



2009

PARLIAMENT OF TASMANIA

**JOINT STANDING COMMITTEE ON  
COMMUNITY DEVELOPMENT**

**REPORT  
ON THE  
DYING WITH DIGNITY BILL 2009**

---

*Brought up by Mr Finch and ordered by the Legislative Council to be printed.*

---

MEMBERS OF THE COMMITTEE

*Legislative Council*

Hon. *Kerry Finch* MLC (Chair)  
Hon. *Ruth Forrest* MLC  
Hon. *Mike Gaffney* MLC

*House of Assembly*

Mrs *Heather Butler* MP  
Mr *Brenton Best* MP  
Ms *Cassy O'Connor* MP  
Mr *Brett Whiteley* MP

## CONTENTS

	<i>Page</i>
EXECUTIVE SUMMARY.....	3
FINDINGS.....	6
INTRODUCTION	
Terms of Reference.....	8
Conduct of the Inquiry.....	8
Part 1 - Terminology.....	10
Background.....	11
DYING with DIGNITY BILL 2009	
Part 2 - Overview.....	13
Part 3 - Analysis of Bill Provisions.....	16
Part 4 - INCIDENTAL MATTERS	
Palliative Care.....	36
End-of-life Care.....	38
Current Practices.....	39
Public Support.....	41
Part5-OVERVIEW OF ARGUMENTS FOR & AGAINST.....	43
APPENDIX 1 – Flow Chart of Dying with Dignity Bill as submitted by Hon. Ruth Forrest MLC.....	52
APPENDIX 2 – EMRS Voluntary Euthanasia Research Report.....	53
APPENDIX 3 – Comparative Table of Euthanasia Legislation.....	58
APPENDIX 4 – Selected Bibliography.....	59
APPENDIX 5 – Submissions Received.....	60
APPENDIX 6 – Documents Received.....	74
APPENDIX 7 – Witness List.....	76
APPENDIX 8 – Divisions.....	78

---

## EXECUTIVE SUMMARY

The *Dying with Dignity Bill 2009* was introduced in the Tasmanian House of Assembly on 26 May 2009 as a private member's Bill by Mr Nick McKim, MP Leader of the Tasmanian Greens. The Bill was referred for investigation to the Joint Standing Committee on Community Development on 18 June 2009 by the Deputy Premier, Ms Lara Giddings, MP to report by 2 October 2009. The Committee made a request to Parliament for an extension of time and a new reporting date, 9 October 2009, was agreed to.

Mr McKim, the author of the Bill, suggested that there is a need for the legalisation of voluntary euthanasia as a compassionate and merciful response to the suffering of a small number of terminally ill patients for whom palliative care has failed to provide relief.

The *Dying with Dignity Bill 2009* provides for mentally competent people suffering a terminal illness, under certain circumstances, to be assisted in ending their life at a time of their choosing by a medical practitioner.

The Bill also ensures that a medical practitioner who agrees to assist in the termination of a patient's life will not be prosecuted for assisting suicide, manslaughter or murder if they act in accordance with the provisions of the Bill.

The Bill provides that there is no compulsion for medical practitioners to participate in voluntary euthanasia and they can withdraw from the process at any time. Medical practitioners who do participate are protected from professional censure or loss of licence.

The Bill also provides safeguards to protect the interests of the patient, including the requirement for the medical practitioner to seek advice from a second medical practitioner who holds prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the person is suffering and is able to confirm the original diagnosis. Further advice must then be sought from a psychiatrist to confirm the patient's mental competence. The medical practitioner must also ensure that the sufferer has been informed of the nature of the illness and its likely course, the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the sufferer alive that may be available. The medical practitioner must also ensure that there are not palliative care options reasonably available to the sufferer to alleviate the sufferer's pain and suffering to levels acceptable to the sufferer, such that all palliative care options have been exhausted before assistance with voluntary euthanasia is commenced.

Furthermore, the medical practitioner is to ensure that at no time during the course of determining and meeting the provisions contained in the Bill to provide assistance to the sufferer to end his or her life, had the sufferer given any indication that it was no longer the sufferer's wish to end his or her life.

Opponents of the proposed legislation argue that just because we cannot control all pain and suffering, is not a reason to kill the sufferer.

Improvements in palliative care methods, including a range of medications that can be used to control pain more efficiently than opioids alone and treating the cause of pain through pharmacological and surgical methods other than the use of analgesics, advances in medications to control the symptoms that result in other forms of suffering associated with

---

terminal illnesses including dyspnoea, delirium and nausea, have provided significant advances in palliative care in recent years. It has been argued that these measures have led to relief of pain and suffering to a greater extent and it has been argued that these measures can control pain and suffering in most patients.

In a minimal number of cases where patients do not respond to such treatments it has become accepted practice to induce a 'palliative coma'.

Proponents of voluntary euthanasia suggest that this practice is merely a slow form of euthanasia as the patient is rarely expected to ever regain consciousness and palliation is increased in the knowledge that it will hasten death.

Data was presented to the Committee to support the assertion that medical practitioners in Australia are participating currently or have participated in voluntary and involuntary euthanasia despite legal prohibition and that 1.8% of deaths in Australia can be attributed to such practices.

Proponents of voluntary euthanasia view this as sufficient justification for legal reform that would regulate the process and provide protection for both patients and medical practitioners.

Currently by law under the Criminal Code a medical practitioner who does agree to help a patient to end his or her life is liable to prosecution for murder or manslaughter.

Neither the medical practitioner's compassionate motive nor the consent of the patient are seen as mitigating circumstances.

Many opponents of voluntary euthanasia believe that the issue is more complex than simply providing for the exercise of individual choice.

A request for assistance to die places the burden of ending the life of a human being onto another person. This, it is claimed, does not only have negative consequences for the participating individuals but for society as a whole. It was also suggested that, unlike suicide, euthanasia should be considered a social act because it requires the assistance of another person.

Proponents of the Bill however suggest that the strong public support expressed in polling data should be reflected in legislation and point to the experience of overseas jurisdictions where voluntary euthanasia has been legalised, such as the Netherlands and the state of Oregon (USA), and note that there is no evidence of vulnerable people being coerced into participating or other misuses. Some suggested that with the advent of euthanasia laws extra finance has been provided to improve palliative care in these jurisdictions.

It is acknowledged that there have been a number of committees of inquiry both within Tasmania and Australia and internationally in recent years including: the Tasmanian 1998 Community Development Committee Report on *The Need for Legislation on Voluntary Euthanasia*; the House of Lords Select Committee on *The Assisted Dying for the Terminally Ill Bill 2005*; and the 2008 Senate Standing Committee on Legal and Constitutional Affairs Report on *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*.

---

The purpose of this inquiry, following the referral of the *Dying with Dignity Bill 2009* to the Joint Standing Committee on Community Development, was to investigate the Bill, with the primary focus of the Committee being to establish whether or not the Bill was appropriately drafted and would achieve the desired outcome as articulated by the author of the Bill, addressing the issue of appropriate safeguards within the Bill. The inquiry also identified the key arguments for and against such legislation and considered the level of support for a Bill to enable mentally competent people suffering a terminal illness, under certain circumstances, to be assisted in ending their life at a time of their choosing by a medical practitioner.

---

## FINDINGS

1. That the *Dying with Dignity Bill 2009*, the subject of this inquiry in its current form does not provide an adequate or concise legislative framework to permit voluntary euthanasia/physician assisted suicide.
  2. The *Dying with Dignity Bill 2009* has been described as containing insufficient safeguards or for having too many safeguards to enable a sufferer seeking assistance to end their life.
  3. There is a range of strongly held views on how our society can ensure the most compassionate medical and legal response to those terminally ill Tasmanians who are experiencing intolerable suffering, for whom even the best palliative care fails to provide relief and who wish to end their lives at a time of their choosing.
  4. The Committee heard evidence from medical professionals and palliative care experts that there is a small number of terminally ill patients for whom even the best of palliative care fails to provide relief beyond resorting to ‘terminal sedation’ or the administration of medication, provided with the genuine intent of relieving suffering but which can also hasten death.
  5. A range of evidence was provided for and against voluntary euthanasia/physician-assisted suicide and there was far less support for the Bill from those professionals who presented evidence.
  6. Opinion within the medical profession is divided on the need for a legislative and regulatory framework that provides an avenue for medical professionals who agree to assist in the requested ending of a sufferer’s life.
  7. National and statewide surveys of public opinion – on the specific question of whether a terminally ill person enduring intolerable suffering should be able to die at a time of their choosing – consistently show majority support for law reform.
  8. The Committee acknowledged that questions remain as to whether survey results include a clear understanding of the cessation/withdrawal of futile treatment(s), non-commencement of futile treatment(s) and a person’s right to refuse treatment.
  9. Opponents of the *Dying with Dignity Bill 2009* consider that the wishes of the terminally ill of competent mind, for whom palliative care is failing, are an external consideration to: the need to support a compassionate palliative care response; the principle of the ‘sanctity’ of human life; perceived potential risks to the vulnerable and to their families; and the wider philosophical and societal questions raised should the State legalise active voluntary euthanasia.
  10. Proponents of the *Dying with Dignity Bill 2009* support the principle of individual autonomy and consider that the current regulatory framework does not provide a compassionate response to terminally ill people for whom palliative care is failing to provide relief and who wish to end their lives, nor do they believe that it provides
-

adequate protections for medical professionals who wish to accede to the requests from the terminally ill to end their life.

11. A broad range of community opinion and facts related to the subject of the *Dying with Dignity Bill 2009* was heard in evidence with support for, and interest expressed in, further community discussion related to ethical and professional standards, community attitudes, improvement in health care service delivery and barriers to appropriate end-of-life health care.
  12. The Committee heard allegations that acts of both voluntary and involuntary euthanasia are occurring in Australian jurisdictions, including Tasmania.
  13. That more community education is required regarding ‘enduring guardianship’.
  14. That further investigation is required into the utilisation and application of ‘advance directives’.
  15. That the community can have confidence in Tasmanian health professionals who are committed to providing quality palliative care.
  16. Whilst palliative care is of a very good standard there is a need to have an improved system of management and resources, particularly in regional areas.
  17. There was overwhelming agreement, in the written and verbal evidence to the Committee, that the Tasmanian Government needs to invest sufficient funds and resources in palliative care services in Tasmania.
-

## **INTRODUCTION**

This report examines the *Dying with Dignity Bill 2009* and provides a brief overview of some of the main arguments and issues surrounding the voluntary euthanasia debate.

The private member's Bill was introduced into the Tasmanian House of Assembly on 26 May 2009 by Mr Nick McKim, Leader of the Tasmanian Greens. The Bill was referred for investigation to the Joint Standing Committee on Community Development on 18 June 2009 by the Deputy Premier, Ms Lara Giddings, to report by 2 October 2009. Each political party has allowed Members a conscience vote on this Bill.

The Honourable Member for Elwick, Mr Martin was a member of the Committee until 26 August 2009 and the Honourable Member for Pembroke, Dr. Goodwin was appointed to the Committee on 3 September 2009. Neither such members participated in the proceedings of the Committee in relation to this reference.

## **TERMS OF REFERENCE –**

*The Dying with Dignity Bill 2009*, together with any incidental matters

## **CONDUCT OF INQUIRY –**

The Committee commenced the inquiry by seeking public submissions.

On Saturday 26 June 2009 advertisements were placed in the three major Tasmanian daily newspapers inviting written submissions from interested individuals and organisations.

A strong public response produced 513 written submissions. Further public consultations were conducted via public hearings in Launceston and Hobart where 36 witnesses were invited to present evidence before the Committee.

The Committee received submissions from a broad range of contributors. Supporters and opponents included representatives of medical practitioners (including nurses and palliative care specialists), academics (including professors of law, philosophy and ethics), religious groups, lawyers and the general public.

This report comprises the following sections:

*Part 1* provides a brief background context including definitions of key terms and a summary of the legal situation overseas and in Australia with regard to voluntary euthanasia legislation.

*Part 2* contains an overview of the various components of the Bill.

*Part 3* is an analysis of the provisions of the Bill highlighting observations presented to the Committee in evidence in relation to strengths and weaknesses of the Bill including drafting concerns.

*Part 4* highlights public opinion and support for change, palliative care and legal issues.

---

*Part 5* provides a summarised overview of the main philosophical, ethical and legal arguments for and against the legalisation of voluntary euthanasia.

## PART 1 - TERMINOLOGY

The Committee has adopted the following definitions for the purposes of this report.

The word *euthanasia* is derived from Ancient Greek, *eu* meaning ‘good’, and *thanatos* meaning ‘death’, when combined literally meaning a ‘good death’. The *Macquarie Dictionary* gives the following definitions:

*Euthanasia*: painless death.

*Voluntary euthanasia*: euthanasia practised at the wish of a person with a terminal illness.

*Active euthanasia*: the deliberate bringing about of the death of a person suffering from an incurable disease or condition, as by administering a lethal drug or by withdrawing existing life-supporting treatments.

The following interpretations are sourced from the 2008 Senate Standing Committee on Legal and Constitutional Affairs report into the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*:<sup>1</sup>

*Active voluntary euthanasia*: where medical intervention takes place, at a patient’s request, in order to end the patient’s life.

*Passive voluntary euthanasia*: where medical treatment is withdrawn or withheld from a patient, at the patient’s request, in order to end the patient’s life.

*Passive in/non voluntary euthanasia*: where medical treatment or life-support is withdrawn or withheld from a patient, without the patient’s request, in order to end the patient’s life.

*Active in/non-voluntary euthanasia*: where medical intervention takes place, without the patient’s request, in order to end the patient’s life.

*Physician-assisted suicide*: suicide using a lethal substance prescribed and/or prepared and/or given to a patient by a doctor for self-administration for the purpose of assisting the patient to commit suicide.

*Double effect*: the administration of drugs (such as large doses of opioids) with the intention of relieving pain, but foreseeing that this might hasten death even though the hastening of death is not actually intended.

*Palliative care*: the provision of therapy or drugs with the aim of relieving pain and making the patient comfortable until death occurs even if it may indirectly shorten the patient’s life. Such treatment is held to be ethically justifiable under the doctrine of double effect.<sup>2</sup>

---

<sup>1</sup> Parliament of Australia, Standing Committee on Legal and Constitutional Affairs, *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*, pp. 6-7

<sup>2</sup> Griffith, G, *Euthanasia: An update*, Briefing Paper No. 3, 2001, New South Wales, Parliamentary Library, p.5

---

## **BACKGROUND**

### **International context**

Voluntary euthanasia in some form has been legalised in a small number of overseas jurisdictions. Voluntary euthanasia and assisted suicide have been practised in the Netherlands since the 1970s however the practice was not codified in legislation until 2002. Belgium and Luxembourg have also enacted legislation legalizing voluntary euthanasia. In Switzerland euthanasia is not legal but doctors are not prosecuted for practising physician-assisted suicide. In the USA the states of Oregon and Washington have enacted legislation permitting voluntary euthanasia through physician-assisted suicide.

There have been a number of unsuccessful attempts to introduce legislation permitting voluntary euthanasia in other overseas jurisdictions over the last decade and a half, including Great Britain, and the American states of Vermont, New York and California, and several major inquiries have been undertaken as part of the ongoing debate.

In a recent development in the United Kingdom the House of Lords required the Director of Public Prosecutions to clarify the law regarding assisted suicide in the situation where relatives or friends assist gravely ill people to travel abroad to access voluntary euthanasia provisions. In September 2009 the DPP published an interim policy detailing the factors to be considered when deciding whether or not a prosecution should be instigated.<sup>3</sup>

### **Australian Context**

Voluntary euthanasia or assisted suicide is not legal in any Australian State or Territory.

For a brief period the Northern Territory *Rights of the Terminally Ill Act 1995* legalised active voluntary euthanasia and physician-assisted suicide in that jurisdiction but the Act was rendered inoperative by the Commonwealth *Euthanasia Laws Act 1997*. Four people chose to access the provisions of the Northern Territory Act before it was overturned by the Commonwealth legislation.

Since then the debate has continued across Australian jurisdictions and a number of parliamentary Committees have held inquiries into the matter. In recent years private members' bills to legalise voluntary euthanasia have been introduced into the Senate and into several State parliaments but were unsuccessful.

An overview of attempts to introduce voluntary euthanasia legislation in Australia can be found in the Victorian Parliament publication *Current Issues Brief No. 2, 2008, Medical Treatment (Physician Assisted Dying) Bill 2008*.

### **Tasmanian context**

The subject was thoroughly examined by the Tasmanian Parliament in 1996 in the Community Development Committee Report on *The Need for Legislation on Voluntary Euthanasia*. The Parliamentary Committee concluded that there should be no change to the law in Tasmania to legalise voluntary euthanasia.

---

<sup>3</sup> See Document No. 23

---

The *Dying with Dignity Bill 2009* proposes to create an exemption from the *Criminal Code Act 1925* for medical practitioners who under certain circumstances assist terminally ill people to die.

Currently the Tasmanian *Criminal Code Act 1925* provides:

Under *s.153 – 162* homicide is illegal, including the charge of instigating or aiding suicide. *Section 163* provides that –

*Any person who instigates or aids another to kill himself is guilty of a crime.*

Under *s.154* homicide by hastening death is illegal:

*A person is deemed to have killed another ... where his act or omission is not the immediate, or not the sole, cause of death ...*

*(d) where by any act or omission he hastens the death of another who is suffering under any disease or injury which would itself have caused death.*

Under *s.53(a)* it is illegal to consent to the infliction of death upon oneself:

*No person has a right to consent to the infliction –  
(a) of death upon himself;*

*...*

*and any consent given in contravention hereof shall have no effect as regards criminal responsibility.*

---

## **PART 2 - OVERVIEW OF BILL**

The *Dying with Dignity Bill 2009* was, according to its author, Mr Nick McKim MP, initiated as a compassionate response to the needs of terminally ill patients who suffer intolerable pain without prospect of relief from any acceptable treatment. Under such circumstances Mr McKim asserts that -

*These sufferers have the right to choose a peaceful and dignified death within a safe, regulated, legal and medical framework.*<sup>4</sup>

Another factor Mr McKim describes as providing impetus for such legislation is the strength of public support demonstrated in recent polling.

Market researchers, Enterprise Marketing and Research Services Pty Ltd, conducted a poll in May 2009 which asked 1000 Tasmanians:

*Thinking about voluntary euthanasia where a doctor complies with the wishes of a dying patient to have his or her life ended; are you in favour of or against a change in the law that would allow doctors to comply with the wishes of a dying patient to end his or her life?*<sup>5</sup>

78% of respondents were in favour of legalising voluntary euthanasia, however it is unclear whether respondents considered the withdrawal of, non-commencement of, or refusal of futile treatments as voluntary euthanasia.

A third reason Mr McKim cites for the need of such legislation is to bring the law into line with existing practises. Mr McKim highlights data<sup>6</sup> that shows that doctors are making end-of-life decisions explicitly intended to hasten the patient's death without the patient's request. Such actions, even if motivated by compassion, could be defined as either manslaughter or murder under the current law.

Mr McKim suggests that legislation to regulate voluntary euthanasia would provide safeguards for both patients and doctors and reduce the level of non-voluntary euthanasia.

In his submission Mr McKim makes it clear that the legislation he proposes is not to replace or reduce palliative care services but simply to provide an option for a small minority of terminally ill patients for whom optimal palliative care cannot provide relief from intolerable suffering.

The provisions of the *Dying with Dignity Bill 2009* are aimed at meeting needs of sufferers who seek assistance to end their lives and protection for medical practitioners who choose to respond to such requests.

The Bill defines who is eligible to make use of its provisions in clause 5:

---

<sup>4</sup> Submission No.494 p.2

<sup>5</sup> EMRS Voluntary Euthanasia Research Report (Appendix 1, Submission No. 495)

<sup>6</sup> Kuhse, H, P. Singer, P. Baume, M. Clark, M. Richard, 'End-of-life decisions in Australian medical practice,' Medical Journal of Australia, 166, 1997, pp. 191-196

---

*A sufferer who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the sufferer, may request the sufferer's medical practitioner to assist the sufferer to end the sufferer's life.*

In clause 6 Mr McKim intends to provide for a medical practitioner to respond to such a request if satisfied that the safeguards and other criteria listed in clauses 8, 9 and 10 are met. The medical practitioner may refuse to assist for any reason and at any time. His or her participation is voluntary and there is no provision in the Bill to compel a medical practitioner to accede to a patient's request.

Clause 8 provides the steps that must be taken and the conditions that must be met before a medical practitioner can respond to a patient's request for assistance to die. The medical practitioner must be satisfied that the patient's illness is terminal. This must be confirmed by another medical practitioner with appropriate expertise in the treatment of the patient's illness and then a psychiatrist must also confirm the mental competence of the patient.

The medical practitioner must ensure that the patient is aware of the nature of the illness and its likely course as well as any treatments or palliative care options that may be available. If the patient wishes to continue with the request for assistance the doctor must be satisfied that the decision has been made freely, voluntarily and after due consideration.

Seven days after making a request and all necessary requirements have been met a certificate of request may be signed by the patient, witnessed by his or her medical practitioner and a second medical practitioner.

To discourage individuals from other jurisdictions from accessing the provisions of this legislation clause 9 outlines a Tasmanian residency qualification.

Clause 10 provides another safeguard by requiring the medical practitioner to explore all palliative care options that are reasonably available to alleviate the sufferer's pain and suffering to levels acceptable to the sufferer before proceeding to assist the patient with his or her request.

Clause 14 requires records to be made at each step of the process and clause 16 requires that these records be forwarded to the Coroner after the patient's death.

To provide legal protection to the medical practitioner who assists the sufferer to die, clause 22 exempts the medical practitioner from civil or criminal action or professional disciplinary action for anything done in good faith and without negligence in compliance with the Act.

To ensure consent is freely given and the request for assistance is truly voluntary, the Bill is deliberately narrow in its application. Only mentally competent persons over 18 years of age who are terminally ill and enduring intolerable suffering may access its provisions. This excludes many categories of individuals who may be subject to similar suffering but who are ineligible to access the provisions of the Bill due to their loss of mental competence.

In his submission the author of the Bill informed the Committee that –

*The Bill I have tabled makes provision for an individual to request assistance. But on top of that, it ensures through safeguards that the sufferer is fully informed and*

---

*mentally competent, and it ensures that the request is on the basis of the sufferer's intolerable suffering and terminal illness. Only when all the requirements are met is the individual able to access assistance.*<sup>7</sup> (Mr Nick McKim)

---

<sup>7</sup> Submission No.494 p. 15

---

### PART 3 - ANALYSIS OF THE BILL

The following is an analysis of the provisions of the *Dying with Dignity Bill 2009* highlighting comments and observations made in evidence presented to the Committee.

#### DYING WITH DIGNITY BILL 2009

##### A BILL FOR:

**An Act to confirm the right of a person enduring a terminal illness with profound suffering to request assistance from a medically qualified person to voluntarily end his or her life in a humane and dignified manner, to allow for such assistance to be given in certain circumstances without legal impediment to the person rendering the assistance, to provide procedural protection against the possibility of abuse of the rights recognised by this Act, and for related purposes.**

##### Comments

*As a legislator, it is my duty to put forward law reform proposals when the law diverges too greatly from reality. A landmark study conducted in 1997 found that, "Australian law has not prevented doctors from practicing euthanasia or making medical end-of-life decisions explicitly intended to hasten the patient's death without the patient's request." Clearly, existing criminal law against assisted suicide has failed to prevent euthanasia.*<sup>8</sup> (Mr Nick McKim)

The title of the Bill attracted numerous comments from opponents of the Bill questioning the inclusion of terms such as, 'dignity' and 'confirm the right' of a person to seek voluntary euthanasia.

*It is concerning that this title of the Bill lays claims to euthanasia as being a dignified death, promoting the premise that any other avenue of death is undignified and euthanasia (or medical assisted suicide) as the only method of a dignified death. The excellent levels of palliative care provided in Tasmanian hospitals and aged care facilities do allow a person to die with dignity.*<sup>9</sup> (Archbishop Adrian Doyle)

*I agree that the name 'Dying with Dignity' is a misnomer. The Bill should be called 'The Physician Assisted Suicide Bill' because that is what it is ... the term dying with dignity implies that other means of death is undignified.*<sup>10</sup> (Dr Gerard McGushin)

*...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' ... 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.*<sup>11</sup> (Mr Rene Hidding)

---

<sup>8</sup> Submission No. 494 p. 2.

<sup>9</sup> Submission No. 231 p. 1.

<sup>10</sup> Transcript 10/8/09 p. 18

<sup>11</sup> Transcript 10/8/09 p.6

It was felt by some that the use of the words ‘confirm the right of a person’ in the title is misleading.

*The reality is that in international law there is no right to death but there is a very strong right to life.*<sup>12</sup> (Mr James Wallace)

Concerns about the establishment of a ‘right’ to die were raised and the findings of the 1993 House of Lords inquiry were noted:

*The value of the Netherlands experience is not in the establishment of a right to die a dignified and humane death. The value is in providing an example of the perils of active voluntary euthanasia as a whole. And for each vulnerable person within that society a right to die, once accepted too easily becomes a duty to die or an excuse to kill.*<sup>13</sup> (Reverend Richard Humphrey)

However proponents of the Bill counter some of these arguments:

*We believe, and we have evidence in our document and in these other documents, that this legislative option is responsible, democratic and safe*<sup>14</sup>. (Dr. Margaret Sing)

*An individual with decision-making capacity should...be able to determine how and when he or she dies as long as this does not interfere with the rights of others ... self-determination does not entail a right to demand and receive active voluntary euthanasia. Rights (as distinct from liberties or privileges) are normally correlative with duties. Thus the creation of any right to active voluntary euthanasia would tend to imply a corresponding duty on the part of someone to become actively involved in bringing about death, which is widely believed to be inappropriate.*

*The Bill [does] not purport to confer on patients an absolute right to active voluntary euthanasia or assistance in suicide and it contains a number of provisions to ensure the voluntariness of the doctor’s decision to provide assistance under the legislation.*<sup>15</sup> (Prof. Margaret Otlowski)

**Be it enacted by His Excellency the Governor of Tasmania, by and with the advice and consent of the Legislative Council and House of Assembly, in Parliament assembled, as follows:**

#### **Short Title**

**1. This Act may be cited as the *Dying with Dignity Act 2009*.**

#### **Commencement**

**2. This Act commences on the day on which it receives the Royal Assent.**

---

<sup>12</sup> Transcript 10/8/09 p.31

<sup>13</sup> Transcript 24/8/09 p. 15

<sup>14</sup> Transcript 24/8/09 p.76.

<sup>15</sup> Submission No. 487 p.8

---

## Comments

Parliamentary Counsel had concerns that commencing a significant piece of legislation such as this upon receiving Royal Assent would not allow for regulations to be in place prior to operation of the Act. It was suggested that -

*The bill requires a number of things to be prescribed such as qualifications et cetera, so regulations need to be in place before this bill commences ... Ordinarily we would commence it 'on proclamation' in order to give the medical profession certainty and to allow all that is necessary to be put in place before this bill comes into force.*<sup>16</sup>

## **Interpretation**

### **3. In this Act, unless the contrary intention appears -**

**'assist', in relation to the death or proposed death of a sufferer, includes the prescribing of a substance, the preparation of a substance and the giving of a substance to the sufferer for self administration, and the administration of a substance to the sufferer.**

## Comments

Difficulties were noted in submissions in respect to the interpretation of 'assist' and 'substance.'

The following questions were raised:

*This appears to be the only explanation of how the act of bringing about the death of the sufferer occurs. It seems to us not to adequately explain that process ... we are not sure whether any thought has been given to this at all. Who prepares the substance? Who administers the substance? What is the substance?*<sup>17</sup> (Southern Cross Care)

Another submission questioned the meaning of 'substance' and 'self administration'.

*It is not clear what ramifications the following words may have - 'the giving of a substance to the sufferer for self administration'. Do they mean that the sufferer is provided with the means of committing suicide, namely physician assisted suicide? If so, what safeguards are there to prevent the 'substance' leaving the possession of the sufferer?*<sup>18</sup> (North West Justice Network (NWJN))

Parliamentary Counsel clarified some concerns by explaining that where a term is not defined in an Act, the protocol for interpreting the meaning is firstly to refer to the Australian Macquarie Dictionary definition. Later a court interpretation may evolve through case law. In respect to the use of 'assist' and 'substance' in clause 3, Parliamentary Counsel noted that:-

*There is a general provision in there that says that a medical practitioner, clause 8(2), ... 'In assisting a sufferer under this Act a medical practitioner must be guided*

---

<sup>16</sup> Transcript 31/8/09 p. 74

<sup>17</sup> Submission No. 270 p. 6

<sup>18</sup> Submission No. 439 p.14

*by appropriate medical standards and such guidelines’ ... so it is implying that whatever a medical practitioner does in assisting someone under this Act, there has to be a medical basis for it.<sup>19</sup>*

Parliamentary Counsel also explained that ‘assist’ as defined above is not an exhaustive definition and that the prescribing of a substance, the preparation of a substance and the giving of a substance to the sufferer are some of the categories ‘included’ in the meaning of ‘assist’.

**‘certificate of request’ means a certificate in or to the effect of the form in Schedule 1 that has been completed, signed and witnessed in accordance with this Act.**

**‘health care provider’, in relation to a sufferer, includes a hospital, nursing home or other institution (including those responsible for its management) in which the sufferer is located for care or attention and any nurse or other person whose duties include or directly or indirectly relate to the care or medical treatment of the sufferer.**

### Comments

Concern was noted with respect to the definition of ‘health care provider’.

*We note that the term ‘nursing home’ is expressly referred to, as is ‘any nurse or other person whose duties include or directly or indirectly relate to the care ... of the sufferer’. This envisages a role of some kind for the nurse or carer within a nursing home. What is that role? There is no detailed explanation of what that role is intended to be.<sup>20</sup> (Southern Cross Care)*

*This definition would include as health care provider cleaners and kitchen staff which turn the definition into a misnomer.<sup>21</sup> (NWJN)*

**‘illness’ includes injury or degeneration of mental or physical faculties.**

**‘intolerable suffering’ means a profound level of pain and/or distress, that the sufferer finds intolerable.**

### Comments

The definition of ‘intolerable suffering’ is seen as problematic by a number of commentators mainly due to the subjective evaluation of the term by the sufferer.

Parliamentary Counsel noted that the use of ‘pain and/or distress’ in the definition was poor practice which leads to ambiguity.

*Because such a lot rides on this notion of intolerable suffering in the bill, to have an ambiguity of the use of ‘and’ and ‘or’ is certainly an issue.<sup>22</sup>*

---

<sup>19</sup> Transcript 31/8/09 p. 75

<sup>20</sup> Submission 270 p.6

<sup>21</sup> Submission 439 p.15

<sup>22</sup> Transcript 31/8/09 p. 75

---

It was suggested that some of what terminally ill patients experience in the way of suffering is existential in nature and can usually be attributed to fear.

*Fear is a huge feature when one determines what is or is not intolerable for oneself. Our current medical system is geared towards the application of high technology and treatment of disease. Much 'dis-ease' is from fear of the unknown. What will they do to me? Can I be sure they will listen to me? Will I suffer ... Alleviate these fears and you alleviate much of the 'intolerability'.<sup>23</sup> (Dr Keith McArthur)*

There was also concern expressed that intolerable pain and suffering is a prerequisite for euthanasia and yet there is no objective measure of these criteria.

*...There is no subjective measure of 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 ... are existential in nature. .. 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.<sup>24</sup> (Mr Rene Hidding)*

*The salient point to make is that, it is not up to [what] I think or anyone else thinks, it is up to what the patient thinks is for them a dignified death. It is up to them to decide what is intolerable. We cannot tell what they are suffering because we are not experiencing it, it is their suffering.<sup>25</sup> (Dr Heather Dunn)*

**'medical practitioner' means a medical practitioner who has been entitled to practise as a medical practitioner (however described) in a State or a Territory of the Commonwealth for a continuous period of not less than 5 years.**

### Comments

Parliamentary Counsel pointed out that the inclusion of 'who has been entitled to practise' in the definition of 'medical practitioner' may pose some difficulty as it not only captures currently practising medical practitioners but may include former medical practitioners who may not have been licensed for years. Parliamentary Counsel suggested that this could be remedied by inserting the word 'is' instead of 'has been'.

Others also raised similar concerns:

*I am concerned that this could be interpreted to mean the medical practitioner was registered and worked as a doctor years ago, but no longer is registered or working as a doctor now ... may not be registered currently in Australia. May not be a resident of Tasmania, flies in for a euthanasia clinic when needed and flies out.<sup>26</sup> (Dr Robyn Brogan)*

Two points raised in respect to this definition were:- firstly, the use of other terms throughout the Bill in respect to medical practitioners that are not defined; and secondly, that the lack of

---

<sup>23</sup> Submission No. 512 p. 6

<sup>24</sup> Transcript 10/8/09 p. 7

<sup>25</sup> Transcript 24/8/09 p. 78

<sup>26</sup> Submission No. 345 p. 2

---

a residency requirement may create difficulties in the enforcement of clauses 14 and 16 of the Bill which deal with the keeping of medical records.

*This definition seems to be inconsistent with section 5 of the bill which refers to the 'sufferer's medical practitioner' and section 9 which refers to the treating doctor. Both of these sections suggest that there is an existing patient-doctor relationship.*<sup>27</sup>  
(NWJN)

**'mentally competent' means:**

**(a) an ability of the sufferer after being given relevant information to understand the general nature of the illness or condition; and to understand the benefits and risks of, and to weigh the pros and cons of, presented medical treatment and palliative care options as well as a request for assistance to end his or her life;**

**(b) a capacity of the sufferer to make a decision freely, voluntarily and after due consideration.**

### Comments

The Committee was advised by Parliamentary Counsel that the use of two criteria in the above definition creates ambiguity. As there is no link between the two criteria, 'mentally competent' may be perceived to be either when a sufferer 'understands the general nature of the illness' or when a sufferer has the capacity to 'make decisions freely'. The definition could be made more precise if it stated that both '(a)' and '(b)' had to be demonstrated before a sufferer could be declared to be mentally competent.

A concern was also raised in respect to the lack of a requirement for the involvement of family in the process:

*... ending someone's life does not occur in isolation and if we look at the effects of suicide, say in the context of depression or anything else, that has a profound effect and can have a profound effect on people's family ... the Bill does not seem to put a great deal of weight on what might be the view of the family. The second part about family that concerns me is that one of the things about assessing someone's competence and whether or not someone might have a mental illness requires getting corroborative history from people like family ... So if someone comes to me saying, 'I want to end it all, this is hopeless', one of the first things I will do is sit down with their spouse or their son or daughter and say, ... 'how long has dad been thinking about this? Have there been changes in his sleep, his mood, his appetite?' I just want to emphasise the importance of getting corroborative history ... It might take some time to get but of necessity it involves families. So there is a bit of a discrepancy there.'*<sup>28</sup> (Dr Martin Morrissey)

**'qualified psychiatrist' means:**

**(a) a person entitled under a law of a State or Territory of the Commonwealth to practise as a specialist in the medical specialty of psychiatry;**

---

<sup>27</sup> Submission No. 439 p.15

<sup>28</sup> Transcript 31/8/09 pp. 91-92

---

- (b) a specialist whose qualifications are recognised by the Royal Australian and New Zealand College of Psychiatrists as entitling the person to fellowship of that College; or
- (c) a person employed by the Commonwealth or a State or Territory of the Commonwealth, or an Agency or authority of the Commonwealth or a State or Territory, as a specialist or consultant in the medical specialty of psychiatry.

*'sufferer'*, means a person who has a terminal illness and experiences intolerable suffering as a result.

*'terminal illness'*, in relation to a sufferer, means an illness which, in reasonable medical judgment, will in the normal course, without the application of extraordinary measures or of treatment unacceptable to the sufferer, result in the death of the sufferer.

### Comments

It was noted by some that no distinction is made between terminally ill patients who face imminent death and those with a longer-term prognosis. Others however found the definition to be appropriate.

*While the sufferer has a right to accept or refuse any medical process, their views on acceptability have nothing to do with defining the illness and it would be improper to give them any power in law ...*<sup>29</sup> (Mr Rene Hidding)

*I have mentioned the problems of the definition of terminal illness ... people point out diabetes is a terminal illness ... if you do not have strategies and treatments that are acceptable to the patient, you can expect to die from diabetes. People have said that is a reason why that definition needs to be tightened. By and large though, I think the definition that you have used is a good one, and you should resist the idea of putting some particular time frame in. The idea of suggesting that you have to die within six months, using the Oregon example ... I think is fraught with an equal number of difficulties.*<sup>30</sup> (Dr Phillip Nitschke)

### **Act to bind Crown**

**4. This Act binds the Crown in right of Tasmania and, so far as the legislative power of Parliament permits, in all its other capacities.**

### **Request for assistance to voluntarily end life**

**5. A sufferer who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the sufferer, may request the sufferer's medical practitioner to assist the sufferer to end the sufferer's life.**

### **Response of medical practitioner**

**6. A medical practitioner who receives a request referred to in section 5, if satisfied that the conditions of section 8 have been met, but subject to section 9 and 10, may**

---

<sup>29</sup> Transcript 10/8/09 p. 8

<sup>30</sup> Transcript 31/8/09 p. 102

---

**assist the sufferer to end the sufferer's life in accordance with this Act or, for any reason and at any time, refuse to give that assistance.**

### Comments

This clause requires the doctor to be satisfied that the conditions of section 8 have been met before proceeding to assist the sufferer but does not provide a process or standard for confirming these requirements.

NWJN raised the issue of how the doctor would be able to confirm the residency requirements, for example, what standard of proof is required.

Comments were also made on the lack of scrutiny mechanisms.

*The Bill has not provided for a position if a medical practitioner relies upon false evidence ... The Society recommends that, should it be determined such legislation is required, that at the very least appropriate pre-death review mechanisms are considered.*<sup>31</sup> (Law Society of Tasmania)

*The biggest problem we identified was the fact that the particular legislation that is being proposed here ... sets up the medical profession as the keepers of the gate ... demonstrating eligibility is turned over to a panel of doctors and doctors do not find this an easy task at all.*<sup>32</sup> (Dr Phillip Nitschke)

### **Medical practitioner not to be influenced by extraneous considerations**

**7. (1) A person shall not give or promise any reward or advantage (other than a reasonable payment for medical services), or by any means cause or threaten to cause any disadvantage, to a medical practitioner for refusing to assist, or for the purpose of compelling or persuading the medical practitioner to assist or refuse to assist, in the termination of a sufferer's life under this Act.**

**Maximum penalty: 100 penalty units.**

### Comments

Parliamentary Counsel stated that drafting irregularities in relation to the use of 'termination' in this clause which is inconsistent with the terminology elsewhere in the Bill where the term 'ending' life is used.

**(2) A medical practitioner to whom a reward or advantage is promised or given, as referred to in subsection (1), does not have the legal right or capacity to receive or retain the reward or accept or exercise the advantage, whether or not at the relevant time he or she was aware of the promise or the intention to give the reward or advantage.**

---

<sup>31</sup> Submission 495, p.

<sup>32</sup> Transcript 31/8/09 p. 101

---

**Conditions under which medical practitioner may assist**

**8. (1) A medical practitioner may assist a sufferer to end his or her life only if all of the following conditions are met:**

- (a) the sufferer has attained the age of 18 years;**
- (b) the medical practitioner is satisfied, on reasonable grounds, that:
 
  - (i) the dying person is suffering from an illness that will, in the normal course and without the application of extraordinary measures, result in the death of the sufferer; and**
  - (ii) in reasonable medical judgment, there is no medical measure acceptable to the sufferer that can reasonably be undertaken in the hope of effecting a cure; and****

Comments

Concerns in respect to the drafting of clause 8(1)(b)(ii) were raised as it is asking for an objective test of a subjective position that the patient may hold. The lack of a definition for 'reasonable medical' judgment was also noted.

- (iii) any medical treatment reasonably available to the sufferer is confined to the relief of pain, suffering and/or distress with the object of allowing the sufferer to die a peaceful death;**

Comments

Parliamentary Counsel notes that the use of 'and/or' in this section again creates ambiguities and is not in keeping with accepted Tasmanian drafting standards.

- (c) two other persons, neither of whom is a relative or employee of, or a member of the same medical practice as, the first medical practitioner or each other:
 
  - (i) one of which is a medical practitioner who holds prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the person is suffering; and**
  - (ii) the other of which is a qualified psychiatrist; have examined the sufferer and have:**
  - (iii) in the case of the medical practitioner referred to in subparagraph (i), confirmed:
 
    - (A) the first medical practitioner's opinion as to the existence and seriousness of the illness; and**
    - (B) that the sufferer is likely to die as a result of the illness; and**
    - (C) the first medical practitioner's prognosis; and****
  - (iv) in the case of the qualified psychiatrist referred to in subparagraph (ii), confirmed that the sufferer is mentally competent;****
- (d) the illness is causing the sufferer intolerable pain or suffering;**

Comments

The introduction of the undefined term 'intolerable pain' creates confusion as it is not clear whether this is a new concept or it is being used interchangeably with 'intolerable suffering'.

---

- (e) the medical practitioner has informed the sufferer of the nature of the illness and its likely course, and the medical treatment, including palliative care, counseling and psychiatric support and extraordinary measures for keeping the sufferer alive, that might be available to the sufferer;**
- (f) after being informed of the matters referred to in paragraph (e), the sufferer indicates to the medical practitioner that the sufferer has decided to end his or her life;**
- (g) the medical practitioner is satisfied that the sufferer has considered the possible implications of the sufferer's decision to his or her family;**

### Comments

Whilst this provision only requires that the sufferer has given some thought to his or her family, the Law Society submission expressed some concern that -

*There is no requirement that any person outside of the patient and the care team (eg. advocate, lawyer, family member, spouse or friend) is notified of the signing of the certificate.<sup>33</sup>*

- (h) the medical practitioner is satisfied, on reasonable grounds, that the sufferer is mentally competent and that the sufferer's decision to end his or her life has been made freely, voluntarily and after due consideration;**
- (i) the sufferer, or a person acting on the sufferer's behalf in accordance with section 11, has, not earlier than 7 days after the sufferer has indicated to his or her medical practitioner as referred to in paragraph (f), signed that part of the certificate of request required to be completed by or on behalf of the sufferer;**
- (j) the medical practitioner has witnessed the sufferer's signature on the certificate of request or that of the person who signed on behalf of the sufferer, and has completed and signed the relevant declaration on the certificate;**
- (k) the certificate of request has been signed in the presence of the sufferer and the first medical practitioner by another medical practitioner (who may be the medical practitioner referred to in subparagraph (c)(i) or any other medical practitioner) after that medical practitioner has discussed the case with the first medical practitioner and the sufferer and is satisfied, on reasonable grounds, that the certificate is in order, that the sufferer is mentally competent and the sufferer's decision to end his or her life has been made freely, voluntarily and after due consideration, and that the above conditions have been complied with;**

---

<sup>33</sup> Submission No. 495 p.4

---

Comments

Parliamentary Counsel noted more ambiguities in the drafting of the bill with the use of the phrase ‘that the above conditions have been complied with’. It is not clear if it requires compliance with the items listed within paragraph (k) or the preceding paragraphs (a) to (j).

- (l) if, in accordance with subsection (4), an interpreter is required to be present at the signing of the certificate of request, the certificate of request has been signed by the interpreter confirming the sufferer's understanding of the request for assistance;**
- (m) the medical practitioner has no reason to believe that he or she, the countersigning medical practitioner or a close relative or associate of either of them, will gain a financial or other advantage (other than a reasonable payment for medical services) directly or indirectly as a result of the death of the sufferer;**
- (n) not less than 48 hours has elapsed since the signing of the completed certificate of request;**
- (o) at no time before assisting the sufferer to end his or her life had the sufferer given to the medical practitioner an indication that it was no longer the sufferer's wish to end his or her life;**
- (p) the medical practitioner himself or herself provides the assistance and/or is and remains present while the assistance is given and until the death of the sufferer.**

Comments

Parliamentary Counsel noted the use of ‘and/or’ in paragraph (p) creates confusion. While it requires the medical practitioner to be present until the death of the sufferer the use of ‘and/or’ implies other options may be possible.

- (2) In assisting a sufferer under this Act a medical practitioner must be guided by appropriate medical standards and such guidelines, if any, as are prescribed, and must consider the appropriate pharmaceutical information about any substance reasonably available for use in the circumstances.**
- (3) 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.**

Comments

Parliamentary Counsel expressed concerns about the use of the phrase ‘special qualifications in the field of palliative care’ in this subclause as no definition of ‘special qualifications’ is

---

provided. When juxtaposed with ‘special qualifications as prescribed’ later in the paragraph it is not clear if it is referring to the same qualifications or two separate categories of qualifications.

*It does not give guidance to the medical practitioner as to whether they are considered to have special qualifications in that sort of palliative care, and if they do or do not whether they need to refer to another person. It does not give enough guidance.*<sup>34</sup>

Others also had concerns with subclause (3) :

*This paragraph is absolute nonsense. The only medical practitioner who has special qualifications in the field of palliative care is a palliative care specialist. To suggest otherwise undermines the entire specialty of palliative care.*<sup>35</sup> (Dr Keith McArthur)

**(4) A medical practitioner must not assist a sufferer under this Act if the medical practitioner or any other medical practitioner or qualified psychiatrist who is required to communicate with the sufferer does not share the same first language as the sufferer, unless there is present at the time of that communication and at the time the certificate of request is signed by or on behalf of the sufferer, an interpreter who holds a prescribed professional qualification for interpreters in the first language of the sufferer.**

### Comments

A general comment in relation to the structure of clause 8 as a whole and how it might be improved was that -

*Section 8 contains many considered conditions upon which a medical practitioner may decide to assist a sufferer. The provision is, as presently written, dense and would benefit from being broken down into a series of steps rather than place all of the requirements in one section.*<sup>36</sup> (The Law Society of Tasmania)

### **Requirement to be a Tasmanian Resident**

**9. At the request of an adult sufferer, the treating doctor may provide assistance to that sufferer to end his or her life. However, the treating doctor may only do so if the treating doctor is satisfied on reasonable grounds that;**

- (1) the sufferer is domiciled or ordinarily resident in the State; or**
- (2) the sufferer has had his or her settled or usual residence in the State for a minimum of 12 months.**

### Comments

The introduction of a new undefined term, the ‘treating doctor’, again creates confusion as it is not clear if the treating doctor is the same as the medical practitioner

---

<sup>34</sup> Transcript 31/8/09 p.84

<sup>35</sup> Submission No. 512 p.7

<sup>36</sup> Submission No. 495 p. 4

assisting the sufferer referred to earlier in the bill or any doctor that may have come into contact with the sufferer.

Parliamentary Counsel also noted that the residency requirement is unclear. The inclusion of 'has had' a residence in the State for a minimum of 12 months could be interpreted to mean was resident for a minimum of 12 months at some time in the past. In subclause (1) the use of domiciled 'or' ordinarily resident again creates ambiguity.

### **Palliative Care**

**10. (1) 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.**

**(2) 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. If subsequently the palliative care ceases to alleviate the sufferer's pain and suffering to levels acceptable to the sufferer, the medical practitioner may continue to assist the sufferer under this Act only if the sufferer indicates in writing to the medical practitioner the sufferer's wish to proceed with the request.**

### Comments

The availability of palliative care specialists especially in regional areas of Tasmania was noted as an important consideration.

*Currently there is no palliative care specialist in north western Tasmania. The degree of unavailability of palliative care specialists varies over time. At best we have had one specialist and other times we have had no specialist for lengthy periods of time. ... What happens if the remission ceases and the cause of the return of pain is directly related to the unavailability of a palliative care specialist? There are many palliative care treatments not available when we do not have a local palliative care specialist.<sup>37</sup>*  
(Dr Keith McArthur)

### **Sufferer who is unable to sign certificate of request**

**11. (1) If a sufferer who has requested his or her medical practitioner to assist the sufferer to end the sufferer's life is physically unable to sign the certificate of request, any person who has attained the age of 18 years, other than the medical practitioner or a medical practitioner or qualified psychiatrist referred to in paragraph 8(1)(c), or a person who is likely to receive a financial benefit directly or indirectly as a result of the death of the sufferer, may, at the sufferer's request and in the presence of the sufferer and both the medical practitioner witnesses**

---

<sup>37</sup> Submission No. 512 pp.7-8

---

(and if, in accordance with subsection 8(4) an interpreter has been used, also in the presence of the interpreter), sign the certificate on behalf of the sufferer.

(2) A person who signs a certificate of request on behalf of a sufferer forfeits any financial or other benefit the person would otherwise obtain, directly or indirectly, as a result of the death of the sufferer.

#### **Right to rescind request**

**12. (1) Notwithstanding anything in this Act, a sufferer may rescind a request for assistance under this Act at any time and in any manner.**

**(2) If a sufferer rescinds a request, the sufferer's medical practitioner must, as soon as practicable, destroy the certificate of request and note that fact on the sufferer's medical record.**

#### Comments

As the sufferer may rescind their request for assistance under the Act at any time and in any manner, they may do so in a way that is not communicated back to the medical practitioner who is assisting them. The medical practitioner may be ignorant of the changed circumstances could not fulfil his or her responsibility stipulated in subclause (2) which requires the destruction of the certificate and endorsement of the patient's medical record.

It was highlighted that there is a need for an extra safeguard by confirming the sufferer's wishes at the final point in the process.

*One measure that I am on record for suggesting is that it is important that at the time of administration that the voluntariness has to be confirmed. At the moment that is not actually a requirement. ... This intervention in a person's life is so important that we need to be absolutely sure that it is what that person still wants at the point of administration.*<sup>38</sup> (Prof. Margaret Otlowski)

#### **Improper conduct**

**13. (1) A person must not, by deception or improper influence, procure the signing or witnessing of a certificate of request.**

**Maximum penalty: 200 penalty units or imprisonment for 4 years.**

**(2) A person found guilty of an offence against subsection (1) forfeits any financial or other benefit the person would otherwise obtain, directly or indirectly, as a result of the death of the sufferer, whether or not the death results from assistance given under this Act.**

#### **Medical Records to be kept**

**14. A medical practitioner who, under this Act, assists a sufferer to end the sufferer's life must file and, subject to this Act, keep the following as part of the medical record of the sufferer:**

---

<sup>38</sup> Transcript 31/8/09 p. 58

---

- (1) a note of any oral request of the sufferer for such assistance;**
  - (2) the certificate of request;**
  - (3) a record of the opinion of the sufferer's medical practitioner as to the sufferer's state of mind at the time of signing the certificate of request and certification of the medical practitioner's opinion that the sufferer's decision to end his or her life was made freely, voluntarily and after due consideration;**
  - (4) the reports of the medical practitioner and qualified psychiatrist referred to in paragraph 8(1)(c);**
  - (5) a note by the sufferer's medical practitioner:**
    - (a) certifying the independence of the medical practitioner and qualified psychiatrist referred to in paragraph 8(1)(c) and the residential and period of practice qualifications of the sufferer's medical practitioner; and**
    - (b) indicating that all requirements under this Act have been met; and**
    - (c) indicating the steps taken to carry out the request for assistance; and**
    - (d) including a notation of the substance prescribed; and such other information, if any, as is prescribed.**
- Maximum penalty: 100 penalty units or imprisonment for 2 years.**

#### Comments

Subclause 5(a) requires certification of the participating medical practitioner's 'residential' and period of practice qualifications. As no definition of 'residential' is provided and no residential requirements are attached to the definition of 'medical practitioner' it is difficult to discern what is being asked.

The last line of clause 14 requires 'such other information, if any, as prescribed'. It is unclear however whether this relates to the whole clause or only to subclause (5).

#### **Certification of Death**

**15. (1) A medical practitioner who, under this Act, assists a sufferer to end the sufferer's life must be taken, for the purposes of any legal requirements concerning preparation of the death certificate, to have been responsible for the sufferer's medical care immediately before death.**

**(2) A death as the result of assistance given under this Act must not, for that reason only, be taken to be unexpected, unnatural or violent, or of having occurred during an anaesthetic, for the purposes of any coronial inquiry.**

#### Comments

Parliamentary Counsel advised that the use of the term 'death certificate' in clause 15 is problematic as no definition is given nor is it provided for in other legislation.

Further concerns were noted in relation to the provisions in clause 15(2) where it appears that deaths resulting from voluntary euthanasia would not be reportable deaths in accordance with the *Coroners Act 1995*. This is then contradicted in clause 16 where there is a requirement for

---

the medical practitioner who assisted a sufferer under the provisions of this Act to report the death to the Coroner.

#### **Medical record to be sent to Coroner**

- 16. (1) As soon as practicable after the death of a sufferer as the result of assistance given under this Act, the medical practitioner who gave the assistance must report the death to a Coroner by sending to the Coroner a copy of the death certificate and so much of the medical record of the sufferer (including that required by section 14 to be kept) as relates to the terminal illness and death of the sufferer.**
- (2) As soon as practicable after the end of each financial year the Coroner must advise the Attorney-General of the number of sufferers who died as a result of assistance given under this Act and the Attorney-General, in such manner or report as he or she thinks appropriate, must report the number to both Houses of the Parliament.**

#### **Coroner may report on operation of Act**

- 17. Coroner may, at any time and in his or her absolute discretion, report to the Attorney-General on the operation, or any matter affecting the operation, of this Act and the Attorney-General must, within 3 sitting days of the Parliament after receiving the report, table a copy of the report in both Houses of the Parliament.**

#### **Construction of Act**

- 18. Assistance given in accordance with this Act by a medical practitioner or by a health care provider on the instructions of a medical practitioner is taken to be medical treatment for the purposes of all legislative enactments.**

#### **Certificate of request is evidence**

- 19. A document purporting to be a certificate of request is, in any proceedings before a court, admissible in evidence and is prima facie evidence of the request by the person who purported to sign it, or on whose behalf it is purported to have been signed, for assistance under this Act.**

#### **Effect on construction of wills, contracts and statutes**

- 20. (1) Any will, contract or other agreement, whether or not in writing or executed or made before or after the commencement of this Act, to the extent that it affects whether a person may make or rescind a request for assistance under this Act, or the giving of such assistance, is not valid.**
- (2) An obligation owing under a contract, whether made before or after the commencement of this Act, must not be conditioned or affected by the making or rescinding of a request for assistance under this Act or the giving of that assistance.**

#### **Insurance or annuity policies**

- 21. The sale, procurement or issuing of any life, health or accident insurance or annuity policy or the rate charged for such a policy must not be conditioned on or affected by the making or rescinding of a request for assistance under this Act or the giving of that assistance.**
-

## Immunities

**22. (1) A person must not be subject to civil or criminal action or professional disciplinary action for anything done in good faith and without negligence in compliance with this Act, including being present when a sufferer takes a substance prescribed for or supplied to the sufferer as the result of the request for assistance under this Act to end the sufferer's life.**

**(2) A professional organisation or association or health care provider must not subject a person to censure, discipline, suspension, loss of licence, certificate or other authority to practise, loss of privilege, loss of membership or other penalty for anything that, in good without negligence, was done or refused to be done by the person and which may under this Act lawfully be done or refused to be done.**

**(3) A request by a sufferer for assistance under this Act, or giving of such assistance in good faith by a medical practitioner in compliance with this Act, does not constitute neglect for any purpose of law.**

**(4) A health care provider is not under any duty, whether by contract, statute or other legal requirement, to participate in the provision to a sufferer of assistance under this Act, and if a health care provider is unable or unwilling to carry out a direction of a medical practitioner for the purpose of the medical practitioner assisting a sufferer under this Act and the sufferer transfers his or her care to another health care provider, the former health care provider must, on request, transfer a copy of the sufferer's relevant medical records to the new health care provider.  
faith and**

## Comments

No time-frame is given in subclause (4) for the transfer of medical records from one health care provider to the new health care provider.

It was also suggested that clause 22 merely implies the purpose of the Bill and a more explicit approach would be useful.

*The Dying with Dignity Bill 2009 has a clear purpose to create a legal exception to section 163 of the [Criminal] Code for certain specific circumstances as approved by the Bill. It would be useful and consistent with usual legislative practice to make such an exception explicit.*<sup>39</sup> (The Law Society)

It was also submitted that -

*Traditionally only three circumstances have been acceptable for the taking of life: killing in self-defence or to protect another life, killing in the course of a just war, and in the case of capital punishment, killing by agents of the State ... Euthanasia is nothing less than a proposal to add a new category of acceptable killing to those already socially accepted.*<sup>40</sup> (NWJN)

---

<sup>39</sup> Submission No.495 p.4

<sup>40</sup> Submission No. 439 p. 7

---

*Killing of a person is only wrongful and constitutes a harm where it deprives a person of their right to life. Where, however, a person has a rational interest in dying and has expressed a clear wish to do so, the killing of that person violates no rights and therefore, does not constitute a 'harm' in the accepted sense. In the absence of harm to any individual, there is arguably no need for the criminal law prohibition of murder to apply.*<sup>41</sup> (Prof. Margaret Otlowski)

Some emphasised the gravity of the changes to social relations that are inherent in this legislation.

Concerns were raised that the protection afforded to medical practitioners from censure, discipline, suspension, loss of licence, certificate or other authority to practise, loss of privilege, loss of membership or other penalty that may be imposed by professional organisation or association would be limited to this jurisdiction and that medical practitioners who agree to assist patients under the provisions of this Act may have difficulties in working outside Tasmania.<sup>42</sup>

### **Regulations**

**23. The Governor may make regulations, not inconsistent with this Act, prescribing all matters:**

- (1) required or permitted by this Act to be prescribed; or**
- (2) necessary or convenient to be prescribed for carrying out or giving effect to this Act.**

### **Act to prevail**

**24. In the event of any inconsistency between this Act and any other Act, including the *Criminal Code Act 1924*, commenced before or after the commencement of this Act, this Act prevails to the extent of the inconsistency unless a contrary intention is stated in the subsequent Acts.**

### Comments

Parliamentary Counsel had concerns that the Bill lacks an administration Act clause that assigns the Minister responsible for the administration of the legislation and the department that would assist the Minister.

### **Schedule 1 - Certificate of request forms**

#### **1. Request for assistance to end my life in a humane and dignified manner;**

**I, have been advised by my medical practitioner that I am suffering from an illness which will ultimately result in my death and this has been confirmed by a second medical practitioner.**

**I have been fully informed of the nature of my illness and its likely course and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures that may keep me alive, that is available to me and I am satisfied that there is no medical treatment reasonably available that is acceptable to me in my circumstances.**

---

<sup>41</sup> Submission 487, p. 11.

<sup>42</sup> Supplementary addition to Submission No. 439

---

**I request my medical practitioner to assist me to end my life in a humane and dignified manner.**

**I understand that I have the right to rescind this request at any time.**

**Signed:**

**Dated:**

**2. Declaration of witnesses;**

**I declare that -**

**(a) the person signing this request is personally known to me;**

**(b) he/she is a patient under my care;**

**(c) he /she signed the request in my presence and in the presence of the second witness to this request;**

**(d) I am satisfied that he/she is mentally competent, of sound mind and that his/her decision to end his/her life has been made freely, voluntarily and after due consideration.**

**Signed: Patient's Medical Practitioner**

**I declare that -**

**(a) the person signing this request is known to me;**

**(b) I have discussed his/her case with him/her and his/her medical practitioner;**

**(c) he/she signed the request in my presence and in the presence of his/her medical practitioner;**

**(d) I am satisfied that he/she is of sound mind and that his/her decision to end his/her life has been made freely, voluntarily and after due consideration.**

**Signed: Second Medical Practitioner**

**3. Declaration of Interpreter where under section 8(4) an interpreter is required to be present**

**I declare that -**

**(a) the person signing this request or on whose behalf it is signed is known to me;**

**(b) I am an interpreter qualified to interpret in the first language of the patient as required by section 8 (4);**

**(c) I have interpreted for the patient in connection with the completion and signing of this certificate;**

**(d) in my opinion, the patient understands the meaning and nature of this certificate.**

**Signed: Qualified Interpreter.**

Comments

The certificate of request has no provision for the psychiatrist to sign the certificate and whilst the first medical practitioner must have a psychiatrist's report the patient may have lost competency in the intervening period.

In their assessment of the Bill as a whole Parliamentary Counsel found that -

*The Bill is not drafted in accordance with Tasmanian drafting protocols and standards ... we found a lack of logical progression in the provisions ... we found some provisions were very difficult to understand and if they are difficult to*

---

*understand, there will obviously be room for legal dispute and it is harder for medical practitioners to follow. The other general criticism we had was the terminology; problems with definitions, problems with terms that are used in the bill that are not defined at all, and also the lack of internal consistency in the use of the language causes problems.*<sup>43</sup>

---

<sup>43</sup> Transcript 31/8/09 p. 73

---

## PART 4 - INCIDENTAL MATTERS

### Palliative Care

Palliative care is seen by opponents of voluntary euthanasia as the appropriate response to the pain and suffering associated with terminal illness.

Advances in palliative care methods, the provision of more palliative care specialists and the training of general practitioners in recent years have minimised the incidence of patients suffering intolerable pain to a small number of cases.

The *Dying with Dignity Bill 2009* is aimed at providing this small group of approximately 5%<sup>44</sup> of terminally ill patients with a further option when palliative care no longer provides relief if they meet the strict provisions of the Bill.

It is acknowledged that palliative care has its limitations.

*Some people believe palliative care provides a realistic alternative to intolerable suffering in the terminally ill. However, it is clear from the medical literature that palliative care cannot relieve intolerable suffering, even when the care is optimal. Five per cent of terminally ill patients experience un-relievable symptoms. This amounts to thousands of Australians every year*<sup>45</sup> (Mr Nick McKim MP)

*Modern palliative care has evolved over the last three decades and a great deal of knowledge and expertise has been gained about how we look after people who are dying. There is almost always something that can be done to improve a person's symptom control, emotional, spiritual and psychological well-being. However palliative care has limitations and it must be acknowledged that the best efforts of multi-disciplinary palliative care services do not always provide patients with what they wish or need. Skilled palliative care can nearly always make a difference for the better, but may be challenged by symptoms such as refractory cancer pain, fatigue, loss of function and independence*<sup>46</sup> (Prof. Michael Ashby)

There was also a suggestion that our society needs education about death and end-of-life issues as this can reduce fear and suffering.

*Part of palliative care is to work with patients and their families to prevent suffering from occurring ... I can't prevent people from suffering because suffering is a human condition that is with us no matter what. I can prevent people's pain, I can prevent their breathlessness, I can treat their symptoms really well, I can provide a level of support and possibly within the widest breadth of the term 'pastoral care' to people to make it normal.*<sup>47</sup> (Dr Paul Dunne)

The Committee was informed that in cases where there is still unresolved pain, palliative sedation may be required but that situation is relatively rare.

---

<sup>44</sup> Dr Rodney Syme cited in submission No. 494 p.8

<sup>45</sup> Submission 494, p. 8.

<sup>46</sup> Submission 482 p.5

<sup>47</sup> Transcript 24/8/09 p. 90

---

*I see about 350 patient a year, so 18 years gives me a fair patient base and over the past 18 years in the unit we have had 17 people in whom a clear decision on palliative sedation at the end-of-life has been made, which is not a large percentage in that group. ... Some of what we do in palliative care will hasten death, that is given. Some of what we do in palliative care will prolong life, that is also a given ... I know that if I admit someone to the ward and they are in excruciating pain, I need to give them medication to get them out of pain. If I pursue that to the point of their unconsciousness I see that as part of my role of being a good doctor.<sup>48</sup> (Dr Paul Dunne)*

Some submissions and witnesses suggested that the practice of palliative sedation is in many ways equivalent to a slow euthanasia and yet voluntary euthanasia is seen as unacceptable.

*Because of the acceptance of palliation and administration of pain relief, even though a doctor knows that it will cause death, that has become a legal exception to the normal rules of murder for intentionally or knowingly causing death. ... It is also known that sometimes under the guise of legitimate pain relief, euthanasia will occur anyway. There is also a practice, sometimes referred to as pharmacological oblivion, where people can be rendered permanently unconscious, ostensibly for pain relief but it becomes very close to slow euthanasia anyway because you know they're not going to come out of that unconsciousness. They may be given a drip for hydration or whatever but it is not far removed from a more direct form of assistance. That is seen as acceptable and lawful and yet euthanasia is not.<sup>49</sup> (Prof. Margaret Otlowski)*

Some submissions and witnesses also conceded that some cases are more difficult and not all suffering can be relieved.

*Clearly not everybody's intolerable pain and suffering can be managed with palliative care ... 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?<sup>50</sup> (Dr Keith McArthur)*

There was overwhelming affirmation of support from individuals and groups for palliative care.

*Let me state, first of all, how important palliative care is and the central role it still has to play in caring for people who have incurable or terminal illness. I acknowledge that. I also would like to state quite clearly that the proposed legislation for assisted dying is not in any way in competition with palliative care. We see it purely as an adjunct, not an alternative, to palliative care. I would like to also point out that there is evidence that where these two coexist –in Oregon, for example– palliative care services have improved ...Having said that certainly palliative care is excellent but it does not have all the answers.<sup>51</sup> (Dr Heather Dunn)*

---

<sup>48</sup> Transcript 24/8/09 p. 90

<sup>49</sup> Transcript 31/8/09 p. 50

<sup>50</sup> Transcript 10/8/09 p. 19

<sup>51</sup> Transcript 24/8/09 p. 77

---

There was also criticism of the level of palliative care available to patients in regional Tasmania.

*At the moment we do not have a palliative care specialist in the north-west, we have not had one all this year ... there are inadequate numbers of palliative care nurses. ... 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. [There is] too frequently pseudo-palliative care – that is ... 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.*<sup>52</sup> (Dr Keith McArthur)

## **End-of-life Care**

Evidence was presented to the Committee which suggests that equally important to good palliation is a care plan and advance directives.

A care plan involves an individualised plan of how the patient will be cared for and procedures that may be undertaken as certain conditions arise in the course of the disease and treatment regime.

The autonomy of the patient could be enhanced with the provision of legally binding and recognised advance directives which stipulate under what circumstances treatment is to cease or proceed. Advance directives would be made prior to an episode of illness or disablement and thus the treating physician can be guided in the treatment of the patient even when the patient loses competence. Thus, for example, if a terminally ill patient suffers a heart attack he or she may have instructions in an advance directive that they are not to be resuscitated.

Tasmania has legislated for enduring guardianships. Under Tasmania's *Guardianship and Administration Act 1995, Part 5* people may appoint an enduring guardian to make medical decisions for them if they lose competency.

*I can't stress strongly enough how important the enduring guardianship provision in Tasmania is and how it is possible for people to put really good instructions and wishes into the enduring guardianship ... you are able to put anything you would put in an advanced directive about your health into that enduring guardianship and once it has been registered it is a legal document.*<sup>53</sup> (Dr Helen Cutts)

*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 care treatment only. ... they can say that 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.*<sup>54</sup> (Dr Keith McArthur)

The use of advance directives and enduring guardianships falls outside the scope of the *Dying with Dignity Bill 2009* as its provisions are only available to competent patients, and advance directives and enduring guardianships are essentially instruments for conveying the wishes of a patient who has lost competence.

---

<sup>52</sup> Transcript 10/08/09 p. 21

<sup>53</sup> Transcript 24/8/09 p. 82

<sup>54</sup> Transcript 10/8/09 p.22

A number of witnesses provided evidence that the use of advance directives and care plans need to be investigated and progressed to ensure that choices related to end of life care can ideally be articulated by all people facing such decisions. As many people currently receive unwanted and often futile or burdensome treatment, this is an area that many suggest should be improved before legalisation of euthanasia is seriously considered as an option.

### **Current Practices**

The law as it currently stands does not take into consideration compassion as a motive nor the consent of the patient if assistance is given by a medical practitioner to end the life of a person suffering a terminal illness.

Proponents of the legalisation of voluntary euthanasia suggest that this lack of accommodation by the law engenders covert practices that are not in the best interests of patients or the medical profession.

Surveys in 1997 and 2001 of medical practitioners show that active euthanasia was occurring in Australia and in such circumstances it is argued that legalisation would provide a regulated environment that would afford protection to both medical practitioners and patients.

*[A] study by Kuhse, Singer and Baume et al<sup>55</sup> (based on a sample of 3,000 doctors Australia wide, with a response rate of 64%) has for the first time, tried to provide an estimate of the incidence of euthanasia as a percentage of all deaths in Australia. According to this study it is estimated that 1.8% of all Australian deaths are the result of euthanasia of which .1% comprise of cases of physician-assisted suicide.<sup>56</sup> (Prof. Margaret Otlowski)*

Mr McKim highlighted additional data<sup>57</sup> in his submission to the Committee which indicates that 36% of medical practitioners responding to a survey published in the Medical Journal of Australia admit to hastening the death of patients.

*Current law is archaic and irrelevant to what actually happens in palliative care wards around Tasmania and Australia and certainly around the developed world. Current law is out of step with current practice I have ... a study published in the Medical Journal of Australia in 2001 which [asked general surgeons the following question]:*

*'For the purpose of relieving a patient's suffering had they given drugs in doses that they perceived to be greater than those required to relieve symptoms ... with the intention of hastening death' –*

*... 36 per cent of respondents to this survey have admitted giving drugs with the intention of hastening death.<sup>58</sup> ...I respect the doctors for doing this but it places*

---

<sup>55</sup> 'End of Life Decisions in Australian Medical Practice' (1997) 166 Medical Journal of Australia, p.191.

<sup>56</sup> Submission No. 487 p.4

<sup>57</sup> Death and the Physician - The intention to hasten death: a survey of attitudes and practices of surgeons in Australia. Charles D Douglas, Ian H Kerridge, Katherine J Rainbird, John R McPhee, Lynne Hancock and Allan D Spigelman. Medical Journal of Australia 2001 175:511-515

<sup>58</sup> Transcript 24/8/09 p.36

---

*them in an intolerable situation, where their desire to act compassionately and in the interests of their patients ... exposes them potentially to charges, and possibly convictions, of manslaughter or murder. That is an intolerably, unfair position in which to place doctors and nurses.*<sup>59</sup> (Mr Nick McKim MP)

The proposed legalisation of such incidents of active euthanasia was criticised by some as a simplistic reaction and a threat to the ethical basis of our society by others.

*We know there are doctors killing their patients; we do not know what the motivations are. That is one of the really problematic issues here. ... The fact that we have this happening tells us there is an issue that needs to be addressed. The question is what do we do next? And I am suggesting that it would be a serious mistake and a severe oversimplification to suggest that what we do is simply legalise the problematic behaviour. In fact if we did I would suggest that we would be pushing the real problem under the carpet because the real problem will require a much broader and more complex set of arrangements in order to address it. ... There isn't going to be one single solution, and physician assisted suicide is certainly not the silver bullet that will solve this problem.*<sup>60</sup> (Prof. Jeff Malpas)

It was also argued that the legalisation of voluntary euthanasia would compromise the ethical and legal foundations of our society.

*...what you are being asked to do as a parliament is to change the fundamental principle within Tasmania ... 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 are being asked to do is to go beyond what parliament now does. ... 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 ... In my view the Criminal Code should remain as a clear expression of Parliament's endorsement of that principle...*<sup>61</sup> (Prof. Michael Tate)

The Director of Public Prosecutions (DPP) can and does modify this principle through the exercise of discretion in the public interest not to prosecute some matters. It was suggested that the DPP's guidelines could be made clearer in respect to assisted suicide so that compassion or consent may be factors that could be considered.

*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 administers a drug to their spouse or partner who is dying and in severe pain, from murder masquerading as euthanasia,*

---

<sup>59</sup> Transcript 24/8/09 p.37

<sup>60</sup> Transcript 31/8/09 p. 19 & 20

<sup>61</sup> Transcript 10/8/09 p.15

---

*where somebody is doing it for gain through the will or something like that.*<sup>62</sup> (Prof. Michael Tate)

## **Public Support**

In 2002 Roy Morgan Research conducted a national poll in relation to voluntary euthanasia involving 1,232 Australians aged 14 years and older. The question asked was:

*Thinking now about voluntary euthanasia. If a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovery asks for a lethal dose, should a doctor be allowed to give a lethal dose or not?*

In answer to this question a national average of 73% of respondents answered yes.<sup>63</sup>

In 2007 Newspoll conducted a national poll which asked the same question. This survey involved 2,423 individuals aged 18 years and older. Results show a national average of 80% of respondents answered yes.<sup>64</sup> (Support was higher in rural and regional Australia with 82% and capital cities averaging 78%.)

In May 2009 Mr McKim commissioned EMRS to conduct a Tasmanian poll<sup>65</sup> on voluntary euthanasia. One thousand people aged 18 years and older were asked:

*Thinking about voluntary euthanasia where a doctor complies with the wishes of a dying patient to have his or her life ended; are you in favour or against a change in the law that would allow doctors to comply with the wishes of a dying patient to end his or her life?*

78% of respondents answered yes to this question.

It is unclear whether respondents support the proposed intent of the *Dying with Dignity Bill 2009* which is to facilitate physician assisted suicide (PAS) or active voluntary euthanasia, as well as options including withdrawal of and the right to refuse futile and burdensome medical treatment.

Evidence was presented to the Committee which suggests that public opinion is insufficient justification by itself to instigate changes to the law.

It was argued that public support for voluntary euthanasia is also reflected in outcomes of court proceedings against individuals who have assisted others to end their life.

It was argued that although no doctors have been prosecuted in Australia for assisting in voluntary euthanasia, overseas examples show the anomalies of the present legal position.

*Although there have to date been no prosecutions in Australia of doctors for assisting their patients to die, the experiences from other jurisdictions such as the United Kingdom and the United States indicates that in the event that a doctor comes before*

---

<sup>62</sup> Transcript 10/8/09 p. 16

<sup>63</sup> Document 3 p. 6

<sup>64</sup> Newspoll Market Research – Dying with Dignity Summary Report – February 2007 cited in Document 3 p.6

<sup>65</sup> EMRS Voluntary Euthanasia Research Report – Appendix 2 of this Report.

---

*the courts charged with murder (or attempted murder) or assisting the suicide of a patient, there is every likelihood that the doctor would escape criminal liability, albeit on spurious technical grounds.*<sup>66</sup> (Prof. Margaret Otowski)

A Tasmanian judicial decision that could reflect social attitudes to voluntary euthanasia was presented in evidence to the Committee.

*In 2004 the Tasmanian Supreme Court refused to gaol a Tasmanian man for assisting his mother to die with dignity. The man's mother was suffering intolerable pain that was not relieved by palliative care and she was too frail to take her own life without assistance. ... Justice Peter Underwood commented that*

*Curiously it might be said that those who wish to end their life but are physically unable to do so, are discriminated against by reason of their physical disability ...*

*Clearly, this is an example of the growing disparity between what the law says about voluntary euthanasia and public attitudes on the issue.*<sup>67</sup> (Mr Nick McKim)

---

<sup>66</sup> Submission 487 p.6

<sup>67</sup> Submission 494 p.7

---

## **PART 5 - OVERVIEW OF ARGUMENTS FOR & AGAINST VOLUNTARY EUTHANASIA**

Although the primary focus of this Committee was analysis of the Bill, it was felt necessary to consider the principles involved in the voluntary euthanasia debate. There is considerable material available providing in-depth analysis of the main philosophical, ethical and legal arguments for and against legalising voluntary euthanasia. (See selected bibliography attached to this report.) This chapter gives a brief outline of some of the arguments presented to the Committee.

The following broad groupings have been adapted from the 2008 Senate Committee report into the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*.<sup>68</sup>

Arguments supporting the legalisation of voluntary euthanasia include:

- Autonomy and individual rights;
- A compassionate response to intolerable pain, suffering and indignity for the terminally ill;
- Shortcomings in palliative care for these sufferers;
- Regulating existing practice to provide protections for patients and doctors under the law;
- Increasing public support as shown in opinion polls.

Arguments opposing the legalisation of voluntary euthanasia include:

- The sanctity of human life;
- Slippery slope and the inadequacy of safeguards;
- Potential to erode doctor/patient relationship;
- Availability of quality palliative care.

### **ARGUMENTS IN SUPPORT**

#### **Autonomy and individual rights**

Proponents of legalising voluntary euthanasia presented arguments based on the principle of individual rights and autonomy, saying that a competent individual should have the right to make self-governing choices as long as they do not impinge on the rights of others.

*An important aspect of the case for legalisation of active voluntary euthanasia rests on the principle of self-determination: the notion that each person has value and is worthy of respect, is the bearer of basic rights and freedoms, and is the final determinant of his or her destiny. An individual who has decision-making capacity should have the right to control his or her body and should be able to determine how and when he or she will die as long as this does not interfere with the rights of others.*<sup>69</sup> (Prof. Margaret Otlowski)

*Those who want no part of euthanasia should be free to decide for themselves and act accordingly, but why should those who choose this path be allowed to prevent those*

---

<sup>68</sup> Document No. 4 p. 34&42

<sup>69</sup> Submission No. 487 p. 8

---

*who accept euthanasia from being able to end their lives with the full autonomy that being human implies?*<sup>70</sup> (Mr Mike McCall)

However opponents of voluntary euthanasia say it is not a private matter and cannot be considered to be a totally autonomous action.

*End-of-life decision-making does not involve only the autonomy or right to choose of one person alone, and individual choices do not occur in isolation, but instead ramify outwards encompassing a network of other persons, other decisions, and other choices. Moreover, every death has an effect on those who are agents in or witnesses to it, and the manner of the individual's dying can itself be enormously affecting to those involved in that death.*<sup>71</sup> (Prof. Jeff Malpas & Prof. Norelle Lickiss)

*In rightly focusing public policy in health care firmly on individual choice, it is nonetheless essential to reflect on the individual's social context ... Autonomy is never absolute, and, health care, particularly palliative care, cannot be conducted in an autonomous vacuum. Little is known about the effects on families and communities of VE/PAS/AS.*<sup>72</sup> (Prof. Michael Ashby)

It was also suggested that:-

*It is very important to understand the nature of the act; and the act is an act of killing. That is one of the reasons this is such a fraught ethical area, it is an act of killing, and the act of killing, as with all acts, has an effect on the one who performs the act and on those who witness the act – not just on the one who is the victim of it. That is one reason why in our society we have such a prohibition against killing because it has such a strong ethical and moral impact on the agent and not just on the victim.*<sup>73</sup> (Prof. Jeff Malpas)

### **A compassionate response to intolerable suffering and loss of dignity**

Many submissions argue that voluntary euthanasia is a compassionate and merciful response to the intolerable pain and loss of dignity experienced by some people with a terminal illness whose pain cannot be relieved. Submissions were received giving accounts of people who died in unfortunate circumstances with claims from family members that these people would have benefited from the relief afforded by voluntary euthanasia. These submissions argue that this level of suffering is needless and cruel.

*It is appallingly cruel to leave terminal patients in pain when they have asked for death – and their final agony often lasts a long time. Painkillers do not always work. When they do, since hospitals are frequently short staffed, nurses are so busy that at times they fail to attend to patients' pain or to notice it when the patients are too weak to complain. And, even when they are not in pain, patients' lives are usually miserable and often extremely miserable ... It would save a lot of anxiety in the old if*

---

<sup>70</sup> Submission No. 41, p.2

<sup>71</sup> Submission No. 480, p.3

<sup>72</sup> Submission No. 482, p. 10

<sup>73</sup> Transcript 31/8/09, p. 17

---

*they knew that, should they become helpless, they could elect for death before their lives become unbearable.*<sup>74</sup> (M &H Murchison)

*She continued to decline slowly in hospital, until she no longer recognised her daughter, and was subjected to heavier and heavier doses of morphine in a fruitless attempt to control the pain. Still, she lived on, dulled and stupefied with drugs, no longer in control of bodily functions, and still in pain ... For the last 6 months, the lady lived in a prison of pain, misery and personal humiliation, uncontrolled by drugs unless she was completely stupefied.*<sup>75</sup> (Amanda Meadows & Hans Iseli)

Others argue that with the continuing improvement to quality palliative care, pain can be controlled for the overwhelming majority of patients and that dealing with the existential pain and suffering and other symptoms associated with end-stage terminal illnesses of these patients, whilst a challenge, can bring relief.

*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.*<sup>76</sup> (Dr Keith McArthur)

*Although we have compassion for those who are dying and who want assistance to achieve that, compassion does not mean simple acquiescence to any patient demand. Proper medical and compassionate care will help them get past that desire. The option of very good palliative care in this country makes euthanasia unnecessary. Relief from pain and distress is increasingly achievable and obtainable.*<sup>77</sup> (Dr Lachlan Dunjey)

### **Shortcomings in palliative care**

Proponents of the Dying with Dignity Bill argue that the law is currently failing sufferers for whom palliative care cannot provide relief. They argue it is more inhumane to prolong the suffering of a terminally ill patient who, faced with the limitations of palliation on their own circumstances wishes to end their life.

*It use to be the rhetoric of the hospice movement that nobody needs to suffer with good palliative care. I think that is changing; I think people are being more realistic. We are getting better at what we are doing, I think. We're always learning techniques to try to relieve pain or other symptoms but we're still a very long way from achieving that ultimate goal of relieving all suffering. We haven't achieved that and it's probably unlikely we ever will. Just about everybody suffers, but of those suffering people, it is only 5 per cent to 10 per cent who are saying, 'I want an out; I don't want to be experiencing this for however long the rest of my life is going to be.' So the question is what do we do with those people.*<sup>78</sup> (Dr Roger Hunt)

---

<sup>74</sup> Submission No. 230, p. 1

<sup>75</sup> Submission No. 265, p. 1-2

<sup>76</sup> Transcript 10/8/09 p.18

<sup>77</sup> Submission No.208,. p. 2

<sup>78</sup> Transcript 31/8/09 p. 37.

---

### **Regulating existing practice**

Another argument raised in favour of legalising voluntary euthanasia is that it would be safer practice to regulate what is already taking place, claiming that doctors are already acting to shorten patients' lives. Concerns have been raised that an unregulated environment can lead to abuse.

*...there is a very real risk of abuse if the law condones what is an unregulated practice. Because of the present criminality of the practice of active euthanasia, doctors may engage in the practice without necessarily consulting the patient, motivated by benevolent paternalism and in the belief that they are acting in the patient's best interests.*<sup>79</sup> (Prof. Margaret Otlowski)

*Death is deliberately hastened by doctors under the guise of "double effect" every day to end the pointless suffering of patients with incurable disease. This practice is carried out without safeguards or scrutiny.*<sup>80</sup> (Mr Marshall Perron)

However these claims have been denied by members of the medical profession, or have been questioned as being open to interpretation.

*Much of the misunderstanding in this area comes from a failure to appreciate the effect of morphine and other opiate drugs. Far from being a common cause of death, or hastening death, the aim of morphine administration is to enhance quality of life, which it does by relieving pain without causing drowsiness or coma when given in appropriate doses ... [which] "neither hastens nor postpones death".*<sup>81</sup> (AMA Tasmania)

*Whether a doctor interprets [giving a drug out of compassion to relieve suffering with the intent of hastening death] as meaning that to some extent they might be attributed with the intent to kill is a difficult one. Whether they should be taken to have that intent is not clear-cut. I think these sorts of issues are seldom as straightforward as they appear ... it's not at all clear how we should interpret that sort of evidence.*<sup>82</sup> (Prof. Jeff Malpas)

### **Public support**

Proponents of voluntary euthanasia place reliance on growing public support for voluntary euthanasia as expressed in opinion polls. The author of the bill cites a recent poll conducted by EMRS which indicates that almost 80% of Tasmanians support the legalisation of voluntary euthanasia for terminally ill people suffering intolerable pain. It is argued that this consistent level of public support is also reflected in the position of various public groups such as Christians Supporting Choice for Voluntary Euthanasia and the Tasmanian Council on AIDS, Hepatitis and Related Diseases (TasCHARD).

*TasCHARD supports the rights of people living with HIV/AIDS, HCV/hepatitis or any terminal illness to make decisions about their own lives, including the right to choose*

---

<sup>79</sup> Submission No. 487 p. 5

<sup>80</sup> Submission No. 6, p.4

<sup>81</sup> Submission No. 492, p.9

<sup>82</sup> Transcript, 31/8/09 p. 21

---

*to die with medical assistance and or supervision where the quality of life has become severely impaired.*<sup>83</sup> (TasCHARD).

*Consideration of polling over the last 20 years reveals consistently high and increasing support ... Opinion polls have been conducted for nearly half a century by the Morgan Research Centre and have been the subject of detailed analysis. This is not, therefore, a “blip” of some sort in attitudes but the clear and established change in public attitudes to the issue. It deserves to be treated very seriously.*<sup>84</sup> (Mr Mike Harris)

Opponents of voluntary euthanasia argue however that opinion polls can be subject to manipulation and do not generally provide enough detail in the questioning so that respondents are able to give a fully considered response. They also argue that public opinion can be unduly swayed by an emotive response to particular circumstances and legislating on this principle would not lead to good public policy.

*After the atrocity of Port Arthur, if we had done a poll of a thousand people and said, ‘Should there be a death penalty in Tasmania?’ a lot would have said ‘Yes’. Then we would have said the people of Tasmania want it so we would now have the death penalty in Tasmania.*<sup>85</sup> (Mr Rene Hidding)

*Opinion polls are so often used to push causes and it is interesting to note that the body which seeks the opinion poll usually obtains the result they want. We suggest that if an individual person who may have said yes in an opinion poll was present when there was a full and proper debate on the issue of euthanasia, it is quite likely that he or she may change their mind. In the United States an opinion poll was taken showing some 80% support for euthanasia but those results were in marked contrast to a later referendum where people were subjected to a range of views over a period of time before formally voting. The end result was that some 55% of voters were opposed to the suggested euthanasia legislation.*<sup>86</sup> (Southern Cross Care)

## **ARGUMENTS IN OPPOSITION**

### **Sanctity of life principle**

The sanctity of life argument is based on the key principle that human life is inviolable. This tenet forms the basis of many religious doctrines and cultural beliefs which hold that the gift of life is sacred. In a secular sense, this argument is based on the rights-based notion that human life has intrinsic value and the state has a duty to protect its members from intentional killing. Those who hold this view believe that the sanctity of life principle is not violated by withdrawing futile and burdensome treatment or by the consequences of double effect in end-of-life medical treatment.

*The starting point is the biblical understanding that it is God who gives life ...and this value of human life is then firmly grounded simply in having life, not in the quality of that life. To argue otherwise would lead to an erosion of the dignity of all human life.*

---

<sup>83</sup> Submission No. 376, p. 1

<sup>84</sup> Submission No. 413, p.7

<sup>85</sup> Transcript, 10/8/09 pp. 12-13

<sup>86</sup> Submission No. 270, p. 4

---

*Central is the concept that all human life no matter what age, with whatever disabilities, is precious and that principle is worth defending.*<sup>87</sup> (Reverend Richard Humphrey)

*Any State law which legalizes medical killing of the terminally ill must be found sooner or later to be invalid. It will be found to have been void ... because it is incompatible with the universal human rights commitments of the [International Covenant on Civil and Political Rights] to protect by law the inherent right to life of every human being, including the inherent right to life of the terminally ill.*<sup>88</sup> (Ms Rita Joseph)

Those in favour of legalising voluntary euthanasia argue that while the value of human life must be deeply respected, the principle of the sanctity of life is not absolute. They hold the view that quality-of-life and dignity considerations are intrinsic to the way they view the value of life.

*In my view, dying with dignity is the best possible way to honour the lives we have been given. For some, this will mean dying with honour and fidelity to their religious or moral convictions. For others, it should mean no less: dying on one's own terms and with fidelity to their convictions – to die with the kind of dignity that honours and values life not less but more.*<sup>89</sup> (Mr Mike McCall)

*While the sanctity of life is undoubtedly an important principle, the law already recognises the principle is not absolute ... In any event, it is a mistake to see active voluntary euthanasia as necessarily undermining respect for sanctity of life. In fact, it can be argued that we must allow freedom of conscience for individuals to make decisions for themselves in order to show respect for the sanctity of life.*<sup>90</sup> (Prof. Margaret Otowski)

### **Slippery slope**

This argument is centred on the premise that the legalisation of voluntary euthanasia is the 'thin end of the wedge' and will inevitably lead to the acceptance of voluntary euthanasia for non-terminal illnesses or for conditions based on quality-of-life issues. It is also argued that pressure will be placed on vulnerable groups, such as the aged and the disabled, to end their lives so as not to be a burden on their family or society, thus there will be a subtle shift towards non-voluntary euthanasia. Some argue that this situation is already occurring in the Netherlands.

*The early Dutch debates about decriminalisation of euthanasia and its initial clinical practice confined euthanasia to competent patients with unrelieved suffering in the terminal phase. However, after the euthanasia of a woman with no physical illness in 1994, the Dutch Supreme Court held that psychiatric suffering could justify euthanasia ... There is growing acceptance of euthanasia for people who are 'tired of*

---

<sup>87</sup> Submission No. 290, p. 2

<sup>88</sup> Submission No. 7, p. 2

<sup>89</sup> Submission No. 41, p. 2

<sup>90</sup> Submission No. 487, p. 9

---

*life' ... The Court of Appeal failed to rule out 'life fatigue' as a legitimate ground for euthanasia.*<sup>91</sup> (Ms Katrina George)

*We do not live on an equal playing field, and inevitably an introduction of the 'right to die' will disproportionately impact upon those who are stigmatized, marginalised and lacking in resources. That is why the legalizing of medical killing can never be a safe or responsible option in a civil society.*<sup>92</sup> (Father Gerald Quinn)

Others argue that the 'slippery slope' argument has not been demonstrated by the experience in the Netherlands and Oregon and refer to a recent study.

*Rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured ... people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses, including depression, or racial or ethnic minorities, compared with background populations. The only group with a heightened risk was people with AIDS.*<sup>93</sup> (Mr Mike Harris)

### **Doctor/patient relationship**

Opponents believe that legalising voluntary euthanasia would fundamentally alter the doctor/patient relationship and the medical professional would be seen in the role of executioner as well as healer. They say this would break the trust patients have in medical staff and would compromise the medical profession as a whole. Medical practitioners expressed the view that assisting people to commit suicide runs counter to the ethics of their profession and they believe they should not be involved in any procedure which has the primary intention of ending life.

*But the difficulty with legislation of this sort is it entirely changes the doctor-patient relationship. It poisons the relationship, in our view. The pre-eminent role of the doctor is as healer ... We do not see ourselves as the executioners of our patients and we think a bill such as this will change the dynamic and the way that patients regard their doctor. Patients will come to distrust their doctors if they think that their doctor might in fact be able to order their demise.*<sup>94</sup> (Dr Chris Middleton)

*There is real concern to what extent ordinary people might be willing to trust a medical system in which one of the options is that they might be killed if it is judged that they are in intolerable pain. Interestingly, I think it is significant to note that in many vulnerable communities the idea that physician-assisted suicide might be legalised is very often an issue that they are very concerned about*<sup>95</sup> (Prof. Jeff Malpas)

Proponents of legalising voluntary euthanasia believe this argument is based on unsubstantiated concerns, arguing that in jurisdictions where voluntary euthanasia is legal there has not been a breakdown in trust in the medical profession. They also argue that the

---

<sup>91</sup> Submission No. 414, p. 8

<sup>92</sup> Submission No. 488, p. 1

<sup>93</sup> Submission No. 413, p. 12

<sup>94</sup> Transcript 24/8/09, p. 60

<sup>95</sup> Transcript 31/8/09, p. 20

---

medical profession has a broad membership holding a range of ethical views on the subject and members are not bound in any way to be involved in the provision of voluntary euthanasia.

*If one has regard to the position in the Netherlands, where active voluntary euthanasia is now openly practised, there does not appear to have been any erosion of trust between doctors and their patients. In fact, for many people, the knowledge that their doctor could assist in administering active euthanasia at their request would have a positive effect, fostering greater confidence, and relieving anxiety about an agonising and undignified death. Thus, contrary to the claims of opponents, the legalisation of doctor administered active voluntary euthanasia could have the effect of strengthening the doctor/patient relationship.*<sup>96</sup> (Prof. Margaret Otlowski)

The emotional and psychological effects and impacts on participating physicians was also an area of concern raised with the Committee. A paper written in 2006 by Dr Kenneth Stevens MD, from Oregon stated that advocates of physician assisted suicide, Margaret Gattin and Timothy Quill, editors of a book favouring legalisation of PAS have stated that -

*...there is no evidence that PAS “legalisation would corrupt physicians and thus undermine the integrity of the medical profession”, and that “there is substantial evidence to the contrary”.*

The paper concluded:

*Physician participation in assisted suicide or euthanasia can have a profound effect on the involved physicians, There is a huge burden on conscience, tangled emotions and a large psychological toll on the participating physicians. Many physicians describe feelings of isolation. Published evidence indicates that some patients and others are pressuring and intimidating doctors to assist in suicide. Oregon physicians feel they have no choice but to be involved in assisted suicides. There is also great potential for physicians to be affected by countertransference issues in dealing with end-of-life care, and assisted suicide and euthanasia.*<sup>97</sup>

*There is a concern about the degree to which doctors become, as it were, desensitised, and that actually is a really major concern because it’s exactly that process of desensitisation that has been seen as lying at the heart of many cases much more spectacular where the desensitisation to begin with has led on to much worse cases of malpractice.*<sup>98</sup> (Prof. Jeff Malpas)

### **Availability of palliative care**

Many submissions argued that rather than legalising voluntary euthanasia much greater emphasis should be placed on funding to allow optimal palliative care options to be accessed more equitably in all regions. Some submissions expressed concerns that legalising voluntary euthanasia would have a negative affect on the provision of palliative care. Others argue that optimal palliative care makes voluntary euthanasia provisions unnecessary. They

---

<sup>96</sup> Submission No. 487, p. 15

<sup>97</sup> Document No. 21, Extract from The Linacre Quarterly – Catholic Medical Association Vol. 73, No.3 August 2006 p. 213

<sup>98</sup> Transcript, 31/8/09, p. 23

---

also argue that the very small minority of cases for whom palliative care does not provide relief is not a sound basis for such a profound legislative change.

*The development of palliative care services has made a huge difference to dying in our community. In Tasmania in 2009 we are fortunate to have both specialised palliative care nurses and specialist palliative care physicians who can visit patients at home and provide ready advice by telephone. It is no coincidence that the previous Northern Territory euthanasia legislation was set up at a time the NT had no palliative care services whatever. The instigator of that legislation, Mr Marshall Perron, has even been quoted as admitting that when he introduced the legislation into the parliament he had never heard of palliative care.*<sup>99</sup> (Prof. Ray Lowenthal)

Proponents argue that legalising voluntary euthanasia should not change the emphasis from the provision of quality palliative care which they see as being complementary to, rather than an alternative to, the option of voluntary euthanasia.

*The legalisation of assisted death has been associated with substantial improvements in palliative care in Oregon, in areas including the appropriate training of physicians, the communication of a patient's wishes regarding life-sustaining treatment, pain management, rates of referral to hospice programs, and the percentage of deaths occurring at home. Effective palliative care and hospice services may address many of the key reasons why patients request assistance in dying – such as loss of autonomy, dignity, and the ability to care for themselves in a home environment – and lead some to change their minds.*<sup>100</sup> (Mr Mike Harris)

**Parliament House  
Hobart  
12 October 2009**

**Hon. K. Finch M.L.C.  
Chairman**

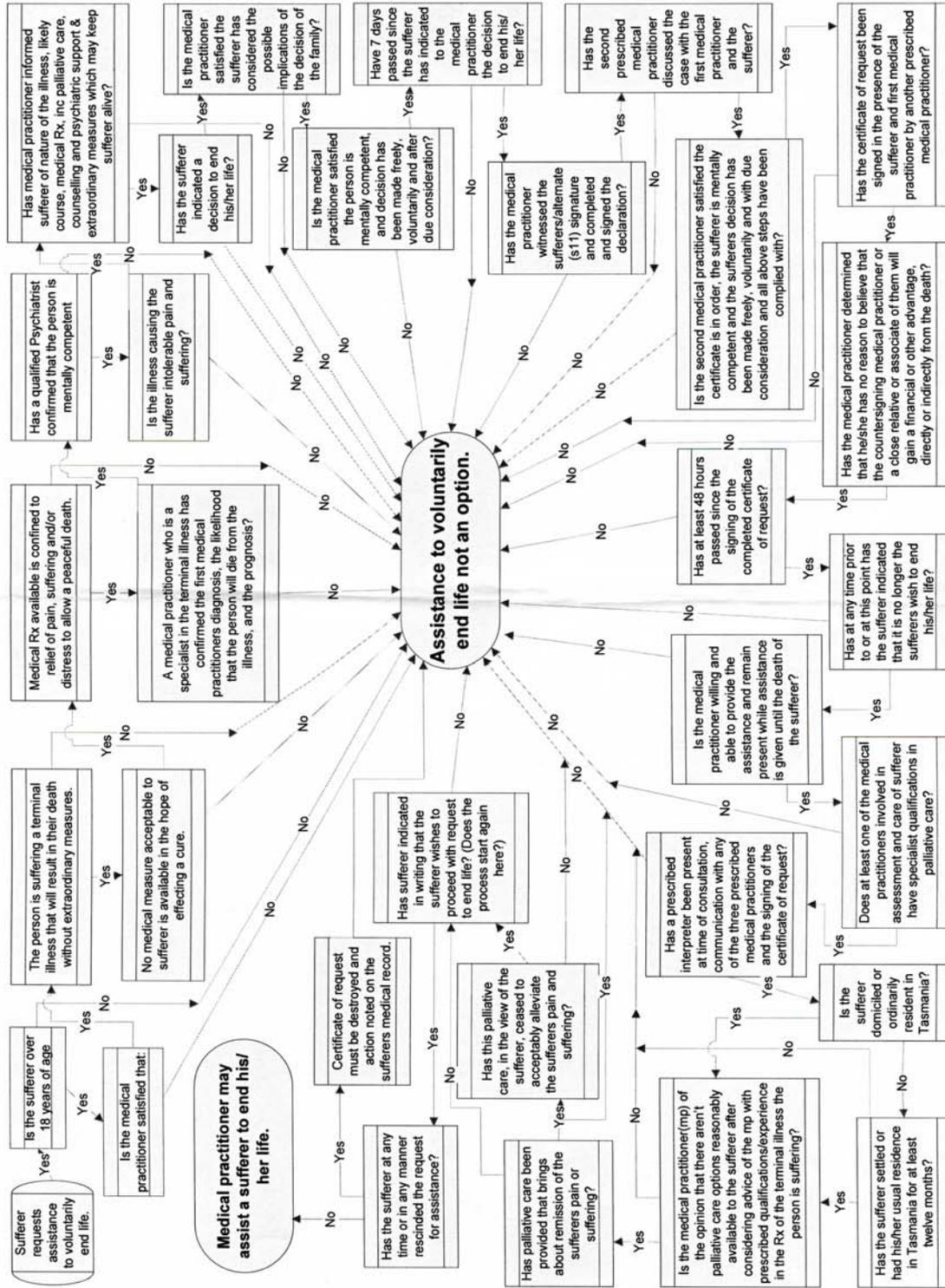
---

<sup>99</sup> Submission No. 493, p.3

<sup>100</sup> Submission No. 413, p. 12

---

### APPENDIX 1 Flow Chart of Dying with Dignity Bill as submitted by Hon. Ruth Forrest MLC



APPENDIX 2

**VOLUNTARY  
EUTHANASIA  
RESEARCH REPORT**

*Prepared for*



by

**Enterprise Marketing & Research Services Pty Ltd,  
60 Main Road, Moonah, TAS 7009  
May 2009**



**About the Survey**

The survey was conducted between the 4<sup>th</sup> and 7<sup>th</sup> May 2009.

In the current round, 1000 householders were interviewed by telephone. Of these, 500 were from the South, 280 from the North and North East and 220 from the North West and West Coast regions.

All enquiries should be addressed to:

Lucy Millen  
Research Officer  
Enterprise Marketing and Research Services Pty. Ltd.  
PO Box 402  
Moonah TAS 7009  
Phone: (03) 62 111 222  
Fax: (03) 62 111 219  
E-mail: [lucy.millen@emrs.com.au](mailto:lucy.millen@emrs.com.au)

---

---

## Voluntary Euthanasia

1000 Tasmanian adults were interviewed by telephone between Monday May 4<sup>th</sup> and Thursday May 7<sup>th</sup> 2009.

### Question:

Thinking about voluntary euthanasia where a doctor complies with the wishes of a dying patient to have his or her life ended; are you in favour of or against a change in the law that would allow doctors to comply with the wishes of a dying patient to end his or her life?

**Table 1 – In Favour of or Against a Change in the Law Regarding Voluntary Euthanasia**

Response	Percentage of the entire sample		Percentage excluding those unsure or unwilling to answer	
	2008 N=1000	2009 N=1000	2008 N=884	2009 N=928
In favour of changing the law to allow doctors to meet the patient's wish to end their life	75	78	85	84
Against changing the law to allow doctors to meet the patients wish to end their life	14	15	15	16
Unsure	5	6	-	-
Unwilling to answer	7	1	-	-

Over three quarters (78%) of the entire sample were "in favour of changing the law to allow doctors to meet the patient's wish to end their life" (an increase when compared to 75% in 2008). When the respondents who were "unsure" or "unwilling to answer" were excluded, this rose to 84% (compared to 85% in 2008).

### In Favour of Changing the Law

Over 80% of each demographic sample was "in favour" of changing the law to allow doctors to meet the patient's wish to end their life, except for respondents who were Liberal Voters (77%) or 70 years or older (70%). However, even amongst these demographic groups, the percentage in favour of changing the law was still quite high.

**Table 2 – In Favour of Changing the Law to Allow Doctors to Meet the Patients Wish to End Their Life (Percentage of each demographic excluding unsure and unwilling to answer)**

Category	March 2008	May 2009
<b>Overall</b>	85	84
<b>Region</b>		
South	84	87
North and North East	87	81
North west and West	85	83
<b>Age</b>		
18-24	82	90
25-34	90	81
35-44	85	91
45-54	89	87
55-69	82	85
70+ years	81	70
<b>Gender</b>		
Male	83	84
Female	86	85
<b>Household</b>		
Single	75	83
Couple/no children	88	88
Family with all children under 16	89	86
Family with a child over 16 at home	85	85
Married – children left home	84	81
Widow	82	82
Sole Parent	89	86
Separated or divorced	91	88
<b>Political Parties Supporting and Leaning Towards</b>		
Labor	84	86
Liberal	83	77
Greens	89	94
Independent	83	93
Unsure	85	83

### Against Changing the Law

There has been a large increase in respondents aged 70 years and over who are against changing the law when compared to the previous round (19% in 2008 compared to 30% in 2009). Except for respondents aged 70 years and over, no more than one quarter (25%) of each demographic sample were against changing the law to allow doctors to meet their patients' wish to end their life.

**Table 3 – Against Changing the Law to Allow Doctors to Meet the Patient's wish to End Their Life (Percentage of each demographic excluding unsure and unwilling to answer)**

Category	March 2008	May 2009
<b>Overall</b>	15	16
<b>Region</b>		
South	17	13
North and North East	13	19
North West and West	15	17
<b>Age</b>		
18-24	18	10
25-34	10	19
35-44	15	9
45-54	12	13
55-69	18	15
70+ years	19	30
<b>Gender</b>		
Male	17	16
Female	14	15
<b>Household</b>		
Single	25	17
Couple/no children	13	12
Family with all children under 16	12	14
Family with a child over 16 at home	15	15
Married – children left home	17	19
Widow	18	18
Sole Parent	12	14
Separated or divorced	9	12
<b>Political Parties Supporting and Leaning Towards</b>		
Labor	16	14
Liberal	17	23
Greens	11	6
Independent	17	7
Unsure	15	17

**APPENDIX – 3****Comparative Table of Euthanasia Legislation (Adapted from Current Issues Brief No. 2, 2008, Victorian Parliament)**

What is included	Tasmania's Bill	Northern Territory (1995-Repealed by Federal Legislation 1997)	Oregon	Netherlands
Physician Assisted Suicide	Yes	Yes	Yes	Yes
Age restrictions	18 years plus	18 years plus	18 years plus	18 years plus; minors 16-18 with parental consultation; minors 12-16 with parental consent; neonates - not under the Act, but case law has provided guidelines.
Preconditions: Terminal illness	Yes	Yes	Yes with 6 months to live	Yes and the illness may be chronic or in exceptional cases, mental suffering (case law)
Cooling-off period	Yes, 7 days following indication to medical practitioner	Yes: 7 days following verbal request & 2 days following written request	Yes: 15 days after verbal request & 2 days after written request	Not a specified period of time, but one of the criteria that must be applied is that the request by a patient must be well considered, i.e. an enduring repeated request.
Pain or suffering	Yes, intolerable pain or suffering	Yes experiencing pain, suffering and distress to an extent deemed unacceptable	Not mentioned	Yes suffering is unbearable with no prospect of improvement; suffering may be mental.
Resident	Yes, minimum 12 months	No	Yes	Yes - in practice. Not specified in the Act - but close association with physician would exclude non-residents.
Mental Assessment	Yes, sufferer must be competent	Yes - mandatory	Not mandatory; If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination	Not mandatory, only if consulting physician thinks it's necessary where there is a mental condition
Palliative care offered	Yes, mandatory if reasonably available to alleviate sufferer's pain and suffering to tolerable levels	Yes-mandatory	Yes-mandatory	One of the criteria that doctors must follow is: 'to become convinced together with the patient that there is no other reasonable solution for the situation that the patient is in'. According to Dutch Govt. policy, this requirement of due care means that it has to be ascertained whether there are further possibilities for palliative care to reduce the suffering. It has been reported in the literature however, that this may not always happen in practice
Mandatory Second opinion from another Doctor.	Yes, 2 other doctors, one of whom must be a psychiatrist	Yes - 3 doctors	Yes - 2 doctors	Yes - 2 doctors, but can consult more
Mandatory participation by Doctors/Institutions	No	No	No	No

## APPENDIX 4 SELECTED BIBLIOGRAPHY

### Parliamentary Reports and Research Papers

Griffith, G., *Euthanasia: An Update*, Briefing Paper No. 3, 2001, New South Wales Parliamentary Library, 2001

House of Lords, *Report of the Select Committee on Medical Ethics*, 1994

House of Lords, *Report of the Select Committee on the Assisted Dying For the Terminally Ill Bill*, 2005

Parliament of Australia, Standing Committee on Legal and Constitutional Affairs, *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*, 2008

Parliament of Australia, Parliamentary Library, *Choice, Quality of Life and Self-control: Summary Arguments in Support of Euthanasia*, Research Note 12, 1996-97

Parliament of Australia, Parliamentary Library, *The Sanctity of Life: Summary Arguments Opposing Euthanasia*, Research Note 13, 1996-97

Parliament of South Australia, Twelfth Report of the Social Development Committee, *Inquiry into the Voluntary Euthanasia Bill 1996*, 1999

Parliament of Tasmania, *Community Development Committee Report on the Need for Legislation on Voluntary Euthanasia*, 1998

Parliament of Victoria, *Medical Treatment (Physician Assisted Dying) Bill 2008*, Current Issues Brief No. 2, 2008

### Other Reference Material

Kissane David et al, *Seven Deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia*, The Lancet, Vol. 352, October 1998

Kuhse, Helga et al, *End-of-life Decisions in Australian Medical Practice*, Medical Journal of Australia, 1997

Otlowski, M, *Voluntary Euthanasia and the Common Law*, Oxford University Press, 2000

Stevens, Jr. Kenneth R., M.D., FACR, *Emotional and Psychological Effects of Physician-Assisted Suicide and Euthanasia On Participating Physicians.*— Extract from The Linacre Quarterly – Catholic Medical Association, Vol 73 No. 3 August 2006

### Parliamentary Library Resource Index

The Tasmanian Parliamentary Library has compiled a considerable resource of current material on this subject, including books, articles and media transcripts, available on the Tasmanian Parliament intranet at: <http://pz005.parliament.tas.gov.au/tpl/ctees/resourceindex.htm>

---

**APPENDIX - 5**  
**SUBMISSIONS RECEIVED**

1. Brian and Muriel Austin - mbaustin@itginternet.net.au
  2. Roy Goldfinch, 1374 Acton Road Cambridge 7170
  3. Kevin Briggs, 13436 Highland Lakes Road, Golden Valley, 7304.
  4. T. J. Esterbrook, 25 Morris Avenue, Devonport 7310
  5. Ian Wood, Co-ordinator, Christians Supporting Choice for Voluntary Euthanasia, 429 Anzac Road, Port Pirie, South Australia 5540
  6. Marshall Perron (marshallperron@inet.net.au)
  7. Rita M. Joseph (rita50@netspeed.com.au)
  8. H. J. Watchorn, 197a Channel Highway, Taroom 7053
  9. Rae Timmins – [Rae.Timmins@usq.edu.au](mailto:Rae.Timmins@usq.edu.au)
  10. Sherryl Stiles, U4/192 Roberts St., Jonndanna WA 6060
  11. Derek and Olive Hindle, 82 Ocean Esplanade, Blackmans Bay
  12. Rozlyn Olding, 9 Hampshire Road, Sandy Bay
  13. Marilyn Laffer, 44 Derwent Avenue, Margate 7054
  14. Kristi Giselsson, 13 Baynton Street, Kingston 7050
  15. Rev. Campbell and Mrs Amanda-Sue Markham, 11 Sherbourne Avenue, West Hobart
  16. Dr. Andrew Corbett, Senior Pastor, 1 Gerrard Close, Legana 7277
  17. Raymond Scott Camac, 164 Mount Street, Burnie 7320
  18. Norman Potter, 1/459 Churchill Avenue, Sandy Bay 7005
  19. David de Bomford, 77 Bel Air Crescent, Devonport 7310
  20. Mark Crawford Dip Min JP, National Leader, Bethesda Ministries International, 200 Florey Drive, Charnwood, ACT 2615
  21. Carol Prichard, 31 Bright Water Road, Blackmans Bay 7052
  22. Phillip and Fiona Coles, 32 Upper Hilton Road, Austins Ferry 7011
  23. Mrs. Kay Cox, 5 Park Road, Lindisfarne 7015
  24. Hollie Zimmermann, C/- Grove Post Office, 1952 Huon Highway, Grove 7109
  25. Lorraine and Larry Dooley, 10 Newlands Avenue, Lenah Valley 7008
  26. Rev. Christina Campton, B.Ed., Dip. Pastoral Ministry, 50 Main Road, Claremont.
  27. Paul Campton, 50 Main Road, Claremont 7011
  28. Mrs. Margaret....., 35/8 Douglas Street, New Town 7008
  29. Stewart McFarlane, 3 Lochner Street, West Hobart 7000
  30. Wayne Williams, 2 Bareena Road, Taroom 7053
  31. A. W. W. Godfrey, 17 Elphinstone Road, Mt. Stuart 7000
  32. Pastor Iain Smith, 3 Grenfell Place, Glenorchy 7010
  33. W. D. Stuart, Apartment 12, Queenborough Rise, Peel Street, Sandy Bay 7005
  34. Robert Hand and Caroline Hand, PO Box 791, Kingston 7051
  35. Mrs. Beth Micklethwaite, 1/132 Roslyn Avenue, Blackmans Bay 7052
  36. Leslie T. Kelly, PO Box 391, Kingsmeadows 7249
-

37. Marianne Gill-Harper, "The Eyrie", 10 Keen Court, Kingston 7051
  38. Jan McInnes, 1/13 Crudwell Court, Burnie 7320
  39. Beverley L. Cooper, 229 Goodland Road, Lower Wilmot 7310
  40. Phillip John Sale, 11 Clarke Avenue, Battery Point 7004
  41. Mike McCall, GPO Box 1991, Hobart 7001
  42. R. A. Fisher, PO Box 13, St. Helens 7216
  43. Beryl Carmichael, 58 Cornwall Street, Rose Bay 7015
  44. Kenneth Noel Higgs, 3 Eldon Street, Lindisfarne 7015
  45. Ms Kay Scurr, PO Box 4, Geeveston 7116
  46. Patricia Dove, 65 Conway Street, Mowbray 7248
  47. G. Muskett, 38 Bayside Drive, Lauderdale 7021
  48. T. D. Nielsen, 42 Faulkner Road, Ravenswood 7250
  49. D. F. Pilgrim, 2/3 Liena Road, Hobart 7000
  50. S Edmondson, 1/183 Cambridge Street, West Launceston 7250
  51. T. & B. Connors, 6A Hill Street, Bellerive 7018
  52. Mrs. P. A. Steeden, 11/17 Beach Road, Snug 7054
  53. Theresia Van Den Berg, PO Box 620, New Norfolk 7140
  54. Leo Stossich, Senior Pastor, Kingborough Family Church, Tasmanian State Leader, Apostolic Church, Kingston 7050
  55. Craig and Rachelle Hawkins, PO Box 363, Beauty Point 7250
  56. Allan Dodds, 89 Shearwater Boulevard, Shearwater 7307
  57. Ms Surmani Rose, 35 Salisbury Crescent, Launceston 7250
  58. Vince Misdorn, 26 Parua Road, Newnham 7248
  59. Maree Triffett, 263 Lenah Valley Road, Lenah Valley 7008
  60. Abe Udy, 1 Forest Heights Drive, Devonport 7310
  61. Bianca Vos, 47 Cluan Crescent, Ulverstone 7315
  62. Bernie and Susie Hartog, Citylight Church, Kingston 7050
  63. Rev. William Bosker, 11 Pearl Place, Blackmans Bay 7052
  64. Frank Hawks (frankh2@airlan.com.au)
  65. Rev David Jones, 3 Lachlan Drive, Mt. Nelson 7007
  66. Gabrielle Saha, 67 Rannoch Avenue, Riverside 7250
  67. Jacqueline Penney, 42 Crandon Crescent, Newnham 7248
  68. Richard Penney, 42 Crandon Crescent, Newnham 7250
  69. D.L. 7 K. M. Storrie, 16 Powell Road, Blackmans Bay 7052
  70. Rev. Prof. the Hon. Michael Tate AO, (mtate@bigpond.com)
  71. Mr. B. D. Heard, 3 Roslyn Avenue, Kingston Beach 7050
  72. Don & Gwen Townend, 234 Gilbert Street, Latrobe 7307
  73. N. & C. Grady, 11 Clearview Avenue, Trevallyn 7250
  74. Karen Enkelaar, 46 Rowsphorn Road, Riverside 7250
  75. Rev. Canon John Tongue, Rector, Holy Trinity Anglican Church, Ulverstone 7315
-

76. D.C.O. .... 4 Kanangra Court, Brighton 7030
  77. Henk Kremer, 16 Strathern Street, Mount Stuart 7000
  78. Family Voice Australia, GPO Box 9894, Hobart 7001
  79. Timothy Petrusma, 8 Kirra Road, Roches Beach 7170
  80. Deirdre Holder, "Danbury Park:, PO Box 113, Launceston 7250
  81. M. van Reit, 41 Campbell Street, Hobart 7000
  82. Henk de Vries, 46 Yarram Drive, Kingston 7050
  83. Paul Duncombe, PO Box 515, Sandy Bay 7005
  84. Sam Mason, 1 Wisteria Avenue, Cremorne 7024
  85. Kim Corbett, 73 Ridge Road, Legana 7277
  86. Wal Ashby (wkandrma@gmail.com)
  87. Tim Lunnon, 486 West Tamar Road, Riverside 7250
  88. Marianne Stafford, 31 Lower Jordan Hill Road, West Hobart 7000
  89. Maureen Aiken, 24/100 Channel Highway, Tarooma 7053
  90. Axel Beard (go.crows2003@hotmail.com)
  91. Malcolm Douglas (malcolm\_douglas@optusnet.com.au)
  92. Barry Brannan, 4B Stephanie Close, Sandy Bay 7005
  93. Philip Crouch, PO Box 511, Rosny Park 7018
  94. Aart M. van der Hek, 1 Symons Court, Young Town 7249
  95. Iain Robertson, 18 Bettina Avenue, Norwood 7250
  96. Wendy Holland, 27 Falmouth Street, St. Helens 7216
  97. Miss Helen M. Fisher, 2/7 Rennie Court, Norwood 7250
  98. D. M. Pitham, 1306 West Tamar Highway, Legana 7277
  99. David Perrin, 2 Blanche Court, Doncaster East, Victoria 3109
  100. Michael Dickson, Chairman, Launceston Christian Broadcasters Inc (WayFM), PO Box 43, Launceston 7250
  101. David Nicholls, President Atheist Foundation of Australia Inc., Private Mail Bag 6, Maitland, SA 5573
  102. Cynthia Wege, PO box 341, Lenah Valley, 7008
  103. Keith Anderson, PO Box 58, Kingston, 7051
  104. Elizabeth Dilger, 409 Phoenix Street, Howrah 7018
  105. M. M. McLaine, 58 Swan Drive, Swan Bay 7252
  106. Mrs. Gaye Clark, Hon., Secretary, C.W.L. Oatlands Branch, 661 Stonor Road, Stonor, 7119
  107. Nara Franz, 239 Roslyn Avenue, Blackmans Bay 7052
  108. Brian Stafford and Annette Oddy, 690A Sandy Bay Road, Lower Sandy Bay 7005
  109. Ken and Audrey Williams, Vaucluse Gardens, 12/319 Macquarie Street, Hobart 7004
  110. Eileen Jelfs, 28/131 Hill Street, West Hobart. 7000
  111. Dorothy Long, 91 Oakview Parade, Caroline Springs 3023
  112. Rev. William Terrance Southerwood, 44 Margaret Street, Launceston 7250
  113. Geoff Miller, 31 Charles Street, Devonport 7310
-

114. P. C. Comas, State Secretary, Knights of the Southern Cross, GPO Box 217, Hobart 7001
  115. Denis Alexander, 17 Sanctuary Road, Austins Ferry 7011
  116. E.A. & E Gewin, 22 Dapple Street, Norwood 7250
  117. Mrs. Phyllis M. Sharman, 175 Channel Highway, Taroona 7053
  118. The Rt. Rev. P. K. Newell, AO and Mrs. M. E. Newell, 4 Howley Court, Howrah 7018
  119. Mrs. Mary Wright, 2/16 Aldinga Street, Blackmans Bay 7052
  120. Dr. Nicholas Cooling, Medical Educator, Senior Lecturer, University of Tasmania, 27 Weemala Court, Mt. Nelson 7007
  121. Isobel Gawler, PO Box 41326, Casuarina NT 0811
  122. Dr. David M. Gawler, C/- Royal Darwin Hospital, PO Box 41326, Casuarina, NT 0811
  123. Peter Dishington, 18 Kelson Place, Acton Park 7170
  124. James Van Dyk, 75 Corin Street, West Launceston
  125. David and Tonia Poxon (currie@bigpond.net.au)
  126. Julianne Orr, 20 Benjamin Street, Trevallyn 7250
  127. Peter Meyer, 12 Bertland Court, Norwood 7250
  128. Annabel Crook, 49 Waimea Avenue, Sandy Bay 7005
  129. Christine Goodacre, 133 Molle Street, West Hobart 7000
  130. Assoc. Prof. Nicholas Tonti-Filippini, 15 Albumum Crescent, Lower Templestowe 3107
  131. Phil Carswell, 22 Thorne Street, Burnie 7320
  132. Marion Rogers (jpsimms1@hotmail.com)
  133. Garry Thompson (garrythompson7@bigpond.com)
  134. William and Rose Briggs, 83 A Auburn Road, Kingston Beach 7050
  135. Jocelyn Head, 37 Acton Drive, Acton Park 7170
  136. Bert Van Galen, 99 Conway Street, Mowbray 7248
  137. Mr. & Mrs. M. Davis, 17 Delungra Road, Trevallyn 7250
  138. L. & J. Smith, 5 Cedar Place, Burnie 7320
  139. Sandra Walkling, Carmel Cottage, 5 Cambridge Street, West Launceston 7250
  140. Mr. & Mrs. R. and A. Brewer, 15 Hall Street, Rosevears 7277
  141. Miss C.J.H. Garvie, 23 Heemskirk Street, Warrane 7018
  142. Joint Submission c/- 40 Fairway Drive, Kingston 7050
  143. Basil Byrne, 5 Wakehurst Road, Austins Ferry 7011
  144. J. Lewers, 6 Mary Street, North Hobart 7000
  145. Carole Lambert, 6 Blyth Parade, Great Bay 7150
  146. John and Brenda Card, 3 Felmingham Street, Binalong Bay 7216
  147. Norma Jamieson, 10 Parker Street, Devonport 7310
  148. Mike Dennett, 33 Blyth Parade, Great Bay 7150
  149. Barbara Claudia Bayles, 20 Ronneby Road, Newnham 7248
  150. WITHDRAWN
  151. Mrs. Elizabeth Heckscher, PO Box 47, Newstead 7250
  152. Miss T. E. McMahon, 1/47 Walden Street, Newstead 7250
-

153. Carol Jolly, 7 Heathfield Avenue, Hobart 7000
  154. T. Wisoky, PO Box 137, South Hobart 7004
  155. Ken Townsend, 2 Atkins Drive, Burnie 7320
  156. Judith S. Woollart, 2/9 Cyrus Court, Rose Bay 7015
  157. L. & V. Gard, 56 Flinders Esplanade, Tarooma 7053
  158. Dulcie Scolyer, 18 Lyons Street, Burnie 7320
  159. Bill Jolly, 7 Heathfield Avenue, Hobart 7000
  160. Ms. Greta Lawrence, PO Box 425, Devonport 7310
  161. W. G. Wisoky, PO Box 137, South Hobart 7004
  162. L. Townsend, 2 Atkins Drive, Burnie 7320
  163. Pamela Neeson, PO Box 636, Launceston 7250
  164. Mary Hemming, Chairman Bellerive-Lindisfarne Catholic Parish Pastoral Council, 2 Alma Street, Bellerive 7018
  165. Rev. Dr. Andrew Corbett, ICI College, Australia, PO Box 1143 Legana 7277
  166. Malcolm Nicholson, 106 Elizabeth Street, Launceston 7250
  167. Members of the Eternal Life Christian Church Inc. PO Box 420, Kings Meadows 7249
  168. Mrs. K. Turner, Secretary, Bracknell District Baptist Church, Jane Street, Bracknell 7302
  169. Emily Windon, 11 William Street, Smithton 7330
  170. Barry and Pauline Oliver, 30 Franmaree Road, Newnham 7248
  171. Henry and Wilma Van Dam, 8 Sophia Street, Kingston 7050
  172. Mrs. N. Lefevre, 6 Kywong Crescent, Ulverstone 7315
  173. I and A Francis, 49 Fisher Avenue, Sandy Bay 7005
  174. Geoff Madden, 153 Bangalee Street, Lauderdale 7021
  175. C. O'Donnell, PO Box 609, Sandy Bay 7005
  176. Beatrice Bentley, 72 Cremorne Avenue, Cremorne 7024
  177. Mrs. B. M. McDonnell, 6683 Channel Highway, Deep Bay 7112
  178. Miss Erinn McDonnell, 6683 Channel Highway, Deep Bay 7112
  179. William Cox, 214 Davey Street, Hobart 7000
  180. Associate pastor, Ron Wilson, Grace Christian Church, 45 Melville Street, Hobart 7000
  181. John Whitehead, 3 Bignell Street, Bellerive 7018
  182. David and Sherrin Drew, 283 Redwood Road, Kingston 7050
  183. Mrs. Beverley Reynolds, 28 Sinclair Avenue, Moonah 7009
  184. Theodorus Riske, Unit 1, 25 Osborne Esplanade, Kingston Beach 7050
  185. Dr. Steven Micklethwaite, 1/132 Roslyn Avenue, Blackmans Bay 7052
  186. Sheila Howe, 10 Victoria Mews, Lindisfarne 7015
  187. Donald C. Mills, 2/14 Fairisle Terrace, Howrah 7018
  188. Frank and Elizabeth Kempa, 2/94A Wentworth Street, South Hobart 7004
  189. Gill Watson, 46 Dransfield Road, Copping 7174
  190. John Hamilton and Jean Taylor, 446 Manuka Road, Kettering 7155
  191. Tim O'Neill, 2 Stephensdale Drive, Riverside 7250
-

192. Susan Wyly, 5 Anderson Road, Trevallyn 7250
  193. Barbara Young, 58 Bald Hill Road, Trevallyn 7250
  194. Drs. Mike and Julie Sladden, 55 Danbury Drive, Legana 7277
  195. Laurence & Kathleen Kennedy, 27 Honey Richea Road, Hellyer 7321
  196. T. J. Lockhart, 4 Veteran Row, Westbury 7303
  197. Brian James Hanafin and F. Kelly, 77 East Church Street, Deloraine 7304
  198. Mr. & Mrs. G. H. K. and J. J. Fawdry, 15 Dry Street, Leith 7310
  199. Francis Williams, 9 Singline Avenue, Burnie 7320
  200. Judith Gawlland, 3/5 Beach Road, Lindisfarne 7015
  201. Jane Cairns, 151 Bindaree Road, Legana 7277
  202. Willy Veltkamp, 30 Fulton Street, Legana 7277
  203. Claire Morgan, 12 Swinton Place, Rose Bay 7018
  204. Jake Towns, 15 Shoreline Drive, Howrah 7018
  205. Dr. Evert Jansen, 166 Nelson Road, Mount Nelson 7007
  206. I. P. (Paddy) Burges Watson MD OAM, and Judith M. Burges Watson (paddyandjudy@clearmail.com.au)
  207. Ron Bennett, 15 Millard Avenue, Aitkenvale, Townsville 4814
  208. Dr. Lachlan Dunjey, "medicinewithmorality.org.au", PO Box 68, Morley, Western Australia 6943
  209. David Mitchell, 18 Proctors Road, Dynnryne 7005
  210. Robert McManus, 299 Acton Drive, Acton Park 7170
  211. Mrs. Cathy Lawrence, 30 Dandenong Road, Trevallyn 7250
  212. Walter Wagner, 147 Nixon Street, Devonport 7310
  213. Yvonne Sypkes, 36 Osborne Esplanade., Kingston Beach 7050
  214. Mark Allan Salmon, 343 Winkleigh Road, Exeter 7275
  215. Peter Smith (petercsmith@hotmail.com)
  216. Brian and Loys Clarke, 352 Clarence Street, Howrah 7018
  217. Jon and Helene Pettersson, RA 168 Wrights Lane, Moriarty 7307
  218. Anne and Jan Oosting, 698 Port Sorell Road, Wesley Vale 7307
  219. Dr. Alan Rothschild, 16 Palm Avenue, North Caulfield 3161
  220. Geoff Woolston, 172 Abbott Street, Launceston 7250
  221. Allan Peter Fawcett, 860 Huon Road, Fern Tree 7054
  222. George and Elwyn Green (geggreen39@vision.net.au)
  223. Trish Kershaw CPA, 1 Ben Street, West Hobart 7000
  224. Luigi Rosolin (luigiros@optusnet.com.au)
  225. Peter Imlach, 1/44 Hymettus Street, Howrah 7018
  226. Peter and Mary Hutchinson, 4 Adelaide Street, South Hobart 7004
  227. Mr. Gayelene Harrower, 48 Leslie Road, Kingston 7050
  228. Mrs. Beverley Burgess, 126 Donnellys Road, Geeveston 7116
  229. Major Graeme McClimont, Salvation Army, PO Box 50, New Town 7008
  230. Mr. and Mrs. Murchison, 1 Tyndal Court, Bonnet Hill 7053
-

231. Archbishop Doyle, GPO Box 62, Hobart 7001
  232. Judy Gross, PO Box 116, George Town 7253
  233. Elaine Dyson, 9A Raymont Terrace, Mount Stuart 7000
  234. Mr. Desmond and Mrs. Tania Kay, 6934 Channel Highway, Cygnet 7112
  235. Geoffrey Hill, 44 Andrea Place, Launceston
  236. Jacqui Box, 59/57 Cadbury Road, Claremont 7011
  237. Mrs. Jill Hale, 17 Powell Street, Sandy Bay 7005
  238. Charles and Helen Rankin, 30 Brinsmead Road, Mt. Nelson 7007
  239. Mrs. T. M. Lee-Archer, 2/29 Country Club Avenue, Prospect 7250
  240. Edward Weekley, 9/16b Stoke Street, New Town 7008
  241. Dr. Helen Cutts, PO Box 239, North Hobart 7002
  242. Richard Davis, C/- Post Office, Westerway 7140
  243. Kaye Shaw, 7304 Channel Highway, Cygnet 7112
  244. Fr. Peter O'Loughlin, PO Box 987, Rosny Park 7018
  245. Fr. Richard Ross, Catholic Youth Ministry, 44 Margaret Street, Launceston 7250
  246. Edwin VanderVelde, 66 Mulgrave Street, South Launceston 7249
  247. Marylouise Townsend, 301 Penquite Road, Norwood 7250
  248. Hilde Nilsson, 16A Talone Road, Blackmans Bay 7052
  249. Jean Dorries, PO Box 749, Glenorchy 7010
  250. Marjorie Luck, 28 Anear Court, Lutana 7009
  251. Phil Pyke, Media Consultant, Archdiocese of Hobart, 35 Tower Road, New Town 7008
  252. Mrs. Jeanne Wherrett, 25 Bay Road, New Town 7008
  253. Kevin Filleul, 41 Acton Court, Acton Park 7170
  254. Josh Mitchell (josh@midnightquills.net)
  255. Sylvia Niekamp (sniekamp@gmail.com)
  256. Isobel Firth, 29 Napoleon Street, Battery Point 7004
  257. Mr. Alan E. Johnson, 14 Banks Place, Turners Beach 7315
  258. Ing. Stephen Hatton, 370 Gilbert Road, West Preston 3072
  259. Heather J. Robinson, PO Box 1, Hawker, ACT 2614
  260. Dr. Gerard McGushin, PO Box 353, Lenah Valley 7008
  261. Ian Pearce, 35 Frederick Henry Parade, Cremorne 7024
  262. Mrs. Sari Kuronen, 15 Mainwaring Street, Beauty Point 7270
  263. Bert Kuipers on behalf of others (bukuipers@gmail.com)
  264. Richard Tyberek, Chief Executive Officer, Mary's Grange, 5 Grange Avenue, Tarooma 7053
  265. Amanda Meadows and Hans Iseli, 134 Nierinna Road, Margate 7054
  266. Mike Anderson, 309 Old Bernies Road, Margate 7054
  267. Heather Filleul, 41 Acton Court, Acton Park 7170
  268. Jo Pyecroft, PO Box 207, Longford 7301
  269. Eric Lockett, Tasmanian Baptists, 66 Loatta Road, Lindisfarne 7015
  270. Ray Groom, Southern Cross Care (Tas) Inc., 85 Creek Road, New Town 7008
-

271. Berend Kuipers, 35 Cormiston Road, Launceston 7250
272. **CONFIDENTIAL**
273. Q. and M. James, PO Box 2003, Lower Sandy Bay 7005
274. Terry Lincolne, 161 Cilwen Road, Cambridge 7170
275. John McCarthy, Saltwood Pty. Ltd.
276. L. Stewart, Hagley House, Station Road, Hagley 7292
277. Heather Stewart, Station Road, Hagley 7292
278. Shirley J. Hancox, 2 Quamby Street, Westbury 7303
279. Kathleen Woolley, 619 West Tamar Highway, Riverside 7250
280. Nina Moselund, Guilford Young Grove, 13 St. Canice Avenue, Sandy Bay 7005
281. Dr. Heather Dunn, PO Box 518, North Hobart 7002
282. Doctors Piercy, Nanayakkara, Lovett, Jayasundera, C/- Goulburn Valley Health, 2 Graham Street, Shepparton 3630
283. E. M. Wilkinson, 57/177 Penquite Road, Launceston 7250 - Submission with over 50 signatories
284. Joan Rosenberg, 76 New Town Road, New Town 7008
285. Brian Collin, 66 Wentworth Street, Hobart 7004
286. Dr. Geoff Downes, Private Bag 12, Hobart 7001
287. Don Boland (dgboland@people.net.au)
288. Louise Le Mottee, 11 Montego Court, Blackmans Bay 7052
289. Yvonne Kromkamp, 4 Gull Court, Shearwater 7307
290. Richard Humphrey, Dean of Hobart, GPO Box 748, Hobart 7001
291. Sam Towns, 22 Howrah Road, Howrah 7018
292. Alaina Flynn, 40 Capells Road, Lapoinya 7325
293. Lynne Rindzevicius (lcr3@bigpond.net.au)
294. Dr. N.K. Roberts and Mrs. B Roberts, 11 Sharps Road, Lenah Valley 7008
295. Greg Byrne, 9 Lambourne Ave, Roweville, Vic. 3178
296. William and Ida Day, 1051 Boxwood Road, Devenish, Vic. 3726
297. Robert F. Richmond, 13 Saundridge Road, Cressy 7302
298. Jack Fox, 120 Mont Albert Road, Garfield, Vic. 3814
299. Maryse Usher, 95a Alma Road, East St. Kilda, Vic. 3183
300. Eamonn Keane (keane.eamonn@gmail.com)
301. Bill Muehlenberg (bill@billmuehlenberg.com)
302. Corey J. Peterson, 273 Bathurst Street, West Hobart 7000
303. Stefan Matuszek, 1422 Huon Road, Nieka
304. Anglican Church of Australia, Diocese of Tasmania
305. George Miller, 8 Seaview Avenue, Taroona 7053
306. Dr. Jeremy Prichard, Lecturer, Law Faculty, University of Tasmania, Churchill Avenue, Sandy Bay 7005
307. Ronald Ross Bennett (rondulcie@bigpond.com)
308. Mrs. Anne-Marie Ovari, 39 Crystal Downs Drive, Blackmans Bay 7052
-

309. Marie Jean White, PO Box 112, Westbury 7303
  310. Rev. Keith Downey, 7 Rowitta Road, Lindisfarne 7015
  311. N. G. Direen, PO Box 145, Blackmans Bay 7052
  312. Estelle McCarthy, 44 Strickland Avenue, South Hobart 7004
  313. Mrs. Olive Lattimer, "Dovedale" 6968 Channel Highway, Gardners Bay 7112
  314. Sister Tess Ransom, St. Josephs Convent, 20 Thirza Street, New Town 7008
  315. James A. B. Finlay, "Ormlington", 203 Glenwood Road, Relbia 7258
  316. Rev. David Rogers-Smith, 42 Charlton Street, Norwood 7250
  317. Mrs. L. E. Forward, 47 McKellar Road, Newstead 7250
  318. Janice Elizabeth Skiller, 9 Balfour Place, Launceston 7250
  319. Barbara Rees, PO Box 184, Newstead 7250
  320. Julie-Anne Smith, 165 Wellington Street, Longford 7301
  321. Lillian Deane, Catholic Women's League Tasmania Inc., 16 Criterion Street, Hobart
  322. Pauline Cartwright, 1395 Bridgenorth Road, Rosevale 7292
  323. Allan Prisk, 5 Fowler Street, Montrose 7010
  324. E. Hanson, 10 Glenburn Crescent, Sulphur Creek 7316
  325. Karen Dickson, MOPS, PO 1143, Legana 7277
  326. Anthony Horton, 4 Suffolk Street, Launceston 7250
  327. Robert Petrusma – No address
  328. Karen Dickson, 73A Rosevears Drive, Rosevears 7277
  329. Matthew & Bianca VanderVelde, 22 Olive Street, Elphin 7250
  330. H & D. Alexander, 4 Roseneath Place, Austins Ferry 7011 on behalf of other signatories.
  331. Howard Simco, 8 Long Street, Penguin 7316
  332. Luke and Christine Reynolds, PO Box 50, Snug 7054
  333. Members of the Parish of St. John the Baptist, Glenorchy, PO Box 41, Glenorchy 7011
  334. Miss Shirley Cox, 2/1 Atkins Drive, Burnie 7320
  335. Jenny Templeton, Hilltop Christian Centre, Scottsdale 7260
  336. Hank and Janny VanderVelde, 3/2 Elphin Road, Launceston 7250
  337. Christine Bergman, 46 Orana Place, Riverside 7250
  338. Rev. D.E. Le Rossignol, 24 Luckman Place, Rokeby 7019. Anthony Boyle, 112 Rosevears Drive, Lanena 7275
  339. Tom McKeown (thomasmckeown@wollemi.nsw.edu.au)
  340. Luke McCormack, Victorian President, National Civic Council, PO Box 251, Balwyn 3103
  341. Rolph and Anita Vos, 11 Allison Avenue, Riverside 7250
  342. Dr. Paul Dunne, 29 Bowden Street, Glenorchy 7000
  343. Janice Skiller, 9 Balfour Place, Launceston 7250
  344. Michael Krieg, Calvary Health Care Tasmania Inc. GPO Box 1523, Hobart
  345. Dr. Robyn Brogan (Robyn.Brogan@utas.edu.au)
  346. Dr. Mary W. Andrews (Gerrand), PO Box 19, Port Sorell 7307
  347. Winsome De John (wdejong@activ8.net.au)
-

348. Dr. Annick D. Ansselin, 378 Manuka Road, Kettering 7155
  349. Vincent Siewruk, 6 Cornwall Crescent, Newnham
  350. Marjorie Nicholls, 90 Wilmot Street, Port Sorell 7307
  351. B. O'Rourke, 4 Adelaide Street, South Hobart
  352. Mrs. Glenda Daly, 33 Cormiston Road, Riverside 7250
  353. Daniel McAuley, 144 Gawler Road, Gawler, 7315
  354. Gabrielle Gannon (gannongm@gmail.com)
  355. Maria Hunter, 40 Sunset Drive, Garden Island Creek 7112
  356. Ryan Kay - no address
  357. Jessica Hunter, 28 Sterling Avenue, Kingston 7050
  358. Denice Armstrong and Jaimi Lee Armstrong 7385 Channel Highway, Cygnet 7112
  359. John Prichard, 461 Tinderbox Road, Tinderbox 7054
  360. Mrs. Elaine Askey-Doran, Principal, St. Aloysius Catholic College Advisory Board and Staff, PO Box 353, Kingston 7051
  361. Dermot Cottuli, State President, Australian Christian Churches Tasmania, 45 Melville Street, Hobart 7019
  362. Angela Stingle, 21 Warring Street, Ravenswood 7250
  363. Ric Peterson and Brian Vaatgstra, Christian Reformed Churches in Kingborough, 17 Denison Street, Kingston 7050
  364. Mark Elliott, 20 Yarraman Drive, Kingston 7050
  365. Mrs. Bobby Court, Principal, Guilford Young College, PO Box 241, Glenorchy 7010
  366. Rodney Jesson, 25 Guilford Road, Riverside 7250
  367. Mrs. Nene Walsh, 4/17 Everest Place, Newstead 7250
  368. M. Jones, 18 Lauramont Avenue, Sandy Bay 7005
  369. Mrs. Karen Becker, 9 Rowlands Court, Kingston 7050
  370. Catherine H. McCallum, 129 Warwick Street, West Hobart 7000
  371. Ronald McCallum, Royal Hobart Hospital, 48 Liverpool Street, Hobart 7000
  372. Elders of the Mount Stuart Presbyterian Church, Mount Stuart 7000
  373. Mark Pennington, 21 Guy Street, Kings Meadows 7249
  374. J. de Boer, 27 Osborne Avenue, Trevallyn 7250
  375. Alan C. Bennett, PO Box 287, Penguin 7316
  376. Kevin Marriott, Chief Executive Officer, tasCAHRD, GPO Box 595, Hobart 7001
  377. Peter Beriman, 6 Madeline Street, Glen Iris 3146
  378. Shelley M. M. Sexton, 10 Michael Street, West Launceston 7250
  379. Mr. John Hennessy, 13 Glen Dhu Street, Launceston 7250
  380. John McCarthy, 1451 Pipers River, Karoola 7267
  381. J. Norelle Lickiss, 8 Byrne Crescent, Maroubra, N.S.W. 2035
  382. Kate Churcher, 612 West Tamar Highway, Legana 7277
  383. Sonia Bowen, 612 West Tamar Highway, Legana 7277
  384. Diana Harris, PO Box 51, Cygnet 7112
  385. Mr. & Mrs. L & P Baan, 2 Fort Street, Riverside 7250
-

386. Anne O'Dwyer, 1 View Crescent, Montrose, Vic. 3765
  387. Martin Laverty, CEO, Catholic Health Australia
  388. Rev. John and Mrs. Roslyn Langlois, 28 Cromwell Street, Battery Point 7004
  389. T. Breen, Lenah Valley
  390. M. Paul Maloney, 7/45 Jackson Street, St. Kilda, Vic. 3182
  391. Ian Gaudry (ian03@tpg.com.au)
  392. Mrs. Shirley Gregory, 46 Greenway Avenue, Devonport 7310
  393. Jenny A Piest, 12 Upper McEwans Road, Legana 7277
  394. Andrew Mullins, Headmaster, Redfield College, 855 Old Northern Road, Dural, N.S.W. 2158
  395. Doris Bartl, 2/328 Nelson Road, Mt. Nelson 7007
  396. Barry Gerrand, 25 Shearwater Boulevard, Shearwater 7307
  397. Anne & Greg Foot, 1/153 Summerleas Road, Kingston 7050
  398. Sharon Lennox (pdlsal@tadaust.org.au)
  399. Nick MacFarlane, Archdiocese of Hobart, 3 York Street, Sandy Bay 7005
  400. Fr. Mark De Battista, Assistant Priest, St. Paul's, Camden
  401. Dr. Rodney Syme, Vice-President, Dying with Dignity Victoria, 20 Woodside Crescent, Toorak, Vic. 3142
  402. Giovanna MacFarlane, 3 York Street, Sandy Bay 7005
  403. Fred Bramich, PO Box 39, Lilydale Vic. 3140
  404. Peter G. North, 45 Cleghorn Ave, Riverside 7250
  405. Kim Barrett (kabarrett@bigpond.com)
  406. Peter Rice, 30 Curalo Street, Eden, NSW 2551
  407. David and Joyce Cumming, 21/26 Channel Highway, Taroona 7053
  408. Christa-Maria Wernick (christawernick@gmail.com)
  409. Ken J. Francis, PO Box 490 Bulimba, Qld. 4171
  410. Kester Rebbechi, 180 Drummond Street, Carlton, Vic. 3053
  411. Philip and Jacqui Crouch, PO Box 511, Rosny Park 7018
  412. Shirley J. Edwards, Geards Road, Cygnet 7112
  413. M. J. Harris, President, Dying with Dignity Tas. Inc. PO Box 1022, Sandy Bay 7005
  414. Katrina George, Senior Lecturer, School of Law, University of Western Sydney, Locked Bag 1797, Penrith South DC, NSW 1797
  415. M. Watts (zwy648rct@gmail.com)
  416. Dr. David Leaf, 44a Bond Street, Mosman, NSW 2088
  417. Tasmanian Catholic Justice and Peace Commission, GPO Box 62, Hobart 7001
  418. Salt Shakers, PO Box 6049, Wantirna, Vic. 3152
  419. Mrs. Susan Langham, 177 Windermere Road, Windermere 7252
  420. Margery Hanna, 1/21 Lyttleton Street, Launceston 7250
  421. Fr. Mark Freeman, PO Box 62, Cygnet 7112
  422. Arthur Wherrett, 25 Bay Road, New Town 7008
  423. Peter Dishington, 18 Kelson Place, Acton Park 7170
-

424. Matiu Chamberlan, Senior Pastor, Launceston Christian Fellowship
425. Matt & Karen Sharples, 4 Terrina St, Lauderdale 7121
426. Pastor Matt & Karen Sharples, Senior Pastors, Abundant Life Church, 490 South Arm Road, Lauderdale 7121
427. Russell MacKenzie (russandkate@internode.on.net)
428. Peter Jones, 24 Brushy Creek Road, Lenah Valley 7008
429. Chris Jones, 240a Churchill Ave., Sandy Bay 7005
430. W. G. Alcock, PO Box 157, Port Macquarie, NSW 2444
431. Thomas de Hoog – No address
432. David Kerridge, Presbyterian Church, 47 Main Street, Ulverstone 7315
433. Dr. Robert Pollnitz, Lutheran Church, Commission on Social & Bioethical Questions, 1 Kermod Street, North Adelaide, South Australia 5006
434. Jonathan Noble Hosford, 454 Windermere Road, Windermere 7252
435. Priyanka Saha (pfsaha@googlemail.com)
436. Dr. Philip Nitschke, PO Box 37781, Darwin, NT 0821
437. David Van Gend, Mackenzie House Medical Centre, 116 Russell Street, Toowoomba
- 438. CONFIDENTIAL**
439. North West Justice Network, 6 Prospect Street, Burnie 7320
440. David Clarke, 28 Mona Street, Battery Point 7004
441. Mrs. Madge Fahy, 29 George Street, Ashwood, Vic 3147
442. David Dingemanse, 71 Beach Road, Legana Tas 7277
443. June Noble, 37 Amanda Crescent, Sandy Bay 7005
444. Senator Eric Abetz, GPO Box 1675, Hobart 7001
445. Elizabeth Hutchinson, 4 Adelaide Street, South Hobart 7004
446. Helen James, 421 Gellibrand Drive, Sandford 7020
447. Dr. Natasha Cica, Faculty of Arts, Business, Law & Education, University of Tasmania, Private Bag 17, Hobart 7001
448. Australian Christian Lobby, PO Box 1262, Devonport 7310
449. Julia Clark, 69 Little's Road, Premaydena 7185
450. Dr. Brigid McKenna, 54 Gordon Road, Auburn NSW 2144
451. Ruth Davies (radavies@postoffice.utas.edu.au)
452. John Dodwell, PO Box 79, Whitemark 7255
453. Ruth Amos, (rijamos@utas.edu.au) 1 Swift Place, Kingston 7050
454. Joan Fitz-Nead, AM, 32 Forest Road, West Hobart 7000
455. Spero Katos, 6 Sycamore Street, Caulfield, Vic 3162
456. Bryan G. Walpole (Bryan.Walpole@dhhs.tas.gov.au), 8 Marieville Esplanade, Sandy Bay 7005
457. Ian Hubble, 15 Gilmore Crescent, Somerset 7322
458. Denise Cameron, President, Pro Life Victoria, PO Box 70, Balwyn, Vic. 3103
459. Brian and Ruth Bosveld, 45 Church Road, Collinsvale 7011
460. Glen Tatersall, 128 Penquite Road, Launceston 7250
461. Penelope Webb, 209 Bligh Street, Warrane 7018
-

462. Mary Sexton, 83 Forest Road, Trevallyn 7250
  463. Peter Phillips, PO Box 348, Springvale, Vic 3171
  464. Margaret Sing, 7 Faraday Street, West Hobart 7000
  465. Marlise Leimbach, 30 Lumeah Avenue, Lenah Valley 7008
  466. Neil Francis, CEO, Dying with Dignity Victoria Inc, 3/9 Salisbury Ave., Blackburn, Vic. 3130
  467. Chris and Louise Burdick, Franklin 7113
  468. Leslie J. Batchelor, 47 Seddon Street, Austins Ferry 7011
  469. Assoc. Prof. Richard Chye, 66 Sackville Street, Maroubra, NSW 2035
  470. G.C. and B. Peatling, 10 Addison Street, Rosetta 7010
  471. Senator Guy Barnett, 33 George Street, Launceston 7250
  472. Rev. Rod Waterhouse, St. John's Presbyterian Church, 188 Macquarie Street, Hobart 7000
  473. J. O'Shea, 21 Rosstrevor Crescent, Mitcham, Vic 3132
  474. Miss Ransley (hransley@postoffice.utas.edu.au)
  475. Richard Mills, 10 Duxford Street, Paddington, NSW 2021
  476. Mrs. Betty Byrne, PO Box 495, Burnie 7320
  477. James Cloudsdale, PO Box 346, George Town 7253
  478. Arthur Wherrett, 25 Bay Road, New Town 7008
  479. Angela Legg, 26 Welcome Avenue, Kingston 7050
  480. Professor Jeff Malpas and Prof. Norelle Lickiss, School of Philosophy, Private Bag 41, Hobart 7001
  481. Mina Brock, 769 Kellevie Road, Kellevie 7176 and Peter Mansour, 54 Charles Street, Moonah 7009
  482. Professor Michael Ashby, Repatriation Centre, 1st Floor, Peacock Building, 90 Davey Street, Hobart 7000
  483. M. Hicklen, 750 Sandy Bay Road, Sandy Bay 7005
  484. Eris Smyth, 30 Waterloo Crescent, Battery Point 7004
  485. Peter Donnelly, 10 Lipscombe Avenue, Sandy Bay 7005
  486. Elaine Bushby, 6 Amanda Court, Launceston 7250
  487. Professor Margaret Otlowski, University of Tasmania, Private Bag 89, Hobart 7001
  488. Father Gerald Quinn, Catholic Chaplain, St. Joseph's Church. 65 Harrington Street, Hobart 7000
  489. Mrs. Dorothy Pilgrim, 17 Coleman Street, Moonah 7009
  490. Robert F. Richmond, 13 Saundridge Road, Cressy 7302
  491. Mrs. Nola Graham, 18 Bairnsdale Court, Helensvale Qld. 4212
  492. Australian Medical Association Tasmania, 147 Davey Street, Hobart, 7000
  493. Professor Ray Lowenthal, 22 Liverpool Street, Hobart, 7000
  494. Mr. Nick McKim, MP, Greens Leader, Parliament House, Hobart
  495. Luke Rheinberger, President, The Law Society of Tasmania, GPO Box 1133, Hobart 7001
  496. Reverend Kevin McGovern, Director, Caroline Chisholm Centre for Health Ethics, Suite 47, 141 Grey Street, East Melbourne, Vic 3002
  497. George Cardinal Pell, Chair, Catholic Bishops Commission for Doctrine and Morals, Polding Centre, 133 Liverpool Street, Sydney, N.S.W. 2000
-

498. Ms. Marion Rosten, PO Box 598, Kingston 7051
499. Mr. David C. Samson, 3 Bourbon Avenue, Richmond, 7025
500. Joseph and Anja Barton, Westbury 7303
501. Stuart Nicholls, 68 Nicholls Street, Devonport 7310
502. Patrick Keefe, 23 Yorkshire Court, Pospect Vale 7250
503. **CONFIDENTIAL**
504. **CONFIDENTIAL**
505. Brian Pollard – No address
506. Dr. Paul Dunne, Vice President, Tasmanian Association for Hospice & Palliative Care, PO Box 834, Kingston 7051
507. Rev. D. E. Le Rossignol, 24 Luckman Place, Rokeby 7019
508. Dr. Mary L. Kille, PO Box 582, Wynyard 7325
509. Fr. M. Jackson, Assistant Priest, Glenorchy 7010
510. Michael Green, 67 Fitzroy Crescent, Dynnyrne 7005
511. John Coles, 20 Otago Bay Road, Otago 7017
512. Dr. Keith McArthur, 152 Whitsitt Road, Wynyard 7325 Submitted at Hearings
513. Rene Hidding, MP, 17A Marlborough Street, Longford 7301 Submitted at Hearings
-

**APPENDIX 6****DOCUMENTS RECEIVED**

1. House of Assembly Community Development Committee Report into the Need for Voluntary Euthanasia Legislation 1998.
  2. Submission to the Tasmanian Law Reform Institute – Voluntary Euthanasia Society of Tasmania Inc.
  3. Victorian Parliamentary Research Service briefing paper on the Medical Treatment (Physician Assisted Dying) Bill 2008.
  4. Report of the Senate Standing Committee on Legal and Constitutional Affairs – Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008
  5. Evaluation summary – Termination of Life on Request and Assisted Suicide (Review Procedures) Act.
  6. Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain.
  7. South Australian Voluntary Euthanasia Society – Fact Sheet 21.
  8. Doctors Reform Society Policy on Euthanasia
  9. Position Statement – Voluntary Euthanasia and Assisted Suicide
  10. Extract from The Journal of Clinical Ethics: The 10 Year Experience of Oregon’s Death with Dignity Act: 1998-2007.
  11. Death and the Physician – The intention to hasten death: a survey of attitudes and practices of surgeons in Australia.
  12. RACGP - Advance Care Plans - Guidelines  
<http://www.racgp.org.au/guidelines/advancecareplans>
  13. Medical care of older persons in residential aged care facilities. - 4th edition. The Royal Australian College of General Practitioners  
<http://www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/TheSilverBook/RACGPsilverbook2006.pdf>
  14. NSW Health - End-of-Life Care and Decision-Making - Guidelines  
[http://www.health.nsw.gov.au/policies/gl/2005/pdf/GL2005\\_057.pdf](http://www.health.nsw.gov.au/policies/gl/2005/pdf/GL2005_057.pdf)
-

15. The Royal Australasian College of Physicians, Paediatrics & Child Health Division - Decision-Making at the End of Life in Infants, Children and Adolescents
  16. Australian and New Zealand College of Anaesthetists: Joint Faculty of Intensive Care Medicine: Faculty of Pain Medicine: Statement relating to the relief of pain and suffering and end of life decisions.  
<http://www.anzca.edu.au/resources/professional-documents/professional-standards/ps38.html>
  17. Australian and New Zealand College of Anaesthetists: Faculty of Pain Medicine: Joint Faculty of Intensive Care Medicine: Statement on patients' rights to pain management and associated responsibilities.  
<http://www.anzca.edu.au/resources/professional-documents/professional-standards/ps45.html>
  18. Australian Medical Association: The Role of the Medical Practitioner in End of Life Care - 2007  
<http://www.ama.com.au/node/2803>
  19. Australian Medical Association: The Role of the Medical Practitioner in Advance Care Planning - 2006  
<http://www.ama.com.au/node/2428>
  20. Submission to the Senate Legal and Constitutional Affairs Committee Inquiry into the *Rights of the Terminally Ill (Euthanasia Repeal) Bill 2008*  
[http://www.aph.gov.au/Senate/committee/legcon\\_ctte/terminally\\_ill/submissions/sub375.pdf](http://www.aph.gov.au/Senate/committee/legcon_ctte/terminally_ill/submissions/sub375.pdf)
  21. Emotional and Psychological Effects of Physician-Assisted Suicide and Euthanasia On Participating Physicians by Kenneth R. Stevens, Jr. M.D., FACR – Extract from The Linacre Quarterly – Catholic Medical Association, Vol 73 No. 3 August 2006, pp 203-216
  22. Letter tabled by Ms. Cassy O'Connor, to the Archbishop of Tasmania, dated 22 August, 2009
  23. Interim Policy for Prosecutors in Respect of Cases of Assisted Suicide – issued by the Director of Public Prosecutions – September 2009
  24. Solicitor-General – Correspondence dated 2 September 2009; and 1 October 2009.
-

**APPENDIX 7****WITNESS LIST**

Mr Rene Hidding, MP

The Archbishop of Hobart, Reverend Adrian Doyle

The Vicar General, Father Mark Freeman

Dr Gerry McGushin

Dr Keith McArthur, GP Liaison Officer NWRH

Mr Jim Wallace, National Director, Australian Christian Lobby

Mr Nick Overton, State Director, Australian Christian Lobby

Professor Michael Tate AO

Mr Ray Groom, Chairman, Southern Cross Care (Tas) Inc.

Dr Helen McArdle, Deputy Chair, Southern Cross Care (Tas) Inc.

Ms Carolyn Wallace, State-wide Care Coordinator of Southern Cross Care (Tas) Inc.

The Very Reverend Richard Humphrey representing the Right Reverend John Harrower, Bishop of Tasmania

Ms Debra Cerasa, Chief Executive Officer, Royal College of Nursing Australia

Professor Tracey McDonald

Mr Nick McKim MP

Professor Ray Lowenthal, Australian Medical Association

Dr Chris Middleton, Australian Medical Association

Ms Margaret Sing, Dying with Dignity Tas. Inc.

Mr Mike Harris, Dying with Dignity Tas. Inc.

Dr Heather Dunn, Dying with Dignity Tas. Inc.

Dr Helen Cutts, Dying with Dignity Tas. Inc.

Dr Paul Dunne, Palliative Care Specialist

Ms Lynsey Spaulding, Chair of Neuro Musclar Alliance Tasmania

Ms Heather Francis, Chief Executive Officer, MS Tasmania

Professor Jeff Malpas, Professor of Philosophy University of Tasmania

Associate Professor Nicholas Tonti-Filippini, John Paul II Institute, Victoria

Dr Roger Hunt, Director Western Palliative Care, South Australia

Mr Marshall Perron (Queensland)

Professor Margaret Otlowski, School of Law, University of Tasmania

Mr Luke Rheinberger, President, Law Society of Tasmania

Ms Ruth Henderson, Parliamentary Counsel

Ms Katherine Woodward, Parliamentary Counsel

---

Dr Martin Morrissey, Royal Australian and New Zealand College of Psychiatrists

Dr Joanna Bakas, Royal Australian and New Zealand College of Psychiatrists

Coroner Rodney Chandler - *in camera*

Mr Jim Connolly, Administrator, Magistrates Court - *in camera*

Dr Phillip Nitschke

---

## APPENDIX 8

### DIVISIONS

The following Divisions were recorded in the proceedings of the Committee.

Amendment proposed by Ms *Forrest*, page 41, paragraph 5, by inserting after “question.” the following words “However, as stated in this report, it is unclear whether respondents support the proposed intent of the *Dying with Dignity Bill 2009* which is to facilitate Physician Assisted Suicide (PAS), as well as options including withdrawal of and the right to refuse futile and burdensome medical treatment.”

AYES

Mr *Best*  
Mrs *Butler*  
Mr *Finch*  
Ms *Forrest*  
Mr *Whiteley*

NOES

Mr *Gaffney*  
Ms *O'Connor*

Amendment proposed by Mr *Whiteley*, that the following be a Finding of the Committee

“That the *Dying with Dignity Bill 2009*, the subject of this inquiry, in its current form, does not provide an adequate or concise legislative framework to permit Voluntary Euthanasia/Physician Assisted Suicide.”

AYES

Mr *Best*  
Mrs *Butler*  
Mr *Gaffney*  
Mr *Finch*  
Ms *Forrest*  
Mr *Whiteley*

NOES

Ms *O'Connor*

Amendment proposed by Mr *Whiteley*, that the following be a Finding of the Committee

“A range of evidence was provided for and against Voluntary Euthanasia/Physician Assisted Suicide and there was far less support for the bill from those professionals from the health and aged care sector who presented evidence.”

AYES

Mr *Best*  
Mrs *Butler*  
Mr *Gaffney*  
Mr *Finch*  
Ms *Forrest*  
Mr *Whiteley*

NOES

Ms *O'Connor*

---