VOLUNTARY EUTHANASIA SOCIETY
OF NEW SOUTH WALES (INC.)
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NEWSLETTER

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Contents

The Netherlands Legalises Euthanasia

Source: BBC, 1 January 2002

Lethal injection will end suffering for the terminally-ill. The Netherlands has become the first country in the world to legalise euthanasia, giving terminally-ill patients the right to end their lives.* The new law means that doctors no longer face prosecution for carrying out mercy killings if they are performed with due care.

Strict conditions apply, with regional review committees made up of legal, medical, and ethical experts carefully judging each patient's request. A second medical opinion will be needed, and the suffering of the patient must be deemed to be unbearable. Only where there is doubt will the case be referred to the public prosecutor. The upper house of the Dutch parliament approved the legislation last April and it came into force on 1 January 2002. Euthanasia has been tolerated for decades in the Netherlands.

The BBC's reporter in The Hague, says the case inflamed public debate over whether a person who is not physically ill should have the right to die. Many feel the guidelines for euthanasia are too strict and that some patients are denied a humane death when their requests for assisted suicide are turned down. The debate is now moving a step further, deciding whether elderly people should be prescribed a suicide pill when they feel the time is right.

* *Editor's Note*: People keep forgetting that in 1996 Australia was the first country to legalize VE with its short-lived *Rights of the Terminally-Ill Act*. Now that the Dutch have their ground-breaking VE law, as Deborah Annetts the Director of Britain's VES, wrote on the front page of *The Times*: 'A psychological barrier has been broken with the legislation of voluntary euthanasia ... now the question must be asked "why can't other countries do the same?"'

Dutch Poll Shows Half in Favour of VE Pill

Source: The Hemlock Society's *Timelines*, Fall 2001.

Almost 50% of respondents in a Dutch opinion poll were in favour of providing a lethal pill to old people who no longer want to live, according to the Dutch television news program *Netwerk*. Many of the 46% who opposed such a pill were aged 60 and older.

A large majority of respondents - 82% - felt that lethal pills should not be made available to anyone who wanted them. The lethal drug has been nicknamed 'Drion's pill' after the former Supreme Court president who lobbied for such a pill in 1992. Dutch Health Minister Els Borst opened a fresh debate on the pill in April 2001 when he voiced his opinion that a lethal pill should be provided to the elderly who have had enough of living. Amidst the public outrage, Prime Minister Wim Kok then said that the idea should not even be discussed.

Belgians follow Dutch by Legalising Euthanasia

Source: The Age 27 October 2001 by Andrew Osburn reprinted from *The Guardian*

Belgium became the second country in the world to approve a law legalising euthanasia last night. The move will give fresh impetus to campaigns for legal mercy killing elsewhere in Europe - especially in Britain, France and Italy, where significant movements are pressing for it. Belgium's upper house, the senate, passed the legislation by 44 to 23 votes, with two abstentions and two senators who failed to vote. It was clear that there was support among all six parties in the ruling coalition of Socialists, Liberals and Greens. Most people were behind the change which has raised strong passions in this predominantly Roman Catholic country. An opinion survey in April showed that three-quarters of those asked were broadly in favour of legalising euthanasia.

Before the vote a spokesman for the senate said that while there would be 'some dissenters', he was confident that the bill would pass. The ballot was a free one, with the 71 senators following the dictates of conscience. The new law must still be approved by the chamber of deputies, but that is also seen as a formality. The vote is expected before the year's end. Belgian proponents were helped by the Dutch decision to legalise euthanasia earlier last year. Marcel Colla, a former health minister, hailed the change as 'a sign of a society which is becoming more mature'. But Christian groups are strongly against the move, saying that life is sacred and that doctors who aid euthanasia are playing God. 'The text goes too far,' said Senator Clothilde Nyssens whose Christian Democrat party has staunchly opposed legalisation. 'We know lots of doctors who don't like this law, who are afraid it gives them too much freedom.'

The legislation lays out the terms for doctors to end the lives of terminally-ill patients - though, with doctors operating an informal system of euthanasia to some extent, no immediate or radical changes are expected in the way they function in Belgium. Patients must be at least 18 years old and must have made specific, voluntary and repeated requests that their lives be ended. They must put this in writing. Requests will be approved only if the patient is terminally-ill, in constant suffering and of sound mind. At least one month must elapse between the written request, which can be made by a nominated adult if the patient is incapable of writing, and the mercy killing. Controversially, there is also provision for patients who are not in the final phases of a terminal illness to opt for euthanasia. In such a case, the person's doctor must get a second opinion. Sometimes this could be from a psychiatrist, in others from a specialist in the disease.

Is It Really Living?

Two Letters in the *Sydney Morning Herald*

Dr K B Orr wrote on 31 December:

I refer to your article 'Surgery prolongs life for cancer patients' (*Herald*, 26 December), claiming that when a patient is treated for a widespread, incurable cancer of the kidney, surgical resection followed by chemotherapy increases lifespan from eight to 11 months.

But what of the 'quality of life' with a major surgical procedure followed by weeks of toxic drugs? Should not the patient be better off with symptomatic palliative care and TLC, accepting the shorter but more comfortable time in the hands of friends and family? Nasty, painful and toxic treatment may be acceptable if there is a chance of cure - but just to gain a few weeks or even months?

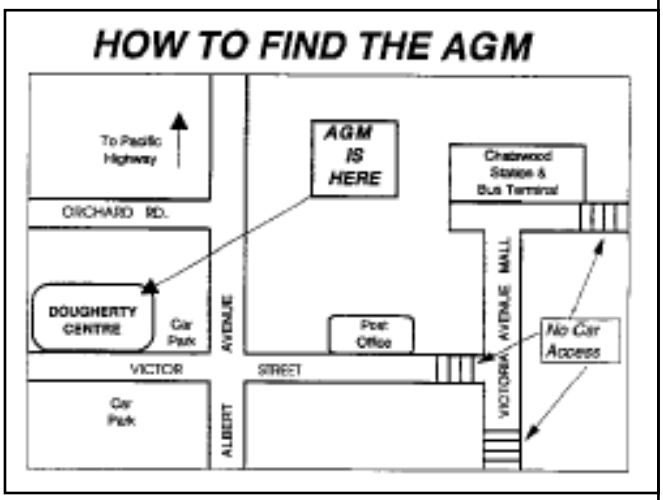
John H Fysh (A VES member) responded on 1 January:

Dr K B Orr quite rightly questions the value of surgery that prolongs life for a period of 'nasty, painful and toxic treatment'. He suggests substituting palliative care and TLC for the surgery.

Although fortunately recovered, having endured complications following major surgery and taken a step or two in the direction of the other side, I could not contemplate a life extending to the end of the road in that condition. While surgery can, in the end, provide a better quality of life, society has yet to confront the alternative when it doesn't. When patients decide not to continue, the processes need to be place, with all the safe-guards, to meet their wishes. I'll go further. When patients are led deliberately to a life of misery and distress, however pain-free, it should be a case of grievous bodily and mental harm before the courts. Otherwise, there might be a higher court to which to answer. That is the dilemma that faces some members of the Catholic Church.

FOR YOUR DIARY

Meetings



- **Kep Enderby,** who was the Attorney General in the Whitlam government, will be our speaker at the Annual General Meeting which will be held at 2 pm on Sunday 24 March 2002 at the **Dougherty Centre Chatswood.** He will speak about **Suicide and the Law** - Is being present when someone commits suicide a human right or aiding and abetting?

- **Central Coast** - Meetings of the Central Coast branch of VESNSW for 2002 will be held on **Mondays at 10 am** at the **Gosford Senior Citizens Centre, Albany Street Gosford.** The dates are: **8 April, 5 August and 2 December. Contact: John Doyle on (02) 4384 6676.** If you would like a lift to the August and December meetings, ring **Debbie Mastin** on **4975 2732** and she may be able to help.

- **14th World Congress** of the World Right to Die Societies 5-8 September in Brussels. Email: euthanasie@nvve.nl

The Slippery Slope

An abridged version of talk given by Associate Professor Helga Kuhse at the VES Meeting on 18 November 2001

A-Prof Helga Kuhse

I first gave this paper at a World Federation of Right to Die Societies meeting last year and because the statistics make it rather dry I am using slides. These figures are important in my argument about the slippery slope - the idea that we shouldn't bring in voluntary euthanasia (VE) because once we do, we will all go down the slippery slope where first the ill, infirm and incompetent and finally everyone will be killed against our will - non-voluntary euthanasia. Similar exaggerations are often used by people who do not want to rely on purely religious or moral arguments. They say - 'Of course, there may be nothing wrong with VE if a terminally-ill patient asks for it, if the patient is suffering badly and if there is a doctor willing to do it, but of course, we can't have it because there would be a bad outcome - harm to others'. They are invoking the Harm Principle which the philosopher, John Stuart Mill included in his 1859 *Essays on Liberty*: this principle lays down that the only defensible reason for preventing people doing with their lives as they wish is if their acts cause harm to others. They say, you can't have VE because if it became public policy and the law there would be the chance of other people being killed against their wishes or without their consent.

This is not a moral argument in the narrow sense in the way it is if you say, aiding somebody's death or killing them is morally wrong because my God says so; rather, it is an empirical argument - about facts - if we bring in VE more people will die without their consent than would if we did not bring in VE. They say the current state of affairs may not be ideal because terminally-ill patients can't do with their lives as they wish, but this is better than it would be if we had VE because then people would lose their lives without their consent. To the extent that this is an empirical argument, it can be looked at quite rationally. The available literature and research at the moment shows that slippery slope argument is quite clearly wrong.

I will look at four studies; two from the Netherlands, one from Australia and a more recent one from Belgium where people looked at the way in which, and how, people died with or without their consent and by what means. These four studies are comparable; they are essentially using the same, or very similar, research methodology, questions and questionnaire layout. These studies, done over a number of years, shed light on the slippery slope argument which is so effectively blocking VE here. If you look at the Senate Committee report which followed the Andrews Bill that helped to bring down the Northern Territory legislation you find even the clergy put forward the slippery slope argument - 'we can't have it - because it will be bad for society as a whole'.

Belgium has recently passed a euthanasia law. They looked at the findings that I will be referring to and it was one reason why they allowed the legislation to pass the Senate and why everybody now believes the passage through the House of Representatives will be a 'rubber stamp'. It is supposed to pass before the end of this year which will make Belgium the third country in the world to have voluntary euthanasia. In Australia, on the other hand, studies which I undertook with my colleague Peter Singer in Melbourne and VESNSW Patron Peter Baume, were ignored by the federal committee which was intent on passing these laws which threatened the 1996 NT *Rights of the Terminally Act* which allowed both VE and medically-assisted suicide. Four patients died under the provisions of the Act which was overruled by the Kevin Andrews legislation in March 1997. Our studies were published in January that year.

I want to challenge this slippery slope argument on two grounds: firstly, there is a workable distinction between VE and other medical end-of-life decisions and secondly, because a public policy approach which

prohibits VE will actually lead to a reduction or fewer pure cases of non-voluntary euthanasia than the proper legislation and administration of VE laws. I am considering competent terminally-ill patients and make no distinction between VE and medically-assisted suicide. When we talk about VE, the doctor gives a lethal injection to a patient after the competent request of that patient. But that is not the only way in which a doctor can bring about or accelerate the death of the patient. Rather than give the lethal injection of say potassium chloride, a doctor can withhold or withdraw treatment and as the foreseen consequence, the patient will die sooner than he or she otherwise would. The doctor can also administer potentially life-shortening pain- and symptom-control - palliative care, and again, as a foreseen consequence, the patient will die sooner than he or she otherwise would.

All these actions or omissions that medical professionals can engage in, are called medical end-of-life decisions and will foreseeably lead to an earlier death of the patient than would otherwise have been the case. Euthanasia is a life-shortening act and I am referring to euthanasia as the giving of a lethal injection which is prohibited. But not all life-shortening medical end-of-life decisions are prohibited, because, with the patient's consent, doctors may withhold or withdraw life-sustaining treatment. They can also, with the patient's consent, administer pain- and symptom-control which can lead to death under the doctrine of double effect because it is said that the intent is to ease the patient's pain or other symptoms and, whilst the patient dies, it was not directly intended and therefore is not euthanasia.

The Netherlands have allowed doctors for two decades to aid a patient's death by VE, medically assisted suicide and in any other way that has been worked out in the doctor/patient relationship. In response to wide criticism, in the early 1970s, the Dutch government commissioned the 'Remmelink Commission'. It was a huge, nation-wide enquiry into medical end-of-life decisions which aimed to find out how patients actually die as a consequence of actions or omissions. This study, 'Euthanasia and other end-of-life decisions', was published in the *Lancet* in 1991. In Australia and elsewhere in the world it had a huge impact and people drew many conclusions from it. In particular, that study found that in the Netherlands in 1990-1991, 0.8% of all deaths, that is of all the people who had died over a 12 month period, 0.8% of them had died as a consequence of non-voluntary euthanasia - they had been given a lethal injection without their consent. This is what doctors recorded in the survey. It was anonymous and there was going to be no prosecution following their honesty in the survey and we can trust the figures.

Many of you will remember statements that came from many people in the anti-VE movement - one of them is Dr Brian Pollard in NSW and another is Ian Flemming from Adelaide who said in 1991 that the Dutch evidence provided conclusive evidence of the slippery slope. He said '0.8% of all deaths occurred as a consequence of non-voluntary euthanasia: now you know what you get when you bring in VE - thousands of Australians will also die as a consequence of non-voluntary euthanasia'.

But the question is, can you actually establish the existence of a slippery slope because 0.8% of all Dutch people died from non-voluntary euthanasia in 1991. Of course you cannot. A single set of figures, taken at one point in time, cannot establish a slippery slope. You need at least two points - Point A and Point B to establish a slippery slope - a survey of this kind before the Dutch allowed VE and one afterwards and then you could have said - 'Ah, they had zero non-voluntary euthanasia in say 1970 and now they have done it for 10 years or so and look what it has led to - 0.8%'. But you cannot do that: speaking of a slippery slope in the light of one study is wrong.

In 1996, the Dutch decided to repeat their study to find out whether there was a slippery slope. In the repeat survey five years later they used same methodology and published their results in 1996 in the *New England Journal of Medicine*. As they compared how people died in 1991 and how they died in 1995-1996, - lo and behold, if we understand euthanasia simply as the administration of a lethal injection, we find that in 1991, there were 1.9% of VE deaths and in 1996 there were 2.6%, so there was an increase in VE, but this is not what this slippery slope argument is about of course. The slippery slope argument is about **non-voluntary euthanasia.** When we compare those two figures, 0.8% of all deaths were non-voluntary euthanasia in 1991 and in 1996,

there was no sign of an increase. So, again, no evidence of a slippery slope from VE to non- voluntary euthanasia in the Netherlands in those five years.

The interesting question was of course, how would Australia compare with the Netherlands if we repeated the study? As I said before, together with Peter Singer and Peter Baume and a couple of others, including a statistician from Melbourne, we got a research grant and repeated the 1996 Dutch study in Australia. We got their form, their survey instrument, the Dutch translated it for us, we had it checked in Canada by a Dutch speaker and an English speaker and we came up with an English translation which we administered in Australia. Now, it is interesting to compare the two countries because Australia and the Netherlands have a similar population size, both have a more or less universal health care scheme and the main difference between the two seems to be that the Netherlands allows and Australia prohibits VE.

We found in our 1997 Australian study that there were 1.9% cases of VE in Australia versus 2.6% in the Netherlands, but when we looked at non-voluntary euthanasia, the crucial figure, we found that the overall figure for Australia is 3.5% versus 0.7% - five times higher than in the Netherlands. That was quite significant. Again, a colleague from the University in Brussels thought it would be wonderful to find out how the Belgian people would fare; more than half the Belgians speak a similar language - there are similar cultural traditions - how would these figures pan out if the study were repeated in Belgium? The resulting study was published in November 2000 in the*Lancet* and, comparing the Netherlands with Belgium, we again found that the rate of VE in Belgium is lower than in the Netherlands, but that the rate of non-voluntary euthanasia is much higher there again - 3.2% versus the Dutch of 0.7%. Now when we put all three countries together in terms of their non-voluntary euthanasia figures, we have:

> 0.7% in the Netherlands 3.5% in Australia and 3.3% in Belgium.

So again, no evidence of a slippery slope. But, of course, not everybody understands euthanasia so narrowly as a doctor giving a lethal injection - if you look for example at the Mexican's *Declaration on Euthanasia*, you find that the Catholic Church and other moralists have defined euthanasia as 'an action or an omission which of itself or by intention, causes death'. So, you don't have to have a syringe with a lethal drug that you inject into a patient before you have committed euthanasia in the traditional and wider sense. Rather, you can commit euthanasia either by not doing something provided that the intention of not doing something is that the patient dies. Or you can do it by using a drug that is used in palliative care and using a sufficient dose and intending to do so, which hastens the patient's death. And this is not just the traditional, moral definition of euthanasia, it is also in the NSW*Crimes Act* which says, that murder shall be taken to have been committed where the act of the accused or omitted by him, causing the death charge, was done or omitted with reckless indifference to human life or with intent to kill.

The definition of euthanasia, in terms of just a doctor giving a lethal injection of a non-therapeutic drug, is too narrow. All the people who have argued about euthanasia have always considered the action in terms of what the doctor's intention is. So that raises an interesting question because doctors have various ways in which death can be brought about sooner than it would occur otherwise: for example; non-treatment; not putting a patient on a certain treatment; or taking her or him off; or administering palliative care in doses sufficient to shorten life. It would be interesting to find out what doctors actually intend when they withhold treatment or administer palliative care, and there is only one way of finding out - by asking them. The Dutch were the first people to ask them. And we asked the same questions in the Australian and in the Belgian study. Here is what the Dutch study found: out of all the deaths that took place in the Netherlands in 1996, we know already that 3.3% died as a consequence of doctors administering a lethal drug. This was 2.6% VE and almost 7% non-voluntary euthanasia. So 3.3% of all the deaths were caused by a doctor administering a lethal non-therapeutic drug. But 13.2% of doctors also said that they withheld or withdrew treatment with the intention of accelerating the patient's death or allowing the patient to die. And they also said that they administered palliative care with the explicit or partial intention of accelerating the patient's death.

So, with the traditional definition of euthanasia, the

rate in the Netherlands would have been 19.5% of all deaths. In other words, 19.5% of all Dutch deaths that year occurred as a consequence of a doctor acting, or omitting to act, with the intention that the patient should die sooner than he or she otherwise would. That is a lot of euthanasia you may think. Now, what are the Australian doctors' intentions? There we find, if we add together VE and non-voluntary euthanasia, we get a higher figure - 5.3% non-treatment decisions made by a staggering 24.7% of doctors with the explicit intention of bringing about death. The figure of the three countries are:

> 19.5% for the Netherlands; 36.5% in Australia and 19.5% again in Belgium on a broader definition of euthanasia.

This leads me to conclude that medical end-of-life decisions are 'malleable and constructible', terms coined by John Bridges, an American lawyer who is working in the Netherlands. Having such decisions

"Please turn off any electronic devices and refrain from using your cell phone as we pass through the darkness and into the light."

means that when you practise as a medical professional, you can practise euthanasia in various ways. If you don't like to act against the law and administer lethal drugs, you might achieve the same result by not providing life-sustaining treatment for the patient or by increasing the palliative care you are administering - and you achieve the same result.

The crucial question for the slippery slope argument is not how many doctors do or do not practise VE but, rather, how many of them practise euthanasia with or without the patient's consent because that is what the slippery slope argument asserts - it says that VE will lead to non-voluntary euthanasia. Now, on the narrow definition of euthanasia, the figures demonstrate no evidence of an increase. How does it look if we understand euthanasia in this wider sense, as any action or omission undertaken with the intention of hastening death? In the Netherlands we have figures where doctors have acted without consent and here I am referring back to the 1991 study because I couldn't get the figures out of the 1996 published data. Here we have 0.8% ie euthanasia in the narrow sense - non-treatment 5.5% and palliative care 2.8% with a total of 8.3% of all deaths in the Netherlands which were non-voluntary euthanasia using this wider definition.

If we turn to Australia, we find a much higher figure: we find that 28.4% of all deaths were brought about by an action of the doctor without the patient's consent; in Belgium it was 18.7% of all deaths - less than in Australia, but more than in the Netherlands and, if we put all three together, these are the figures for euthanasia in the wider non-voluntary euthanasia sense:

> 8.3% in the Netherlands, 28.4% in Australia and 18.7% in Belgium.

This leads me to the fourth conclusion that non-voluntary euthanasia in the wider sense is higher in the two countries namely Australia and Belgium, where euthanasia is not allowed, than in the country where it is allowed - the Netherlands. So, again, there is no evidence of a slippery slope. On the contrary, you might say, if there is a slippery slope, this evidence at least suggests that it might slope the other way. One might ask, why is there less consent in countries where euthanasia is not allowed? I should also say that the fact that an action is done without the patient's explicit consent does not of itself show that this action was morally wrong. In all three countries, patients were often drugged to death. Unable to be consulted, many had indicated previously, but not explicitly, that they wanted to be allowed help to die. Nonetheless, in some cases patients could have been asked but were not asked.

Why? One plausible explanation is that in a country where VE is not allowed, doctors might get into a lot of strife if they discussed these methods with their patients because once they have raised the matter and the patient dies, they may face serious charges. If doctors do not raise the matter but act in a way, as they

see it, as being in the patient's best interest, then they act without the patient's consent. That would be one explanation, that when you can openly discuss VE without fear of being legally persecuted, then you may do so, whereas in Australia and Belgium doctors can't do that, and as well, there are cultural and other differences could also be a reason. The mere fact of prohibition is a factor that encourages non-voluntary euthanasia is a hypothesis at this stage, but I think a plausible one. I also say that a law that prohibits VE is not a very workable law because of the constructability and malleability of medical end-of-life decisions: you can prohibit doctors from practising euthanasia in the narrower sense of giving people a lethal injection at their request, but you cannot stop them from practising euthanasia in some other way, namely by non-treatment and palliative care decisions, because many types of end-of-life decisions are allowed in these circumstances and doctors will implement them if they are seen as being in the patient's best interest.

There has also been an argument by some other people in the field such as Dr Roger Hunt that the prohibition of VE which focuses on the doctor's intention, not on what the patient wants, is totally the wrong thing. Why should one actually focus on what a doctor intends to do rather than on the outcome that he or she knows comes from this decision: a dead patient? And if there is a dead patient, aren't the patient's wishes and the fact that the patient will die, much more important than the mental state of the doctor? What matters is that the doctor knows what will happen as a consequence of what he does and if he intends to kill the pain and kills me in the process, I would be very angry if I hadn't been asked about it. I think it is wrong to focus on the doctor's intention rather than on the patient who is crucial. It is also wrong from a legislative or public policy perspective, because you can't enforce the prohibition of euthanasia. People using the slippery slope argument also say 'don't bring in euthanasia because it will cause a worse state of care'. Now, all available evidence so far, shows that of the slippery slope argument is not working in the way people suggest, but rather that it is working the other way - recognition of the practise of VE will reduce non-voluntary euthanasia.

So for all these reasons, I think the slippery slope argument is an extremely bad one, and one we should oppose and demand evidence to show its existence and some is available. Belgium will bring in euthanasia legislation [this] year and they now have data from before the legislation was brought in and the researchers who devised this first Belgian study, have already a research grant to do a study in 2003 or 2004. So they will find out whether there are any changes in the data that comes out of Belgium before VE was allowed and after it was regulated and that will be very interesting indeed. I didn't argue for voluntary euthanasia, I didn't give you the traditional argument which I could have done if I wanted to, rather it was about empirical evidence which does not support the slippery slope argument that we hear all the time whenever we listen to someone arguing against VE.

Questions and Answers:

Q: What does the Right to Life say about such arguments?

A: They say the figures don't tally and that it is not surprising that the Australia figures came out this way because three supporters of VE did the study. We should have had Margaret Tighe on our study as well and had I foreseen this outcome, we would have, but Peter Singer, Peter Baume and I did it so the Right to Life came up with peripheral arguments - some said the 'books were cooked'. But not everybody is saying that. And they argue that the translation of the questionnaire is incorrect. They are not tackling the issue head on and they are still asserting the slippery slope argument. This is not a convincing argument because the differences in our three studies could be cultural. I cannot show that it is merely a consequence of there being these differences, because one country allows and one country doesn't allow, but it points in this direction especially now that we have got these three different countries involved.

Q: Have the Right to Life ever been asked if they would they like to do studies to prove that the slippery slope exists?

A: That would be nice, but I think they haven't done one and I don't think they have any interest in doing one.

Dead, Death, Dying - By Any Other Name

Absence of vital signs, accidental death, act of dying, Angel of Death, asleep in Jesus, assisted suicide, at the Pearly Gates, awake to life immortal;

Be no more, bereft of life, the beyond, beyond mortal ken, beyond the grave, beyond the veil, the big sleep, biological death, bitten the dust, blessed relief, brain dead, breath one's last;

Called to God, carked it, casualty, catch one's death, clinical death, cold fingers of death, collateral damage, come to an untimely end, commit suicide, conk out, croak, crossing the bar, crossing the Lethe, crossing the River Jordan, crossing the Styx, curtains;

Dance of death, dead, dead and buried, dead and gone, dead as a dodo, dead on arrival (DOA), dear departed, death by misadventure, death with dignity, deceased, defunct, depart this life, departed, die by one's own hand, die in harness, die untimely, die young, die well, died on the job, done for, done in, drown;

Easy death, end, end of life, end one's life, entered into life, eternal rest, ethnic cleansing, euthanasia, execution, exit, expiry, extinct;

Face the firing squad, fall asleep, fall off the perch, fallen, fatality, the final thrill, friendly fire;

Genocide, get cut down, give up the ghost, glorious dead, go belly up, go the way of all flesh, go to Davy Jone's locker, gone, gone before, gone but not forgotten, gone to glory, gone to God, gone to join one's ancestors, gone to the happy hunting ground, the great adventure, the Great Leveller, the great divide, the Grim Reaper, gunned down;

Hand of death, hang, happy release, history;

In Abraham's bosom, in God's hands, in the hereafter;

Jaws of death, join the choir invisible;

Kaput, kick the bucket, kill oneself, killed, King of Death, knocking on Heaven's door, known only unto God;

The **L**ast debt, the Last Summons, the long sleep, the late-lamented, launched into eternity, legalized killing, lifeless, loss of life, the loved one;

Made the supreme sacrifice, meet a sticky end, meet one's Maker, MIA (missing in action), Mors;

Natural death, no sign of life, no longer in the land of the living, no longer with us, numbered with the dead;

Old-age death, one's number being up, the other side, out of one's misery;

Passed away, passed over, passing, pay the debt of nature, peg out, pop off, pushing up daisies;

Quiet end;

Reached the bourne from which no traveller returns, release, rest, road fatality;

Sainted, sands of time ran out, sent to his or her account, shadow of death, six feet under, shuffled off this mortal coil, slip away, snuff out the candle, a statistic, stiff, stillbirth, stone dead, sudden death, suicide, supreme sacrifice, surrender one's life, swan song;

Taken by God, terminal, Thanatos, the Thief in the Night, turn to dust, turn up one's toes;

Ultimate sacrifice, unexpected loss of life, unknown warrior, untimely end;

Violent death, voluntary euthanasia;

Walk the plank, watery grave, welcome end;

X-person;

Yesterday's person;

Zombie.

Lords Dismiss Die Appeal

Source: Reuters, 2 November, London

In a ruling that could lead to a change in Britain's ban on euthanasia, the House of Lords agreed to hear a terminally-ill woman's appeal to allow her husband to help her commit suicide. Diane Pretty, 42, who has motor neurone disease, wants her husband, Brian, shielded from prosecution if he helps her kill herself. Currently, if her husband of 25 years were to help her commit suicide, he could face up to 14 years' jail.

Two weeks ago, the High Court dismissed Mrs Pretty's case and denied her permission to appeal against the ruling except to the House of Lords, Britain's highest court. The decision in the landmark case appeared to have underscored a long-standing legal block on euthanasia, but three senior law lords today granted Mrs Pretty permission to challenge it. "We are conscious of the fact it raises issues with which the courts in this country have not had a previous occasion to deal,'' Lord Bingham said. Mrs Pretty's case is expected to be heard in the Lords in the next two weeks as a matter of urgency because of her deteriorating condition. The Prettys' claim the refusal to allow the assisted suicide infringes their human rights by subjecting Diane to degrading treatment and by failing to respect her private life. The argument was rejected in the earlier hearing by High Court judge Lord Justice Tuckey, who said the law gave greater priority to the right of life than the right of a person to do what they liked with their own body. In today's hearing, Jonathan Perry, for the director of public prosecutions, said there was no power to grant immunity for someone wishing to commit an act which would be a crime, nor could he give an undertaking that the director would be unlikely to prosecute if an assisted suicide was carried out.

Editor's Note: Her case was dismissed but Diane Pretty intends to take her fight to the European Court of Human Rights in Strasbourg.

Pain-Killers 'Hasten' Deaths

Source: West Australian, 19 November 2001

More than a third of surgeons admit using high doses of pain-killers to speed up the deaths of terminally-ill patients, according to a study. Philip Nitschke said the finding should lead to a review of euthanasia laws.

Pro-life groups condemned the study, published in the *Medical Journal of Australia*. The University of Newcastle's survey of 683 surgeons in NSW found 247 had given a terminally-ill patient high doses of pain-killers with the intention of hastening death. That intention was defined as euthanasia under Australian law and was illegal, study author Charles Douglas said. But he said many surgeons probably gave the same doses of pain-killers with the intention to relieve pain - and that was legal. The only difference was the surgeon's intention. 'If doctor A is a Catholic and says, "I never do this", he reports his intention as only to treat pain,' Dr Douglas said. 'But doctor B could be comfortable with euthanasia and says his intention is hastening death.' Dr Douglas said only a few of the patients had clearly asked for euthanasia. 'The vast majority of patients were only a few hours or days away from their death,' he said. 'The patient is barely conscious and not in a situation to discuss what happens next.' About 5 per cent of surgeons admitted giving a patient a single, lethal injection after the patient's clear request.

Right to Life Australia chairman Margaret Tighe said the study's results were misleading. She said some surgeons probably had given extra doses of pain-killers and suspected they had hastened a patient's death. 'There may be some who find it necessary to end the patient's pain and suffering but not do it because they want the patient to die,' Mrs Tighe said. 'That's a very important distinction.' Australian Medical Association vice-president Trevor Mudge also condemned the findings, saying he would be surprised if that many surgeons intended to kill the patients. Dr Nitschke said the survey showed the need for the law

to change so that surgeons could do a quick rather than a slow death. 'There's obviously a need for some form of legislative protection,' he said. Families generally knew when a doctor was hastening a patient's death under the cover of administering pain-killers. 'There's a nod and a wink and an understanding that this is what is going on,' Dr Nitschke said. A spokesman for acting Health Minister Michael Wooldridge said the Minister was concerned about the findings. According to the AMA, there are about 4,400 surgeons in Australia, with half of them in NSW.

Editor's Note: The article, 'The intention to hasten death: a survey of attitudes and practices of surgeons in Australia', by Charles D Douglas and others is in the *Medical Journal of Australia*, vol 175, 2001, pages 511-15 on the journal's website at http://www.mja.com.au The authors thanked Professor Miles Little for critical reviews of their questionnaire and methodology, and Professor Grant Gillett and Dr Bernadette Tobin for providing opinions on the wording of key questions.

Living Wills

The Society encourages members to have a Living Will (also known as an Advance Health Directive)

- If you feel you need help in preparing a Living Will, a solicitor can provide professional advice.
- Another commercial service is provided by Giles Yates PhD who produces a personalised Living Will based upon a private interview. Tel: 9571 8937

Enforced, Prolonged Life is a Fate Worse Than Death

by Dr Roger Hunt

Source: Sydney Morning Herald 19 November 2001, p. 12.

Fear and irrationality should not be the basis of our legal framework for end-of-life care; fact and reason should be. I engage in the voluntary euthanasia debate as a palliative medicine specialist with more than 17 years' experience. I have cared for many hundreds of people who have suffered with terminal illness, and many of them have spoken to me of their desire for a hastened death. The voice of the dying (and the dead) is too often not heard in the clamour of the euthanasia debate, so others must advocate for their wishes and interests.

I am also concerned about the risks facing doctors who must respond to their patients' requests for a hastened death. Under the existing criminal code, doctors could be charged with murder for intentionally hastening the deaths of terminally-ill patients. According to a survey published in the current issue of the *Medical Journal of Australia*, [see above] more than one-third of Australian general surgeons have, for the purpose of relieving a patient's suffering, given drugs 'in doses greater than those required to relieve symptoms, with the intention of hastening death'. This suggests that if the existing criminal code was unswervingly applied, large numbers of surgeons would be prosecuted for murder, and possibly imprisoned.

Murder laws carry severe penalties and serve the general purpose of protecting people from violent, wrongful killing. But it is inappropriate and unjust to apply these laws in many terminal-care situations. Terminally-ill patients are the victims of advanced, progressive and sometimes violent disease, and around 5 to 10% request a hastening of their death, even when the get the best palliative care. Rather than something that is "bad", death at the end of a harrowing terminal illness is frequently seen as a 'blessed release', not only by patients but also by their loved ones and other carers. Doctors who compassionately accede to their terminal patients' request for a quick, peaceful death should not have to be pursued as murderers by the police and public prosecutor. In the Freemantle Supreme Court just last month, however, a doctor - along with his deceased patient's brother and sister - were acquitted of wilful murder charges. The jury took

about five minutes to reach its verdict. Mercy from judges and juries is common in such cases that waste public resources.

According to the *MJA* survey [discussed earlier], more than half the general surgeons thought there were circumstances in which it was morally acceptable to give large doses with the intention of hastening death, although this varied widely - from 31% for Catholics to 70% for those of no religion. Traditionally, church hierarchies have vigorously opposed medical euthanasia but the Christian values of compassion, helping people who are suffering - the principle of 'do unto others' can be compatible with euthanasia. There is an obvious discrepancy between the existing legal framework and what Australian doctors see as morally acceptable terminal care. The doctor's duty is to strive for the satisfaction of their patients' wishes and interests, and this duty can be seen to conflict with the crude application of the criminal code. This conflict serves neither medicine nor respect for the law.

Terminally-ill patients should be able to discuss their wishes for a hastened demise without fear of implicating their doctors in a serious crime, and doctors should be able to openly discuss these cases. If a doctor can demonstrate competent care that is in accordance with the patient's wishes and interests, there should be immunity from serious charges. Medical organisations should promote the special nature of the therapeutic relationship, seek to protect doctors and support the refinement, rather than the continuance, of law that is being unnecessarily imposed on terminal care.

Opposition to VE law reform, mainly from career churchmen, medical hierarchies and politicians, is not founded on fact or reason but on fear and irrationality, distrust and a desire to control. Those in positions of power exhibit little sympathy for the liberty of ordinary people to have control over the ending of their lives. They dismiss the views of about 75% of Australians who think the option of voluntary euthanasia should be allowed for terminally-ill patients - only about 15% of the public are against this option according to the Morgan Gallup polls (and the rest are fence-sitters).

Eventually, I hope, the weight of public opinion and the evidence that accumulates (such as the recent survey) can convince our leaders that it is time to change the existing legal framework for end-of-life care. The pressure for reform will grow in our aging society as the post-World War II 'baby boomer' generation encounters more death. Sometime in the future, people of civilised societies will look back and wonder why it took so long to make the reform that is now needed by people who are dying, and those who care for them.

Editor's Note: Dr Hunt is a clinician at Adelaide's Daw House hospice - a reprint of the talk he gave to the VESNSW Society, 'When Voluntary Euthanasia Meets Palliative Care', is in our Newsletter, no 89, November 1999, pp. 2-6.

Dr Nitschke Calls For Legislation

The jury decision in Perth last October to acquit Dr Daryl Stevens, Warren Hayes and Lena Vinson of the charge of wilful murder, demonstrated just why legislation on voluntary euthanasia was long overdue claimed Dr Philip Nitschke. 'Those who are dying need to be able to seek help to end their lives if and when they feel this is necessary. They should not have to suffer the additional burden of worrying that those who might help them could find themselves charged with murder', Dr Nitschke said.

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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 also available from the Society's office.