

# South Australian Voluntary Euthanasia Society Inc. (SAVES)

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To all members of the South Australian Parliament

## **Parliamentary opposition to Voluntary Euthanasia Legislation in South Australia**

Dear member,

For as long as medical-aid-to-die remains a covert and illegal practice it will return to the parliamentary agenda and the issue must remain under review.

In an enclosure to this letter reasons given in the Legislative Council for opposing the passage of the Anne Levy and Sandra Kanck Bills, in debates between 1996 and 2004, are assigned to ten categories based on what was said or implied. There is some overlap as speakers did not always express themselves precisely and there was a good deal of rhetoric. Brief responses are given in each category. The views of the speakers are reflected in short extracts from Hansard: a copy of these is available on request.

There were sixteen opposing speakers in that period: Zollo, Schaefer, Davis, Griffin, R.R. Roberts, Stephens, Gilfillan, Redford, Evans, Lawson, Lensink; Irwin, Lucas, Cameron, Zenophon and Holloway. Stefani, who consistently voted against the Bills, did not contribute to debate. Of the seventeen, Davis, Griffin, R.R. Roberts, and Irwin did not vote at the last count when the Dignity in Dying Bill was defeated by thirteen votes to eight. Davis, Griffin and Irwin had left parliament, while R.R. Roberts had become President. Kanck, Gazzola, Reynolds, Dawkins, Roberts, Gago, Sneath and Ridgway voted in favour.

I hope the enclosed information will provide a useful reminder of the state of the debate when the issue is next raised in either House.

Yours sincerely

**Frances Coombe**  
**President**

*A summary of objections to voluntary euthanasia legislation raised in the Legislative Council between 1996 and 2004, with brief responses.*

Figures in brackets represent the number of occasions on which each particular objection was raised.

1. **Palliative Care** (12). *The Consent to Medical Treatment and Palliative Care Act is sufficient.*

Voluntary euthanasia is not an alternative to palliative care. It can only be implemented where that alternative is available and has been explored. It is widely acknowledged, including by Palliative Care Australia, that palliative care has limitations and cannot always provide an acceptable quality of life to those who are hopelessly ill, nor relieve their pain or distress.

2. **Vulnerable people**. (11). *People who are elderly, infirm, unproductive, undervalued, may easily be persuaded, either by others or by their own depression, to seek to end their lives because they feel a burden on loved ones, or society.*

The law is designed to ensure that only those whose request is freely made and whose clinical condition is independently confirmed will be helped. The alternative is irrational or bungled suicide.

3. **Safeguards**. (15). *They are easily evaded; people may act in bad faith; errors are possible; if an advance request was made, a last-minute change of mind would not be recorded. Adequate safeguards are impossible.*

No legislation is proof against human error or evasion, but this is no reason for not passing laws. Surveys show that voluntary euthanasia already exists within medical practice. It is dangerous to leave it unregulated: it should be controlled by parliament. Monitoring in places where assisted dying is a legal possibility show that it is working according to its safeguards.

4. **Slippery slope/thin end of the wedge** (8). *An inevitable shift from voluntary to non-voluntary euthanasia; unintended outcomes.*

Such speculation is not well founded. It could only happen if the law was amended reflecting the will of a future society. Otherwise all outcomes will be under parliamentary review and monitored within the medical profession.

5. **“Hopelessly ill”** (13). *The definition is too broad, vague, subjective and puts the mentally impaired at risk. Why not “terminally ill”?*

The term is taken from the medical literature. It expresses the plight of those whose condition has robbed them of a quality of life acceptable to them, with no clinical prospect of remedy. Why should they be required to live on, if they do not wish to? There are two difficulties with the terminally ill. Firstly, doctors cannot readily predict death within a specified time. More seriously, patients suffering unbearably from an incurable condition, for whom death is not imminent, and who are not on life support that could be legally terminated, could be condemned to years of suffering.

6. **The Netherlands experience** (7). *Laws have been broadened and people killed without consent.*

Any widening of the law there has been with parliament's approval. The Netherlands government carefully monitors outcomes and publishes its findings. Most people whose lives were ended without request had in fact made their wishes known although not in the strict form required by law. The Netherlands studies have been replicated in Australia showing that the situation is less satisfactory here. In 30% of deaths where a medical decision was made explicitly to end the patient's life; only 4% were in response to a direct request from the patient. This is five times worse than in the Netherlands.

7. **Medical ethics**. (3). *The doctor's purpose is to save life. The Hippocratic Oath and Declaration of Professional Dedication of Flinders University were quoted..*

Doctors are bound to serve the best interests of their patients. These are not served by preserving, against the patient's will, a life that has become meaningless to the patient, or is overtaken by intolerable suffering or distress, with no prospect of remedy.

**8. Cost-saving (4).** *As it is cheaper to kill than cure; increased health costs and economic rationalism will pressure the health service into unwarranted acceptance of euthanasia requests.*

Unless parliament changed the law it would be against the law. Procedures would be accountable under coronial and parliamentary scrutiny, and monitored by doctors' professional guidelines. Monitoring in places where assisted dying is a legal possibility show that the provision and use of palliative care has correspondingly increased.

**9 Adverse reports by other authorities. (6).** *The following were quoted – New York Task Force on Life and the Law; British House of Lords Select Committee; Tasmanian Community Development Committee; Canadian Senate (?); International Congress on Chemotherapy; South Australian Select Committee; British Medical Association; Australian Medical Association; and World Medical Association.*

These are the opinions of groups not necessarily widely representative and they are not enshrined in law. We are not bound by them and there is no reason why we should not lead the way as we did with votes for women. Surveys have shown that many, perhaps a majority, of doctors are not opposed to law reform, despite the opinions of the medical associations.

**10 Objection in principle (16).** *Those who indicated that their opposition would remain whatever the content of the Bill*

At least ten of the thirteen who voted against the bill at the last count fall into this category. Xenophon held that any voluntary euthanasia legislation must inevitably do more harm than good. Zollo, Redford, Evans, Stephens, Holloway, Lucas, Schaeffer, Gilfillan and Lawson stated or implied a basic religious objection. It is, however, the responsibility of elected representatives to weigh the potential harm and benefit to society of any bill, irrespective of their own personal value systems. Of the other three who voted against the Bill, Stefani did not speak, Cameron denied any religious belief, and Lensink did not indicate an objection in principle.