To the Northern Territory Legislative Assembly

# Petition against proposals to legalise active voluntary euthanasia in the Northern Territory

Organised by the Northern Territory Catholic Medical Association (NT CMA)

Supported by:

- NT CMA members and
- NT residents either fully or partially sharing NT CMA views

As an association of Catholic doctors, nurses and allied health professionals caring for many Territorians, we would like to express our deep concern with potential upcoming legislation proposals to reintroduce active voluntary euthanasia in the Northern Territory.

By active voluntary euthanasia we are referring to the current forms of medical interventions legalised in all other Australian States which allow eligible patients to take their own lives by either being administered or self-administering medically prescribed lethal medications. We will apply this definition to the term “euthanasia” in this document for the sake of simplicity.

Although our views against such practices are rooted in and confirmed by our Catholic faith, they are by no means exclusively religious in nature. Many of the arguments we wish to present can in fact also be agreed upon on the basis of objective medical, ethical, social and religious concerns without imposing any Catholic moral principles on any person wishing to support our cause.

We believe that our arguments may resonate with people of other faiths and creeds as well as with people who do not profess any religion at all.

We also acknowledge that while our individual arguments may resonate with our signatories to different extents, their signatures still testify their ultimate agreement with our definite stance against the legalisation of euthanasia in the NT.

As an association of Catholic doctors, nurses and allied health practitioners working in the NT we are initiating this petition – not limited to association members, but rather also open to all NT residents – because we genuinely believe this form of euthanasia will bring about many profoundly negative consequences for us Territorians on many levels.

Here are our medical, ethical & philosophical, civil & social as well as religious concerns which we would like you to consider.

## Medical Concerns

1. There is emerging evidence that euthanasia is a medically sub-standard approach to managing the suffering of terminal illnesses, with palliative care being able to provide better clinical outcomes

Palliative care treatments have made very significant progress in recent times, and their clinical outcomes have greatly improved. They can be safely started earlier on in the course of terminal disease progression, not only to manage chronic and progressive pain, but also the rarer "refractory pain". The latter is an important achievement because it can assure – through a holistic approach and careful titration of palliative sedation (Palliative Care Victoria, 2015) – a dignified death to all people. The reality is that palliative care can provide the reassurance that no-one will have to experience unbearable and refractory pain any longer. There is also emerging practical evidence from specialists in the field that euthanasia requests are invariably withdrawn once palliative treatments are properly optimized (Haines, 2016).

2. Once introduced, euthanasia may easily be confused with or wrongly equated to palliative sedation.

Palliative sedation is an important approach to the treatment of refractory pain. However, it vastly differs from active euthanasia. Firstly, there is evidence that it does not hasten death (Maltoni, 2009) (Valeo, February 2010). Secondly, its purpose is not to cause death, but rather provide effective relief of intractable pain with the least possible reduction of consciousness by careful titration of sedative medications (Palliative Care Victoria, 2015).

3. Gradual erosion of patients' trust in healthcare professionals, particularly Aboriginal patients who already often lack trust in the healthcare system.

This point has already been tested and verified as true when euthanasia was legal in the Northern Territory (John J Collins, 1997) (Care for Life, n.d.).

4. Gradual erosion of NT healthcare professionals' vocational sense of purpose and role.

We acknowledge that Australian healthcare professionals have differing opinions on euthanasia, especially when it comes to borderline or extreme clinical dilemmas. However, a law potentially impacting the lives of so many people should not be based on very few borderline clinical cases.

We are deeply concerned that if euthanasia is introduced as one of many other medically allowed interventions, there could be a dangerous shift in the sense of professional role and purpose of many current and future healthcare workers: from "life-savers" to "on-demand death-givers" (Euthanasia Prevention Coalition, 2014).

5. Gradual erosion of NT healthcare professionals' conscientious objection rights as well as undue coercion to violate professional oaths

Many health workers based in the NT have made oaths, at the time they obtained their primary medical qualifications, to safeguard life until its natural end. This firm stance against euthanasia has also been recently acknowledged at a global level by the World Medical Association in 2019 (World Medical Association, 2019). A law that requires any degree of cooperation with active euthanasia by health workers – including a potential referral duty in case of conscientious objection – would be a grave violation of the ideals and beliefs that have drawn many people to dedicate themselves to health professions in the first place.

6. The administration of lethal medications for the purpose of active euthanasia can itself result in potential clinical issues such as patients' inability to self-administer the drug/s, re-

awakening and even failure to complete resulting in further distress (Groenewoud, 2000) (Assisted suicide, euthanasia and the dying with dignity bill 2020, 2020).

# Ethical & Philosophical Concerns

7. Acknowledging a right to active euthanasia teaches individuals a false concept of unlimited autonomy.

This falsehood is easily unmasked by the reality that many important events in our lives – such as our births – are not under our own autonomous control. Although we might like to increase our level of personal control, we simply do not have a natural right to control everything that happens in our lives. Personal autonomy is an important principle not only inscribed in our Western culture, but also in Catholicism and other religions. However, it is not absolute one, but rather it is mitigated by mutual respect for others, collective interests and other societal principles. Australian "mateship" is certainly one example in our culture (Affairs, 2020).

8. Active euthanasia actually restricts patient autonomy, while it is a health professional's duty to preserve it.

By accepting that individual autonomy is not an absolute and unrestrained right then it is not difficult to understand that committing suicide – even in a medicalised fashion – is an abuse of individual autonomy as this choice prematurely deprives people reliant on us of our presence with no regard to the pain it may cause them.

Moreover, we know that the outcomes of choices that a person makes by virtue of exercising autonomy do feed back onto his or her own degree of autonomy: either to enhance it or limit it further. This is because choices are never morally neutral, and wrong choices are often easily recognizable by their restrictive consequences on personal freedom.

Because of this, our society accepts the idea of limiting the personal autonomy of some people for their own best interest and out of a duty of care to one another. An important example are our laws that currently allow health professionals to not only detain mentally ill, but also mentally disturbed patients in hospital for involuntary treatment if they are deemed a risk to themselves or others (Northern Territory Government Department of Health, 2006)

It should be noted that the "mentally disturbed" category does not necessarily include people suffering from an actual mental health condition that deprives them of their capacity to exert their autonomy. Instead, we accept that some people may fit into this category if they exercise or threaten to exercise their personal autonomy in such irrational way that would cause them or other an unacceptable level of disproportionate ham.

Based on these considerations we believe that euthanasia is – among all the choices with negative outcomes on one's future degree of autonomy – the most radical: by definition, death irreversibly and fully destroys a person's autonomy once and for all. By not wanting to experience any suffering whatsoever one chooses the disproportionate negative outcome to give up his or her own autonomy for good.

If we already have autonomy-limiting laws granting health workers special powers to prevent people from committing suicide on their own – such as mandatory hospital admissions and treatments – why should we then cross this point of no return and allow medically-assisted suicide?

If, as a society, we restrict the autonomy of suicidal people because we recognize the intrinsic value of their lives when they cannot recognize it themselves – regardless of how "useful" or socially disenfranchised they may be – why then, should we not step in and apply the same principles to people requesting medically assisted suicide?

Would it not then be a health professional's ethical duty to protect the patient's autonomy and reject euthanasia?

# Civil & Social Concerns

9. Active euthanasia will damage the social structure of our society by establishing a "slippery slope" that will eventually confer individuals an automatic right to dispose of their own lives when suffering crosses an arbitrary threshold of "quality of life".

Suffering unfortunately is part of life. The desire to alleviate it is one of the chief reasons why most of us health workers have been drawn to the medical profession. The practical reality experienced by all people is that life entails suffering, to some extent or another. Rejecting suffering also means rejecting life, and this is what euthanasia has to offer: rejecting life so as to eliminate a level of suffering that has exceeded some arbitrary threshold of "quality of life". However, it is obvious that we could not function as a society in which we rely on one another if people acquired an automatic right to suicide whenever their suffering exceeded some arbitrary threshold, leading to a "slippery slope" effect. The reality and magnitude of this danger have now been internationally confirmed and demonstrated with unequivocal evidence from Belgium and the Netherlands (Lerner, 2015) (Mildred, 2018). Clinical practice evidence from these countries with long-established euthanasia laws has shown a relentlessly progressive broadening of access to active euthanasia: starting from an initial handful of extreme/borderline cases to then including people with mental illness (based on a false principle of non-discrimination), those affected by impaired cognition and even minors and children.

10. Active euthanasia poses a risk of normalization of suicide in the community

It is well known that any form of suicide is linked with the Werther effect of suicide contagion (Niederkrotenthaler, 2007). This is particularly concerning when considering how strongly active euthanasia would clash against the current Northern Territory suicide prevention initiatives (NT Health, 2020).

11. Active euthanasia can be highly disrespectful to a patient's own family and the society and culture he or she lives in. It can also be an unduly ideologically-loaded act.

As human beings we are born at a particular time, in a particular family and place. Our lives then become integrated within a community, a Territory, a nation and so forth. We are nurtured and become who we are thanks to our social and cultural background. Suicide – in a violent form – and euthanasia – in a medicalized form – can both be offensive acts from social and cultural points of view: they can be tinged with more or less explicit contempt not only toward suffering itself, but also toward a person's family, social and cultural backgrounds. Indeed, there is emerging evidence from Switzerland that euthanasia deaths are linked to post-traumatic stress disorders in family members and friends (Wagner, 2012). Choosing to die "on our own terms" through euthanasia therefore can even become an ideologically-loaded act, misleading the public into believing that suicide is not a form of abuse of individual autonomy.

12. The significant potential of occult coercion into opting for euthanasia by vulnerable patients and those already experiencing social stressors

This point has been acknowledged in Australia. The state of Victoria included a provision in its euthanasia legislation whereby there has to be at least an attempt by medical assessors to exclude patient coercion when deciding on euthanasia eligibility (Parliamentary Library & Information Service , 2017). It is obvious that either medically or socially vulnerable patients, like the elderly, may feel considerable occult pressure to "not be a burden" to their families and thus choose euthanasia (Public Health Division, Center for Health Statistics, 2018) (Washington State Department of Health - Disease Control and Health Statistics Division, 2018). These pressures may still go undetected even after appropriate medical assessments with emerging evidence of the same in New South Wales (Care Alliance, n.d.).

13. Even after excluding "external" coercive factors, mental illness or other medically explicable impairments of autonomy, it would not be sensible for an individual to make a decision about ending his or her own life while living in a state of demoralization

The distortive influence of demoralization on decision-making has been extensively discussed by Dr David Kissane, who specifically reviewed the medical records of patients who elected to be euthanized in the Northern Territory over the period of time when euthanasia was legal in the NT (Kissane, 2002). What emerges from his review – along with the common sense that people tend to acquire through life experience – is that sound major life decisions cannot be made when feeling demoralized. Because many people with terminal illnesses can live in a state of chronic demoralization – even if not clinically depressed – a potentially distorted decision-making loophole may be created, effectively leading a person to a decision that he or she would not have otherwise made.

14. The political risk or occult convenience of promoting euthanasia as a cheaper, or "more sustainable" strategy to manage end-of life care as opposed to palliative care.

Unfortunately, from a merely cynical and financial perspective, the convenience of euthanasia for the NT is obvious. This is even clearer when considering the already limited access to quality nursing home and palliative care throughout the Territory (Carey, 2001) and the highly vulnerable Aboriginal population with its high burden of chronic illness and social disadvantage (Roberts, 2020) (SBS News, 2019).

# Religious Concerns

15. Euthanasia fails to truly address deep-seated existential issues that inevitably emerge in patients who are approaching death

Regardless of a person's creed, all patients approaching death grapple with existential questions about reconciling the meaning of their lives and the pressing question about whether there will be anything after death, leading to further spiritual questions and, potentially, spiritual issues. If these issues are not adequately addressed, often by making contact with a chaplain or the relevant spiritual leader, they exacerbate suffering and lead to an undignified death. Moreover, for those who believe in the afterlife, there may be potential permanent consequences affecting an individual for eternity. After all, no one can demonstrate the existence of the afterlife, but nobody can disprove it either. What may be at stake could be invaluable for an individual, and this needs to be acknowledged and respected. It should also be noted that people without religious convictions do occasionally experience

religious conversions if adequately accompanied through their spiritual needs during their dying, resulting in greater peace, dignity and wellbeing. Euthanasia offers a "quick" escape from all these issues but does not address the underlying problems because it fails to acknowledge the transcendent nature of human beings.

16. Euthanasia clashes against the religious moral principles and beliefs of patients who identify as faithful to any of the three main monotheistic world religions: Christianity, Judaism and Islam.

This has been publicly stated and agreed upon by all the major representatives of these major religions at a meeting on the issue of euthanasia which took place in Vatican City in 2019 (Twomey, 2020). This should be carefully considered in terms of community support when introducing a law to allow euthanasia: as shown the 2021 census, 40.5% of the NT population identifies as Christian, plus 1.4% identifying as Muslim (Australian Bureau of Statistics, 2022). This is a non-neglectable minority of Territorians whose religious belief would clash against euthanasia.

17. For Catholics, Christians, and people of other religions, euthanasia fails to acknowledge that suffering at the end of life can not only become a valuable but also a "redemptive" experience leading into a life of eternal joy.

As Catholics – and more widely as believers of Christianity – we do not seek suffering, but we try and live through suffering as a form of love for God and others. We offer our suffering firstly to the God who created us, because He became human and suffered himself a tremendously painful death to grant us an eternal life of joy with Him after death. Therefore, aware of not being the owners of our own lives, we have further confirmation from our faith that we do not have a right of disposal over life, regardless of our sufferings. Therefore, do not take for granted the idea that suffering is meaningless for most people. It is certainly not the case for Catholics and Christians, and this may also apply to people of other faiths and none!

With these concerns, as health professionals and people living in the NT with a right to voice our opinions, we strongly recommend that no laws allowing euthanasia be approved in the Northern Territory.

Instead, we do ask for greater investments for adequate access to quality nursing home, respite and palliative care for the greater good of our community.

Yours, respectfully,

[List of signatories]

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