



# VOLUNTARY EUTHANASIA SOCIETY OF NEW SOUTH WALES

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## NEWSLETTER

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## Vale Norma Hall

The legal minefield which faces doctors if their patients choose to die became front page news after VES member

Norma Hall killed herself in January. Before her death, this brave, articulate cancer-stricken woman spoke about her decision to avoid a slow, painful death on the ABC's *7.30 Report*. VE advocates, including VES Patron Dr Peter Baume, supported her wish for a comfortable



*Norma Hall*

death. After her appearance on television and her subsequent death, most of the intense media coverage was positive, apart from the predictable opposition from the religious groups and some palliative care advocates. Dr Robert Marr, spokesman for the Coalition of Organisations for Voluntary Euthanasia, said 'We can relieve a lot of stress and suffering of a dying patient. Modern palliative care cannot relieve all suffering. It simply cannot'.

Her advocate, **Dr Philip Nitschke**, issued this statement on 23 January.

Norma Hall, 72 years of age, from Sydney attended a clinic run by the Voluntary Euthanasia Research Foundation

early in 2000. She explained that if her cancer should ever develop to such a point that her quality of life was such that death was preferable, she wanted to be able to end life at the time of her choosing. She was anxious not to break the law. In December she asked me to travel to Sydney so that I might be with her while she went down this path. She rejected the treatment options proposed by her oncologist and remained under the care of her palliative care doctors. I was not her treating doctor and did not prescribe for her.

She elected to end her life by refusing fluids. After several days she left a note saying that this process was too slow and voluntarily consumed all her prescribed analgesic drugs and died.

At all times Norma Hall was lucid, coherent and acted lawfully. No one advised, counselled or assisted her suicide. Her decision to exercise her right to end her life by refusing fluids illustrates why Australian needs good voluntary euthanasia legislation. Norma Hall would readily have qualified to use the NT 'Rights of the Terminally Ill' Act if that had been left in place by the Australian Federal government.

Throughout this period, my role was one of

patient advocate, and I sought at all times to explain the options that were presented her. I intend to cooperate with the police, and will readily give a statement if and when this becomes necessary 9

As a result of her death, the *Daily Telegraph* reported on 26 January that the NSW Greens had vowed to push ahead with a voluntary euthanasia bill when the State Parliament resumed on 27 February. Greens Upper House MP Ian Cohen said that terminally ill patients would continue to suffer unless the laws were reformed. 'For too long, terminally ill patients have had to endure unnecessary pain and suffering', he said. 'Mrs Hall's case shows the debate is far from over. People in her situation should be allowed to die peacefully'.

*Editor's Note:* We will keep you informed of developments. In February, Ian Cohen and Philip Nitschke spoke before a very large and enthusiastic audience at Tweed Heads. The meeting was arranged by the Gold Coast of the VES and received wide and positive media cover.

## Perth Murder Charges Revived

The July 2000 issue of the Newsletter reported the arrest and murder charges against Perth surgeon, **Daryl Stephens** and the patient's sister (**Ms Vinson**) and brother (**Mr Hayes**). Unfortunately, despite a magistrate ruling in November that there was insufficient evidence to go to trial over the death of Stephens' terminally-ill cancer patient, prosecutors have revived the charges. *The West Australian* (12 January) reported that WA's Director of Public

Prosecutions, Robert Cock QC, has reinstated the wilful murder charge and the indictment will include an alternative charge of aiding a suicide. Wilful murder carries a mandatory life sentence with a maximum of 15 years. Aiding a suicide has a maximum of life imprisonment but a lesser sentence can be imposed. Dr Stephens, Mr Hayes and Ms Vinson will make their first Supreme Court appearance in February or March.

## Advance planning

Mrs Norma Hall's decision to elect to die rather than face a life of pain and without quality is to be admired. There are countless numbers of senior citizens confined to nursing homes suffering from dementia, incontinence, and other degenerative ailments awaiting the blessing of death to release them from their despair.

I would strongly recommend that everyone prepare an advance directive and appoint an enduring guardian so that he/she has the authority to liaise with a doctor in the preparation of a health care management plan when quality of life is lost.

Such a plan may provide that you not be subjected to any medical intervention or treatment aimed at prolonging or sustaining life, and that any distressing symptoms (including any caused by lack of food or fluid) are fully controlled by appropriate analgesic or other treatment, even though that treatment may shorten life

I, like the majority of citizens, fear degeneration far more than I fear death, so for those wishing to avoid distress to family and prolonged confinement in a nursing home, I strongly recommend that they take the action as outlined above while they are still of sound mind.

**Bill Alcock,**  
Port Macquarie, January 23.

*Sydney Morning Herald*

## Dying With Dignity Guidelines

In February VES NSW mailed out a package containing news about two exciting developments: members were sent the Dying with Dignity guidelines issued by the NSW Department of Health and urged to let the Department know our views.

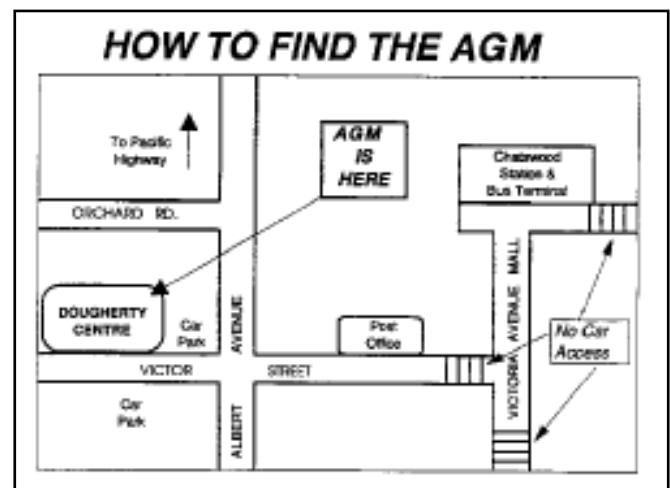
## Professor Goodwin Lecture

An invitation was also issued for members and friends to attend a Parliament House meeting on 28 February in which US Professor Peter Goodwin discussed the Oregon experience with legalised physician-assisted death. **Note:** Reports of Professor Goodwin's Melbourne meeting and a report of the third year's experience of the Oregon Death with Dignity Act are published on page 8.

# FOR YOUR DIARY

## Meetings

- **Professor Malcolm Fisher, Head of the Intensive Care Unit at Royal North Shore Hospital, will be our speaker at the Annual General Meeting which will be at the Dougherty Centre, 7 Victor Street, Chatswood at 2 pm on Sunday 25 March 2001. Professor Fisher will speak about Conflicts at the End of Life.**
- **Oncologist Dr Fran Boyle will be our speaker at the informal meeting on Sunday 22 July - her topic is When is terminal, terminal?**
- **Dr Helga Kuhse will speak about Legislation and the Situation in Belgium at the Sunday 18 November meeting.**
- **Central Coast - The three 2001 meetings of the Central Coast branch of VESNSW will be held on Mondays at 10 am. The dates: 2 April, 6 August and 3 December at the Gosford Senior Citizens Centre, Albany Street Gosford. Contact: John Doyle on (02) 4384 6676. If you would like a lift to these meetings, ring Debbie Mastin on 4975 2732 and she may be able to help.**



# Aged Care in Australia and Overseas

An abridged version of Dr Michael Fine's 19 November 2000 talk to the VES meeting.



*Dr Michael Fine*

I have been associated with the NSW Association of Gerontology for many years and at one stage I asked Dorothy Simons to speak to the Association about end-of-life decisions. There are links between euthanasia and aged care but sometimes there is confusion, some of which is genuine

misunderstanding but some is due to deliberate misrepresentation by media and by church groups who like to make out that aged care is an alternative to euthanasia.

There is a fear that aged care is a cost which our society can't bear and some people say the answer to that is euthanasia. That, too, is deliberately exploited by groups such as religious conservatives. I will briefly look at the history of aged care in Australia, and then consider some of the existing aged care provisions and compare them with overseas services. What seems to be most characteristic of the Australian system is that a large number of nursing homes are in private hands and many other residential care facilities are run on a voluntary basis with a very strong clerical domination. The large number of funding problems make the system confusing and difficult. Nevertheless, the system in Australia has a number of good points and is not dependent on government's whim. I am going to suggest the value of an alternative approach to funding aged care in Australia, based on social insurance which is very much like that used in the Netherlands, Japan, Germany and Israel.

We can think of care as an expression of social support. As children we are dependent on nurturing and as adults, we are also interdependent and all aspects of our being are social aspects. In our basic needs for food, housing, income and so forth, we depend on others - we have a pattern of social

interdependency. Care is an extreme expression of social support. We think of caring **for** somebody - doing those tasks that they would normally do for themselves but are unable to accomplish for some reason. For example, a person may be unable to cook for themselves, so part of the tasks might involve cooking for that person. Someone who is disabled might not be able to dress or shower themselves without assistance. Showering them or providing food, is considered to be care. There is also an element of emotion in caring - caring **about** someone and ideally these two together. But if that is not possible real problems start to arise. When we talk about aged care, you almost think that there was a peculiar set of services which were unique to older people. It really is a range of services for those, who as a result of disability or chronic illness, need support and it is provided to people of all ages on the basis of some objectively defined need. These services are called aged care services because there is an increased incidence of need for assistance with age. As we age, the incidence of disability and disability increases, so that our likelihood of needing services are much higher at the age of 95 than they are at the age of 25. They are also much higher at 95 than they are at 65 or 75. In the history of aged-care services we see a process by which aged care has become differentiated from health care services and from the model of welfare/relief services which were the work houses and the indoor relief services of the 19th century and the early part of the 20th century. In current-day Australia and many other countries, we can see three broad stages:

The first stage was a shift away from 'indoor relief', a euphemism for the work house - such as the Lidcombe Old Man's Home - for people who were old, could no longer work and didn't have money to support themselves, or families to look after them. The biggest and most successful revolution in welfare in Australia was the introduction of the aged pension, first in NSW in 1900 and throughout Australia in 1908, fifty years ahead of most European countries. Britain didn't get the aged pension till the 1930s, Holland in the 1950s. Giving this income to people, gave some alternative to indoor relief but until the

1950s you either got cared for at home by your family, or in hospital if they couldn't look after you. People with bad rheumatism, stroke, all sorts of conditions, would be in the hospital wards long-term.

After the 1950s we started to see the development of more high-tech forms of health care. As they started to remove long-term chronically ill patients and began using hospitals for more acute care, a set of health care facilities started to develop. Some were private nursing homes and convalescent homes - some were run by churches and by the 1960s there was such cry for such services in all parts of Australia that the Commonwealth government decided that they needed to provide funds. This funding continued until about 1983 and that was really what aged care was - nursing homes which were a sort of secondary hospitals. Although they looked like hospitals they seldom were as good, but they certainly smelt and were staffed like hospitals.

Australian communities, underestimating difficulties, often just start services for community shopping, community transport and day care. Countries such as Japan and Holland are really worried about how they run day care centres, how many doctors you will need per resident and how many physiotherapists; the service is good but incredibly slow. Here we think of a day care centre as something which gets people out of their homes for a while; most are run by volunteers with a nurse in attendance. The people who attend seldom have the benefits of physiotherapy but they have the benefits of social activity and they are very cheap to run. It helps build up the 'social capital' of Australian communities through that sense of belonging and people doing something for others.

From 1996, however, we saw a different emphasis. Over a ten year period the nursing home lobby had found themselves increasingly excluded from determining policy. Now, instead of getting their way on everything, they had to meet representatives of consumer groups, the AMA, the Nurses' Association, states and commonwealth governments and they didn't automatically get their way any more. So they started to court the Liberal and Coalition Government or parties and, when the Coalition came to power in 1996 they brought with it a raft of promises to the nursing home industry.

Prominent in this was Doug Moran, who gave over \$1 million to the Liberal Party's 1996 election campaign. So aged care once again started to mean residential care in nursing homes and the first thing the Government tried to do was to show that the cost of the aging population was absolutely horrific and they did this in the Commission of Audit which was introduced in 1996 by the Treasurer, Peter Costello. It was largely constructed of two things:

One was a short-term one - that year of the budget deficit but the longer-term one was a huge black hole, this Commission uncovered, so they said, based on the fact of an ageing population, that was going to cost us far more than we could ever afford and we needed to take very drastic action to stop these costs escalating. The result of all of this in the short-term was the introduction of nursing home entry payments, a changed system of administering nursing homes. Then community care became more or less forgotten for a couple of years. There was a huge political outcry when people realised they would have to sell their own house to make these payments. We have seen a rejigging of that, with an attempt by the government to redefine aged care as being nursing home care and, rather positively, they have taken up the development of Community Aged Care Packages (a part of the Home and Community Care programme), which was initiated in the early 1990s.

The Home and Community Care Programme is an incredibly diverse, very promising programme which includes such assistance as home help, personal care, home maintenance, food services, respite care, transport, community nursing, assessment, and the co-ordination of information. These services get government funding of about \$700 million a year - less than one third of the money that is given for private health insurance rebate - it is a great bargain and every community has them. However, it is still built on traditional services, most of which are very specialised and fragmented. Home help comes from one organisation, home nursing from a second, meals on wheels from a third and transport is from a fourth organisation.

Community Aged Care Packages (CACPs) sit somewhere between home and community care and residential care and are a very interesting philosophical development. Nursing homes provide



both the accommodation and nursing care. What about a person who is living in their own house and just wants the services? From the early 90s there were a series of experiments to get hostel providers to start to provide these services at home, so they put together a package of services, it was costed at the same amount as in a hostel and delivered to a person in their own home. This was a huge success. The government had been trying to expand hostel facilities, but it had really not been as successful as it should have been, although they doubled or trebled the amount of money put into it, it still hadn't reached \$100 million in hostels because property speculation in the 1980s meant that the groups' contributions towards building hostels were suddenly worth nothing. This suddenly provided a way in to expand the CACP services.

We are now seeing a new development, to provide nursing home care services in the home - called EACH packages: Extended Aged Care in the Home. Now the current government is trying to say that we are not really interested in hostels and nursing homes - we believe that people should be able to 'age in place', so instead of moving you around whenever you need care, what we do is leave you in the same place and change the care mix for you, which is a good philosophy. If you were in a hostel and needed much more care, you should be able to stay there so this 'ageing in place' philosophy suddenly made hostels and nursing homes one system instead of two separate systems. The problem is of course, government planning. All of a sudden we have doubled the number of nursing home beds that should be available - how many hostel beds are going to be left after this, especially with private sector interests involved that get paid more for a nursing home level care patient than they do for a lower level care.

Strangely, for the government, this 'ageing in place' philosophy did lead to a very big blowout in the budget - it is one of the little known facts of the current budgets that we have seen. Instead of there being a cut in government expenditure in aged care, once they had to make the adjustment to abolish the entry payments in 1997, because of this mechanism where the hostel beds started to be funded at the level of nursing home beds, what we saw was the commonwealth government's commitment to aged

care funding actually double. It has gone from around \$2 billion to about \$4 billion a year. No-one seems to see that as a problem, in fact we have just heard what a wonderful set of budget figures we have and what a good manager the government is.

At the moment you will often hear of these schemes and they actually rate people when they go in - they rate them at a level of dependency one to eight. One is the highest need, eight is the lowest and that person gets funding attached to them according to their assessed level of care need.

There are some good stories here and the first is that you can care for people who need on-going assistance at home. Not only have we shown that it is possible in a sort of scientific way, but it has been done and has become a mass programme. Between 1988 and 1998, the number of people with profound or severe handicaps aged over 65, or the proportion of people with profound handicaps who live at home, has actually gone up more than 5%. In 1988, already 80% of people with profound or severe handicaps who were aged lived at home, and by the year 1989 it was 85%. So we see that these policies have had an effect.

I have gone through the different types of care available. The system is somewhat confusing for Australians and I think this disguises from us the degree of success we now have. It is by no means a perfect system but all around the world aged care is a difficult issue - no country has a perfect system and, compared for the amount of money that we put into it, we have a very efficient and reasonably equitable system despite the changes introduced since 1996. There are, however, problems which are very much to do with it being a mixed system. It is a small component of service actually delivered directly by government, a large component of residential care is delivered by private providers many of which are of course like in any other business, always trying to increase their profit, and there are different ways to do that.

The other major providers of residential aged care tend to be church-based organisations. They have a fairly good record in providing good quality care, but there are issues sometimes of access for people who don't belong to a particular community. For example, one area in which this is very clearly expressed at the moment is a group of people who are

expressing great dissatisfaction, are gay couples. What do you do when you are gay? Which sort of homes can you go? You can forget the church-run homes.

All over the world, we are facing an aging population. This is something to really rejoice about and I do think this an achievement of contemporary society. This has been humanity's age-long dream to be able to grow old and have a meaningful life in old age and we now are beginning to see this internationally. Let's look at some comparisons of Australia, Japan, UK, US, the Netherlands and Sweden. Australia has the smallest aged population of all these countries. Japan had a population younger than ours, largely because they used to have very large families and people would die early, but now their life expectancy is the highest in the world and their families are very small it is very unusual to find Japanese families with more than two children, most have only one, so that has meant that the proportion of people aged over 65 has been

escalating. It overtook us in Australia in 1990. Japan's aged population is about 17% of the population and by 2020 it will be over 25%.

We have about 12.6% of the population aged over 65 who no longer work. We start considering how we are going to pay for aged care. Sweden, the UK, the Netherlands and Japan manage it without going bankrupt. Each of these countries has planned to make changes in how they are going to do it, but Australia has already made those adjustments and we are heralded as the country to follow. The World Bank has written reports comparing the way in which our pension operates and our health care system and said that this is the way it should be done.

When we start to look at factors that do drive costs, aging hardly rates. I will just read through the

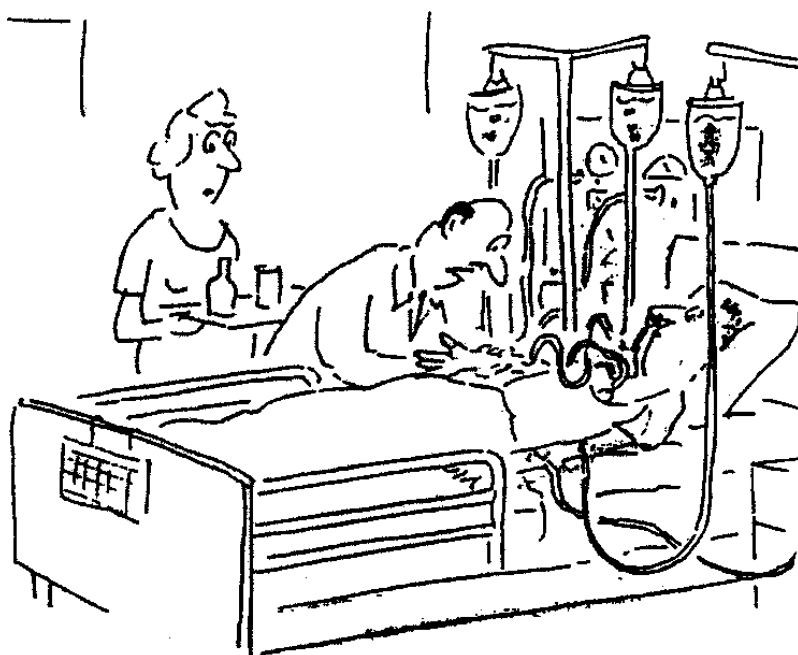
percentage of Gross Domestic Product (GDP) spent on health care in various countries. In 1999 the percentage of GDP spent on health care spent in Australia was 8.6% In Japan it was 7.2% in and in the Netherlands 8.8%; Sweden 7.2%, with a much older population than we have, spent less of their GDP on health care than we do; the UK 6.9%, the US 14.2%. That has since gone over 15%, so it is not the aging of the population which drives health care costs, it is the way in which the health care system is organised. In the US it is organised for profit so you can have wonderful health care if you can pay for it and also encourages people to use additional services who might not need them. The comparable systems

in the UK or Sweden are very socially oriented and try to ensure that everybody has access to good health care, but try to minimise the amounts that people use. Australia is much closer to those countries.

What is most interesting about the services in those countries is that although we differ a little bit in our emphasis in each country,

broadly we have got about the same sort of mix in every country that I can speak of, including the US, although this is the one that has least followed this path. We have seen a move away from reliance on nursing home care towards increased used of community care. This is the case in Australia, Japan, the Netherlands, Sweden and the UK. There are differences in the provision of these services - in Sweden and the Netherlands they are providing around 20 hours per month for every person aged over 65 in community care and we are providing about eleven.

One of the issues I think we need to pay most attention to is developing a viable funding scheme so that we don't just have this sort of whim of the government making choices about whether we are



"Good heavens! Who hooked you up? This one is Cable TV"

shifting towards more community care or abolishing our entitlements to equitable nursing home access or whatever. There are different projects around the world for looking at various alternatives of costing, whereby most users of aged care (apart from the US) pay a small component of the cost. The other options are private insurance, government funding through general revenue or a social insurance scheme.

Private insurance assistance schemes advocated very strongly in the US and the UK have been total failures. It has been proposed here and a government enquiry is looking at it right now. Private insurance doesn't really work because any insurance has to limit the risks - people won't pay huge premiums, and insurance companies try to limit the benefits they allow. People in the US start paying huge insurance contributions when they are about 60 find that the insurance won't cover nursing home fees and they have to sell their house to enter a home. Private long term care insurance is taken up by less than 5% of the population in the US and it is a constant source of trouble for those who have it.

The second option is to do as we are now doing: some contribution by users themselves, but largely by government. That's the way they operate the system in Sweden, Britain, France and in many other countries. But the difficulty is that it depends on the state of the budget. If the national government

budget deteriorates, they are going to want to cut costs as we have seen in 1996/97 in Australia.

The third option is the very interesting social insurance model. It was first developed in the Netherlands in 1968 when they introduced a system of funding by which every person who worked or drew an income contributed to this insurance. This was a means-tested entitlement, but everybody was entitled to have access to long term care - including mental health care - in nursing homes or the community. Initially people contributed only 1% of their income but this rose to 4%. If you are a Dutch citizen, you pay a national levy and you get access to all aged care services. It is a fantastic system. They now have social health insurance schemes in Germany, Israel and Japan. Japan's was introduced in April 2000. An interesting a very popular feature of it and that is you don't pay for this insurance until you are 45, so young people don't pay for it. Once you are 45 you do pay for it. You don't pay for it from your own account like you would for superannuation.

Adopting such a system in this country would really give us reason to celebrate in the centenary of Federation. Building on the basis of what we already have, making the system high quality and affordable to government and citizens would be a signal that we are truly beginning to come of age as a society.

## Appeal to Rethink Euthanasia

A report of Professor Goodwin's address, arranged by VES Victoria, was published in *Melbourne's Age* on 22 February.

'In the mid-1970s Peter Goodwin witnessed the deaths of two men in their homes after many years battling prostate cancer. It was that experience, long before the popularisation of euthanasia as an issue, that swayed the veteran American doctor's opinion on whether people should have a say on how and when they die. "They were incredibly moving experiences and seeing how the men's families came together and supported each other over their deaths contrasted greatly with the less intimate way I saw

many of my patients die in hospital," he said.

Since then Dr Goodwin has been at the forefront of the push to ensure his home state of Oregon became the leader on euthanasia issues. Oregon became the first American state to legislate for physician-assisted suicide under the Death With Dignity Act seven years ago. Dr Goodwin spoke to a meeting arranged by the Voluntary Euthanasia Society at the Alfred Hospital last night where he urged Australians to revisit the issue and not dismiss it as a "dangerous initiative".

Three million citizens in the small north-west state of Oregon passed a euthanasia referendum in



1994. Dr Goodwin said the movement was a community-driven phenomenon and had succeeded despite a well-funded campaign opposing the law by religious groups. Fifteen people used the law to end their lives in 1998 and 27 in 1999 and 2000. He urged the Australian community and governments not to put the issue in the “too-hard basket” as Oregon was an example of how well-considered legislation could work. “When I started I was on the fringe, but I am not in that position now and everything that has happened has reaffirmed my faith in this process,” he said. “It will always be opposed, but that is good, it should be opposed to ensure it maintains the most rigorous standards, it should not become a slippery slope,” he said.

The Oregon system has many safeguards. Only people with a terminal illness with less than six months to live are prescribed the lethal, quick-acting sedatives; there is a waiting period of 15 days; and the process must be documented, including a written request from the patient which says they understand their disease and prognosis. “They want autonomy at this time, to be allowed to die at home with the comfort and support of their families,” Dr Goodwin said’.

## Oregon’s 27 assisted deaths in 2000

The Oregon Department of Human Services issued the following Press Release on 22 February:

“Twenty-seven patients used legal physician-assisted suicide in 2000, the same number who did so in 1999, according to a report by public health officials at the Oregon Department of Human Services. “The number of deaths remained small in relation to 29,365 annual Oregon deaths,” says Katrina Hedberg, MD, deputy state epidemiologist with the Oregon Health Division.

“Physicians who were interviewed reported that, as in past years, patients had several reasons for requesting lethal medication,” Hedberg says. “These include concerns about losing autonomy, losing control of bodily functions, physical suffering, and decreasing ability to participate in activities that make life enjoyable. This year, physicians reported increasing patient concerns about being a burden on

friends, family and caregivers.”

Health Division epidemiologists identified patients who received prescriptions for lethal medications through required physician reporting and collected additional information using physician interviews and death certificates. Report findings include:

- In 2000, 39 prescriptions were written for lethal doses of medication and 27 patients died after using this medication. Of these patients, 26 obtained their prescription in 2000 and one in 1999.
- Eight of the year 2000 prescription recipients died of their underlying illness and five were alive at the end of 2000.
- The median age of the 27 patients who took the lethal medications in 2000 was 69 years. Twelve were male, and 26 were white. Eighteen were married. 13 were college graduates with eight of those having advanced graduate degrees.
- 21 patients had end-stage cancer. All patients had health insurance and 23 were in hospice before death.
- One physician was reported to the Oregon Board of Medical Examiners for submitting a written consent form with only one signature, although other witnesses were also present.
- One patient regurgitated some of the medication, but nonetheless became unconscious within one minute and died within seven minutes.

No other complications were reported.

The Health Division is legally required to collect information on compliance with the Death with Dignity Act and to make that information available on a yearly basis. “Our role is a neutral one. In releasing the information for 2000, we recognize that it is critical to have accurate information on the Act so that informed ethical, legal, and medical decisions can be made”, Hedberg says’.

*Editor’s Note:* The fact that in its three years of operation so few people have taken advantage of Oregon’s Death With Dignity Act shows that, despite the critics’ dire warnings, there has not been the expected avalanche of physician-assisted suicides. In the next issue of the Newsletter we will print a copy of the speech Professor Goodwin gave to the meeting VESNSW arranged at Parliament House on 28 February.

# Lessons From History

‘As I chose the ship in which I sail and the house which I inhabit, so will I choose the death by which I leave life’

Seneca (4 BC - 65 AD).

*Editor’s Note:* Unfortunately, this Roman statesman and philosopher met an untimely death: he was forced to commit suicide after the Emperor Nero ordered him to end his life. Roman methods of suicide, such as cutting wrists, taking hemlock or falling on your sword, are not recommended.

VE supporters often quote the following but few know who wrote these lines:

‘Thou shalt not kill;  
But need’st not strive  
Officiously to keep alive’

They come from ‘The Latest Decalogue’, written by an English poet, Arthur Hugh Clough.

*Editor’s Note:* Clough (pronounced ‘cluff’), the son of an aristocratic but twice bankrupt cotton merchant, was a brilliant student who became the favourite of Rugby headmaster Dr Matthew Arnold. Clough went to Oxford intending to become a clergyman but left the university because of his increasing religious doubts. Radical in politics as well as religion he went to France in support of the revolution of 1848 and to Italy the following year to participate in Mazzini’s republic and helped his wife’s cousin, Florence Nightingale in her work for hospital and nursing reforms. In 1861 he died of malaria

in Italy at the age of only 42. His widow published his poems which were extremely popular.

Steve Weaver PhD observed that Clough’s well-known couplet ‘offered a cogent, if ironic, distinction between killing and not prolonging dying. It is a compelling axiom that is in direct line with Catholic doctrine and seems to have been taken on board by the medical profession even though it is in direct contrast to the ... [vows of] the Hippocratic Oath. On the issue of euthanasia, the Greek was unequivocal against any such course of action. “I will give no deadly medicine to anyone if asked, nor suggest any such counsel”.

The maxim served physicians for two and a half thousand years, until 1947 when the World Medical Association (WMA) was formed and rephrased the Hippocratic Oath into the Declaration of Geneva from which the no-deadly medicine quote was omitted’.

The modern Oath was adopted by the WMA in 1948, amended at its meeting in Sydney in 1968 and again in Venice in 1983. The British Medical Association updated it in 1997 to put the patient first with such statements as: ‘I recognise the special value of human life but I also know that the prolongation of human life is not the only aim of healthcare’. Copies of the original and revised Oath are at: <http://www.bma.org.uk>

## Correction

On page 6 of Issue 92 of the Newsletter the *Editor’s Note* should read: ‘A show of hands showed that the majority did favour such a trial’.

# Historic VE Vote in Holland

On 11 December 2000, *Time* magazine devoted a page to the historic decision by the lower house of the Dutch parliament to legalize the practice of euthanasia. They reported it from the perspective of Dr Henk Maarten Laane of Amsterdam who 'has exercised his talents not to prolong life, but to hasten death. He prefers to call it "mercy dying", not mercy killing, and he doesn't like it. This is his response to the overwhelming vote: 'Worldwide there are always doctors helping their patients to die. The importance now is to show the

world that it can be done in a legal way, in a good way, open and controlled'. The new law, which still has to be approved by the upper house, sets forth rules that will make a long-tolerated Dutch practice legal. It allows a doctor to help end the life of a patient suffering unbearable pain from an incurable condition. The patient would have to request assisted suicide rather than simply concurring with a physician's suggestion, and a second examining physician would have to agree. Polls show that 92% of Dutch support euthanasia.

*Editor's Note:* Predictably, the Roman Catholic Church condemned the Dutch decision as 'an affront to human dignity'. The *Sydney Morning Herald* reported on 29 November that Vatican spokesman Joaquin Navarro Valls said the bill, which was adopted by a vote of 104 to 40, 'violates the dignity of human being and goes against the natural law of individual conscience'. Here is the worldwide overview of euthanasia which *Time* published to accompany their December article:

## Northern Territory

**The Law:** In July 1996 this Australian state became the first place in the world to legalise voluntary euthanasia and physician-assisted suicide. The Rights of the Terminally Ill Act allowed a mentally competent, fatally-ill patient to seek a medical practitioner's assistance to end their life.

**The Practice:** The Act was repealed by federal legislation in March 1997. Four people took their lives lawfully under the Act. Bob Dent, 66, who suffered from prostate cancer, became the first person in the world to die legally assisted.

## Switzerland

**The Law:** Euthanasia is illegal. If a person helps another commit suicide without selfish motives, however, the deed is not punishable in the courts. EXIT, the Society for Humane Dying, has been aiding people who want to die in accordance with the law and the group's own preconditions.

**Practice:** Around 100-120 terminally-ill patients die each year with the assistance of EXIT members.

## Colombia

**The Law:** In 1997 Colombia's Constitutional Court reaffirmed an earlier ruling that doctors would not be held criminally responsible if they followed a terminally-ill patient's request for euthanasia.

**Practice:** No legislation has followed up the court ruling. There are no reliable figures for assisted suicide in this strongly Catholic country.

## Oregon

**The Law:** In 1997 the US Supreme Court ruled that physician-assisted suicide is not unconstitutional. So far, 43 states have deemed it unlawful and six have no laws or vague ones. Only Oregon has legalized euthanasia. Its 1997 Death with Dignity Act stipulated that patients must be terminally-ill and administer the lethal dose themselves.

**Practice:** Last year 27 people took their lives complying with the law.

# A Bequest - Our Turn To Say 'Thank You'



VESNSW has received a generous bequest from a former member, **Mr Keith Earl Thomas (1924-2000)**. We are extremely grateful to him and have published an advertisement in *the Manly Daily* to honour his memory. Naturally we respect the wishes of our benefactors and only publish such details if asked to do so. When you think about Advance Directives and the appointment of an Enduring Guardian, please also think of the VES. Such bequests ensure that we will be able to continue fighting the good fight to make voluntary euthanasia a reality. A bequest form is below.

**Keith Thomas** left school at 14 and was largely self-educated. He served in the Australian Navy during World War II as a Coder and then joined the Department of Construction for the rest of his working life and served in Indonesia when the Australian Embassy was being built. His partner, Mildred Cannon describes him as a handsome, generous man whose special interests were nature, history and reading - 'he'd worn a path to the local library in Manly', she said. They had both meant to join the VES but the springboard for doing so was Keith's letter in favour of VE which appeared in the local newspaper. Sadly, Keith died unexpectedly after surgery. His generous decision to leave a bequest to the VES helps the Society to fund vital work and ensures that his memory lives on.

## BEQUEST

For inclusion in, or as a codicil to, a Will

I unconditionally give the Voluntary Euthanasia Society of New South Wales ('The Society')\*

\_\_\_\_\_

\_\_\_\_\_

and I declare that the receipt of the Treasurer or other properly authorised officer of the Society shall be a sufficient discharge to my executor.

I agree to the Society using a small part of this bequest for an advertisement in a metropolitan newspaper to encourage membership in the Society.

The advertisement would be headed

'In the name of the late (full name) \_\_\_\_\_',

\_\_\_\_\_

**Or**

Please do not my name in the advertisement.

\* Please specify the 'gift'

### VOLUNTARY EUTHANASIA SOCIETY OF NEW SOUTH WALES

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### SUBSCRIPTIONS AND BEQUESTS INFORMATION

Membership subscriptions to VES NSW are \$19 single and \$33 for a couple. Concession rates of \$13 single and \$23 for a couple are available for pensioners and students. Life membership costs \$220 single and \$330 for a couple.

Many loyal friends have found that a bequest is one way they can make a significant gift to further our Society's efforts to change the law and to educate the community. A bequest form is included in this issue.