - in the 1998 report there were a lot of references given to the provision and the availability of palliative care. I think we would all want to see that those services were available to anyone and everybody and that there would be no discrimination. Having said that, and we live in a prosperous country, do you feel there is still room for more available services? I'm not questioning better treatment, I think the treatment is fantastic, but there seems to be a concern that maybe it is not as available to all across the State as it could be and that we should be addressing this issue rather than talking about an option that wants to see people exiting early because we are not providing those services.

Dr McGUSHIN - I think that is possibly so but as long as you have a sympathetic doctor and a nurse or some other person to look after the person who is dying then I think that is good palliative care. I do not think you need to have the term palliative care specialist to provide good palliative care. Even in the absence of palliative care where some people might have to travel to access some services, I do not think that is a reason you should be considering a dying with dignity bill.

Mr WHITELEY - But do you think there is still room for improvement though in the availability of services?

Dr McGUSHIN - There is always room for improvement.

Mr WHITELEY - For example, in the south of the State we have the Whittle Ward but yet the same level of service is not available, say, on the north-west coast.

Dr McGUSHIN - That is right but that is the reality of medical care. We do the best we can with what we have.

Mr WHITELEY - Taking away the issue of fiscal restraints or anything like that, have we still some options open to us to make sure we can take this to an even better level?

Dr McGUSHIN - Yes, I think so.

Ms FORREST - I think we all accept, and I certainly accept living on the north-west coast, that if I have a very premature baby then I am going to end up in Hobart or Melbourne. I also accept that everyone dies and we need services to be improved. When we say there are no real palliative care services on the north-west coast of any substance, it is a glaring lack, and we are saying it could be improved. We accept that some things are only available in Hobart, and that is acceptable, but do you think it is acceptable to have a very good service in Hobart and barely nothing on the north-west coast or is that an area that we need to look at?

Dr McGUSHIN - I don't think that is acceptable at all, but the trouble is everyone wants to live in Hobart.

Ms FORREST - No, only 50 per cent of the State want to live in Hobart.

Dr McGUSHIN - I worked 19 years in Queenstown. Try getting a Tasmanian or Australian doctor to go the west coast. It is that rationale that Australian doctors or Australian people are probably a little soft and like to remain in the cities. They don't want to tough it out here in the areas that produce all the wealth, like the west coast of Tasmania. It could be done better on the north-west coast if had the facilities, but as to what to do about it -

Ms FORREST - That is not your problem.

Dr McGUSHIN - No.

Ms FORREST - In relation to Calvary, and there are other facilities which are run by various religious groups, do you see this bill as potentially posing a problem if it became law that there may be situations where if you had a doctor or nurse who was happy to be involved that was against the ethos of the facility - do you see that is going to be an issue or does the bill deal with that adequately?

Archbishop DOYLE - I think it is going to be a very, very serious issue. A fair bit of my submission is really around these implications that could arise down the track. As I mentioned a little while ago, if you did have a patient and if you had a doctor in these facilities who were wanting to pursue that then it could cause enormous difficulty for our organisation. The future of the whole place could be up for questioning. It is as serious as that.

Ms FORREST - I am not sure how involved you are with the recruiting of medical staff, but for whoever is involved in that, would there be a requirement to ask potential staff for their view on voluntary euthanasia? If they said that they supported it would they then be discriminated against and not employed? Can you do that?

Archbishop DOYLE - That is another question. We face this already with the issue around abortion in our Catholic hospitals. People would know that these practices are not acceptable in our facilities and so far we are able to function properly. But there are some serious issues in Melbourne around the viability of our facility regarding the abortion legislation in Victoria going down the path that it did. There are some serious issues for us here.

Mr BEST - We heard earlier today from another witness about the Netherlands, where there is a media campaign promoting euthanasia, saying it is brave, wise and progressive. The understanding of the community about palliative care is interesting. Is there any recommendation that you might like to make or comment about what we could do to promote a greater understanding of services that are provided in palliative care?

Dr McGUSHIN - We are a rich country with an extremely good health service, no matter how much we moan and groan about it. We have universal access. Don't moan about spending two hours in an accident emergency department, try living in an African country, or go to America. America has the best and worst medical system in the world. If you have money it is great; if you have no money it is the worst and you cannot get access. Promote the idea that palliative care in Tasmania is like other services in Tasmania, it's first class. The rest of the world envies the medical system that Australia has and it is the same with palliative care. We are an advanced country with advanced medical teams. This is one of the reasons Australians live so long. Australia has the second-highest life expectancy in the world.

Ms O'CONNOR - With your extensive experience as a medical professional and also in an isolated rural community dealing with all manner of sick people, do you accept that there are some people who are suffering from terminal illness for whom palliative care, short of an induced coma, does not provide relief?

Dr McGUSHIN - Yes, and on that basis I think induced coma is still relieving the symptoms. I think the main example of that is probably people dying from motor neurone disease. Some people will need to have an induced coma to relieve the symptoms of motor neurone disease. It is like drowning. If they need to get rid of that symptom by rendering them unconscious, I would do it. My intention is to relieve that symptom, not to kill them.

Ms O'CONNOR - Do you accept that maintains the quality and dignity of the sufferer's life?

Dr McGUSHIN - I do. If you can relieve that symptom then, yes, do it.

Ms O'CONNOR - Clause 10 of the bill addresses palliative care. Do you accept that this clause provides sufficient support for palliative care options in Tasmania and protection for the GP? Clause 10(1) says:

> 'A medical practitioner must not assist a sufferer under this Act if, in his or her opinion and after considering the advice of the medical practitioner referred to in subparagraph 8(1)(c)(i), there are palliative care options reasonably available to the sufferer to alleviate the sufferer's pain and suffering to levels acceptable to the sufferer.'

Dr McGUSHIN - I do have some problem with that because it leaves the actual decision in the hands of the patient.

Ms O'CONNOR - Of the medical practitioner, isn't it?

Dr McGUSHIN - The last words were 'suffering to levels acceptable to the sufferer'. What is 'acceptable to the sufferer'?. The sufferer might say, 'I don't what to suffer' and only the sufferer will know.

Ms O'CONNOR - And then it goes on to subclause (2) which I will not read entirely into *Hansard*. It says:

> 'If a sufferer has requested assistance under this Act and has subsequently been provided with palliative care that brings about the remission of the sufferer's pain … the medical practitioner must not, in pursuance of the sufferer's original request for assistance, assist the sufferer under this Act.'

So essentially what the act is saying is if the palliative care options are providing relief then the medical practitioner must not under the law assist in the request for voluntary euthanasia.

Dr McGUSHIN - That is true but I would say to you what is your definition of 'relief'? You might say we are relieving physical symptoms but what about mental anguish? To me you still have problems with saying levels acceptable to the sufferer. That person is suffering from mental angst about what is possibly going to happen and say, 'Look, I don't care about the palliative care options, I want to go down this pathway'. I don't think this guards them in stopping them going down that pathway.

Ms O'CONNOR - If you have a person who is suffering from stomach or bowel cancer and they are actually choking to death on their own excreta, do you believe that their request for physician-assisted suicide is legitimate and that intolerable suffering for them, based on their symptoms, is exactly as I have described it; it would be intolerable to die that sort of death?

Dr McGUSHIN - No. As I said earlier about the motor neurone disease, I do not regard it as legitimate and the person's symptoms can be relieved if necessary by rendering them comatosed. With palliative care we use syringe drivers for pain relief and all the rest of it. A lot of people are semi-comatosed for the last few days before they die and if it meant that you had to render them comatosed, to me that is good palliative care and I would do it. The primary intention is not to end a person's life.

Ms O'CONNOR - No, I appreciate that.

Mr GAFFNEY - Mr Hidding referred to 68 per cent of Christian faith back in 2001 and I think he said, for the churches, 68 per cent of your fellow citizens still bothered to identify themselves with the teaching of those churches and euthanasia is a simple proposition, it's wrong because God forbids it.

I am just wondering whether there has been any more recent analysis and statistics since 2001 of the Christian faith in Tasmania because we have seen some submissions from practising Christians who say, 'Yes, I believe in Christian values but my religion believes in life but even more strongly in compassion'. So we are getting some messages coming through from people who have Christian values that they are actually supportive of this bill. Going back to Father Mark, and that was the same sort of thing with the discussion you had, so I suppose my question is: how does the church fully engage with the feelings of its membership and through this perceived process, how will it reconnect with those Christians who have Christian values who are actually supportive of euthanasia or of this bill? There is a dilemma there. I appreciate your position as the head of the church, but in reality you want the church to be strong throughout our communities. How is that dilemma going to play out?

Archbishop DOYLE - It is quite a challenge. Part of what I think we have tried to do is to not draw solely and completely on our Christian directions of teaching because, interestingly enough, in the Catholic tradition there has been a strong emphasis on the natural law, that there is within the human person the capacity to think through to certain positions which are really basic positions of conduct. If we take, for instance, sexual abuse, we do not need Christian people to tell us that that is wrong, we do not even need Parliament to tell us that is wrong; we know it is wrong because of something within us that tells us that this behaviour is totally unacceptable and so I would have a responsibility to try to inform the Catholic people. As was mentioned earlier, I have done it with a letter. It is a very complex subject. It is very difficult, the passive and the active euthanasia, the issues that have been brought up by the doctor. My sympathy goes to you people who have to make decisions about this. Not for one moment do I underestimate the significance of the decisions that you have to make. Irrespective, I think, of just whether the percentage is up or down, this is the position that I hold personally, but certainly in my position as the Archbishop this is one that I would be expected to uphold in light of the church and the traditional teachings that we have elaborated, and the wisdom of centuries in regard to all these things, and also, in light of the very significant contribution that we make in the field of palliative care.

We'd like to have them up on the north-west coast and all that sort of thing, too, but at least I believe we are, along with the Whittle Ward in Hobart, making a very significant contribution and we do it because we believe in the dignity of every human person, and to assist them in this most important moment and phase in their life, when it all comes to fruition in what we believe is eternity.

CHAIR - Thank you, everyone. Is there anything else you'd like to submit to us before we close?

Archbishop DOYLE - I would just like to repeat what I said a few seconds ago, that I do appreciate the opportunity to come here. I was thinking on the way up it was a bit like going to an oral exam.

Laughter.

CHAIR - Okay, we'll give you a mark out of 10.

Archbishop DOYLE - I greatly appreciate the seriousness with which you've undertaken this task with your parliamentary colleagues. I would have to say that the position of the Catholic church which I lead, with its extensive involvement in the care for those who are terminally ill and dying, and because of our general philosophy, is to urge that you reject this bill. Thank you.

CHAIR - Thank you very much for your time.

THE WITNESSES WITHDREW.

<u>Dr KEITH McARTHUR</u>, GP LIAISON OFFICER, NORTH WEST REGIONAL HOSPITAL, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Finch) - Thanks very much for joining us today. I will give you an opportunity to make a presentation to us and I am sure the members will want to question you at the end of that.

Dr McARTHUR - I have never prepared anything like this before so I have done it as a fairly informal thing. I am a currently registered medical practitioner in the State of Tasmania and have been registered in Tasmania since 1986. I was initially registered in New South Wales in 1985. Since arriving in Tasmania, I worked as a resident for a year in the old Burnie Hospital. I had 16 years full-time experience as a rural general practitioner in Wynyard, which for a while included admission privileges to the Spencer hospital, which has now been closed and bulldozed. I have three years' experience as a registrar in psychiatry at the North West Regional Hospital in Burnie. Since the beginning of 2006 I have had several part-time jobs. From mid-2006 to mid-2008 I managed a federally-funded project aimed at improving medical care of residents within residential aged-care facilities. I have been employed from January 2006 to the present day as a psychiatric medical officer at Rivendell Clinic, which is a private psychiatric facility of the private hospital in Burnie. From mid-2006 to the present I re-entered the general practitioner work force, at the Upper Burnie Medical Practice, which is now Burnie Medical Practice. Also from mid-2006 I took on caring for between 40 to 50 residents at Umina Park, which is a residential aged-care facility in Burnie. I am a member of the Guardianship Board and also a member of the State Advisory Committee for Aged Care and Rehabilitation. I am a member of the State Advisory Committee for Palliative Care and a member of the subcommittee of the Aged Care Rehabilitation Committee. We are developing a capacity assessment tool for professionals so that we can assess capacity better. In the palliative care area I am on a subcommittee designing a statewide advance care plan template. Do you all know what an advance care plan is?

CHAIR - I don't. Do you want to elaborate on that now?

Dr McARTHUR - An advance care plan is where people make a plan, not in a strictly legal sense, of what options they would like to be considered when certain events happen - for instance, if they have a heart attack or stroke, if they get pneumonia or a serious infection, if they break a hip or if a serious terminal medical situation arises.

Ms FORREST - You said it was legal to do it, but it's not legally binding?

Dr McARTHUR - That's correct.

CHAIR - Who is this plan made through, the Guardianship Board?

Dr McARTHUR - No. If the patients have capacity then they can appoint an enduring guardian through the Guardianship Board. They can write a statement of wishes which can include as few or as many details as they like and that is usually similar to an advance care plan and that is legally binding. If they lose capacity their appointed guardian will make decisions that are legally binding on behalf of that person.

Mr WHITELEY - Based on the advance directive?

Dr McARTHUR - Based on the patient's wishes. An advance care plan is generally done when people have loss of competency and they do not have the ability to legally appoint a guardian. So you have this mixture of family and friends and caring next-door neighbours all of whom who have some thoughts about what we should or should not be doing. If you wait until the final event happens you can find you are in a real pickle with all sorts of things being suggested that maybe are not quite true or reflect particular beliefs.

So with an advance care plan you usually have a fairly good indicator of what the person wanted or does not want. Their degree of incapacity may be mild or extreme and they may be in a vegetative state with dementia but nevertheless the people who have known them have a fair idea of what they would want. A person responsible is chosen and that is a non-legal position but usually the guardianship board will support a person responsible; so, for instance, if you lost capacity and you had five kids, then the five kids could get together and nominate Tom, who is the middle or the eldest, to be the person responsible, and so then he has a pseudo-power to make the decision. It is not legally binding and it can be challenged. In situations of challenge, the public guardian would have to be consulted to determine what is fair and reasonable.

So an advance care plan is second place to an enduring guardianship or a statement of wishes.

Mr GAFFNEY - Regarding enduring guardianship, is there a psychiatric assessment of the person's state of mind when they do that? We have just heard that they are weak and vulnerable, so does that have to be done at a certain level?

Dr McARTHUR - No. The assessment of capacity in this State is pretty poor. There is very little, if any, formal training on how to assess someone's capacity. Capacity is not a switch; you do not have it and then suddenly lose it. It is a transition and you may have capacity to make some decisions but not others. You may have capacity to decide what colour car you want, but you may not have the capacity to run your empire of millions. It may come down to where you do not have the capacity to decide what you want for breakfast. There is no definition as to what your capacity has to be before you can appoint a guardian, but it is generally perceived to be that you need to understand what the enduring guardian will have the powers to do should you lose your capacity or have reduced capacity.

Ms FORREST - If the Guardianship Board was of the opinion that the person was not fully aware of what they were doing, would it accept the advance plan or not?

Dr McARTHUR - That is very interesting because I have been on a hearing where something similar happened and there are no rules. There is nothing that says we go this way or that way, so it was put to a tribunal and a decision was made.

Ms FORREST - The Mental Health Tribunal?

Dr McARTHUR - The Guardianship Board.

CHAIR - Do you wish to go on?

Dr McARTHUR - We all die. Some die quickly and others slowly. Some die from misadventure and others from illness. Some die accepting their fate and others fight bitterly to their very last breath. Some have a peaceful death and some die in misery.

Over my career of 20-odd years as a medical practitioner I have seen many deaths. I have known many people, particularly through my psychiatric training, who were suicidal. I have also known some who wanted to be assisted to die and I certainly know some who have died by their own hand. I have seen people who have died in pain, with nausea and vomiting, leaking body fluids and faeces, fistulas, ulcerating lesions, extremely malodorous because they have had necrotic tissue exposed, and infection - and also in mental anguish from serious mental health issues. I have also seen patients gasping for every breath and I have seen someone who vomited blood until they bled to death. I have seen good and bad deaths.

With regard to euthanasia, I'm not going to be making any particular statement about whether or not I believe we should make any rules about euthanasia. The submission I am making is centred on the equality of all Tasmanians to access their rights, in particular dying with dignity. One of the things that almost everybody who is dying has is fear. Fear is an emotional response to threat and danger. It's a basic survival mechanism and it is a response to specific stimuli. Pain or the threat of pain can cause fear. Psychologists suggest that fear is one of a small set of basic innate emotions. The other emotions in that set are joy, sadness and anger. Fear is different to the related emotional state of anxiety. Anxiety usually occurs without an immediate external threat. Anxiety is the result of threats which are perceived to be uncontrollable or unavoidable. Nevertheless both fear and anxiety are related to behaviours of escape and avoidance. It is worth noting that anxiety relates to future events, such as the worsening of a situation or continuation of a situation that is or is becoming unacceptable. Fear and anxiety are the most distressing emotions for anybody to tolerate. It doesn't matter whether this is a mental health issue or a pain issue, fear and anxiety are the two most distressing emotions one can have. Fear and anxiety frequently cause intolerable suffering, or at least exacerbate other forms of intolerable suffering.

Why do some people wish or request death? They generally wish for death because they perceive that it is the only avenue of escaping their intolerable suffering. I have found it extraordinarily rare to find a person who really wants to die. I have never met anyone who really wants to die. In all of my experience, if I can offer them relief to their suffering then they will choose to stay alive. If I can reduce their fear and anxiety then they usually prefer life over death.

Why do we want to relieve distress? I believe this bill is being considered because our human society has compassion, but what is compassion? Compassion is a human emotion prompted by the pain or distress of others. It is more vigorous than empathy. The feeling commonly gives rise to an active desire to alleviate someone's suffering. It is more often than not the key component in what manifests itself in the social context as altruism. In ethical terms, its expression down through the ages is the golden rule. It embodies by implication the principle of compassion. It is ranked at the greatest virtue by a number of philosophies. Compassion is considered in all the major religious traditions as amongst the greatest virtues. This ethical reciprocity is more commonly known as the golden rule. It is an ethical code that states one has the right to just treatment and the responsibility to ensure justice for others. Reciprocity is arguably the most essential basis for the modern concept of human rights. A key element of the golden rule is that a person attempting to live by this rule treats all people - not just members of his or her group - with consideration. The golden rule has its roots in a wide range of world cultures and is a standard which different cultures use to resolve conflicts. It is present in ancient Judaism, Indian philosophies, Greek and Chinese, and is the principle that modern philosophers have stated in different ways.

If you are going to be compassionate, how do we choose a compassionate option if we believe someone to be in intolerable or profound suffering? In order to make a choice, the sufferer must know and understand all of the available options and their implications, and they must have an access to all of these options. Does a compassionate society offer to euthanasia its members because it lacks the will to provide equity for palliative care services to the whole of the population? Providing good palliation is much more than merely providing pain relief. Would it not be more compassionate to provide good palliation first? Why prefer to kill those who suffer and not first provide the ability to live without their intolerable pain? Should we not first provide a well-developed palliative care service before we decide that the only way to relieve intolerable pain and suffering is to kill them? I know Dr McGushin had some things to say about palliative care, but living on the north-west coast is considerably different and I will get to that later.

Almost universally, all the patients who have requested euthanasia from me have withdrawn their request once I am able to ease their suffering or even the fear they may suffer. Patients are reassured once they understand I have their comfort as a priority, that I will listen to them, inform them as best I can about options available, and promise to involve them in any decision making. Providing good palliative care is very time consuming, very challenging and requires an enormous amount of support for the sufferer and the carers. Many GPs are unable to spend the necessary time and do not have the specialist skills required to provide gold standard palliative care, which is what we can, as a society, offer with all our technology.

So what are human rights? They are the basic rights of freedom to which all humans are entitled. All human beings should be born free and equal in dignity and rights. They are endowed with reason and conscience, and should act towards one another in the spirit of brotherhood. Would you prefer to have the right to euthanasia before you have the right to good palliative care?

The bill states that 'intolerable suffering means a profound level of pain and/or distress that the sufferer finds intolerable'. Fear is a huge feature of what one determines is or is not intolerable for oneself. Our current medical system is geared towards the application of high technology and treatment of disease, however much dis-ease is the fear of the unknown. What will they do to me? Can I be sure they will listen to me? Will I suffer? How can I be sure they will acknowledge my fears? Are they too busy for me to bother them with my fears? I believe if you alleviate these fears you alleviate much of the intolerability.

Regarding conditions under which a medical practitioner may assist, every one of us who does not die suddenly will find ourselves in this predicament - that is, we are over 18 and we are going to die. Clearly not everybody's intolerable pain and suffering can be managed with palliative care so, unlike the previous speakers, I know that there are people where the best palliative care cannot relieve their symptoms unless you include induced coma as palliative care.

The better the quality of palliative care the lower the requests for euthanasia. Before we consider euthanasia should we not ensure that the palliative care available to us is of the best standard? In the clause 8(3) of the bill it says:

> 'If a sufferer's medical practitioner has no special qualifications in the field of palliative care, the information to be provided to the sufferer on the availability of palliative care must be given by a medical practitioner (who may be the medical practitioner referred to in subparagraph (1)(c)(i) or any other medical practitioner) who has such special qualifications in the field of palliative care as are prescribed.'

That is a nonsense. You either are or you are not a specialist in palliative care. You have either done the extra study and you have become a physician in palliative care or you haven't. You would not regard a general practitioner who had done a bit of surgery to be a specialist neurosurgeon. It is mind boggling that you would consider somebody to have special skills in palliative care if they weren't a palliative care specialist. The only medical practitioner who has special qualifications in the field of palliative care is a palliative care specialist, to suggest otherwise completely undermines the entire speciality of palliative care. If we are going to use this logic in other situations, for example, in the case of cataracts I could allow you to go blind without offering you the opportunity to see an ophthalmologist because I know a bit about eyes. In the case of somebody with appendicitis, I could say, 'I will manage your appendicitis you do not need to see a surgeon'. So how can you offer somebody good palliative care if you are not a palliative care specialist?

Clause 10(1) says:

> 'A medical practitioner must not assist the sufferer under this Act if, in his or her opinion and after considering the advice of the medical practitioner referred to in subparagraph 8(1)(c)(i), there are palliative care options reasonably available to the sufferer to alleviate the sufferer's pain and suffering to levels acceptable to the sufferer.'

Now I am going to go into the north-west Tasmanian situation. Currently on the north-west coast we do not have a palliative care specialist. The palliative care specialists who service the area fly-in or drive-in and we have them for one or sometimes two days a week. In other times the palliative care nurses obtain telephone advice from palliative care specialists who are in other areas. This degree of unavailability of palliative care specialists on the north-west coast varies over time. At the very best we had one specialist at other times we have no specialists for long periods of time. What happens when there are good palliative care options but, due to geographical constraints, those options are unable to be delivered to the sufferer? Make no mistake, a general practitioner doing their absolute best as regards to palliative care for a patient will find that, at times, he needs input from a palliative care specialist in order to effectively deliver good palliative care.

Ms FORREST - It is not about pain relief really, is it?

Dr McARTHUR - No, it is not about pain relief. It is very easy to administer pain relief but I have seen patients who have been given sufficient morphine to do the reverse, it can induce pain. Recently, one of these occurred in one of the beds in the private hospital in Burnie where a doctor gave more morphine as the patient developed more pain and they just chased their tails. The patient was on the equivalent of 600 mgs of morphine and died uncomfortable.

Ms O'CONNOR - What is the solution, Dr McArthur, for that patient?

Dr McARTHUR - The solution is to know your medicine and not use only narcotics; you would use other agents to either help the narcotics work or ameliorate the anxiety or nausea, or change narcotics. I don't possess all the answers, but I certainly understand that I need a palliative care specialist to help me in those cases.

The next subclause says:

> 'If a sufferer has requested assistance under this Act and has subsequently been provided with palliative care that brings about the remission of the sufferer's pain or suffering, the medical practitioner must not, in pursuance of the sufferer's original request for assistance, assist the sufferer under this Act.'

The question I ask about that is, what happens if the remission ceases, the pain and suffering return, but the cause of the pain and suffering returning is the unavailability of a palliative care specialist?

There are many palliative care treatments not available where we do not have a local palliative care specialist. I then quote parts of the request for assistance form and ask how would euthanasia work in the north-west? In this bill we are asking the terminally ill patient who already has intolerable pain and suffering, to find a GP to make their initial request. If their GP is not willing to participate they then have to find another GP. In the north-west it is exceedingly difficult to find a GP; most GPs have closed books. Some patients may attend casualty facilities for months while they try to get a GP. Not only do they have to find a GP, but that GP then has to become knowledgeable about that patient's medical history.

We then assume that the sufferer has obtained a GP to assist them with their request, now they have to find a specialist who specialises in their particular illness. Again, in the north-west that can be troublesome. We do have some clinics where specialists come into the area once a fortnight or once a month. Those waiting lists are frequently long. If they don't want to wait to see the specialist at a clinic, they then have to travel; they may be travelling to Launceston or Hobart or possibly interstate. They are doing all this while they have intolerable pain and suffering.

That specialist then has need to confirm that they are, in fact, terminal, and there are only extraordinary measures that may ensure their survival. Also, if that specialist does not want to endorse their wish to be euthanased, then they have to go and find another one. Assuming that they fulfil both those requirements, they then have to find a palliative care specialist who will offer, presumably, excellent palliative care management. How does somebody in the north-west do that if we don't have a specialist?

The bill suggests that the requirement for a palliative care specialist can be negated if the specialist in the particular disease believes they have sufficient understanding of palliative care to say that palliative care is not going to help. I think that would be a very foolish specialist indeed. I know specialists in other areas of medicine who openly declare that they do not have good specialist care skills or knowledge, they have not done the actual training. Managing patients who are dying is complex, and in fact I believe many GPs possess more skills in palliative care than a lot of specialists that you see in hospital.

At the moment, we don't have a palliative care specialist in the north-west, we have not have one all this year. We don't have an idea of when or if we will ever get a specialist, and in fact I know there is thought being given to not having a specialist but having the area serviced by general practitioners who have done a diploma in palliative care - that is a six-month study course as opposed to a three-year speciality training course. The proposition is, because we can't get a palliative care specialist, to have these GPs manage palliative care services in the north-west. I ask, why are there two palliative care specialists in the north and five in the south? The same Government that is now considering this Dying with Dignity Bill has not made provisions for adequate palliative care services for 20 per cent of the State's population. There are problems affecting the provision of palliative care to residence in the north-west. There are inadequate numbers of palliative care nurses. Currently there is no palliative care liaison nurse in either of the two regional hospitals. There used to be, but there are none now. What that means is that there is no liaison between patients in the hospital and palliative care staff. There are no palliative care hospital or hospice beds in the north-west. When somebody is dying in hospital there is no palliative care team or policy as to when to initiate palliative care management. Too frequently pseudo-palliative care - that is my term for pain relief - is tacked onto the end of an episode of treatment. This is when the medical teams have decided that further efforts are futile.

In 2006 there was a report from the Tasmanian Palliative Care Service looking at provided in-patient palliative care services to regional and rural hospitals. This project looked at a number of different ways of providing good palliative services to a remote area such as the north-west of Tasmania. As far as I am aware, three years later, none of the recommendations included in the report have been enacted.

I now manage between 15 to 30 deaths a year. Most of these are in nursing homes and are patients who are suffering incapacity. Nursing homes have very dedicated staff who go to great lengths to offer these considerably disabled people the care, nurture and reassurance they need and to offer them medication.

This bill dealing with euthanasia for people who have capacity will in fact exclude a lot of people. When people have pain and suffering they are medicated with narcotic analgesics; they are medicated with calming medications and psychotropics. Does someone really have the capacity to understand what they need to understand to obtain euthanasia through this bill? Dementia is a terminal illness. People don't often think about that. If you get dementia there is no cure. Despite what is said, there is no proven treatment to slow its progress. Everybody who gets dementia will die from it unless they are lucky enough to have other illness intervene. People with dementia are robbed of themselves over a period of years. I do not know, nor have I ever met, anybody who would wish dementia on another human being. The majority of patients with dementia suffer from pain, from arthritis, from the fact that they can't move or other conditions. Frequently this pain causes behaviour changes which are difficult to manage. It is reasonably common for these patients' behaviours to be treated by medication such as Valium and psychotropics. It doesn't alleviate their pain at all. They just become too sedated to cause trouble. Some people appoint enduring guardians and write a statement of wishes so that if they lose their quality of life they can elect to have palliative treatment only. In other words, they can say, 'When I get to a certain point in my life I don't want any antibiotics or operations. I just want to be kept comfortable'. I believe there are about 8 500 people in our State who have appointed enduring guardians. Frequently with the level of palliative care services available in the north-west, patients with dementia who are suffering are not even on the radar of a regular palliative service team because they are too busy dealing with the other stuff.

The majority of people in nursing homes have not applied for an enduring guardian. In fact I would say that for every 100 conversations I have with families maybe one or two know what an enduring guardian is and have already appointed one.

The others have already lost the capacity to determine their preferred treatment options and it is too late for them to appoint an enduring guardian. An advance care plan can be formulated and this takes a great deal of effort and time of nursing home staff and the general practitioner if he can spare the time. Also, interestingly, Medicare does not offer any rebate for the time a GP may spend doing a palliative care - none, no item number; you cannot claim it. These plans usually request a palliative approach. Again, these people do not fall in the radar of a palliative care team most of the time.

These people with enduring guardians or advance care plans do not fit into the Dying with Dignity Bill parameters at all. There is nothing offered to them for euthanasia to alleviate their suffering. Their access to good quality palliative care is limited until they are in acute distress at the very end of their life, so a lot of these patients are suffering. Their behaviours are difficult, they get sedated sometimes for years. This bill is never going to offer them the option for euthanasia.

The acuteness of someone's illness will often precipitate an ambulance getting called and off they go to hospital. Once they arrive in hospital heroic measures may well be employed. Hospitals by their very nature are there to save our lives and nobody here would like to arrive in hospital and they hold your hand and say, 'Well, we can keep you comfortable or we can just get on and fix your ruptured spleen'. Hospitals are there to save lives and they do it very well. The life may be saved only to have the person continue their steady decline into a vegetative state. This is not dying with dignity.

The person survives, they are transferred back to the nursing home. It is very common for them to be heavily sedated because whilst they were in hospital these patients became unmanageable with an acute delirium. Does everybody here understand what delirium is? A delirium is being delirious. It happens to particularly older folk with very little provocation. They become severely distressed, they hallucinate, they imagine things, they become paranoid but what is worse is when you have a delirium you remember every second of it. You remember the contents of your delirium.

There is no palliative care service in the hospitals to assist with managing this situation. Frequently the patients are discharged back to the nursing home to die as the heroic treatment has failed and there is nothing more to be done. The patient again may be suffering unrecognised pain and this has been contributing to the acute delirium.

I believe the Dying with Dignity Bill does not offer any dignity to this group of Tasmanians. They are our parents and our grandparents. The palliative care service could do much to alleviate this if sufficient services were available.

What do we do for our patients with intolerable pain and suffering who reside in the north-west of Tasmania? We have the least availability of any area in Tasmania to access palliative care services and with the proposed Dying with Dignity Bill we will also have the least availability to voluntary euthanasia. It is my firm belief that our society has not reached the point where we should be contemplating euthanasia. At this point we have not even decided whether we will properly palliate those who are suffering. Once we have chosen to palliate as effectively as possible an instituted gold-standard palliative care services to all then I believe it would be an appropriate time to consider delivering euthanasia.

CHAIR - Dr Keith, thank you very much for the preparation of that. It is very good for us to have it on *Hansard* to be able to refer to and you made some very interesting points.

Ms O'CONNOR - Dr McArthur, thank you for that presentation. I am curious as to whether you're stating that good-quality palliative care and a person's right to choose voluntary euthanasia are mutually exclusive because the bill is about where palliative care as an option for relief runs its course. Then and only then is a person able to access the dying with dignity provisions.

Dr McARTHUR - How can proper palliative care run its course when you don't have a fully-equipped, up-to-date, comprehensive palliative care service available?

Ms O'CONNOR - I'm not here to answer your questions. You have stated in your submission that for some people who are suffering terminal illness and extreme pain as a result of their illness, palliative care does not provide relief. Do you agree with that?

Dr McARTHUR - Absolutely.

Ms O'CONNOR - So, as the person who has expertise in this field, what would you propose as the path for these people, even if it was a gold standard of palliative care?

Dr McARTHUR - Are you asking whether or not I support euthanasia or whether or not I support their right to choose?

Ms O'CONNOR - I am interested to know whether you support their right to choose.

Dr McARTHUR - I support their right to choose.

Ms O'CONNOR - So you're not in principle opposed - and I don't read your submission that way at all - to the right to choose; your concern is with the inadequacies, particularly in regional Tasmania, in palliative care. If the Bartlett Government finally did the right thing and funded proper palliative care options on the north-west coast, do you think there would still potentially be room for a voluntary euthanasia scheme?

Dr McARTHUR - Absolutely. But I also believe there is room to consider an involuntary euthanasia scheme for those who have lost the capacity to decide.

Ms O'CONNOR - That was one thing I was interested in, your concern for people who are suffering from dementia and who have no capacity to choose or direct their care. You would understand that the provisions in this bill are about people being conscious to make the choice. What if the potential solution for people who are in the latter stages of dementia was palliative care?

Dr McARTHUR - That's a very good question. Palliative care is not going to fix everybody in intolerable pain or suffering. The question I ask is, do we go to euthanasia now before we can provide good, gold-standard palliative care to everybody or do we provide that with gold-standard palliative care and then see where we go from there? If we are going to provide the option for euthanasia, do we restrict it to some of the population who have possessed capacity right up to the point or do we permit it for people who have made their wishes very clear that when they lose capacity they want to be euthanased, because that does not exist in that bill.

Ms O'CONNOR - It's interesting, because we have heard testimony this morning about what excellent standards of palliative care we have in Tasmania and there is very different evidence coming from you. You are putting forward that we have a very deficient palliative care system in Tasmania.

Dr McARTHUR - In the north-west, in my region. I'm not going to even make a statement about what the other areas are like. They have specialists, they have bigger teams. Fifty per cent of the State's budget for palliative care is consumed by the 10 beds in the Whittle Ward and the other 50 per cent, I believe, is distributed amongst the other areas. North-west Tasmania has 20 per cent of the population and gets far, far less than 20 per cent of the budget.

Ms FORREST - I also understand that a portion of that 50 per cent is still spent in the south in the community. It's not 50 per cent that comes north of Hobart in the funding for palliative care, as I have been informed by a palliative care specialist..

Mr BEST - Do you don't know what the global budget is?

Dr McARTHUR - I can tell you that the budget for pharmaceuticals for palliative care in the north-west coast is $20 000, and normally they exceed that by threefold. We have patients having to privately buy their medication because they can't get it through palliative care. The other interesting catch-22 we have is that they are training up GPs to be better equipped so we can handle more patients properly with palliative care, so they are not on the palliative care register. If they are not on the palliative care register then there are medications they can't get through palliative care, so they are training GPs to do a better job and then saying, 'OK, you're doing a better job so you can't have these drugs'.

Mr BEST - If they were on the register, they could then access them?

Dr McARTHUR - Yes.

Mr BEST - So why aren't they?

Dr McARTHUR - Because we're managing their palliative care. They haven't fallen into -

Mr BEST - How come they can't afford to? You're managing their care so they can't go on the register.

Dr McARTHUR - No, no, it's not because I'm managing their care. Their terminal care, their palliation, is being managed by the GP. Then if they come to a point where they need extra care, the specialist, they then have to be involved in the team there, and they register. Frequently the patient has a problem and needs some medication. Ring palliative care services, they're strapped, but it would be a while before palliative care services can help.

Mr BEST - But why can't they get on the register?

Dr McARTHUR - They can, but you've got to think about it in advance and it's very difficult.

Mr BEST - So what's the time frame that's required then to go on the register? Would it be 24 hours or longer?

Dr McARTHUR - I have examples where I know a patient is terminal so I ring up palliative care, send a referral and say, 'I don't need your services now'.

Mr BEST - That seems like a sensible thing. I don't understand why you wouldn't go -

Dr McARTHUR - My practice is very special; I do one session a week of general practice. I look after 50 patients in a nursing home and spend an enormous amount of time doing that. Most general practitioners when they go to a nursing home flit in and flit out. If you are going to be a general practitioner visiting a nursing home then you have to travel to the nursing home, you have to find the patient, find a nurse, see the patient and get out of there and get back to your surgery. It is usually done by fitting into the lunch break or at the beginning or end of the day. If you are doing it at the beginning of the day or the end of the day, it's very hard to find a nurse in the nursing home because there's only one nurse maybe for 80 or 100 beds.

Mr BEST - I'm not criticising, but some of the GPs perhaps might need more information about the register.

Dr McARTHUR - Absolutely. The whole point is that the ability to provide good palliative care is lacking.

Mr BEST - Surely that wouldn't be an insurmountable exercise.

Dr McARTHUR - It's perfectly surmountable.

Mr BEST - So basically it's an education issue with GPs, and that's what needs to occur in that regard. So resource issues -

Dr McARTHUR - Yes.

Ms FORREST - You get nine hours of palliative care training in the five-year medical degree. Do you know if that's still the case?

Dr McARTHUR - No, I don't.

Ms FORREST - It seems that it might be but I can check that out. Even so, even if it was more, it is sort of an insult to a palliative care specialist to say that a doctor could be considered to be an expert in palliative care because they looked after dying patients in the past. So for anyone to receive palliative care from their GP, they would need to have at least six months' education in not more. With the northern issue again, how do we treat that if we haven't a palliative care specialist to look after patients let alone help train GPs?

Dr McARTHUR - Let us look at obstetrics and gynaecology. You go through medical school, you learn obstetrics and gynaecology, you get hands on delivery. You know the process of how babies get delivered and you could probably deliver a baby if everything went your way. You can then do a six-month extra degree in obstetrics. If you are at Smithton or down the west coast or on King Island then that gives you the ability to manage a greater diversity of obstetric issues but there will still be issues where you are completely out of your depth. The patient then needs to be referred to an obstetrician and gynaecologist because they have the knowledge and they have the resources. Palliative care is no different.

Ms FORREST - How long is a palliative care speciality?

Dr McARTHUR - Three years postgraduate.

Mr WHITELEY - Thanks, Keith. I have found this very insightful. I very much appreciate it and genuinely appreciate the insight in relation to issues of fear and anxiety and vulnerability.

On a practical level, though, I want to ask a question. It is not pointed at this State because it is happening all over this country. We do not need to focus on palliative care beds or hospice centres or whatever because we have this new thing happening - hospice without walls. I get that for those people at whatever point in their terminal journey they are at. It is probably quite appropriate but it is also based on, in my view, the fact that it works pretty well when everybody lives in a close knit geographical area because specialists such as yourself or GPs or whoever can get to those places quickly and we have the resources to do it. I think it becomes a bit of an issue when you start getting into those areas where some of us live, where it is very decentralised, where there is a lot of regional activity and rural activity. Would we not be better served by more dedicated clinics, whatever you want to call them, where there is a real sense of purpose and focus, where people can be at home away from home in the last part of their lives? Is there merit still -

Ms FORREST - You are talking about a hospice that has walls around it.

Mr WHITELEY - Yes. I am not saying a hospice without walls does not have a role to play. I think it does but I don't think it should come at the expense of a dedicated, focussed place of intent to provide palliation. Is that still a very much a relevant service?

Dr McARTHUR - If the vast majority of people want to die in their homes then the vast majority of people can die in their homes and have a good death in their home if you have the resources, which means you have to have nurses who can get about -

Mr WHITELEY - That's right.

Dr McARTHUR - So a nurse who has to travel 200 kilometres a day or more will not be able to see as many patients as a nurse who is inside a building. You have to have a specialist. You have to have the ability to transport equipment and beds; you have to have volunteers; you have to have a lot of stuff but I believe a hospice without walls is the best model. This is my belief. However, there will be patients who fall out of that. They need something more, for whatever reason. They can go to hospital. Now it is incredibly expensive, I believe, to have a few dedicated beds in a hospital for palliative care, but if you had a palliative care team that had the mission then the care could just flow without changing anybody in particular staff-wise.

Ms FORREST - Nothing stays with the patient?

Dr McARTHUR - Yes.

Ms FORREST - Where the patient is that is where the funding and resources are.

Mr WHITELEY - The location may be in a hospital -

Dr McARTHUR - Yes.

Mr WHITELEY - but not provided by the hospital in that sense? You have a dedicated palliative care team that arrives at that place rather than arriving at my house?

Dr McARTHUR - Yes. However, within the hospital you would need nursing staff and residents et cetera to help service the day-to-day facets.

Ms O'CONNOR - I was just looking at your second paragraph under 'a compassionate society' where you're talking about voluntary euthanasia as an option. You say, 'Would it not be more compassionate to provide good palliation first?'. Do you accept that the bill provides for that, that the bill provides for palliative care as a first care option?

Dr McARTHUR - From my understanding of the wording of the bill it provides that palliative care information is given to the patient but I do not see within the bill that it mandates that the patient has to have it - and I might be wrong in the way I read the bill.

Ms O'CONNOR - When the GP becomes aware that palliative care can provide relief then he or she must not withhold that information. There is a sentence here, 'Should we not first provide a well-developed palliative care service before we decide that the only way to relieve intolerable pain and suffering is to kill the sufferer?'. Would you agree that the bill is not saying that the only to provide relief to a sufferer is to -

Dr McARTHUR - Yes, I agree the bill is not saying that's the only way.

Ms O'CONNOR - That's right. The bill is providing an individual choice.

Dr McARTHUR - Yes, it does.

Mr GAFFNEY - I have found this very interesting and I take on the comment about the need to free up our nurses, especially in our aged-care facilities, from their drug trolley roles. How do you free up one nurse who has to administer pills four times a day to residents? You can't free her up; she has to do it. What you need are more nurses or a para-nurse or another level of nurses who are able to give out that medication under supervision and thereby free up your nurses. Regarding guardianship plans, how would you make this more known to our wider community? I have read it in a couple of the submissions; how would you get that through into our society more?

Dr McARTHUR - If you're trying to tell a general practitioner that a service exists, you are setting up a new service, you are a new psychologist, then you mail out to all the GPs and tell them you are there. A few referrals trickle in and then they dry up because the GPs have forgotten. They have so many other things to remember. There is a guardianship board and enduring guardians. At some stage of your life you might want it, but unless it is actually there and smack in the face all the time then you will forget it. My belief is that if we're going to let more Tasmanians know about this then we need to tell them periodically - one a year, once every six months.

Mr GAFFNEY - I might have a chat with you about how I think we could get that message out more effectively. There are other organisations other than just doctors. I think there are a lot of community groups out there that would -

Ms FORREST - The Guardianship Board needs more funding so they can get out there and do it themselves.

CHAIR - Dr McArthur, we appreciate this information very much and the trouble you have taken to appear before us today.

<u>THE WITNESS WITHDREW</u>.

Mr JAMES WALLACE, MANAGING DIRECTOR, AUSTRALIAN CHRISTIAN LOBBY, AND **Mr NICHOLAS OVERTON** WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Finch) - We appreciate very much you taking the time, particularly you, Jim, coming from Canberra, to make a presentation to us today. I am assuming that you will have a presentation to make in tandem and then we will follow on with questions.

Mr WALLACE - We both appreciate the consideration of the committee in allowing us to put our point of view. For the record, I am the Managing Director of the Australian Christian Lobby and Nick is our State director in Tasmania.

This is an extremely important issue. As you are aware, better than I am, the issue is not entirely new to the Community Development Committee which in 1998 examined the need for legislation on voluntary euthanasia. The inquiry received a staggering 1 162 submissions and 91 witnesses presented evidence before the committee. The evidence was comprehensive and the findings were clear: the committee unequivocally rejected legalised euthanasia, which found - and I quote, 'The legislation of voluntary euthanasia would pose a serious threat to the more vulnerable members of society' and that 'the obligation of the State to protect all its members equally outweighs the individual's freedom to choose voluntary euthanasia'. Nothing has changed, including it would seem the determination of those with this euthanasia ideology, except on evidence this morning what has changed is the effectiveness of palliative care. More importantly, the rationale behind the finding remains valid and we request that the committee acknowledge this in its recommendation. This remains the central danger of euthanasia. There's no doubt that legalised euthanasia will put at risk the lives of the vulnerable in Tasmania because it forever changes the relationship between the State and its most vulnerable citizens. The core value of a civilised society is respect for life, all life. For Christians, and strongly reflected in western societies, this inherent respect for life goes even further to try to encourage those who society might view as inconvenient or non-productive that they are equally valued by God, who loves them no less, and therefore requires that we do the same.

The underlying assumption of euthanasia is that life is not of objective and inherent value simply because it exists, but that the value of life is to be subjectively judged by its quality or even productivity. It suggests that certain lives can be terminated because they've lost their value. We fundamentally reject that assumption and therefore euthanasia which, to us, is its expression. Legalised euthanasia sends a clear message claiming, as it would, both government and societal endorsement, that some lives are better than others and that some lives are not worth living. The consequences of such reasoning are tragic. Vulnerable, sick, elderly and depressed people who are already subject to social disadvantage, abuse and coercion would be given an expectation that their lives are of little value. Many would feel an expectation, perhaps even pressure, whether real or imagined, to request an early death to relieve others of the burden of care.

Euthanasia forever alters the relationship between the medical practitioner and the patient. Patients would no longer be assured that their doctor's primary concern is to protect life. Uninformed and vulnerable patients would particularly be at risk of a medical decision to shift from care to procuring death. I might say that vulnerable patients, I think, are not restricted to those of poor intellect or people who are less educated. If you are ill, you can be vulnerable.

I have a 95-year-old father who was with the very first to join up in World War II. He fought subsequently in Tobruk and Milne Bay, and the same motivation - that same selflessness that saw him do that all those years ago - would doubtless see him elect euthanasia now if it was available, so as not to burden us. I know that was certainly how he felt six months ago, when he was in pain as a result of a fall, but my time caring for him, having to do everything for him, gave us the best, most precious time in our relationship ever. Now he is healed, out of pain, and enjoying his children and his grandchildren. I would not want to be part of a society that gave him an expectation that he should have sought euthanasia because he was depressed, in pain and at 95, a burden to society anyway.

But people will say, 'We're not going that far; we have safeguards'. We are assured by the advocates that legalised euthanasia can be made safe and that no vulnerable lives will be lost. But even if we wanted a society making subjective judgments about the value of life, we know from experience that legislative safeguards do not work, particularly when administered by euthanasia ideologues. We know that voluntary euthanasia quickly leads to involuntary euthanasia and that the supposed right to die becomes a duty to die. A cultural change from preserving life to procuring death within medicine will create a blind eye to such deaths, regardless of the safeguards.

In the Netherlands, around 1 000 patients per year are euthanased without their consent. This figure has remained relatively constant since the legalisation by a court decision in 1973 and, importantly, the rate of deaths without consent has not dropped significantly despite the introduction of legislation with supposed life safeguards in 2002.

Interestingly, too, for those who believe in safeguards to the scope of what might be legalised under euthanasia, there has been a rapid extension of the category of people considered eligible for physician-administered death to include children aged 16 and over, who can now request euthanasia without parental agreement. Children aged 12 to 16 can be killed by euthanasia if they request it and a parent agrees. Children up to the age of 12, including newborns, may be killed by lethal injection with parental consent. Psychiatric conditions, such as depression or anorexia, have been accepted as sufficient justification for requesting euthanasia. This is expansion of scope.

Please do not suggest we should have any confidence in safeguards, protecting the creep in scope of any euthanasia legislation. Even the short time the Northern Territory legislation was in operation proves we simply cannot trust supposed safeguards on the administration of such legislation, safeguards that supposedly protect the intent of the legislation as determined by legislators. The present bill before the inquiry is essentially a rehash with some very slight adjustments of the Northern Territory terminally ill legislation. Dr David Kissane, a palliative care expert, spent several hours interviewing the only doctor to have facilitated death under the Northern Territory act, Dr Philip Nitschke. His findings are documented in a number of academic publications which demonstrate the farce of euthanasia safeguards.

For example, to access assistance under the act, a patient had to be suffering from a terminal illness, but when a doctor refused to certify a particular patient as terminally ill, there was a public appeal on television for one willing to do so, and a sympathetic specialist came forward to meet the requirements of the act. The same patient was experiencing depression, which was supposed to make her ineligible to receive assistance under the act. This problem was ignored, however, as the focus was on bureaucratic processes to satisfy the requirements of the act. After she died, the coroner also ignored the breaches of the legislation.

Of the seven patients who officially sought assistance under the Northern Territory act, three were socially isolated, and symptoms of depression were common, summarising the absolute failure of the act to protect sick and vulnerable patients, Dr Kissane wrote, despite considerable legislative effort to draft safe regulations that would protect the vulnerable. A review of the clinical accounts of patients who had sought access to this legislation revealed a blatant failure of the act to achieve its purpose. Given the level of error rate that does occur in medical practice, this experience suggests it would be impossible to safely legislate for doctors to kill. Certainly the gate-keeping roles designed by this act fail to protect depressed, isolated and demoralised patients. Cast in a legislative and bureaucratic stance, these gate-keepers cease to practice the craft of medicine to the neglect of patients they sought to serve.

When the Tasmanian Community Development Committee examined the legalisation of euthanasia in 1998 in response to the Northern Territory experience, it found that the codification of voluntary euthanasia legislation could not adequately provide the necessary safeguards against abuse. For those without a belief that life is sacred and to be protected at all costs, euthanasia might seem an appealing idea for empowered individuals who would like to exercise autonomy over their lives and deaths, but it is dangerous to the disadvantaged.

We should carefully consider the wise words of the UK's 1994 euthanasia inquiry, which found that it would be next to impossible to ensure that all acts of euthanasia were truly voluntary. We are concerned that vulnerable people, the elderly, lonely, sick or distressed would feel pressure, whether real or imagined, to request an early death. We believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.

Legislation that fails to protect the most vulnerable members of society is bad law. For the sake of vulnerable Tasmanians, let us not revisit the failed Northern Territory experiment. We would call on the committee to recommend to the Tasmanian Parliament the rejection of this terrible bill. Thank you very much for your consideration.

CHAIR - Just a couple of questions, Mr Wallace. You mentioned that 1 000 - I just want to clarify these figures - a year were earmarked in the Netherlands.

Mr WALLACE - This is 1 000 people who it has been revealed have been euthanased without their consent. That is a really scary figure to me. This has been reasonably consistent, apparently, since 1973, when a judicial decision essentially legalised euthanasia. Then there was legislation, I believe, in 2002, but the number of people euthanased without their consent has not dipped much. I hear claims that it has reduced, but I understand not substantially at all.

CHAIR - Can you clarify for me where those figures come from?

Mr WALLACE - We have accessed them from an article in the *Lancet*, a very well regarded peer-reviewed medical journal. That quotes analysis or research that has been done from government reports.

CHAIR - Do you think we could be provided with a copy simply for clarification?

Ms FORREST - It's all in there.

CHAIR - Okay. Do we have those figures about the extension of eligibility in the Netherlands?

Mr WALLACE - You may not actually because I only found that last night, to tell you the truth, in a statement by Liberal Party members to a 2008 Federal Senate inquiry which was considering the same topic. They quoted one of the submissions that they had received, and I can only assume they first made sure of the facts in it. I can give you that information, though.

CHAIR - Thanks very much.

Mr BEST - I have asked this question today on a couple of occasions but we have heard in the media of situations where sincere, loving partners, a husband terminates the wife or the wife terminates the husband due to extenuating circumstances and they are charged with murder or manslaughter and usually what you read is that there is a good behaviour bond or acceptance of the situation. Would you agree that those people should be charged?

Mr WALLACE - I think that wherever an issue is contestable the court is the right place to determine the rights and wrongs of an issue like that. We understand the torture in people's minds and their experience of this, killing a loved one to try to help them out of pain and suffering, but I can equally say that there are a lot of instances, too, where we have people who have claimed that reason for killing someone and as it has transpired and the courts had a look at it, it was not the reason that they were killed at all, it was to get an inheritance, an insurance claim or something of that nature. I think that there has to be a lot of discretion in this and we cannot have a situation where the law automatically defaults to putting the burden of proof onto the other side because in at least as many cases we have a situation where the people are not acting in good faith at all and in fact are acting to relieve themselves of the inconvenience or to grab something.

Mr BEST - You were involved, as you said, in the 1998 committee of inquiry here -

Mr WALLACE - I was not personally involved but I am aware of it.

Mr BEST - Has anything moved on? Have we become better at something in particular in relation to this issue or have we become worse? What is your view then about what might have happened in, say, the last decade?

Mr WALLACE - The important thing here that has changed, as I understand it, is what is possible through palliative care and I take that from speaking about this to my wife who is a doctor, I have heard the testimonies of qualified medical people here and it is a common theme that I hear all the time in the circles that I mix in with my wife. I think that while there are still, as expressed this morning, some tragic circumstances where you cannot do much to relieve the pain except perhaps to induce a coma, nonetheless the instances that are beyond relief through palliative care are very, very few. I cannot help but think that if the danger is to a whole lot of other clients, the people, despite our obvious concern for those people and the fact that the only recourse might be in the end to induce a coma, we should not be passing legislation that creates a liability and a vulnerability for a huge additional class of people. I think these advances in palliative care are very important.

Obviously there is a cost with palliative care but I would hope that as a society we never place ourselves in a position where we put convenience or the ability to reduce the health budget above our concern for people. Certainly as a Christian I believe that very strongly and I think as a society we do too.

Mr BEST - Just following on from that then, we did hear you mention about people being vulnerable and we have heard already today about safety, the test of safety being basically the foundation stone in all of this. This is an anecdotal question but you may also enlighten me with some facts. It would be your contention, I suppose, that in the Netherlands there has been the act of murder under the guise of this. Do you honestly believe that?

Mr WALLACE - I do. I think the reports you have there do attest to that. It won't be murder in Holland because of the legal framework that's around it, but nonetheless there is also proof in those reports you have there, which equally quote the figures I gave of 1 000, that doctors after the event, despite immunity, are still suppressing the reasons or methods they have used necessarily to terminate a life. That must be a worry. I don't know the detail of that, I'm not medically trained, but certainly I know that the reports reflect that. I think more it is that we make a shift in cultural mores and societal expectations where we put an expectation on people that they might consider being euthanased, or indeed even should allow themselves to be euthanased, in the same way I know my father would. If you look at the Oregon example, and we know that the law was passed in 1997, when they did some research and polling into this in 1998, 12 per cent of those who were polled said that it was wanting to relieve someone of a burden - or words to that effect - that was one of the reasons that they selected euthanasia. By 2000, only two years later, we had changed the societal expectation and the culture to the degree that 65 per cent of people were saying that. This is a huge cultural impact. I think it is a cultural change for the worse because we must be valuing all life.

Mr BEST - Obviously you don't agree with euthanasia. I must admit I have some concerns about legislation and I had a view on it before other witnesses came in. In fact, I think Fr Mark Freeman put it quite well in regard to society's view as to how with younger people in certain circumstances it is okay to take your own life. Do you think that it is a fair proposition, if people in an absolutely sane frame of mind, not sick or vulnerable, given a certain circumstance, that they could give consent in the context of decriminalisation? That's not to say a full-on piece of legislation that says that it is your right to take your own life, but decriminalisation in the context of it being ended. I think I know what the answer is going to be but I have to put the question to you.

Mr WALLACE - Are you talking about almost decriminalising suicide?

Mr BEST - The bill does that, doesn't it, in a sense; rather than go that way, to seek to remove sections of legislation or amend existing laws in some way, so to decriminalise, maybe, in that instance that I gave earlier.

Mr WHITELEY - Decriminalisation of assisted suicide.

Mr WALLACE - I wouldn't agree with that. You are talking about the circumstance where someone isn't sick, where they are stable, but how do you tell that? How do we tell when someone is able to make a decision about this? After the accident my father was in immense pain with a back injury, trying to sit up in the hospital bed, aged 95. His mental capacity then was at risk, but it's not normally. How do you assess that someone is able to make that decision? I would say anyone who's sick or is in those circumstances is immediately vulnerable and therefore I do not think you can expect them to. I do not think the law should assume that they can make a decision of that nature because more often than not it is a transitory thing.

Ms FORREST - In relation to palliative care we have talked about the recent changes and people are saying it is so much better now in the last 10 years since the 1998 committee's work. Palliative care is a fairly new science that has only recently been recognised in that last 10 to 15 years.

Mr WALLACE - Certainly.

Ms FORREST - We hear from a lot of people who have been suffering, and their loved ones suffered some years ago, or we hear from doctors who say that they cannot relieve all pain and suffering and there is a very small percentage currently who can't be relieved. Years ago I would have disagreed.

Mr WALLACE - Yes.

Ms FORREST - Does that put us in a position, though, where by far the majority of our Tasmanian GPs, even a lot of our medical specialists, even oncologists, and surgeons who do mastectomies for breast cancer and the like, would still be seeing palliative care in the way it was 15 years ago, rather than with the recent advances? Only those who had undertaken a course in palliative care, whether it be the three-year speciality or the six-month course that a GP can take, would know So when we hear from some of these medical professionals, with all the right intensions, that palliative care does not relieve the suffering and we still see people dying unfortunate deaths, is that because we are not talking about the same?

Mr WALLACE - I am not professionally qualified to say that. One of the great outcomes of this committee could be to make recommendations that ensure there is a very deep and broad, within the medical profession, knowledge of and ability to administer palliative care. I think that would be a very useful outcome. But I am unable to comment on the degree to which is known and practiced efficiently within the medical profession. I think it is a key question, though.

Ms FORREST - That comes back to a resourcing issue in getting all those GPs up to speed because we have an ageing population of health professionals right across the board from medical to nursing.

Ms O'CONNOR - It says on page 3 of the Australian Christian Lobby's submission that the law rightly rejects the alleged right to die. But isn't it a fact that it is not against the law to attempt or to commit suicide in Australia?

Mr WALLACE - I believe it is.

Ms O'CONNOR - No, it is not against the law to attempt or commit suicide in Australia.

Mr WALLACE - I will accept what you say, but the point is?

Ms O'CONNOR - Why do you believe that the Australian Christian Lobby, or any other religious organisation for that matter, has the right to tell any individual how they should live or die?

Mr WALLACE - No, it is not what I am doing. Let me make it very clear. I will just take up the implication there that somehow religious bodies have less right to speak into the public space.

Ms O'CONNOR - It is telling people how to live their lives or to die their deaths.

Mr WALLACE - Sure. Regardless of what philosophical basis you come from, you have the right to equally put your view forward in society and that is what we are doing. In terms of the effect of this bill, the effect of legalising euthanasia, what we are talking about is the effect on community. We are saying, as we believe good law should be, is this for the common good or not? We would say that it is not for the common good and it is specifically not for the common good because of the effect it has on the more vulnerable. I am including anybody as vulnerable who is ill or who is depressed because they have terminal disease or whatever. So I think the outcome of this bill, regardless of whether I am talking from a religious point of view or any other, is bad for society.

Ms O'CONNOR - So you do not believe that any individual has the right to decide how they ought to exit this life?

Mr WALLACE - No, because the problem is that once you as a society and as a government create a societal expectation and culture that a person has the right to terminate someone else's life you cannot control where that goes.

Ms O'CONNOR - No, no, not someone else's life; we are talking about an individual making a choice that they no longer wish to live because their suffering is intolerable. Now this law provides for them to get medical assistance to do that. Is that not the right of an individual who is suffering intolerable pain, for whom palliative care provides no relief, to seek ultimately seek relief? What do we have control over in our lives other than our own mortal coil?

Mr WALLACE - I think you heard from the Archbishop this morning, and I agree with him, that this assumes that the dying process is necessarily something that is to be rejected and avoided at all costs. I do not think it necessarily is, even as a process which might be brought about by some terrible disease, some painful disease of which palliative care will mainly ameliorate the pain - except in a few cases.

Ms O'CONNOR - What is your moral solution for those for whom it does not provide relief?

Mr WALLACE - I think you create in society a much worse moral result if you condone this. You have people and jurisdictions overseas which look at, as I just quoted, anorexia or depression as a reason to terminate your life.

Ms O'CONNOR - But this bill certainly doesn't.

Mr WALLACE - No, but most of these jurisdictions, if not all, started there. Once you create an attitude to life that says it is okay to terminate your life if you do not feel good then you are creating a class of people who are going to be vulnerable. You are always going to have a class of people who are vulnerable to believe that, and I would say that is a bad thing for society to do.

Ms O'CONNOR - I am curious as to how you think that this bill puts vulnerable people at risk given that the individual has to decide they want to seek assistance to end their life. They have to go through medical professional checks. There is a cooling off period and at any point they can withdraw. What we have seen from the Oregon statistics is that overwhelmingly people who access the scheme are highly educated, informed, white Anglo-Saxon -

Mr WALLACE - What difference does highly educated and informed do when you are in pain? It makes no difference. Let me tell you. I have run essay selection courses, to just to give you a bit of an example here, and I have had people who thought they were in intolerable pain who have got up, rung the bell and gone off the course. They have had a shower, have seen their mates all pass it and suddenly they realise they were not in intolerable pain. Now that is a fickle example but it is a relevant one of the principle involved here, except that the consequences in the case of euthanasia, if you ring the bell, are that you are dead. I think that you do not create a society that cheapens life to that degree.

Ms O'CONNOR - But you do not think it is a compassionate response to someone who has a terminal illness to deal with and who is in agony?

Mr WALLACE - Not when we know that palliative care can deal with the great majority of those cases. We will probably increase its ability to deal with a greater range of those instances. There are consequences for the rest of society in doing that. You heard this morning that even if palliative care cannot deal with it then you could perhaps as a part of palliative care induce someone into a coma. So we have means of limiting the effect of that pain and we are talking about a very small number of people, yet the consequences for society, as we have seen in overseas jurisdictions and in the very short experience of this in Darwin, are horrific.

Ms O'CONNOR - What is the difference between someone who is placed into an induced coma because they are suffering? That must be seen as a form of involuntary euthanasia because they did not give their consent to the palliative drugs that will ultimately hasten their death, rather then actively choosing and taking control of the circumstances?

Mr WALLACE - The difference is that you heard this morning that the motivation for placing someone in an induced coma, and the motivation for giving some additional shots of morphine, are to reduce the pain.

Ms O'CONNOR - In full knowledge that it will hasten death?

Mr WALLACE - Well, of course. When I saw these figures that said 3 per cent of doctors have carried out involuntary euthanasia or assisted euthanasia, I mentioned that to my wife and she was just askance. She has practised for 30 years from Canberra to Perth to Darwin and in London and she obviously mixes around the whole medical profession, and she just shook her head and said it was ridiculous. She said what people are mistaking here is the fact that in order to reduce pain - and I thought the doctor was very clear on this this morning - you may end up shortening someone's life by hours -

Ms O'CONNOR - Or days.

Mr WALLACE - Well, he said hours.

Ms O'CONNOR - He said hours or even days.

Mr WALLACE - Did he? Okay - but your motivation in doing that is to reduce the pain, and of course we would all want to do that.

Ms O'CONNOR - Of course, I accept that completely. This will be my last question for now. I just want to get some clarification on what you think the implications of the bill are because on page 6 you talk about vulnerable newborn babies also being at risk from euthanasia - you agree, though, that that has no relationship whatsoever to this bill.

Mr WALLACE - It has no expression in the bill at the moment of course -

Ms O'CONNOR - No, but we are here determining this particular piece of law which talks about adults making informed choices.

Mr WALLACE - But we would be negligent not to look at overseas experiences and how they tried to contain the scope of their legislation, only to have it change over time. Now let me tell you as a Christian that I look at abortion. We still have abortion laws in quite a few of our States but for years these have been ignored and people have practised abortion despite the laws there because of a sort of community acceptance, the turning of a blind eye to this thing. That is one thing and I put that aside as an issue, but what I am saying is you cannot tell me with experiences in places like Belgium and Holland that we should not take those into account and say, 'Well, we're trying to do what they did, so isn't the result likely to be the same?'

Ms O'CONNOR - Really the last question, Mr Chairman. In Oregon, which has had these laws in place for 11 years, 341 people have accessed the right to die or physician-assisted suicide and there the doctor gives you the pill and you take it home and make your own choices there. Would you agree that in Oregon there is no evidence of the law slippage to include newborn babies, for example? It is about adults, about people who are terminally ill.

Mr WALLACE - I will just ask Nick to comment on that because he has a report on the Oregon bill, but what I will say is that it has changed the culture so that now a year afterwards where we had 12 per cent of people listing not wanting to be a burden to others as the reason for them trying to access euthanasia, only two years after the operation of this bill we had 65 per cent of people listing that. That is a huge cultural change, so we may not have got down to the point of applying it to babies, I agree with you -

Ms O'CONNOR - Well, we haven't.

Mr WALLACE - No, that's right, but I am saying to you that it has made a significant change to the culture and particularly, I would think, reflected in those figures, the respect for life.

Mr OVERTON - The only thing I would add to that is that I have statistics here of the 341 deaths and so on, and they make it very clear that the actual number of deaths is unknown because their reporting does not actually allow for that. It also says that the number of reported deaths has increased by 306 per cent since the law was first introduced. I think it is clear with the increase in people feeling like they are burden and therefore the increase in requests for euthanasia as a result of that and it says very clearly the number of deaths could be far greater than 341, but they are not aware of that.

Ms O'CONNOR - But Mr Overton, isn't it the case in Oregon that each request a person makes to their physician for the medication is actually registered under this act?

Mr OVERTON - Well, this states that there are major flaws in the state's reporting system and therefore not all of those cases may be registered. I have to check that out and I would probably encourage you to check that out as well, but certainly all indications here - and I know members of the British House of Lords have been in the same boat - have struggled to get accurate figures, and even the statistics in the report I have here are as a result of closed-door meetings and so on, because it just seems to be very hard to get their hands on the actual facts and the actual numbers. I don't know where you're getting your figures from and so on -

Ms O'CONNOR - From a report that was published two weeks ago, which was the statistical correlation over 11 years.

Mr OVERTON - I assume it is probably the same as what I have in front of me. This was sent to me on 6 July, so maybe this one's a bit older. But I think what you can't ignore, as Jim said, is that there has been a significant increase in the number of deaths since the law was first introduced, as well as that significant increase - in fact only two years back to 2000. I don't know how high that figure is now and I'm not sure if there was a figure in there on why people are requesting physician-assisted suicide.

Ms O'CONNOR - Because there's a legislative framework there now for them to do it rather than having to be behind closed doors.

Mr OVERTON - Yes, but is it because they feel like they're a burden of care? Is it because those figures have gone up - 63 per cent, I think it is, technically. You've got to ask some questions there because when you start to change the culture of a society through a legislative framework such as this, as all overseas places would tell us, it does lead to a whole lot of circumstances outside the legislative framework. If we haven't got a legislative framework in place now and supposedly it is happening, although I don't believe it is; as Jim said, I think we're sort of confusing the issue of increasing pain relief and dealing with symptoms, with the side-effect being hastening death, but let's say it was happening now and there's no legislative framework, what makes us think that having a legislative framework is going to stop other things from happening outside of that framework if it's currently happening illegally anyway? Surely those unscrupulous doctors and physicians are going to continue to behave that way in spite of the law, because they're doing so now.

Ms O'CONNOR - No-one's suggesting that there are unscrupulous doctors or physicians administering palliation inappropriately. We're not talking about unscrupulousness, we're talking about the facts of medical practice when you're dealing with people who are terminally ill and in agony.

Mr OVERTON - But you'd have to agree it's illegal at the moment.

Ms O'CONNOR - It's illegal to take someone else's life, certainly, but does that mean it's not happening? It doesn't mean the medical practitioners are unscrupulous; it may be an act of compassion.

Mr OVERTON - I think it comes back to what you're talking about, and as we and previous people have talked about here, because I think people are confusing the issue of what is happening with this law of double effect, which has been talked about a number of times. I don't know if you've got any figures or statistics on what's happening, but as Jim said regarding the 3.5 per cent of Australian doctors, I think what is actually happening is not technically euthanasia in terms of what this bill's talking about.

Mr WALLACE - You mentioned the issue of babies there. In Belgium when their legislation was passed, it was referring, as I understand it, only to competent adults. I have not recorded the date they passed the legislation, but certainly by 2005, 7 per cent of deaths of newborn babies were by lethal injection, and that was via a piece of legislation which was supposed to cover and only be relevant to competent adults. This creep, once you cross this line, is real, and I don't believe, for that minute amount of cases you're talking about, you can afford to create that attitude to the sacredness of life by introducing legislation.

Mr WHITELEY - Thanks, Jim and Nick. We've had representation from the Catholic Archbishop this morning and his staff. You obviously work amongst most Christian denominations. Would it be fair to say that across those denominations there is a ready acceptance, a morally thought-through acceptance, of the way in which palliative care is current being delivered? In other words, nobody for one moment is suggesting amongst the people you work with that this form of palliative care that hastens death is of moral concern compared to the belief that we're talking about. So you're not a killjoy at that point, you are accepting that's a compassionate response, what we're doing at the moment?

Mr WALLACE - Absolutely, and I think the way it was expressed this morning by the Catholic doctor was absolutely right and it would be reflected amongst the sort of orthodox and evangelical constituency that we tend to represent, if I could say that loosely. We have 10 000 members across Australia, but that membership's right across evangelical and orthodox. I would say that's the case. The important thing here is that it is probably important to consider for a moment that the word 'compassion' has by definition 'com' - with - and 'passion' - pain and suffering. In other words, compassion is about going through suffering with people. I think that is very much the Christian view. Someone said this morning that there had been a survey of Christians that had shown a high percentage of Christians were in favour of euthanasia. I just say that that is certainly not in the circles that I mix in and I am at churches every other weekend. I think you will find there that, first of all, obviously the church is a very broad church. Secondly, Christians are likely to be as ill-informed about the detail of this debate as the general population is. When I first started looking at this, particularly having been through what I had just been through with my father, I felt some sympathy in looking at the issue for those who were calling for euthanasia. But when I got into the details of it and looked at the experience overseas and in the Northern Territory, we are told by Professor Robert Goldney that two of four deaths that occurred in the Northern Territory - and this is a very small experiment with euthanasia in Australia - had serious questions about the propriety of the way in which these people's lives were terminated. When I looked at all that, suddenly I hardened in my view against euthanasia. Most people in the population would be as ill-informed, or more ill-informed, than I was before I started. Certainly in the church they would be the same. But I will guarantee you that if you go and do that same survey across that 19 per cent of those who register themselves as Christian, Catholic, Anglican in a census, those 19 per cent who go to church once a month, you'll find that the percentage of those against euthanasia would be very high indeed. They would nonetheless, as you have asked, agree totally with the use of palliative care and its administration in the way it's done at the moment, in an effort to reduce the suffering of people through that last stage of life and into death.

Mr OVERTON - In recent weeks I have been talking to Christians and I think they have wanted to make sure we're not talking about withdrawing life-prolonging treatment and those sorts of issues, or that we're not talking about increasing morphine or pain relief with a view to deal with the pain relief even though a side effect may have been. If people understood we were talking about that distinction, I think the surveys that have been referred to would come out a lot different than those that are reported. It's not about allowing somebody to die a natural death and somebody refusing treatment or resuscitation, it is about actively ending somebody's life. When people understand that distinction, I think certainly in the Christian community there wouldn't be support.

Mr GAFFNEY - The Netherlands scenario comes up quite often. They are an enlightened community and society and yet I believe they have not sought to change and reverse their law because of the numbers they're now finding. Have you any information or update on the situation? It has been there for quite a while now but there's been no reversal of that and I'm just wondering why.

Mr WALLACE - I'm not aware of any move to reverse it. I know that the Netherlands has experimented a lot with drugs, for instance, and they are trying to pull some of their policies back. I would not be surprised if in time there's a similar move to do this, but I am not aware of any movement at the moment to reverse the legislation. Holland has been a place where, as you said, there's been a lot of so-called enlightened policy, liberal policy, and I think it's one of those experimentations that we will see correct itself over time. That's just my view.

Ms FORREST - You almost got to where you were answering Brenton's question, but when I asked the same question about the views of people in answering the question about what they think about what we are talking about here - doctors and medical and nursing staff who are unsure as to what we were talking about - many thought we were talking about withdrawal of treatment as well as increasing medication that may hasten death. I think it is a little bit hard to know how much we would hasten death by because no-one knows when somebody is going to die.

Mr OVERTON - That is right.

Ms FORREST - Nick, I am seeking some feedback from you. When you have had discussions amongst people in the church, are they confused? Does there seem to be this view that if we ask the question whether they support a person's choice to - I cannot think how it was worded now but Cassie may be able to help me with the question that was asked in the survey -

Ms O'CONNOR - Choose the right to die with dignity - it was quite straightforward.

Ms FORREST - Are they agreeing with it, not knowing what they are really agreeing with? Is there a blurring of the boundary there and no appreciation that actually giving something that actively and intentionally kills somebody is different from withdrawing treatment or not instigating treatment such as antibiotics for pneumonia, that used to be called 'the old man's friend', for instance?

Mr OVERTON - I think you are absolutely right in what you are saying and when you said that earlier on today I resonated with that. During the last few weeks I had an e-mail from a member of one church here in Launceston who was taking us to task on our position on voluntary euthanasia. But as it turns out, the core of his argument was, why cannot somebody say, 'Do not resuscitate me'? So they are confused about what voluntary euthanasia is and they are connecting it to withdrawal of life-prolonging measures and refusing treatment and so on, which is why in our submission we have a terminology paragraph there just so that people are clear on what we are actually talking about and what this bill seeks to do. It is very clear in what it seeks to do and it is giving a patient a treatment or action that directly or deliberately results in their death. I believe there is confusion out there.

Ms FORREST - By increasing the morphine or whatever the person may die, but maybe they were going die anyway. But they sometimes don't.

Mr OVERTON - Most people do not have an issue with allowing someone to die a natural death. If somebody says they have cancer, they do not want treatment, they do not want surgery, they do not want this or if they have a heart attack do not resuscitate them, I do not see any issue with that because they are dying a natural death but -

Ms FORREST - However, Nick, you look to be a relatively young, healthy man, and if you had tattooed on your chest 'Do not resuscitate' and you came to the A&E and I was on, I would resuscitate you.

Mr WALLACE - I think there are two very important issues here and it is important to differentiate between the them. If somebody is ill in hospital and someone said to them that they are going to die and they say that they do not want treatment or if they have cancer and say they do not want chemo then that is their right.

Ms FORREST - But what if I have a heart attack and do not want to be resuscitated?

Mr WALLACE - That is a different -

Ms FORREST - No, I am talking about them having cancer and they are dying.

Mr WALLACE - Yes, sure, but if they make that decision in what is an inevitable progress towards death then I think that is a right decision. When my wife spoke about what she believed was part of the confusion in those figures, she said that often people say to them that they do not want the chemo or a certain drug or whatever, and then they die a natural death. In other words, they are dying naturally.

Mr WHITELEY - And no-one gives them an injection to finish it off.

Mr WALLACE - No, and I think most Christians would agree that dying a natural death, and with the medical profession doing everything they can to make that painless, is the right way to go. There is a different scenario, though. As you said, Nick is sitting there fit and he makes a decision that he does not want to be resuscitated.. But in 10 years' time, when he has more kids, does he still really mean that? This is a completely different issue and I think that is a completely different debate. But certainly, where they are sick, they have a right to not undergo treatment.

Mr WHITELEY - One final question. A lot is said about compassion and you did move towards addressing it. I, too, accept that there is a part in all of us that senses that this makes sense. I sat with my dad for three months while this occurred and so on. So I think we all get this as an act of compassion. Do you think it is compassionate, though, for somebody to, in one way, claim the right to make a choice for themselves? Do not resuscitate or withdraw treatment, that is all a right. But how compassionate is it for that person then to compel others to do their dirty work? How compassionate is that to leave that burden with other people, albeit medical professionals and nurses, for that matter?

Mr WALLACE - I think it is quite a selfish position. It was interesting in the case of euthanasia's short operation in the Northern Territory. It was only Dr Nitschke who ended up facilitating the administration of euthanasia. This, as I understand, was because no-one else wanted to be involved in it. For someone to ask someone to terminate their life or even to facilitate it is quite a selfish position - and I understand in Dr Nitschke's case he sets this thing up and the person themself pushes a button or something which causes the death.

Ms O'CONNOR - But you accept that under this current bill no medical professional can be compelled to accept the request to assist?

Mr WALLACE - Yes. While that is fine and good, if the bill were ever to be passed, which I hope it will not, I would want to see that in there.

Ms O'CONNOR - It is in there.

Mr WALLACE - The fact that somebody is nonetheless a vulnerable individual - ill, sick or depressed, whatever they are - is the key issue here. Are we going to create an environment and a culture where those people feel - I think you mentioned earlier that they are termed 'sufferers'. It seems to me that we would create an environment where once you are turned into a sufferer it would be like being put on death row. You are a sufferer so you are now on an inevitable pathway towards euthanasia. I would never want to create in a medical system or in a society that expectation or environment and I think we must not. I would really ask the committee to ensure that we do not.

Mr WHITELEY - Just on that, this morning Mr Hidding talked about the weeks and months after Martin Bryant killed all those people in Port Arthur; if a vote had been taken the next week, then the death penalty would be here. We could have had a piece of legislation that said that was legal, and we were not going to compel anyone to pull the trigger, but there would always be someone prepared to line up and do it. Does that it make it right. Will it benefit the community? Your evidence today is that you do not think those decisions, even though there seems to be a logical argument, will benefit society generally.

Mr WALLACE - I think the argument is illogical if we put a high price on life.

Ms O'CONNOR - I want to be sure about the terminology that is used here on page 2 because you talk about the term 'euthanasia'. You accept, though, that we are talking here about voluntary euthanasia, that this is an act free will and choice from someone who is suffering terminal illness for whom palliative care provides no relief. So we are not talking about euthanasia, which is quite a different thing because if I hit a rabbit with my car and it is only half dead, I will run over it again. That is an act of euthanasia. That is awful but it is true.

Mr WHITELEY - Just remember not to stand in front of Cassy's car.

Laughter.

Ms O'CONNOR - But it is very different, though, from a rabbit with free will, if you like, deciding they are going to head out into the traffic. It is about free choice.

Mr WALLACE - I accept precisely what you are saying; it is your intent. I understand that but I would say again that we asking people to make this decision who are necessarily vulnerable because of their circumstances.

Ms O'CONNOR - Do we give them a choice?

Mr WALLACE - It is no good giving a person who is vulnerable, who is not making logical decisions, a choice.

Ms O'CONNOR - Who says they are not making logical decisions?

Mr WALLACE - But who says they are making logical decisions? This is the important thing.

Ms O'CONNOR - The bill provides for a psychiatric assessment.

Mr WALLACE - So did the one in the Northern Territory, so what did they do? They could not get a psychiatrist in the Northern Territory so Mr Nitschke paid for a psychiatrist to come and talk to the person.

Ms FORREST - A 20-minute consult, wasn't it?

Ms O'CONNOR - I do not know the details.

Mr WALLACE - What I am saying is that here we had someone who believed passionately in euthanasia, so much so that he would facilitate this. This makes that person even more vulnerable. The evidence of the UK and the evidence of your own committee in 1998 is that you cannot prescribe these things so that they are watertight. As long as you cannot do that you are creating a new class of vulnerable people and I do not think that the Government should do that.

Mrs BUTLER - In regards to the ethics of the professional bodies, you have made quite a few comments about how difficult it is for the psychiatrists, the doctors and the nurses to make these sorts of decisions. To me it smacks of great difficulty and all sorts of ramifications for those legal entities. I am wondering if you would like to comment on the challenges in ethics for those bodies?

Mr WALLACE - I can only comment by using the analogy of my own ethical position, which is founded on my faith, but I would certainly find myself, as someone who had to live in a society that accepted euthanasia, really compromised by the culture that accepted euthanasia.

Ms O'CONNOR - Voluntary euthanasia.

Mr WALLACE - Oh well, euthanasia or voluntary euthanasia. I can only imagine by analogy regarding people who are in a profession which was caused to be a part of this process that you either held the same philosophical basis as I do, one of faith, or had professional reasons, such as a doctor who believes and has taken the Hippocratic oath and believes that their role is to save life and to enhance life and quality of life. I can only assume that they equally, a number of them if not the great majority of them, will be placed in a similar and very confronting situation, almost a torturous situation, in terms of trying to reconcile what the law is asking them to do because the law is now asking them to do it. Some patients would have an expectation that they did it and yet their internal principles would in many cases be against it.

CHAIR - I am wondering if you would like to conclude before we wrap up?

Mr WALLACE - The title says it is there to confirm the right of a person essentially to terminate their life. The reality is that in international law there is no right to death but there is a very strong right to life, so I would ask the committee that they look at what is the very strong expectation in international law that a domestic law would reinforce the right to life and that there is no right to death.

Thank you very much for your consideration.

CHAIR - Thank you, Mr Wallace and Mr Overton.

THE WITNESSES WITHDREW.

THE REVEREND PROFESSOR MICHAEL TATE AO, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Finch) - Thank you very much, Michael, for taking the time to join us here today and to present to us. We are happy to hand over to you for a presentation and then we'll ask some questions.

Prof. TATE - Thank you, Mr Chairman and committee. I am honoured that you should call on me, even at late notice, to appear before you on this very important issue. Tomorrow and on Thursday I am lecturing to law students in Launceston and Burnie - I am a professor at the Law School - on war crimes, crimes against humanity and genocide. The first two minutes of those lectures will be drawing the fundamental distinction between combatants and non-combatants; those who are combatants are properly regarded as proper targets for the use of lethal force, while those who are non-combatants, civilians or prisoners of war, for example, can't have legal force used against them. It's a very fundamental distinction and it boils down to the basic Red Cross, worldwide moral principle that you should not use lethal force against those who are not themselves using lethal force against you, or those for whom you have some real responsibility, like your children. I think that is a wonderful and fundamental distinction which over the last 20 years in international humanitarian law has tried to be given some teeth by the creation of such institutions as the International Criminal Court in order to back up that general principle.

Now that might sound a little bit vague, but I think it's important to recognise that what you are being asked to do as a parliament is to change the fundamental principle within Tasmania. At the moment the fundamental principle is that it is wrong to use lethal, deadly force against a person who is not harming or attempting to harm you. This bill is designed to modify that principle and it does so in relation to the Criminal Code. What you're being asked to do is to go beyond what Parliament now does. It states in the Criminal Code that the deliberate killing of a person - not in self-defence and so on - is murder, and that the assisting of somebody to die is a crime. I will come back to your point in a moment, which was very well made, that suicide is not a crime. You are being asked to change the Criminal Code in relation to a specific profession - and it is ironic that I don't think the profession is very much in favour of it - so that they will be allowed to use lethal force against a person who is not themselves using deadly force against them.

In my view the role of Parliament is always to safeguard that very fundamental principle. It's a great civilising principle; it means that we can live in a community where we have confidence that as long as we don't offer harm to somebody we won't ourselves be subject to deadly assault.

In my view the Criminal Code should remain as a clear expression of Parliament's endorsement of that principle, but then we come to the very hard cases and in my view Mr McKim has put forward a bill motivated by compassion and respect for personal autonomy. I was reflecting just sitting there and that wonderful film *Shadowlands* flashed into my mind - I don't know if you've seen it - based on C S Lewis' experience of his spouse's succumbing to very painful cancer. He started off very adamantly on the anti-euthanasia bandwagon and ended up silent by the end of the film. Everyone should see it. I feel a bit that way in relation to these issues, but since the bill is here, I would just like to tender my submission.

My view is that Parliament should always safeguard the bedrock principle, but I am inviting the committee to have a look at two groups within society, well-regarded and publicly-known entities who already modify the operation of that principle. The first is the DPP. Under the common law system the prosecuting authorities never have a 100 per cent obligation to prosecute all crime, and in fact the DPP exercises a discretion in the public interest not to prosecute any number of matters. The evidence is there, it's been brought to his attention and put together by the police and probably provable, but for one reason or another, in the public interest, he decides not to proceed.

No doubt the committee's secretariat could provide for you a copy, if he hasn't already, of the guidelines used by the DPP in Tasmania. There are maybe 10 or 12 factors that he takes into account, but in any case they're all non-exhaustive and he still has the public interest discretion. I am quite sure that he has exercised or would exercise that discretion in a way which distinguishes between what you might call the case of 'spousal compassion', where a spouse or partner administers or helps to administer a drug to their spouse or partner who is dying and in severe pain, from murder masquerading as euthanasia, where somebody is doing it for gain through the will or something like that.

That is a well-recognised discretion, but only 10 days ago the Lords of Appeal in the House of Lords made a decision in the case of Purdy. That was a case where a woman wanted to go to Switzerland to one of these 'Dying with Dignity' clinics with her partner. She was concerned that if he accompanied her and helped, I guess, in the final moments of the administration of whatever drug was involved, he would be liable to prosecution back in England. The Lords of Appeal heard the case and directed the DPP to come up with more precise guidelines and indications of the factors he would take into account in exercising his discretion not to prosecute in cases such as that.

It may well be that this committee has before it, or at least recommends, that the DPP consider making somewhat clearer the factors he would take into account which could include of course compassion, and could, I believe, include the question of the consent of the person concerned. The consent in itself doesn't reduce the criminal responsibility of a person doing it, but it would be proper for the DPP to exercise discretion in relation to it. In considering the big picture of what a parliament and other entities in society should do, I think the committee should have a good look at the DPP and perhaps make a recommendation in that respect.

Secondly of course you have the criminal courts which, once they are seized of the matter of a trial, act quite independently of Parliament. In an extreme case it may be that a jury would say, 'We won't convict', even though the evidence is clear that they should and perhaps the judge has said that they should. This would be an extreme case but it would be a case perhaps where social commonsense comes through. It could be appealed nevertheless. That is a possibility but I'd downplay that.

The DPP makes it clear in the guidelines he has put out - which is probably common to all Australian jurisdictions - that if he does decide to go ahead and prosecute, nevertheless the very factors that he vests are the sorts of factors a judge would take into account in mitigation of a sentence. A judge in a criminal trial can decide that, because of factors of compassion regarding the voluntary euthanasia aspect and the agreement of the person concerned, he or she will not record a conviction or record a conviction with a penalty which is reflecting that diminished situation.

Mr WHITELEY - A suspended sentence?

Prof. TATE - Or a suspended sentence. There is everything available of course - up to 20 years jail for pretending it is euthanasia but in fact hoping for something under the will.

I am trying to paint a picture of the major public entities which help to express and shape social life in Tasmania and our ability to live together as a civilised community, so my conclusion would be that the committee should recommend against the passage of the bill.

Mr WHITELEY - In your submission, which I thought was terrific, there was a third element - medical practitioners.

Prof. TATE - I thought the AMA was here this morning.

Mr WHITELEY - No, they weren't.

Prof. TATE - I see; I beg your pardon. Well, I just think it is ironic that the very profession which is being granted an exemption from the operation of the Criminal Code - because that is what the bill amounts to - is as I understand it not seeking that exemption. I am not privy to their submission - have they made a written submission yet?

Mr WHITELEY - Yes, they'll be here later.

Prof. TATE - I don't know the content of it but if it's consistent with the ethics and guidelines that they've published so far it would seem that they're not in favour of the passage of the bill, but I cannot say that for certain.

Yes, you were quite right, Mr Whiteley, to say that there are at least four major social entities involved. I was really concentrating on three: the interplay of Parliament, the DPP and the courts in setting up a social understanding which enables us to keep the bedrock principle that you will not kill or assist in the death of somebody not doing you harm, whilst recognising the proper operation of the DPP and the courts.

I submit that the committee should recommend against the passage of the bill, thus leaving the Criminal Code to protect the principle that no-one should kill or assist the death of a person not directing lethal force towards them. The committee could also recommend that the DPP publish further guidelines to indicate the factors which should be taken into account in deciding whether or not to prosecute.

I have not had the privilege of hearing the previous evidence, but Ms O'Connor's point was very well made, that suicide is not a crime. The present situation under the Criminal Code is that assisting the death of someone even if it was expressed as assisting suicide, is not like the old aiding and abetting of a crime. I would make that point clear and you are quite correct. We are not talking about aiding and abetting a crime. Assisting the death of another is criminalised because it breaches that fundamental rule, not because it is assisting suicide but because it is doing something by way of lethal force against somebody who themselves is not attacking you.

Mr GAFFNEY - If you take the Oregon example where the physician provides the drug and the person takes it home, is that assisting? The fact that they have given the drug and the person takes it home and then decides whether they want to take it, is that assisting?

Prof. TATE - I think that is assisting.

Mr GAFFNEY - In a court that would be assisting?

Prof. TATE - Sure.

Ms FORREST - They would not have access to the drug without that assistance.

Prof. TATE - It is not as though they are lying in their bed and putting in the injection.

Mr GAFFNEY - You are giving them -

Ms FORREST - The means, like giving them a gun.

Prof. TATE - You may need a criminal lawyer to deal with all those situations - one, two or three steps away from it - but you see my point.

Mr BEST - At least once or twice a year there is a high profile case in the media where the husband assists the wife or vice versa, due to their circumstances. Are you suggesting that we should explore a bit further as to what the definition of that ought to be in those cases?

Prof. TATE - I have here the guidelines put out by the DPP. He says that it is not the rule that all offences brought to the attention of the authorities must be prosecuted. He then lists various factors in the public interest, one of which, for example, is any mitigating or aggravating circumstances - 'the youth, age, intelligence, physical heath, mental or special infirmity of the alleged offender, a witness or victim'. These are things that can be taken into account - the attitude of the victim of the alleged offence to a prosecution.

Ms FORREST - That is bit hard to determine.

Prof. TATE - Not if they say, as Ms O'Connor points out, these are voluntary. What the bill envisages, anyway, is a fairly clear voluntary statement. So it would be clear in that situation what the attitude of the victim is to the alleged offence. Whether the consequences of any resulting conviction would be unduly harsh and oppressive, I think there would be plenty of scope for him even there, but there is an overriding public interest, even so, if he has not listed them. But it may be that he could clarify some issues for you or should be asked to.

Mr WHITELEY - But, as your evidence was earlier, not to remove the basic principle?

Prof. TATE - It is a balancing act, but I think the role of the Parliament is distinct from that of the DPP in the courts. I think the role of the Parliament is to safeguard. There are only three or four principles which society needs to work. One is obviously respect for private property to some extent, or telling the truth where the other person has a right to hear it. There are certain basic ones like the nurture and education of children. One of them is that you do not do harm to somebody who is not harming you. It has been a huge struggle in international criminal law to bring this about. It is beginning and everyone is recognising it as a civilising moment when it now expressed by the Security Council and by treaty in the criminal codes which apply to the International Criminal Court, for example. I think there are many ways in which the Tasmanian Parliament could express and safeguard this principle. The Criminal Code is one of them. You have done this since 1924, one way or another, and I think it is a good way for the Parliament to express that bedrock principle.

Mr BEST - We have had a lot of evidence about states of mind and people being vulnerable. It would be interesting to hear how that would then translate in some of those guidelines that you have read out from the DPP.

Prof. TATE - The DPP would just have a look at the brief that the police hand him to try to work out -

Mr BEST - Whether someone has been coerced.

Prof. TATE - Yes. I do not know the exact mechanics of it. I am not so much arguing from that point; I am arguing from a big picture - parliamentary and social.

Mr WHITELEY - The basic principle.

Prof. TATE - Yes, the basic principle. I just think you ought to recognise these other elements in society which have a moderating role which is publicly understood.

Ms O'CONNOR - Professor Tate, you have devoted your professional and personal life to compassionate pursuits. You must have juggled at times your commitment to justice and to your faith. Is there some place inside you where you wrestle with this, that it is not so black and white? Because of the detail and nuance of your submission, I understand that but how do you balance the individual's right to choose the manner of their death should they be in terminal pain and suffering and these wider societal issues that you have talked about to us today?

Prof. TATE - Thank you. I am not coming here from a faith position, by the way. I have tried to put it in the broadest terms of achieving the full scope that the Security Council could endorse. They have come from so many different civilisations and cultures and so on but they have thought it worth endorsing this and expressing it in a criminal code. Have you seen that wonderful film, *Shadowlands*? I think, frankly, you should give to every anti-bill advocate a video of that film because it goes through this movement of C S Lewis from being very adamant and sure of his moral principles to being affected by the terrible pain and suffering of his wife.

Everyone of my age has now sat next to one's mother or father as they have spent their last weeks and it is heartwrenching and heartbreaking. I recognise that and I recognise the proper motivation of the bill, so perhaps this is, as you mentioned, the Minister for Justice coming through me - the big picture. How do you build a society which will endure for the next 20, 40, 60, 100 or 200 years? You have to have certain basic principles expressed by the representatives of the people, and this is just one of them which needs to be safeguarded. At the moment we safeguard it and express it in the Criminal Code. The McKim bill asks for an exemption for medical practitioners, who do not seem to want it but I may be wrong there. I think we should leave it as it is. If I could say no more, I think you could say, 'You're being completely harsh and unreal'. I have brought to your attention a couple of other public entities who have a role in moderating that position. I have no doubt that the DPP and the sentencing judge would take into account the sorts of factors that are expressed in the bill.

Ms O'CONNOR - Just on that point, can you see how whatever guidelines the DPP puts out and operates under, people such as Bill and Stuart Godfrey, who assisted their mother, Elizabeth, in the Underwood case - which was five or six years ago - must then go through a criminal trial, that people will be made more vulnerable in a way by the lack of protection in the law, should they be acting absolutely out of compassion for people they love? There is no real protection in the law for them now other than the discretion of the DPP who, in the first instance, from what you're saying, acts as a kind of preliminary judge and jury before it even goes to trial.

Prof. TATE - In a way, but it's always been the case in common law that the prosecutor has that discretion. Maybe when we have sufficient cases in the Australian jurisdictions building up - I can't recall that case of five or six years ago, perhaps I was out of the State, but maybe the DPP thought it worth testing the law in some respect. Once you get a few of these cases decided then I think the sorts of guidelines he might be able to put together and clarify would enable people to have some certainty about the action they take, which is what the House of Lords asked the DPP in England to do.

Ms O'CONNOR - But then how many people might have to go through that terrible dilemma and awful choice that they choose to make on behalf of the people they love? How many people will be put through the criminal justice system before there is certainty in the law that offers them some protection? We're still dealing with people's lives, you know.

Prof. TATE - Yes, but you're asking for certainty in relation to a particular profession.

Ms O'CONNOR - Well, this bill asks for certainty in relation to the medical profession, but you've been talking more in a way about family members and carers who may assist someone they love to commit suicide.

Prof. TATE - Sure, but your bill doesn't deal with that anyway.

Ms O'CONNOR - No, it doesn't.

Prof. TATE - Just for the record, I might quote the opinion of the Lords of Appeal in the House of Lords. By the way, this was decided a week or two after the House of Lords had decided not to pass a euthanasia bill. In the full House of Lords, in their parliamentary capacity, they decided not to, but there was this Purdy case going ahead and a week or so later it was decided, on 30 July, and the leading judge, Lord Hope, said in paragraph 56:

> 'I would therefore allow the appeal and require the Director to promulgate an offence-specific policy identifying the facts and circumstances which he will take into account in deciding, in a case such as that which Ms Purdy's case exemplifies, whether or not to consent to a prosecution under section 2(1) of the 1961 Act.'

So it may be that as one of the recommendations of the act you ask the DPP to do something like that.

Ms O'CONNOR - But as the law currently stands there is no protection for medical professionals and people who, for example, operate in palliative care. Do you think that that makes professionals vulnerable, as well as providing no protection to the vulnerable people who have been spoken about in a number of submissions today? There is nothing in the law currently.

Prof. TATE - You say it doesn't give any protection, but what it doesn't do at the moment is give them an exemption from the Criminal Code. The McKim bill, with all due respect, doesn't quite make it clear; when you take away its very good, elaborate, protective devices, it amounts to a three-line bill saying, 'We exempt the medical profession from section 157 of the code dealing with murder and section 163 dealing with assisting death'. That is what it boils down to and I think that is a step too far in constructing the sort of society that we want to have. I acknowledge, and I don't know how to deal with, a couple of cases where a particular medico might want to do something but the Criminal Code inhibits him from doing so.

Ms O'CONNOR - Finally, and this is an ethical question, what do you think the solution is for someone who has been diagnosed with a terminal illness and, as the weeks and months go on, they are in excruciating pain and the palliative care is not working? Where, ethically, is our response? Where does it fit? What is our response to the suffering of these citizens?

Prof. TATE - Well, that's the hardest question - that's the C S Lewis question. I just hope to God it doesn't happen to me.

Ms O'CONNOR - Well, that's right.

Prof. TATE - But I still think you have such a role. You are public policy people. The individual case -

Ms O'CONNOR - They are not isolated necessarily; they happen semi-regularly in our society, where people just -

Prof. TATE - Yes, sporadically. I don't have a clear answer, to be honest.

Mr WHITELEY - I thought it was very profound. You referred earlier to C S Lewis; it was Anthony Hopkins who played that role.

Prof. TATE - Did he?

Mr WHITELEY - Yes, but you said he went from being anti to being silent because the big question does remain. I think I have said to you privately that I accept that the big question in life does remain, as it does in many other situations, like why children are born with a disability and so on.

Our role as I understand it, Mr Chairman, is to scrutinise the veracity of the bill as public policy, I suppose, and to make a recommendation to the Parliament in regard to whether it should be supported or not. We may find there is an opportunity on the edges to make some recommendations such as what you have just given us as well as some of the other stuff we have heard today regarding palliative care. Getting back to the bill's terms of reference, am I hearing your evidence correctly in that, based on the bill that is before us, the way in which it is written, the way in which it would seek to change some of the fundamental principles you have spoken eloquently about, you do not believe the bill itself should be supported?

Prof. TATE - No, I don't believe it should be insofar as it amounts to granting an exemption from the Criminal Code for the medical profession in certain limited circumstances.

By the way, no doubt you will take evidence on the actual provisions of the bill but, as you said, in an extreme situation where the patient is not able to be relieved by palliative care there is some movement in the bill, isn't there, between the subjective assessment of that and objectively whether it is the case? I am not quite sure how the doctor will work all that out but that's another issue. isn't it?

Mr WHITELEY - We've already heard a bit of evidence on that.

Ms O'CONNOR - Yes, how do you measure pain?

Prof. TATE - I am not getting into that.

Ms FORREST - It comes down to the patient's living experience.

Prof. TATE - Yes, sure.

Ms FORREST - When was *Shadowlands* made?

Prof. TATE - As I get older everything is a long time ago.

Mr WHITELEY - There have been two or three versions of it.

Ms FORREST - But it is based on a situation that happened many years ago?

Prof. TATE - I see what you mean; I think just after the war, World War II.

Ms FORREST - So it was at a time when palliative care was anything but what it is now. We know there have been a lot of advances made in palliative care but there are still people who will not find their symptoms relieved to a place where they feel it meets their individual needs. Many of the submissions we have received, particularly from the people supportive of the principle of the bill, don't comment on the content of the bill and how it is framed or anything like that, because most of them wouldn't be in a position where they could, which is fine. But a lot of those people have related events of caring for their loved ones, with some very lovely death experiences and a lot of unfortunate and unpleasant death experiences.

The thing is that obviously that event happened a time ago, whether it be a year ago or many years ago, so it's really hard to sift out what we're talking about. If we look at what's happening now in palliative care -

Prof. TATE - Yes, I heard you with the previous witness.

Ms FORREST - Yes. It's quite different to what it was 15 or 20 years ago, so in recommending that everyone should watch *Shadowlands*, and I think it's certainly a valuable suggestion, I don't think we should be sidetracked too much by it, except for the fact that science is perhaps a better option here because there is a really big elephant in the room that we're finding very difficult to talk about. The elephant in the room, to my mind, is the suffering that goes on, but what we're trying to deal with in this bill is a little blemish on the elephant's toenail. What we're talking about is a very small percentage of people who actually fit into this category who will ever seek voluntary euthanasia or be in a situation where they become eligible for it. So are we really wise to -

Prof. TATE - Well, except that for the person suffering, it's not the toenail, is it, it's the whole person; it's the whole physical, spiritual and mental anguish. That's what I am saying. My mother died about 20 months ago now, and in the end Richard and I consented to her being administered a drug which reduced her pain and agitation, and so on, but we knew - and the medical advice was - that it would reduce her life by a couple of days or something like that. Even that was a hard decision, so I don't know. I think sometimes it's very hard as politicians to lift yourself out of the personal situations that we all know about into the necessary dimension of public policy to create the sort of society that will endure. I really think this is one of those fundamental moments where this principle has to be endorsed in the way that it is.

Ms FORREST - That is the challenge, to separate out those personal experiences.

Prof. TATE - I was just going to say, I spend a lot of time in the Gibson Ward in Hobart -

Ms FORREST - Which is?

Prof. TATE - Palliative care; there are two palliative care wards down there, the Whittle Ward and the Gibson Ward. I am there most weeks in my other capacity, so I am pretty well aware of the wonderful ability of the good palliative care units to provide not only the physical care but the mental and environmental care, you might say, of those who are dying. That should be enhanced as much as possible.

CHAIR - All right, it's a good point to close on, Mr Tate, so thank you very much for joining us here today and preparing yourself for your efforts at the university tomorrow.

Prof. TATE - Yes, right; you've given me another dimension. Thank you.

CHAIR - Thanks. We appreciate your submission and your appearance today.

THE WITNESS WITHDREW.