

THE LAST RIGHT? AUSTRALIANS TAKE SIDES ON THE RIGHT TO DIE

**Simon Chapman
Stephen Leeder (eds.)
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Going To Sleep

Now the day has wearied me.
And my ardent longing shall
the stormy night in friendship
enfold me like a tired child

Hands, leave all work;
brow, forget all thought.
Now all my senses
long to sink themselves in slumber.

And the spirit unguarded
longs to soar on free wings
so that, in the magic circle of night,
it may live deeply, and a thousandfold.

Hermann Hesse (from Richard Strauss' Last four Songs)

At Gloaming

Through want and joy we have
walked hand in hand,
we are both resting from our travels
now, in the quiet countryside

Around us the valleys fold up,
already the air glows dark,
only two larks still soar
wistfully into the balmy sky.

Come here, and let them fly about;
soon it is time to sleep
We must not go astray
in this solitude

Joseph von Eichendorff (from Richard Strauss' Last four Songs)

Preface At 3.15am on the morning of May 26 1995, the Northern Territory's Assembly became the first legislature anywhere in the world to pass a bill which allowed doctors to actively assist patients to die.

The crescendo of debate leading up to and following Marshall Perron's bill has engaged the whole country. In March seven Victorian doctors "came out" on the front page of the *Melbourne Age* declaring their past participation in voluntary euthanasia. Since then the *Age* and many other newspapers have been alive with opinion. As we write, the Australian Capital Territory and South Australian legislatures are grappling with the issues. Impassioned speeches documenting the extremes of suffering are up against thundering spirituality and the potent claims being made for high-tech palliative care. What started out as a whisper a mere three months before the parliamentary assent in the tropics has become a pre-occupation of politicians everywhere. Jeff Kennett has proposed a consensus debate within the medical profession; Bob Carr has announced his willingness to debate as long as direction comes from the public first; and Carmen Lawrence has proposed wide community debate involving all concerned. At present both major political parties seem unwilling to hang their hats on one side of the debate or the other, perhaps mindful of the potential to alienate voters in critical seats. Of all the politicians we approached to contribute to this book, only two -- Marshall Perron and Michael Wooldridge -- agreed to declare their hands.

The preferred political route seems to be that exemplified by the Northern Territory, private members' bills with politicians free to exercise their consciences. The fears are well founded -- there can be no more dangerous area in which to legislate than life and death itself. The heavy weight of responsibility is evidenced by the torrent of passion the events in the Northern Territory have unleashed.

The medical profession is divided on the issue. On the surface orthodox medical opinion as espoused by the AMA stands against legalising euthanasia, whilst reformist opinion is in support. However, once you scratch the surface the reality is somewhat more murky with doctors from both camps swearing unswerving loyalty to one side of the debate or the other. In a recent editorial in the *Medical Journal of Australia*, editor Martin Van Der Weyden highlighted the gravity of the issue for doctors; 50% have been asked by patients to hasten their deaths and 19% - 27% have taken active steps to bring about the death of a terminally ill patient, and a majority of public opinion has repeatedly approved of euthanasia or other form of supported death.

The most recent poll published as we go to press. AGB-McNair polled 2,061 Australians on June 2-4 1995 and asked "Lately there has been much talk about euthanasia. Would you support or oppose the introduction of a law which protects doctors who assist terminally ill patients who choose to end their own lives?" Seventy five percent of those polled said they supported such a law, 16 percent were opposed, 6 percent were neither for nor against and 3 percent said they did not know¹.

We can only echo Dr Van der Weyden's sentiments when he declared that "The time has surely

¹. Sharp M. Mercy killing favoured by most. Sydney Morning Herald 1995;June 7:3.

come for society to openly address the taboo of dying. Active euthanasia should be widely discussed in an open forum free of the polemics of opponents and advocates, and without the political, religious and legal prohibitions that have stifled the debate"².

We were inspired to take the "sides" approach to this book by three similar projects undertaken in Britain in 1937 (by WH Auden, Pablo Neruda and others) about fascism and the Spanish civil war (*Authors Take Sides on the Spanish War*; in 1967 about American involvement in Vietnam (*Authors Take Sides on Vietnam*); and in 1982 (*Authors Take Sides on the Falklands*). Euthanasia is of course not a war, although arguments about it have often become very heated and sometimes violent.

Whatever one's views on the end of life, it seemed to us that there was no fudging two core questions that lie at the heart of most debates now occurring in many countries about euthanasia and the right to die.

"Are you for, or against, the proposal that a person with a terminal or incurable severe illness should be able to have their request granted that their life should end?"

"Do you believe that doctors should be able (with legal impunity) to actively assist such people who request that their lives be ended through euthanasia?"

We put these to each of the people who have contributed to the book and asked them to respond. The list of people we approached was designed to cover a wide spectrum of both prominent Australians and some who are not so well known but who have special interest or experience in questions of death, dying, chronic disease, ethics and religion. Brief details about each contributor precede each response. With the prominent Australians, we had no idea of which way they would respond. Some of those from health, medical, ethics and religious backgrounds have been participants in public debate about this topic, so here we knew what to expect. In writing to these people, we tried to balance our invitations between an equal number of people who would take each side.

Our original invitation list had 209 names. Sixty-three people sent their responses; 37 declined usually citing pressure of work; 104 failed to respond; and five promised contributions but did not deliver. We offered no payment and asked that people respond in whatever way seemed most appropriate.

The 63 contributions in this book show that while both questions could be answered with a simple yes or no (Gough Whitlam apologising for being too busy to respond, sent a message that he supported both questions) there are deeply personal and moral ravines in which many contributors wandered on their way to an answer.

Until events in the Northern Territory euthanasia was somewhat of a sleeping giant. Debate has

² . Van Der Weyden MB. Medicine and the community - the euthanasia debate. Med J Australia 1995;162:5 June.

been largely confined within the church and to the medical profession. Unfortunately professional opinion has masqueraded as community values leaving little space for the voices of ordinary men and women. Our own mortality and the mortality of family and friends gives us all a stake in how our communities deal with life and death. We hope that these contributions will help fill in some of the silences. Tragedy and spirituality are integral to the human condition, by sharing the thoughts of other Australians we hope to provide an entry point for all to participate so that consensus and tolerance can be achieved.

Finally, we would like to thank all the contributors who responded to our letter. Thanks also go to Jennifer Byrne at Reed Books who shared our sense of how important a book on this subject done in this way could be. Thanks also to Darlene Sebalj for chasing the addresses of many of our contributors, and to Peter Singer and Helga Kuhse for their advice on the project in its early days.

Simon Chapman
Stephen Leeder 9 June 1995

PHILLIP ADAMS

Phillip Adams is a writer, broadcaster and film-maker. He is a weekly columnist for the Weekend Australian and presenter for Radio National's Late Night Live.

I've been campaigning for voluntary euthanasia for decades. Not only do I believe that a person with terminal or severe illness should be able to request that their life be ended, but I believe, equally, that we have a right to register our desire for this long in advance of need. People supporting voluntary euthanasia might not be in a position to plead their case, so such a request could be made a part of a wider declaration involving, for example, one's willingness to donate organs.

I find it intolerable that religions can impose their theologies on a secular society, overruling the passionate convictions of others, in particular my fellow atheists and agnostics.

Yes, I believe that doctors should be able to actively assist people requesting that their lives be ended, without fear of state or professional retribution.

Lately there's been an attempt to derail this debate onto issues of pain control. My support for voluntary euthanasia is not predicated on the notion that a patient should be saved from physical suffering. Let us assume that, in future, physical pain can be entirely eliminated through medication.

There are those of us who would still wish to end our lives for psychological or philosophical reasons, involving notions of human dignity. Whilst we cannot choose to be born we most emphatically have the right to choose our time of death and an efficient form of suicide will not always be available or doable.

EUGENE AHERN

Fr. Eugene Ahern is pastor of St Francis of Assisi Parish, Mill Park, an outer suburb of Melbourne. He made the special focus of his theological course in Rome a study of natural law theory. He has had a long involvement with the Right to Life movement and is on the board of Right to Life Australia. He has participated in various forms of non-violent direct action to oppose abortion in Australia and in the United States.

No one likes the idea of suicide. It is seen as a tragedy when people take the step to kill themselves. Euthanasia is about exactly that, the decision to take steps to kill oneself or have oneself killed believing mistakenly that one would be better off dead.

Of course we all want to have a good death. Unfortunately the phrase "die with dignity" has become a euphemism for euthanasia. In the Northern Territory a recent poll showed most people were confused about what euthanasia actually involves. Many thought it involved simply pulling the plug or turning off life support systems. Let's get it clear that euthanasia is when a doctor, not an illness, kills a patient.

The fact that patients may request to be assisted to commit suicide or that they are seriously ill are not the decisive elements in justifying euthanasia. A bleak prognosis is no ground on which to justify in the doctor's mind the plea to be killed, even if the doctor genuinely believes the patient is dying. The emphasis given in the case for euthanasia to the voluntary nature of the request is at best a smoke-screen. Though presented as a safeguard, it is no safeguard at all.

The supposed safeguard that access to patient killing be limited to those terminally ill is equally spurious, apart from being totally arbitrary. In the end what difference does it make whether the deceased had been terminally ill or not?

The vital element is the doctor's own judgement that "this patient would be better off dead." The nail is struck in the coffin by the doctor's judgement. Once a doctor, or for that matter anybody else, has made that crucial judgement regarding a patient then it is a small but decisive step to entertain the thought of deliberately ending the patient's life. Put simply, it is the judgement that death is seen as preferable to life. Put philosophically it is that non-existence is preferable to existence.

Such a judgement is profoundly inhuman. It strikes at the sense of the inherent value of every human life which is the basis of human society. It is a direct attack on the fundamental sense of equality of all humans, and so subversive of justice for all.

When one decides that a particular person would be better off dead one is concluding that the person no longer has a worthwhile life. It is that judgement which really strikes at the worth and dignity of every human life without exception. The phrase "worthwhile life" immediately reminds us of the great catchcry "life unworthy of life", of the German euthanasia movement, after the publication in 1920 of Hoch and Binding's book *Permission for the Destruction of Life Unworthy of Life* which propagated the idea that euthanasia was the throwing overboard of dead ballast from the Ship of Fools.

Put very simply the justification for euthanasia is based on the assumption, and I would say false assumption, that human life does not possess an inherent value. This denies the basic dignity, and equality of every human being.

Our nation along with almost every nation in the world has had and continues to have a long and painful struggle to recognise the true dignity and worth of every human person without exception. One immediately thinks of the discrimination in our nation on the basis of colour and race which has been not only a denial of true equality, but a denial of the true dignity of those being discriminated against. The absurdity of the situation was that discrimination was often justified in the most high sounding terms of taking "proper care" of Aboriginal people but was only a cloak for a very negative judgement as to their true dignity. The removal of aboriginal children from their families is a glaring example. Much the same can be said of our mistreatment of disabled persons. I almost hesitate to even refer to the terrible way in which people with Down's Syndrome were labelled as "Mongols." The true dignity of these people was almost totally denied. To accept euthanasia would go against the positive achievements of this century.

Some euthanasia advocates claim they recognise the dignity of the person to be killed while

they argue that the person is better off dead. It is arguing that the continued life of the person is a negative value and that death itself is thought of as a positive value. This argumentation is not only fallacious but dangerous. It is fallacious because it is based on an assessment that non-existence can have a higher value than existence. It is dangerous because it can be invoked to justify the elimination of many in society starting with those whose demise is justified on the grounds that they request it. But if its logic was to be accepted it would be a mercy to grant the same fate to other groups judged "better off dead".

The so-called "right-to-die" deserves close scrutiny. It is a demand for a right to be able to decide when one kills oneself or is to be killed by another. Now if a person demands such a right, it would impose a duty on others to agree with that demand. It would mean a duty to stand by and watch people kill themselves or worse, a duty to kill the people claiming the "right to die". No caring person would agree with that. Refusing the request for euthanasia is equivalent to refusing to push someone, who asked for it, over a cliff. The "right to die" is no right. It is a cruel hoax.

A case is made for euthanasia on the basis of personal autonomy, a so-called right to privacy or to free choice. A closer analysis reveals that the right to free choice, like all rights, is not unbridled or unrestricted. We may have free choices but they are always exercised in the context of the common good of society. No right is absolute or unfettered. The state has a prevailing interest in upholding the value and dignity of life. It is precisely that interest which is implicitly accepted by euthanasia advocates in their acceptance of restrictions on the availability of euthanasia. The state quite properly judges that it will restrict any right to free choice or freedom of conscience in order to protect the value of human life even to the extent of outlawing acts of deliberate killing. Pursuing this logic, the Canadian Supreme Court in 1998 decided there was no right to assisted suicide in the Rodriguez case.

Given the lament over our high suicide rates, it is unconscionable that our community would endorse not just patient suicide, but cross a huge gulf and license suicide actively assisted by doctors, under the guise of false compassion. Gradually we will see the need for strong laws to protect lives threatened by quick fix solutions labelled as "euthanasia"

In the drama of life the cry of pain is not a demand to be dispatched out into the cold of death. It is a cry of anguish, the anguish of mistakenly thinking one would be better off dead! The truly human response is a loving embrace and the gentle words, "I would miss you if you were to die." People want to be needed, even missed.

A strong antidote to the pessimism of the euthanasia movement is the recently published encyclical letter of Pope John Paul II *The Gospel of Life*. Having lived through the attacks on life by two totalitarian regimes, the Pope founds his hope filled teachings on the life issues on the incomparable worth of the human person.

The collective wisdom of over two thousand years since Hippocrates is that society must never sanction medical killing. Doctors must be healers and carers, never purveyors of legal potions.

YVONNE ALLEN

Yvonne Allen is a psychologist, author, public speaker and founder of Yvonne Allen and Associates, Human Relations Consultants and Introduction Services. Her mother Betty Patricia Allen died on 4th October 1994.

As I think about the dilemmas associated with the controversial issue of euthanasia, my mind turns back to the torment of the pain-filled months that preceded my mother's recent death. On many occasions during that awful time I was tempted to ask her what she thought about the option of choosing to decide to die when faced with inevitable death through terminal illness -- but I hesitated, knowing that her Catholic faith would make this impossible for her to contemplate, no matter how desirable a choice it might seem.

As someone who does not identify with any particular creed, I can perhaps more readily speak my mind about what I regard as the inalienable right we have to decide to terminate our own existence once life has become unbearable, and when the circumstances are unlikely to ever improve. This is surely the case for many, like my mother, who are sentenced to death by a terminal illness. In her instance the diagnosis was an incurable tumour on the brain and the initial prognosis of six months stretched out to eighteen. It is sad to reflect on just how much pain and distress she endured as her body and mind succumbed to her terrible disease. It was hell on earth -- and not just for Mum but for all who loved her.

It would seem that in many instances the argument against an individual's right to choose death with dignity comes from those who just do not want to see a loved one die. To me this is a selfish motive on the part of those who are to be "left behind" -- in some cases it could even be deemed to be sadistic. Surely love would say "go in peace" rather than "linger on in torment" when suffering is all that is left in store for a person who is dying!

Life at any cost seems a spurious value. If it is judged heroic to die in the name of one's god or country through war, how can it be considered criminal to choose to meet one's god or destiny by seeking peace?

RAYMOND APPLE AM, RFD

Rabbi Raymond Apple has been Senior Rabbi of the Great Synagogue, Sydney since December 1972. He is lecturer in Judaic Studies at the University of Sydney. His services to the community have been recognised by the award of Member of the Order of Australia, the Queen's Silver Jubilee Medal and the Reserve Force Decoration.

Euthanasia is not a new issue brought into focus by advances in medical technology. As far back as the time of the Biblical king Saul there were those who believed it was a mercy to put a suffering person out of his agony: II Samuel, chapter 1, records that Saul, mortally wounded, asked an Amalekite to slay him in order to hasten his death.

In most circumstances, death is the great enemy, to be opposed with heart, soul and might. Life is the great friend, to be loved, cherished and hung on to. One waxes poetical. Life is the

great blessing, the great privilege, the great opportunity. Every ounce of life, my own and every other person's is precious and must be guarded and preserved at whatever cost.

But there are times when the poetry becomes a mockery, when it is death that becomes the great friend and life ceases to be such a blessing. It is then that the plea is heard, "Let me die in dignity". The implication is "I can no longer live in dignity".

The problem is that any deliberate induction of death sends shudders through most people. It certainly raises moral issues of massive dimensions. Can we afford to pay its price? The arguments have been articulated so often that they hardly need to be repeated. But better than the conventional distinction between active and passive euthanasia is the question "What are we talking about - shortening life, or shortening dying?"

If it is shortening life that is the issue, the clear principle surely has to be that life, every life, has inherent value and sanctity, and even the noblest, best-intentioned induction of death is a violation of the right to stay alive, however limited the quality or duration of a given life might seem to be. Euthanasia is too easy an option.

What right do I have to dispose of or write off my own or another person's body? The question of who owns my body is complicated in law, but in religious morality it is unequivocally the property of God, given to me as a trust, not a possession. To make decisions about disposing of it is to meddle in matters that belong in another dimension.

Who am I (doctor, minister, counsellor, relative) to judge that a life is now no life? ("Who made you a prince and a judge over us? Thinkest thou to kill me?" asks Exodus 2:14). Do I have my own agenda or vested interests? Whose life is it that is in the balance? Does it make a difference that the patient may be old, poor, lonely, black, or homosexual, or belong to some other category that the Nazis used to call "useless eaters"?

What does the phrase "quality of life" mean? Is it limited to active participation in social interaction? Does quality of life not fluctuate? Aren't there times when it is less visible than at other times? And whose quality of life am I concerned with - the patient's, or my own (I may suffer diminished quality of life if I have responsibility for a gravely ill patient).

Where will it all lead? If I start diminishing human lives will a banality of euthanasia set in so that I find I no longer exert myself too greatly to preserve life? Will there come a time when I do not wait for the consent of the patient or relatives and perform involuntary euthanasia because I deem it to be in the patient's (or society's) best interest?

Yet if the issue is not the shortening of living but the shortening of dying, the situation changes. One has a right to live. One also, when the time comes, has a right to die. If the natural life forces are clearly ebbing, why should they be artificially held back by machinery or medical instrumentation that prevents death from occurring? Interestingly, rabbinic tradition, which by definition believes in the efficacy of prayer, asserts that as there is a time to pray that a person live, so too there is a time to pray that they may die. Indeed, a Jewish legend finds God imploring His creatures, "Do not try to take away the sword of the angel of death; My world

needs death!"

But the circumstances in which it is legitimate to withdraw artificial impediments to dying have to be properly addressed. Amongst rabbinic ethicists, Moshe Feinstein asserts that when a patient is gripped by unbearable pain and suffering, nature should be allowed to take its course. Thus when a patient is on a respirator and the machine is temporarily removed for servicing, if the patient shows no signs of life the patient need not be restored.

The distinction between shortening life and shortening death is helpful but there is a difficult grey area between the two. Making day to day decisions in that area is not likely to be carried out frivolously, but guidelines and safeguards need to be developed by the medical profession in consultation with ethicists.

But even that is not the only question that has complicated our agendas. Sonya Rudikoff, in an article in *Commentary* as long ago as February 1974, makes the important observation that medical treatment is so complex today that almost any death is in some way an act of euthanasia; "Recent developments," she writes, "are troubling, and they provide ample warrant for wondering whether anyone can die his own death any more". Indeed, the possibility of euthanasia in an extended sense is there from the moment I first visit my doctor and repose my trust in him to make the right decisions about my treatment and ultimately my life.

It is clear, then, that society has to ensure it sets its standards.

PETER BAUME

Peter Baume is a physician. He is Professor of Community Medicine at the University of New South Wales, Chancellor of the Australian National University, Chair of the Australian Sports Drug Agency, a Commissioner of the Australian Law Reform Commission and Patron of the Voluntary Euthanasia Society of New South Wales. He was a Senator for New South Wales from 1974-91 during which time he was a Minister in Cabinet.

Have you ever seen a person die of terminal cancer? Or of AIDS? Or of motor neurone disease? Each of them is, more often than not, a bad way to die and the dying is often associated with awful suffering.

It is emotionally shattering to sit with a person with unrelieved symptoms and watch a bad death. Since we are all to die, it is the manner of that death which becomes important. For some people I have treated, the fear of unrelieved symptoms has dominated their thoughts and their remaining lives: for other it is fear of (and dealing with) the loss of dignity and control that so often accompany dying.

No-one should have their life ended without their specific request. To allege that acceptance of voluntary euthanasia will lead to non-voluntary and then to involuntary euthanasia is convenient but unsupported and logically nonsensical. No practitioner should be party to non-voluntary or to involuntary euthanasia (just as no medical practitioner should have anything to do with official executions. No patient should have to give up all their dignity or control at the

behest of those for whom social control of others is a goal.

Where a person has requested that their own death be hastened, that request should be taken seriously and assessed. People with endogenous depression should be identified and treated. Safeguards can be developed to ensure that requests for voluntary euthanasia are genuine and sustained.

But people are masters and mistresses of their own destiny. Personal autonomy and personal sovereignty are supreme values. Doctors and third parties are only agents and society has no proper role in attempting to control this part of peoples' lives.

Not only should medical practitioners accede to considered requests from patients that their lives should end, but many do so already. Fourteen percent of a large sample of practitioners in New South Wales already acknowledge that they have practised voluntary euthanasia³, some more than once. Most believe they have acted correctly, and a majority of all doctors want some change to the law to regulate and regularise what now goes on outside the law.

Medical practitioners act now in defiance of law whenever they assist in the practice of voluntary euthanasia. Since most practitioners wish to be law abiding people, it follows that some alteration to law is needed. First, the decision belongs to the patient and not to the attending practitioner or to churches or to relatives, or to the society. Second, if the patient makes a request for voluntary euthanasia, then practitioners who assist should be immune from prosecution, provided that they comply with appropriate guidelines and procedures.

The Northern Territory legislature has attempted to progress the law on this matter. Objections based on religious doctrine are not sufficient if they deny to people a right to make decisions for themselves -- after all, each such personal decision is amenable to God's influence, if theologians are correct.

Social control policies to limit private actions are generally unwelcome and inappropriate in whatever policy arena they occur. Policies in area designed to control the private and personal actions of others are as ill-founded as any other.

CHARLES BIRCH

Charles Birch is emeritus professor at the University of Sydney where he was formerly Challis Professor of Biology. He was written extensively on ethical and philosophical problems in biology and in 1990 was the joint recipient of the \$725,000 international Templeton Prize for progress in religion.

There is a *prima facie* case for one's right to die rather than being forced to live on in a degenerating condition, should these become one's only options. We should question why does society assume that it has the responsibility to keep one alive even against one's desires

³ Baume P, O'Malley E. Euthanasia: attitudes and practices of medical practitioners. *Med J Aust* 1994;161:137-44.

and to the benefit of on one. Why do individual persons not have the right to decide for themselves? That is the issue I wish to face in this essay. It is different from the issue of euthanasia when decisions by one group of people are made about the life and death of others. That is an important aspect of the right to die that should not be avoided but it is not primarily the issue I am concerned with here. The question here is does anyone have the right to force another to live when that other wants to die.

There are five serious arguments directed against the right to die that need to be considered seriously. However it is a mistake to regard any one of them as having an absoluteness.

The first argument raised against the right to die is that humans should not 'play God'. This expression is used in the sense of trying to replace God as a primary determiner of the course of events in the world, some would even say the only determiner. However, for at least two centuries people have 'played God' in the sense of taking human destiny into their hands. The scientific revolution is but one example of how we have accepted science and technology as shapers of human destiny. The experiment has had mixed results. The future has become more precarious while we appraise the benefits of the technological revolution against its negative impact on the environment and on the possibility of nuclear war. Yet few would give up the enormous benefits of science and medicine. We 'play God' by prolonging lives, by inoculations against diseases, by taking medicines and by keeping people alive who would have died without human intervention. People 'play God' in family planning to avoid unwanted children. People also 'play God' in self defence, punishing criminals and going to war. We exercise human control over many aspects of our lives from birth onwards. Why then exclude what happens at the one event at the very end? The justification for this cannot be found in a general prohibition against 'playing God'.

A second argument against the right to die is that human life is sacred. But what does sacred mean? Often the word is replaced by the phrase 'infinite value'. That has been a core belief of much of the modern world. But the words 'sacred' and 'infinite' are designed to do away with conditionals. This absoluteness, if taken with complete consistency leads to conclusions drawn only by a few. These few oppose killing in self-defence or defence of loved ones and refuse to participate in military service. Furthermore it is argued that the affirmation of sacred or infinite value to human life is necessary for the avoidance of slavery and of the holocaust mentality of those Nazis who had no respect for human life. No doubt absolute respect has been important in leading to desirable laws to check exploitation of the weak by the powerful. But it has yet to be shown that only absolutist formulations can protect against these evils.

The absolutist ethic implied in the words sacred and infinite value needs to be reassessed. A way of doing this is to make a distinction between the instrumental value of life and the intrinsic value of life. Instrumental value refers to the useful value of a life to the world. It is petty small at the beginning, perhaps it reaches a maximum and at some stage declines when one become incompetent. We should not judge people by their instrumental value alone. That is to regard a person as an object and not as a subject. Each one of us has a value independent of our usefulness to society. It is the value of our life in itself to ourselves and if you will to God. This is our intrinsic value. It is our intrinsic value that makes us subjects and not just objects. The phrase infinite value suggests that our intrinsic value remains unchanged from birth to death. But that really does not make much sense. A measure of intrinsic value is the richness

of our experience. That is pretty small when we are embryos and when newly born. It rises to a peak as life matures. Then at some stage decline sets in for most people. And for some the intrinsic value, in the sense of the quality of life, must get close to zero when the person has a mere 'vegetable' existence. I am thinking of a friend of mine whose aged wife has been in a nursing home with Alzheimer's disease for many years. She no longer recognises him. He said to me recently "she really died several years ago." At that stage of life it makes no sense to talk of infinite value. It does make sense to talk of a reduced intrinsic value and reduced quality of life for that person.

Yet there is almost a taboo against questioning the infinite value of everybody at all times of their lives. It is necessary to broach the subject frankly. If the locus of intrinsic value is in the richness of human experience and if these vary from person to person and from time to time in any individual life, then it seems clear that there are differences of individual worth. It can be stated frankly. There is no substantial reason to believe that all persons have equal intrinsic value and that for any individual person intrinsic value remains constant throughout life.

It follows that there is no rational reason to keep alive human bodies when there can no longer be significant human experience at all. Indeed there is an indignity in the conception of the meaning of human life revealed by vigorous attempts to maintain its outward, visible, and entirely trivial signs. If one seeks primarily to save life, one is likely to forget the purpose of life. It is not breathing and urinating and similar functions that make a human being important. There is no intrinsic value in these mechanistically maintained appearances. There is nothing sacred in every breath and every heartbeat, if they are merely maintaining a shell without the possibility of any purpose being fulfilled. The intrinsic value of human life lies in the capacity for feeling and in the experience itself. When that capacity has gone, so has intrinsic value. The wise man, said Seneca, lives as long as he should, not as long as he can.

The third argument against the right to die is the consequences to emotional attachments. Even when the quality of relationship that evoked love is no longer possible, the love retains its force and is directed to a living body. Another way of thinking is more realistic. Much of the experience of intimate connectedness is in the past. As the past it is still real and effective in the present. But that reality is not dependent upon the continued presence of a living body. There is such a thing as a healthy letting go, difficult as that might be to practice. I had to do that myself at my mother's funeral by saying to myself but that coffin does not contain my mother. My mother is someone who lives in my memory right now and cannot be reduced to a body at this seeming end point. My friend whose wife has severe Alzheimer's disease does not any more identify his wife with the incomplete mortal remains that now confronts him. He has great respect for the life that is left but it is not the life she once had.

The fourth argument against the right to die is the slippery slope argument. Once the door is opened to individual cases of suicide or euthanasia, there will be no clear place to hold the line. It is better to hold to an absolute in which such issues are not allowed to arise. But is it? There is another alternative. It is this. *The right to die is accepted as a basic right to be opposed only when it can be shown that the legitimate needs of others, or the deeper needs of the person contemplating deliberate death, outweigh the right.* But you may object that if this principle were adopted the question of whether to kill oneself might be considered almost routinely whenever one is in acute trouble, the already alarming rate of adolescent suicides would

increase. This kind of argument must be taken seriously. Absolutes have had their function in society.

Ideally mature people do not need them, but such people are rare. Most people seem to want black and white rules. The task now is to find an ethic and moral code that affirms the right to die without undercutting the emphasis on the preciousness of each individual person. It is a task for the future. It is not unachievable. We need to start working on it right now.

The fifth argument against allowing people to choose death is that suicide is unnatural, This was strongly formulated by Thomas Aquinas in the middle ages. Everything seeks to keep itself alive. It is natural to want to do this. It is unnatural to go against this law of nature. Defenders of this argument know that people do choose `unnatural' things . All such choices are deemed morally unacceptable. The supposed principle is that it is immoral to oppose `natural law'. Natural-laws theory has had a long history and it has doubtless checked on the idea that the law is whatever those in power decide should be done. But it has also functioned in a repressive way, especially in the area of sexuality. It has been declared that by nature the function of sexual intercourse is procreation, so sexual intercourse has its only justification when this intention is present. But who is to say that the intention of procreation is natural but the intention of mutual enjoyment is unnatural? And why should choosing to die rather than to live on as a burden to oneself and others fall below the law of nature? Perhaps it is according to nature that at some point people are ready to die, and perhaps it is 'against nature' to protract life beyond that point when health or mind has failed.

Restrictions on the right to die

A guiding principle of this essay is that rights are never absolute. This applies to the right to die. The duty to live is not absolute, but this does not mean that it has no validity at all. For an individual to take his or her own life, with no regard for other considerations, is not morally acceptable. The right to die should be circumscribed in a number of ways. It could be required that a person wait thirty days after first expressing the intention before implementing it. During this period several responsible professional persons, not otherwise closely related to the person who wants to die , might interview him or her. The state could then require concurrence of a majority of these with the decision before it would be allowed. Perhaps these persons would be required to talk with family members to find out their feelings and judgments. These restrictions should reduce the anxiety of those who fear that the loss of an absolute prohibition will have widespread negative consequences. Thus these laws could support the right to die while expressing the general consensus of society that terminating one's own life is not merely a personal decision, that one's right to die is not absolute.

Those who fear that a relaxation of the prohibition will open the door to complex moral and legal questions are correct. There may be times when the person whose life's termination is being considered is not able to take the lead in the discussion. A person may have repeatedly stated or even put into writing that he or she does not want to continue living if seriously mentally incapacitated. The incapacitation may come suddenly as a result of an accident or stroke. Then the injured or disabled person cannot make the request that will start the procedures leading to death. Someone else must make that request based on earlier statements. Difficult judgments may be involved. Is there any reasonable chance that the

person may recover? There are other judgments too that might have to be made.

The need for reform is urgent. The appeal to absolutes is all too common a ploy in defence of an intolerable *status quo* that is not logically justified. For desirable changes to become possible changes must occur in public opinion, in medical practice and in the law. Changes must occur also in theology and in the church since much of the church still opposes these changes and sticks to an absolutist ethic that is no longer tenable.

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VERONICA BRADY

Veronica Brady is a Loreto nun who has also been a member of the Department of English, University of Western Australia where she specialised in Australian Literature. She has also been a member of a number of boards, including the board of the ABC. At present she is chairperson of the Older Australians' Advisory Committee in Western Australia. She has published widely on Australian literature, culture and belief. Her most recent book is Caught In the Draught.

I began writing this on Good Friday. I thought it would help because the whole question of death and dying, suffering and pain is so confused by charge and counter-charge, by presuppositions of virtue and accusations of moral turpitude and by invocations of authority - of reason, of the Church, of medicine and of feeling - and of rights and freedoms that it seemed to me that I needed some kind of clarity.

I thought, for instance, of Wittgenstein's reflection:

"The general form of propositions is: This is how things are ... One thinks that one is tracing the outline of the thing's nature over and over again, and one is merely tracing round the frame through which we look at it.

A picture held us captive and we could not get outside it".

I also thought about a quotation from an essay by Andrey Tarkovsky about the painter Goya, sent to me by a poet friend (who had been recently engaged in the same battle):

"Single-handed, Goya took on the cruel effete power of the King and made a stand against the Inquisition. His sinister 'Caprichos' became the embodiment of dark forces, flinging him from savage hatred to animal terror, from vicious contempt to quixotic battle against madness and obscurantism."

In this whole debate, it seems to me, it is not only the forces of the Inquisition, that is, of religious absoluteness and moral inflexibility but also the forces of the King, of the 'liberal' establishment, which may need to be contacted. Maybe when we remove the frame through which we look at the question we shall have to confront the dark forces head on.

That confrontation, I think, is what happened on Good Friday. Thinking about the brutal, bloody and humiliating death of Jesus reminded me of the one or two horrible deaths I have seen and the many more I have heard or read about. It reminded me but at first it did seem to help: suffering remained ugly. It also became all the more clearly offensive. Jesus died not because some cruel God had decided that he ought to but because his life and words challenged the rich and powerful and threatened the comfortable accommodation they had come to with Rome. He did not want to suffer, he feared it and according to the gospels cried out in agony during it, and would have lived if he could.

For some 'religious' people suffering and unhappiness may seem a moral obligation. It was not for Jesus. He came that people might have life and have it to the full. Joy, generosity, love, forgiveness and compassion are the marks of his life. As I read it at least, Christianity is not life-denying but life-affirming. Suffering may be more or less inevitable. But it is not something to be desired and we should do everything we can to prevent others from suffering.

That much is clear, and in the current secular framework that would mean that a person with a terminal or incurable disease who is suffering intolerably should not have that suffering prolonged unnecessarily. But Christianity is by definition counter-cultural. The might of technological society, as Adorno remarked, is lodged in most people's mind today. But there is, I believe, another and superior form of power whose authority Christians acknowledge, the power signified by the word 'God', "in whom we live and move and have our being." Prometheus may be the culture hero of our society and culture but for me life is oriented towards the ground of life, a mystery which is at once present and distant before whom I must bow down in obedience. Life, death and suffering are part of that mystery.

"... Incomprehensible energy
creates us and destroys, all words are made
in the long shadow of eternity,"

(words from Judith Wright's *Love Song in Absence*, written in memory of one she loved). In this long shadow words fall away.

Their meanings alter even as the thing is said.

What is left is a sense of the mystery and faithfulness to it, readiness to do what the mystery calls us to do or not to do according to the logic of love, of the mystery as well as of the women and men we love.

In saying this I am not saying that there may not be a case for contesting intolerable pain so vigorously that death results.

"... he hates him.

That would upon the rack of this tough world
Stretch him out longer"

as Shakespeare made the sympathetic Kent say at King Lear's death. But I am wondering whether any human being has a right to play God - though, as I say that, I also reflect on the fact society does just that with capital punishment and in the case of war, nearly always with the blessing of the Churches. As for the person in agony who longs for death, no one surely can pass judgement here. The problem is with those who are well, with the medical people involved and with the person's family and friends and the decisions they must make.

Generalisations are impossible for me. What remains are certain propositions which seem in a sense contradictory: that there is a God, to whom life and death belong and whose will we must obey; but that God is compassionate and full of love for each human being whom he destines for dignity and happiness; that God did not create suffering but that it is the consequence of the choices we have chosen and that, to quote Judith Wright again:

"... man is more than man -
is central to the maze where all's made new.

The Vision

I know that this will seem unsatisfactory, even distasteful, to many for whom the human horizon is all. But, to return to Wittgenstein, the crux of the issue we are discussing is essentially about horizons, whether or not we see life as monological or polyphonic, whether we are in charge of life and death or whether we acknowledge a mystery beyond ourselves and our understanding which we must obey. This is the mystery acknowledged by the inscription found on the wall of a cellar in Cologne where a number of Jews hid themselves for the duration of World War II:

I believe in the sun even where it is not shining,
I believe in love even when feeling it not;
I believe in God even when He is silent.

A last point. It may be that one of the failures of Enlightenment and post Enlightenment culture is the loss of a sense of mortality and with it the failure to develop what used to be seen as an art of dying - that, indeed, is the original meaning of euthanasia, a quiet and easy death.

So let me conclude, with these lines from a Jesuit priest to a friend:

"I am being led, gently for the most part but firmly, to the uneven point our nature shrinks from. And what was good enough ... for the teeming millions of others, must be good enough for me ... I'll probably have to fumble my way along for anything between one and three years yet before my occasional squawks and hisses are transmitted into that final music...`Life is difficult, tremendous God'...`But you are the life of all that lives, and my love'.

Death is not necessarily the enemy.

JOHN BUCHANAN MB BS, M.Med., DPM, FRACP, FRANZCP

John Buchanan is a consultant psychiatrist in private practice. Until recently he was consultant psychiatrist to the Palliative Care & Oncology Units at the Repatriation General Hospital and the Austin Hospital, Melbourne.

Should a person with a terminal or incurable severe illness be able to have their request granted that their life should end?

An ethical consideration of this issue involves not only a patient who raises such a request, and what such a request might mean on clinical examination, but also the effects on others in society who may suffer unintended consequences of legislation to allow 'homicide by consent'.

A. What does it *mean* if a person asks a health professional to end that person's life? The experience of most palliative care professionals is that a request for euthanasia means there is an unsolved clinical problem, that has not been identified as a solvable problem, by patient, relatives or professionals.

The unsolved problem may be pain, depression or anxiety about 'what may happen'. The problem may be located in the patient's illness experience; or be found in relatives who have become depressed; sometimes the problem is in professionals who do not know how to handle these difficult clinical problems.

Some assume that 'nothing can be done' for many symptoms of terminal illness. Nothing could be further from the truth; for example, the vast majority of cancer pain problems can be controlled completely; pain can always be at least partially controlled. Depression and anxiety can usually be improved considerably. The assessment and treatment of such clinical situations are specialised medical and psychiatric tasks in which many health care professionals are not experienced.

The morale of most seriously ill persons depends more than they may recognise on the attitude to them of relatives, friends and health care professionals.

If relatives or health professionals are chronically fatigued by care demands, or ambivalent about the patient in some way, their support will subtly diminish, leading the ill person to feeling a burden and come to believe they should 'get out of the way'. A patient or relative may not be fully aware of what the 'unsolved problem' is, other than a feeling of despair; they may regard the problem erroneously as something about which 'nothing can be done'.

A request for 'euthanasia' can therefore not ethically be taken at face value. Such a request demands full clinical investigation of the question "Why is this person feeling like this?" - with the focus on seeking out the likely 'unsolved problem' which may be in the patient or the

psychological environment. Proper assessment, followed by relief of factors causing distress, virtually always brings about a change in a patient's request for euthanasia.

B. What are the risks to the patient and the community of legislation to permit 'homicide by consent'?

What do the words *terminal*, *incurable* and *severe* mean in practice? Diagnosis of a terminal condition is not always clear-cut. Most experienced physicians have seen long term survivors of a condition which is usually fatal; spontaneous remissions occur for reasons unknown. Determination of whether an illness will be terminal in a defined period is always only an educated guess. Many chronic medical and psychiatric conditions are 'incurable'. 'Unrelievable suffering' to one health professional, may be 'treatable suffering' to a practitioner trained and experienced in palliative medical and psychiatric care.

Risks of patient abuse and violation of informed consent.

Ill patients are vulnerable to conscious and unconscious influence from people who may stand to gain in various ways (including financially) from the patient's death. Subtle withdrawal of emotional support by a 'fed up' family may result in depression and loss of will to live. In these circumstances, a request for euthanasia may not psychologically be 'informed consent'. The risk of violation of natural justice exists.

A law change to permit euthanasia (homicide by consent) would result in an unreasonable pressure on *all* terminally ill patients. Patients often feel they are a burden to their family even if they are not. If the law was changed to permit 'homicide by consent', defenceless patients may be easily manipulated into accepting it by relatives who may (consciously or unconsciously) regard it as a solution to *their* coping (or financial) problems. Increasingly recognised are the maladaptive ways some relatives cope with ill family members by what is known in the USA as granny-dumping or elder-abuse. Ill, vulnerable patients deserve better than this pressure hanging over them.

The euthanasia proposal has been examined by inquiries in the U.K and in Victoria, and by the World Health Organization with the conclusion that adequate safeguards are not possible. The influence of economic pressures.

As economic pressures on health care increase, the funding of care for patients with terminal illness will inevitably be questioned as not being 'good value for the community'. Pressure will come to bear on terminally ill patients to accept 'voluntary' euthanasia. A serious risk of denial of the right to good palliative care may arise for those terminally ill patients who do not wish to volunteer for euthanasia.

Risks of unintended injustice for other patients. An inevitable consequence will be the creation of a pressure on all seriously disabled 'incurable' people in society. A law to permit euthanasia creates the concept of 'a life not worthy to be lived'. The possibility of euthanasia would inevitably arise for those with severe physical handicap, those with severe psychiatric illness and severely mentally retarded people. The Rummelink Report of the Dutch experience of

allowing euthanasia, documents that some deaths have been due to doctors deciding *for* their patients -- ie: *involuntary* euthanasia.

The better approach to 'dying with dignity' is to improve palliative care and make it more available. In my opinion the risks of a law to permit euthanasia (homicide by consent) are serious and not sufficiently appreciated. Adequate safeguards are not possible. The risks include violation of informed consent, psychological and financial abuse of ill patients, and deprivation for future patients of the natural justice of their right to adequate medical care.

JIM CAIRNS

Jim Cairns PhD was a minister in the Whitlam Labor government and prominent in the peace movement.

I believe that everyone has a right to decide to die. Life, and probably human life on earth is the supreme value. It is only in the most extreme circumstances that it should be ended.

If a person has a terminal, incurable or insufferable illness they have a right to request that their life should end. But in these and every other case, every possible assistance, care, affection and compassion should be given and more than possibly this may make life acceptable. In a very significant sense the relationships between those around the sufferer, especially a doctor, are of vital importance. Not only is there a right to die but there is a greater right to live as well.

It may be that acceptance of the right to die may reduce assistance, care, affection and compassion. Doctors may tend to select euthanasia rather than spend time to prevent it. Shortage of public hospital facilities may reduce assistance, care and affection for patients who may be sent home once it seems they are incurable.

Acceptance of euthanasia and abortion mean that far more should be done than is done now to make them unnecessary.

DENISE CAMERON

Denise Cameron is a registered nurse working in public health. She has been involved with the Pro-Life movement for 20 years and is currently secretary of Pro-Life Victoria Inc.

A recurring question in what has been written on the recent remembrances of Auschwitz has been "Did the Catholic Church speak out strongly enough against the holocaust?" I was born after the war so can't answer that question personally. What I do ask myself is would I have had the courage to speak out publicly against it? Would I have even known it was happening? Would I have bothered to find out or just preferred not to know, especially if as a gentile, it didn't affect me?

Claiming to only wish to promote community debate on euthanasia, Northern Territory Chief Minister Marshall Perron on announcing his Right of the Terminally Ill legislation, immediately pre-empted criticism by suggesting debate would be muddied by "irrational critics using words like murder, extermination!" and conjuring images of Nazi Germany in the 1930s. Pro-euthanasiaists are always sensitive to the relationship between Nazism and euthanasia, especially as some spell it 'euthanzia'.

As a nurse, I know this historical connection dates from the heinous medical abuses carried out before and during the Nazi era and that these abuses began with a watering down of traditional opposition to euthanasia within the medical profession. I *will* speak out now. Fifty years from now I don't want it asked 'Did the nursing profession speak out strongly enough?' I also want to know who Marshall Perron intends to do this killing. It isn't fair that people who joined a profession with the noblest of ideals, the preservation of human life, the alleviation of suffering and the promotion of health should find themselves drafted to kill. Reassurances that 'only doctors and nurses who believe in euthanasia' will be involved are useless. Euthanasia will divide the profession into 'those who do' and 'those who don't'. Subtle pressure, tensions and suspicions will inevitably result. Will young nurses, as in the case of abortion, find themselves (as one I know of) in the Director of Nursing's Office asked to explain why she refused to be involved? "After all, you're not a Catholic so you have no excuse!" More importantly, experienced, committed nurses know in this day and age, with such advances in pain relief and palliative care, euthanasia is simply unnecessary.

In December 1993, *On the Record* the Victorian Branch newsletter of the Australian Nursing Federation published an article on the Voluntary Euthanasia Society's Medical Treatment (Assistant to the Dying) Bill 1993 on which Marshall Perron has based his Bill. A storm erupted forcing the ANF to declare it did not have a formal position on either the proposed Bill or voluntary euthanasia. The Palliative Care Nurses' Special Interest Group wrote objecting to the authors, one of which was Helga Khuse (*sic*) "use of obviously proactive and generalist language which only goes further to cloud an already confusing and emotive issue". "As a collective of skilled nurses, Palliative Care Nurses Special Interest Group feel very concerned that to support and opt for active euthanasia nurses are abrogating their obligation to provide palliative care and ensure quality of life this way. Palliative care is surely a far better way to ensure client control right to the end", they wrote.

Professor Peter Singer and Helga Khuse's (*sic*) claim that a Monash University survey revealed euthanasia had a 75% support among nurses has been publicly criticised by nurses as being "in no way representative of the number of practising nurses in Victoria and that the slant of the questions asked in the questionnaire made no allowance for responses that would indicate any opposition to euthanasia as an option for the terminally ill. The phrasing of the questions made

the desired result inevitable".

Compassionate doctors and nurses provide dignified deaths with adequate and appropriate pain control, nourishment, fluids, bodily comfort, spiritual and family support. Not with a lethal syringe. The families of terminally ill patients who are not getting this should change their doctor, and their nurse.

This Bill affects all Australia. Marshall Perron has virtually invited us all up there. Jokes have been made about the Top End becoming the "Dead End" and Darwin the "Gateway to Euthanasia", but I wouldn't underestimate the entrepreneurial spirit of some. After all, we have 'pokie' bus tours. Australian Medical Association President Dr Brendan Nelson, who opposes this Bill has exposed to all Australians the neglect of Aboriginal health. Marshall Perron should be concentrating on this. The Northern Territory doesn't need euthanasia. Its Chief Minister needs bereavement counselling for the death of his mother five years ago.

JOHN CARGHER

John Cargher has presented Singers of Renown for the last 29 years and Music for Pleasure for the past 28 years on ABC national radio. For 20 years he was managing director of Melbourne's National Theatre and has written nine books on music.

The acceptance of voluntary euthanasia for terminally ill patients who are in pain will inevitably be accepted by a society which condemns cruelty. We do not endure the inflicting of pain on people and, sooner or later - almost certainly sooner - insisting that anybody should suffer pain *involuntarily* will be recognised as morally and legally indefensible. The only argument against such acceptance lies in religious beliefs, to which people are entitled. At the same time, the right to differ has been defended (and offended) in court, in government and, ironically, in wars which have caused endless suffering, not to mention the death of millions.

All of us are indoctrinated with some kind of belief, or acquire it in the course of life. My view is that God did not create man, but that man created God (in whatever form) in primitive times and for good reasons. The laws by which so-called good men live are good laws, but they were not laid down by some divine power, nor will there be punishment after death for those who break those laws. Nobody believes in the concept of hell any more, why does the concept of eternal salvation persist? It is up to man, not God, to punish those who break the rules and, justice being an imperfect thing, the rules are constantly being amended, as this very book is trying to do.

I can see no humane argument against euthanasia, while admitting that it is open to abuse, against which protection will have to be provided, no easy task. But that is only the first step toward an issue which, I also believe, will become morally and legally accepted, if not in my lifetime. It should be considered at this time, when the swing toward voluntary euthanasia is gaining momentum and I have not yet seen it proposed, let alone discussed in print. Several contributors to this book have agreed with what I am about to say, at least one going far beyond my own proposed line of action.

All arguments have been concentrated on the sufferings of terminally ill patients. Nobody pays any attention to the fact - and it is a fact - that healthy people of an advanced age may wish to end a life which, in the opinion of the person affected, holds little or no attraction in the future. Physical decay is an inevitable part of growing old. In the surroundings of a loving family most of us can grow old gracefully, and I would be the last person to suggest that any such life should be terminated prematurely, but there is another side to the picture, which is less clear-cut.

Anyone of reasonable intelligence is capable of foreseeing the shape of things to come. Why should it be necessary to decline in health and wealth (if any) when staying alive is likely to become a burden not only to the individual, but on the community and/or those who feel that it is their duty to look after dad or mum, no matter how great the hardship involved? How many children are denied this, that or the other because the household budget has to provide for some relative in a granny flat, old people's home or hospital?

Legally regulated euthanasia for the non-terminally ill has never been publicly aired, but at present opposition may be automatically assumed. My thoughts on the subject began many years ago when the then famous actor George Sanders committed suicide at the age of fifty-nine, because he felt that he had had a good life and that he could not see a better, or equally good one, ahead of him. His action could be considered a form of self-indulgence, particularly since, as a rich man, he had at his disposal the means of passing away in a peaceful manner.

Suicide is an ugly word and it is usually a tawdry affair because most people commit it under mental stress and in what is perhaps best described as a messy way. To be suicidal is not a good thing, but to evaluate one's own life and, after careful consideration of its effect on others, to terminate an existence quietly and legally is not at all unattractive to the elderly. To suggest, as one of my colleagues has done, that anyone of any age is entitled to take his or her life is preposterous; it offends at the very least the guiding principle which inspired the publication of this book: not to inflict pain on others. Teenager crossed in love are *not* entitled to inflict the resulting emotional trauma on their families.

Nevertheless. mental pain is as real as physical pain and it has been one of my publicly stated claims that voluntary euthanasia should be extended to the mentally stressed, who are rational intelligent human beings. You cannot be described as 'insane' simply because you are old and poor and neglected, and know that in time a possibly painful disease is the only release from your loneliness and physical hardships which no state can alleviate. And why should anyone financially in a position to depart from this world in an orderly fashion not be able to go to a court, pay the necessary legal fees and put a case that voluntary euthanasia should be made available? This could be legalised more easily than the present proposed legislation; malfeasance would be almost impossible.

Even for the well-off, is it not better to end it all at the point where the joy of living declines? The ability to make rational decisions is reduced with each day that passes. Some of us are old at fifty, some are young at seventy.

Each and every one of us surely looks into the future. Senility is a deterioration of the brain

which causes inability to make sensible decisions. Many of us would prefer not to reach that point. The evaluation of the advantages and disadvantages of a continued existence is surely the prerogative of the individual, yet we are denied the right to die at the time of our own choice.

Unless we act while our mind still works at peak capacity, the day of inexorable mental decline is bound to arrive, and danger looms that we become living vegetables, who consider every extra day of life an achievement. The corniest line of all is: 'It's good to be active'. Of course it is for the majority of people, but the phrase without qualification is meaningless. You cannot define *why* it is good to be alive. Not even the Bible says that we have an obligation to live. I do not believe that it says we are not allowed to die, if we so wish. But then, I have never studied the Good Book.

MIKE CARLTON

Mike Carlton is a Sydney journalist, satirist and broadcaster. He has won broadcast awards on three continents and now presents the breakfast program on Sydney's MIX FM station as well as writing a weekly column for the Sydney Morning Herald.

If there is a right to live then logic suggests a corresponding right to die. If you come, in all reason, to believe that a life of illness and pain is worthless to yourself and a torment to others, then you have the right to seek an end to that life.

When a patient has rationally expressed a wish to die, a doctor - or better still, doctors plural - exercising both medical judgement and the higher faculty of conscience should be legally permitted to assist that death.

SIMON CHAPMAN

*Simon Chapman is a sociologist and associate professor of public health and community medicine at the University of Sydney. He has been internationally active in advocacy for tobacco control for over 15 years and has written three books on the politics of tobacco. His latest book (with Deborah Lupton) is *The Fight for Public Health: Principles and Practice of Media Advocacy* (British Medical Journal Books 1994). He is co-editor of this book.*

On February 10 1984, my mother Margaret died in bed at her home. About a year before she been diagnosed as having breast cancer. She had a mastectomy soon after, followed by radiotherapy. For the next nine months she seemed mostly her usual optimistic self. She looked forward to coming to Sydney every three months to see her oncologist. At her November 1983 visit, it was discovered that the cancer had metastasised into her lungs. She came from the hospital straight to my office, where looking at my face for the slightest sign of hope, she told me that she had made up her mind to fight it.

After I started university in 1970, mum would sometimes come and have dinner with me and my student friends. She threw herself into every conversation about politics, sex and all the big topics. Then, as at home, I recall her many times saying things like "heavens, when my time's

up, I don't want to linger around in pain and misery ... I'd like to just go off at a time of my own choosing." If someone had knocked on the door with a survey about voluntary euthanasia, she would have told them the same.

But from the moment she was told the news about her lungs, all this changed. There was not a moment when even a crack appeared in her resolve to "fight it". She dredged up all that fighting spirit stuff -- the sort that had been with her during the London blitz, which had allowed her to live in the drab back room of her first business after migrating to Australia, knowing she would work her way out of it. From that morning on, her life became focussed on how she was going to beat this thing.

Two days later she went back into hospital and was knocked sideways with chemo- and radiotherapy. I visited her every day in a huge barn of a public ward and sat with her as she lay almost motionless, screened off by a thin white curtain. I had never seen anyone looking so sick. Still through this, she would cling to the smallest fragment of hope passed to her by the doctors and nursing staff trying to give her comfort. "The doctor said it had all gone well ... he said I'd be feeling much better in a week or two, and then it will be wait and see." "The way I see it, if I don't give it a go, then I'd never give myself a chance, would I?"

After two weeks she came home and was so exhausted she could barely bother to walk a few yards into the back garden to get some sun. She insisted on cooking us what would be her last Christmas dinner.

As the cancer grew, her breathing became increasingly shallow and rapid. Three weeks before she died an oxygen cylinder was brought in beside her bed. When you can't breathe properly, every moment of your life becomes preoccupied with getting the next breath. Lack of oxygen -- hypoxia -- causes disorientation and confusion. My sister and I had been taking it in turns to go down to her house in a small town and help. In the evenings we would sit with her and feed her junket through a straw. When we left the room, we left a bell near her hand so she could ring it if she needed anything.

I was sleeping on the floor in the next room the night she died. Dad woke me at 4am and asked me to come and see if mum was alright. I could see straight away that she was dead. The bell had fallen to the floor. Her body was still warm. Dad felt it right that the local doctor should be phoned right away so she could come down and tell us what was obvious. I pretended to phone and then sat with dad drinking scotch, every now and then going back in with him to hold mum. The last thing she said to me was about how the next day she was going to tell the doctor that she wanted to go back into hospital for another try with "the treatment".

When the news about her lungs came through, we knew mum was going to die. We didn't know when, but we knew it could be soon. All we wanted to do was comfort her, give our love and hope that it would happen with minimal suffering. Both my sister and I stifled the impulse to talk with her as we would have normally. We said to each other "She's going to die. The only thing she has to look forward to is this crazy hope she clings to. Who are we to try to take that away from her?" Dad has always been frightened and appalled by talk of death, regarding it as profane and unseemly. This made us keep him away from our often angry discussions about the way medicine conspired with the fear of death to build these optimistic artifices that were

deceitfully called "treatment". So the option that she take no further therapy was never really discussed.

I fell upon the phrase that the treatment she received after her November lung cancer diagnosis was in fact a form of medically sanctified torture. I said this to everyone I met when they asked how things were going. I did literature searches in oncology journals, confirming my understanding that the probability of the treatment she was getting giving any decent remission was practically zero.

The last weeks of her life were appallingly wretched. She existed in total exhaustion between the kingdoms of fear and anger, whipped along by what we sensed was an unflagging burden of virtuous stoicism. There seemed no respite from this tyranny of false hope. Our temptation to ease the subject into the open with her retreated beneath the force of the plea behind her often terrified eyes that we didn't. One night as I stroked her arm, she angrily brushed my hand away.

Where does this false hope, this "break my bones, but don't dare take away even the tiny chance I have" thing come from? Partly it must come from our culture's denial and sanitization of all things to do with death. Expressions like "brave", "battle with cancer" and "never stopped trying" say much about the way we spurn any resignation about imminent death.

Yet how needless much of her suffering all seemed. I tried to put myself in her consultant's shoes. Here was a warm, articulate woman only 64 years old, begging for hope ... pleading with them to do something, jumping at any nuance of a chance, stoically prepared to weather any misery involved. Was it fair of me to expect him to deny her any chance, no matter how remote or at what suffering? If her two children, with a lifetime of talking with her, were not prepared to raise the subject of putting up the white flag and accepting death, why should I expect him to do it on the basis of having known her for a cumulative total of perhaps a few hours?

It seems to me that above everything else, many in medicine feel the need to do *something* in the face of threatened death. It is almost as if it is sacrilegious to do nothing, particularly in circumstances when death may be still months away. If it can muck in with technochemical heroics which signify the defiance of all odds, there will be plenty of people there to cheer it along, and very few who will feel it reasonable to be angry if these attempts fail as they almost invariably do in cases like my mother's. Culturally, medical heroics dovetail with the arrogance of our collective belief in our earthly immortality. They represent the institutional expression of the cultural denial of death. For doctors trained and expected to rescue, revive and restore, the open recognition of the limits to medicine can come close to an admission of failure.

And if the decision to be frank about doing nothing is difficult, what of hurrying things along - what of the attitude that says "if I am honest with this person, I will not seek to hide that it is nearly certain they will die within weeks. These weeks are likely to become progressively miserable and will become more devoid of hope for any reprieve. Is part of my duty of care at such times to offer to end this suffering if it is requested?" In my mother's case this misery did not mean pain that could be relieved with drugs, giving the doctor a valued and sanctioned palliative care role. It meant instead that she would slowly suffocate to death over several weeks while becoming increasingly disoriented. She would have never wanted that. Who in

their right mind would? And what sort of medical ethics says that she should just have to put up with it?

If her doctor had not tempted her with treatment, she would have developed hypoxia but avoided the weeks of nausea and misery brought on by the treatment. The local GP who attended her in her last weeks did not offer and mum did not ask if her life might end with a sedative injection or drink. Each day she visited I would ask as mum lay gasping in the next room "how much longer do you think she has?" The answer was always indeterminate. Medicine devoid of any vocation to actively assist in the right to die, has no answer to such pointless suffering.

There are those who argue that there *is* some point to such suffering. I say let them feel free to exercise that option with their own deaths if it brings them a higher comfort. But I have only contempt for ethics that insist such degrading suffering should be compulsory for those whose fates select such paths. Any laws or codes of conduct which institutionalise a denial of the dying's right to determine their time of death do not reflect a civilised view of the end of life. The hastening of death in such circumstances, when the dying who have requested it are often incapable of taking action themselves, will require assistance. It follows for me that doctors and others should be able to assist such deaths with impunity where it is beyond any doubt that the dying person has consented.

Would my mother's experience have been any different if she had lived her life knowing that as well as tending you all through your life when you are sick, doctors could be there, like priests, to come at your call and give you the medical equivalent of the last rights? To supply you with a way of choosing your own time to go? If she had grown up in a culture when it might be as natural as day and night to say "my time is near, let's have the doctor help me avoid the worst of the suffering" ... would she have felt to impelled to put herself through so much wretchedness for what was really no chance at all?

And how different might her death have been if her doctor had decades of a medical tradition behind him which better enabled him to be frank rather than surreptitious about what lay ahead; about the futility of aggressive chemicals and radiation in prolonging her life; and who could instead offer options of assisted, painless death at a time of her choosing.

So yes -- to both questions.

EDWARD CLANCY

Cardinal Clancy is Roman Catholic Archbishop of Sydney. He is the most senior ranking Catholic churchman in Australia, and president of the Australian Catholic Bishop's Council. He is also Chancellor of the Australian Catholic University.

Euthanasia is given many fancy definitions, but in the end euthanasia always means killing somebody. The justification proposed for such killing is to save the person from suffering. After we have ploughed through all the rhetoric of the euthanasia debate, tried to understand all the complicated arguments, separated the emotion from the logic and looked up all the big words

in a dictionary, we are still faced with the bottom line: is it alright to kill somebody for reasons of compassion?

The answer to the question has to be an emphatic NO. Society has learnt from centuries of reflection and experience that profound respect for human life and a commitment to its protection is a foundation of our civilisation. The House of Lords Report on the euthanasia situation in The Netherlands contains these words:

"That prohibition (of intentional killing) is the corner-stone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia".

The traditional respect for human life is being assaulted on many fronts today.

Whatever the kindness and compassion of one's motives, deliberately to kill somebody, even at that person's request, in order "to put him out of his misery" is a barbarous act. To legitimise it in law would have disastrous consequences for our society. The calculated killing of somebody can never be just a private matter. It has repercussions that touch us all.

Those who believe in God have added reasons for condemning euthanasia: We are made in the image and likeness of God; human life is sacred; only God has dominion over human life. But quite clearly, opposition to euthanasia is not just a "religious" stance.

"We have a right to die with dignity", so it is said. To die can scarcely be described as a "right"-- it is going to happen anyhow, whether we like it or not. But we certainly do not have a right to be killed! And as for dying "with dignity", there is no dignity in taking an overdose or a lethal injection or in adopting some other such means in order to cheat some of the circumstances of dying. To die with dignity is to face and sustain those circumstances with endurance and courage.

That does not mean that such circumstances cannot be modified by means that are acceptable medical practice. The sufferings of the terminally or seriously ill are often presented in the most graphic and exaggerated terms. In point of fact, however, the science of palliative care has, in our day, achieved such sophistication in controlling and reducing pain that in most cases pain is no longer a significant problem. Arguments about euthanasia that do not stress the availability today of such treatment are inadequate and misleading.

It is also clearly to be understood that nobody is bound to undergo life sustaining treatment that is disproportionate to the expected outcome, excessively burdensome for the patient and futile. The withdrawal of such treatment, even if death is hastened as a consequence, is morally justified and is in no way to be confused with euthanasia.

Any law that permits euthanasia, however carefully framed, will, because of the very nature of the subject, be exposed to almost unlimited extension and abuse. Anybody who thinks that this is just so much fear-mongering should read an impartial review of the Dutch experiment, for example, The House of Lords Report. Assessments favouring the experiment have been shown

to be prejudiced and deficient.

The difficulty of containing the practice of euthanasia is one reason why no country, not even The Netherlands, has attempted to enshrine euthanasia in law. The Netherlands maintains respect for life in its law, but facilitates the practice of euthanasia, as an exception, through the courts. If Australia were to pass a law in favour of euthanasia in whatever terms, it would be the first and only country in the world thus far to do so.

Some individuals who in their terminal illness express a desire for euthanasia are given maximum publicity. This creates the impression that they are representative of the terminally ill in general, but they are not. They are the exceptions. The real push for euthanasia comes from other members of the community, who are often no more than self-appointed social engineers.

More and more do the proponents of euthanasia draw attention to the escalating numbers of the aged in the world and to the limits of available resources to treat the aged, the sick and the handicapped. This association of ideas is chilling in the extreme.

On no account should persons with terminal or incurable illness have the option of being killed. On no account should doctors be able with legal impunity to kill such patients on request. Australians must not allow themselves to be seduced by this culture of death.

EVA COX

Eva Cox has a formidable reputation as a social policy commentator with a long record in raising unpopular but important issues. She is a university lecturer in social welfare at University of Technology Sydney, a regular broadcaster on ABC radio and writing a book on women and leadership. She will be the 1995 ABC Boyer lecturer. At age 57, with both parents and step parents dead, she finds this topic uncomfortable.

Question 1. I believe that we should have the right to end our lives. And if we choose to do so freely, be assisted, where appropriate. This is probably the most private and individual decision we would make, because it must be our choice of whether further life is bearable.

It must be driven by guilt being a burden, or lack of services and support, so the community must ensure that this is an informed and free choice. There must be good access to all the necessary support services: good palliative care, counselling if requested, adequate pain relief and other alternatives must be available including the support and care that relieves family of the compulsion to provide care.

Question 2. And of course there must be medical practitioners prepared to act on people's request so dying can be done well. Paradoxically, I feel the right to die will make it easier to live longer, as the security of knowing the choice is there, may mean we choose not to exercise it. I have my own need to stay in control and go when I decide my quality of life is not worth having. While I appreciate this may be hard on family and friends I do not think I should have to live only for their comfort.

LORRAINE DENNERSTEIN AO

Associate Professor Lorraine Dennerstein AO is Director of the Key Centre for Women's Health at the University of Melbourne. She has a background in psychiatry and gynaecology. Her research and clinical interests include the psychological, social and hormonal factors in women's experiences of the menstrual cycle. Professor Dennerstein's contribution to medical education and to research in women's health was recognised by the award of the Order of Australia in 1994.

I recall the first time that I was personally involved in someone's death. As students, the consultants had discussed the suffering of patients with terminal cancer, and how drugs used to relieve pain often hastened death in weakened patients. This did not prepare me for the impact of actually prescribing the last dose of morphine to a frail, elderly man.

I was the night resident on duty for wards other than my own and called out of my sleep to authorise more medication for this patient. His family were around him at 3 am and we all knew that in relieving his pain, he would not see the morning. It was a joint decision that he needed the medication. After attending to other matters in the hospital I came back and sat with his family. He had died a few minutes before. They expressed their gratitude that his suffering had not been prolonged and that the edge had been taken off his pain in his last hour with them. I believe strongly that people with terminal illnesses should not have to suffer needlessly. Individuals in these circumstances are quite capable of making informed decisions about the manner in which their lives should end. Doctors should be able to assist such people without fear of legal constraints.

In contrast to this situation a great deal of my time as a psychiatrist has been spent trying to prevent people from taking their own lives. The distinction is that the suicidal ideation and behaviours of my psychiatric patients has been secondary to disturbed cognitions, the result of psychiatric disorders such as depression and schizophrenia. In these circumstances the psychiatrist is obliged to treat the underlying disorder, and the wish to die then resolves. Thus the wish to die was not occurring in the setting of clear consciousness. Rather the wish to die reflected the patient being out of touch with reality.

One patient in my practice succeeded in suiciding. She did not suffer from any psychiatric disorder at the time. Rather she was demoralised with life. Despite considerable psychological and social interventions and her own psychiatric nurse with her full time, she obtained drugs from other doctors and eluded her nurse in order to take her own life. She had spoken of her wish to end her own life many times, and did so in the setting of clear consciousness. I do not advocate assisting such individuals to end their lives. In fact I did all that was possible to prevent it. In the end she made her own decision and we must respect that.

ANNE DEVESON

Anne Deveson is a writer and documentary film-maker, and chairperson of the Australian

Society of Authors. Her last book, Coming of Age led her to decide that getting old was better than the alternative, provided euthanasia was an option should she suffer from a painful and lingering illness.

Question 1: Are you for, or against, the proposal a person with a terminal or incurable severe illness should be able to have their request granted that their life should end?

My grandmother, two of my three aunts, and my mother, all developed Alzheimers. This means that in periods when I lose my front door keys and find them in the fridge, I brood on what I would wish, should I develop the same illness. Without hesitation, I would want my life to end before I reached a point of total breakdown not only of my mind, but of my body. I would have the same wish should I be suffering from any other terminal illness and be at a point of prolonged and intolerable pain.

There are times when I romanticise this decision, when I fancy a splendid farewell feast where I would lie, serene and wise, and exit to the glorious sound of Richard Strauss' *Four Last Songs*. This is the stuff of fables though, the reality is more likely to be a hospital, or a hospice, but whatever the situation I believe that it is my life, my mind and body, my right to decide when I have had enough.

Two memories come mind. One of a gaunt fierce old Scottish woman in a London hospital. She had cancer. She was in pain. She had no control over her bladder or bowels. I can still see her in her long white nightgown, clinging to the bedrail and shouting into the night "If I were a dog you'd have let me go by now."

The other is my mother, telling me that she was lost in a cruel and terrible fog. She was in great fear, and she wept as she clung and begged me to help her to die. She had left it too late to do anything herself, and I did not have the courage to do it myself, so that in the last stages of her dementia, she was kept alive by antibiotics and by being force-fed; she was unable to control her bladder or bowels; unable to walk without falling over; her speech had gone, her limbs had become ulcerated and gangrenous. This was a woman once spirited and intelligent, a courageous woman who did not deserve to die in such abject disintegration. Come to that no-one deserves to die in such a manner, but then life does not deal in just deserts which is where I believe we should be able to intervene, just as we intervene in so many other aspects of living, in an attempt to provide justice and compassion.

Question Two: "Do you believe that doctors should be able (with legal impunity) to actively assist such people who request that their lives be ended through euthanasia"

Yes, is my answer, in spite of all the murky possibilities of harassment, personal or social, the potential for misuse against people who are mentally or physically disabled; of people opting to be bopped off because they feel they are a burden on friends and family; of a slippery slide to eugenic control and the gas chambers of Nazi Germany. But most areas of social intervention hold the possibility of abuse, and that should be no reason for opting out. Eugenic programs of the Holocaust were driven by racist and political attitudes already in place. Some doctors already quietly help terminally ill patients to die - and this isn't because we've developed new killer guerilla doctors.

Of course there would be need for stringent control, for monitoring and review, and for ways of ensuring that it is the wish of the individual - whether by Living Will or some other means.

People don't make decisions about dying lightly. It's not as if you wake up one morning and think "Oh, goodie, I'll ask nice Dr. Finlay - (grandson - emigrated) - for one of those new strawberry pink one-way injections today. Any more than women opt easily for abortion. So that what we are talking about is not a society which devalues life, but rather the reverse. We are talking about a society which does not wish to see people suffer unbearable pain and indignity when they are terminally ill, but to help them die free of pain when they wish.

I am not sure that the total burden should fall on doctors, and I do not think that anyone should be required to participate in euthanasia if it is against their wish.

JULIA FREEBURY

Julia Freebury is a feminist, civil libertarian and convenor of the Right to Die -- Dying With Dignity action group in Sydney. She was a leader of the abortion on request movement in the 1970s, once being president of the Abortion Law Reform Association.

Mahatma Gandhi said "Death is our friend, the truest of friends. He delivers us from agony. I do not want to die of a creeping paralysis of my faculties -- a defeated man." And Derek Humphry, author of *Exit* said "The option of self-deliverance for the terminally ill person is the ultimate civil liberty."

I have always held these views which were reinforced by my deep involvement 25 years ago fighting -- under the Askin regime --for the right to have an abortion. The arguments are almost the same. Those implacable "anti-free choice folk" not only say it is wrong but they find reasons for using their political know-how to use every trick to block reform. To them the distortion of facts is quite permissible. I have read with dismay in the press some well known commentators (lawyers and journalists) who were outspoken and good supporters of having the law changed on abortion, but who are against this issue. I too have come across people who were against euthanasia, then, when it affected them personally, changed overnight.

Marshall Perron's Bill requires that a second doctor, who has to be independent, must hold a degree in psychiatry. This insistence is poorly thought out. In some country areas there simply are no such doctors available. Bureaucratic delays will become a disaster.

A cooling-off period and two doctors with several years' medical experience and a living will is surely all that is needed? Living wills and advance directives must become legal and registered on a national computer base. What happens now sometimes is that if a senior citizen arrives at a hospital after a severe stroke, there is no way of knowing (without a computerised living wills scheme) if such a patient had signed such a document and would prefer not to be resuscitated. There is no reason why patients admitted to hospital cannot be given a leaflet on patients' rights and on living wills and advance directives. This has been done in the USA after Congress made it compulsory in 1991.

I would wish to see the establishment of a "retreat" where after a cooling off period, dying folk can elect to go to where they can be helped to die.

Fifty eight years ago, King George V was in great pain. It was the Queen who could not bear to see him suffer so, and asked Lord Dawson, the King's physician, to give the King his last injection of morphine. If a King can have his right of choice, why then can't we?

MORRIS GLEITZMAN

Morris Gleitzman writes children's books and magazine columns.

Could the people who are uncomfortable with me choosing the time and manner of my own death please drop round to my place soon as my gutters are leaking and my fridge is making a strange noise and I'd appreciate responsibility for these aspects of my life being taken out of my hands as well. By 9am Monday if possible. Thanks.

HARRY GOODHEW

Harry Goodhew has been Anglican Archbishop of Sydney since 1993.

The call for euthanasia comes at a time when life for so many people has never seemed so fragile or futile. In Australia, the teenage suicide rate is among the highest in the world; we suffer tragically high levels of unemployment, homelessness, drug abuse and family break-up; our population is ageing, creating greater demands on our health resources; and our streets are filled with the lonely, unloved and unwanted.

Against this backdrop we are being asked to sanction the intentional killing of one person by another. This, we are told, is an enlightened step toward personal autonomy; the compassionate response to individual suffering. I fear it is the counsel of despair.

Indeed, I am afraid that unless we turn the tide now, unless we say yes to life and act accordingly, euthanasia will increasingly become the 'easy' solution to some very tough questions. No longer will it be the answer to the terminally ill alone, but also the disabled, the aged, vulnerable and emotionally distraught: a response of hopelessness to the so-called 'too many' and to the 'wrong sort'. Death, in other words, will become the answer to the troubles of life.

How should we challenge this counsel of despair? I believe we need to capture a vision of generous care, an alliance of hope that recognises the value of each life, at each stage. Life is a gift from God, and humans, made in the image of God, are unique. This uniqueness carries with it special obligations to love our neighbours, care for the weak and support the dying.

Rather than justifying killing, the distress of a patient will demand from us greater efforts to relieve pain and discomfort. In compassion we will want to do all in our power to eliminate the suffering of the patient, not eliminate the patient who suffers.

The challenge to the medical profession, and indeed us all, is to relieve that distress through specialised palliative care. This will require a regard for the whole person - body, mind and spirit - a willingness to take on each other's burdens, and a commitment to act for the dignity of the individual. To give doctors the power to kill the innocent is a repudiation of our responsibility as a community and a contradiction of their very role.

Ultimately, euthanasia cheats us into believing that suffering is a totally negative experience. It is a view bereft of reality. For even death has its own lessons to teach us. It is the dying that awakens us to the gift of life, the dying that confirms the creativity of living, the separation through death that makes us experience more acutely our deepest human bonds, and the seeming wastefulness of death that makes us ask whether there might be something beyond the grave.

On that first Easter morning Jesus passed through death to life, never to die again. This is the ground of our confidence, that even for us, death is not the end. Socrates said that as humans we can suffer with dignity, Jesus shows us that we can suffer in hope.

NIGEL GRAY AO

Nigel Gray is Director of the Anti-Cancer Council of Victoria and President of the International Union Against Cancer, headquartered in Geneva. He is internationally renowned for his work in advocating for tobacco control by governments. His contribution originally appeared in The Age on 10 April 1995.

Everybody is agreed that patients should die where they like, with whom they like, and in comfort. Not everybody is agreed that they should have the right to say when and this, not surprisingly, engenders debate - there are principled and honest people on both sides.

Victorian law is already pretty good. Patients have the right to refuse further medical treatment. Given this instruction, doctors have the right to give suitable palliative care and wait for Nature to take its course. This is legal and is not called euthanasia. It is, in Victoria, possible to make dying patients comfortable and this is particularly the case with cancer. The process can be handled by a competent general practitioner or other suitable medical attendant, with family, friends and nursing support.

Euthanasia is often discussed in relation to cancer. Existing law and very rapidly improving palliative care should make this part of the debate progressively less necessary, if it ever was. However, a rational person with a committed desire to die poses a dilemma for many people. Broadening our palliative care services to help those with *progressive* diseases (motor neurone disease for instance) ought not to be impossible. The dilemma arises most with rational patients, suffering *stable* but *persistent* diseases, who want both the right to die and help to achieve it. Many of our more literal thinkers want the law changed for this purpose, as do some patients, to specifically permit active euthanasia.

Regardless of their wishes and good intentions the consensus to change the law clearly does not exist now; and we can only work to use existing law, the existing right to refuse medical treatment, and better palliative care to help these patients. It's my opinion that very few well cared for patients will need formal euthanasia of the sort proposed by those who wish to change the law, but this view is open to dispute.

Legal euthanasia is a rather bureaucratic process - regulations, multiple opinions, certificates and signatures - whereas palliative care *is not*. There is a problem of definition too; one person's euthanasia is another person's palliative care.

One can't object to the right of those wanting legal change to bring it about but I would hate to lose sight of the main target - more widespread use of the techniques and laws we already have.

These comments illustrate why the Anti-Cancer Council of Victoria is seriously neutral in this debate. We have great diversity of view in our ranks of voluntary advisers. However lack of unanimity is no excuse for not trying to do what we are already able to do, better, and for more patients, while the debate continues.

KATE GRENVILLE

Kate Grenville is a Sydney writer. She holds degrees from the University of Sydney and the University of Colorado. Her novel Lilian's Story won the Vogel/Australian Award in 1985. Her latest novel is Dark Places.

Voluntary euthanasia has been happening for as long as people have been dying, and it will keep on happening until the last Trump sounds. It's a reasonable thing to wish for a speedy end to suffering which isn't going to result in recovery or even respite, and people are going to go on finding ways of ending their lives in intolerable situations.

Since it's going to keep happening, it seems to me humane as well as rational to allow this last decision of one's life to be taken in an open, honest and dignified way. The situation at the moment is that everyone's grief and pain is increased by the fact that euthanasia is illegal and difficult. The person wishing to die is aware that anyone who assists him or her is breaking the law. That's a heavy burden to place on a loved one or doctor. However an equally heavy burden must be to stand by helplessly while another human being suffers for a needlessly long-drawn-out time.

Of course voluntary euthanasia needs stringent legal safeguards, but surely these aren't beyond our ingenuity. The main problem, I imagine, would arise in situations where the person involved isn't able to make a clear request. Perhaps we should all make our wishes clear before the situation arises, by making a "living will". This would give us the peace of mind of knowing that we would not be kept alive in a situation where we would rather be dead. It would also relieve our relatives of making a terribly difficult decision on our behalf.

BILL HAYDEN

Bill Hayden has been Australia's Governor General since 1989. His contribution is part of the Arthur E Mills Oration he delivered to the 1995 annual meeting of the Royal Australasian College of Physicians.

Passive euthanasia is already sanctioned by law. The Catholic Church, with its impressive concern for human life, accepts the practice of double effect and proportionate and disproportionate means, within certain strict guidelines Pope Paul VI has stated, 'The duty of the physician consists more in striving to relieve pain than in prolonging as long as possible with every available means a life that is no longer fully human and that is naturally coming to its conclusion.'

The Northern Territory has recently legislated to permit active intervention hastening death for the terminally ill, practised within strict guidelines. Opinion polls reveal three out of four respondents support active euthanasia. Within the past several weeks there has been comment from within nearly every parliament in Australia that a private member's bill will be introduced to legalise the practice. I would anticipate that this form of legislation will be Australia-wide before the turn of the century. It is a development which I would support. It is human and preserves the right to death with dignity for those who choose it or who, through a 'living will', have arrangements in place for the decision to be competently taken on their behalf.

Palliative care, prolonging life through the difficult terminal stages of a medical condition, is a compassionate response. So is passive euthanasia. The preferred option for some of us - most people according to those polls - would be the choice of active euthanasia. In principle I fail to see any difference between passive and active euthanasia. By consciously deciding not to do something of which I am capable and another person's death ensues - a death otherwise avoidable at that point - I am actively collaborating in bringing about that person's death. The distinction between that and my actively intervening to meet a dying person's wishes to avoid distress and effect a speedy and dignified end to that person's life seems to me rather narrow. What I am discussing is the ethics of hastening death in certain conditions.

The utilitarian judgements of, for instance, economists and many health workers cannot be totally ignored in this discussion, in spite of the sanctity which our society invests in human life. For instance, US studies disclose that people over sixty-five use medical services at 3.5 times the rate of those who are younger, that the 11 percent of the population who are over sixty-five use nearly 40 percent of short-stay hospital days, and the 4.4 percent who are over seventy-five used 20.7 percent.

People over eighty consumed on average 77 percent more medical benefits than those between sixty-five and seventy-nine. For US Medicare recipients, which covers the aged and some low-income groups, those who died were only 5.9 per cent of enrollees but they accounted for 27.9 percent of program expenditures. The undeniable fact is that 'a unit of medical care consumed late in life will have much less effect in preserving life and

maintaining normal species-typical function than a unit of medical care consumed at a younger age'. *Prima facie* the case for more spending on preventive care and on direct assaults on specific diseases would allow more people to live a normal life span and in good health.

Attitudes to death, of course, are a product of social conditioning. The Inuits left their aged to float away on ice floes; the Trobriand Islanders celebrated the impending departure of their

aged with a feast and entertainment. The aged then went away to quietly die in the bush from the effects of their food which had been poisoned, as they well knew beforehand. The elderly

among the ancient Japanese retreated to a mountaintop for the same purpose. Certain nomadic tribespeople abandoned their aged and infirm by the side of the trail.

The Greeks on the island of Ceos, while it was under siege, required people sixty-five years of age and over to commit suicide. The Stoics of Greece and Rome, such as Seneca, proposed suicide as the responsible act of a wise man instead of attributing excessive importance to mere life itself. It was better, they believed, to establish a level of disengagement and wisdom allowing one to calmly end one's life at the appropriate time.

Now this all seems rather primitive and brutal by our standards. It made good practical sense for the times and the people concerned.

Thus there are some in our community who, denied the choice of medically-administered, painless voluntary euthanasia, would wish to exercise the death option themselves. Several years ago a former Governor of the Reserve Bank and his wife, both quite healthy, did just that according to newspaper reports of the time. Having concluded they had lived a full and satisfying life, and that there was little ahead of them but to wait for the emptiness of death, they drank a draught of whisky and swallowed some pills, lay down and went to sleep for ever.

I view the prospect of the closing days of my old age with apprehension. I have visited too many nursing homes, seen too many vegetating old people who were once vigorous, vivacious

personalities now dependent on their middle-aged children, much as when infants those children were dependent on them. This loss of personal control, of autonomy, of human personality would destroy my sense of human dignity. Moreover, having had a full and satisfying lifetime, there is a point when the succeeding generations deserve to be disencumbered – to coin a clumsy word - of some unproductive burdens. That is why I support voluntary, medically-assisted euthanasia and the provision of a 'living will'. In the absence of these I would, like those Trobriand Islanders, prefer to leave the community early rather than too late, go out and find my place of lasting rest in forest glades. Perhaps I may want to do that early even, at a point after a full life has been lived and before the breakdown of body and mind take over a once-sentient personality.

In summary, I have been talking about certain key principles in a liberal democracy. The right to choose one's lifestyle, provided it does not harm others; the right to be autonomous and free; to be a responsible citizen by exercising choice and not have the state coercively impose a narrow, predetermined form of morality by which all are supposed to conform. It has also

been about accepting the consequences which come in the wake of choice, including a radical change in values, and to accept that if we had not properly thought our way through those consequences beforehand, that is our fault. The determinists, of course, would challenge this view and there is something in their argument. But for people like me who have spent most of

their life autonomously determining their fate, alibis for failure cannot be found in blaming someone Or something else. In short, I must rule myself by my own judgement and my conscience.

The authentic life is led from the inside, by what one genuinely and decently believes, rather than having those things imposed from the outside either by social convention, which can be badly flawed where true personal freedom and autonomy are concerned, or by government fiat.

Aquinas probably said it best in his *Nicomachean Ethics*, 'If a [person] acts according to his [or her] conscience and ... conscience is right, well and good: if ... conscience is mistaken but through no fault of [that person], then his [or her] action is not morally bad.' And this is, really, where I started. The pace of change, the complexity of our social relationships, the rapid reshaping of our values, the increasing autonomy of individuals all mean greater responsibility to make choices. They imply we must redefine our relationships so that we can understand and make our social system function satisfactorily, and I trust fairly.

The challenge to do this can be confusing, even disturbing. We have been used to social guideposts which hitherto seemed permanent markers, but which have been uprooted and replaced in this modern age. We are at the existentialist point of making ourselves by our choices, of being responsible for ourselves.

The more who fail to do this, the smaller the group who will make the decisions for them. And that would be a most unfortunate consequence: for it would be neither liberal nor democratic.

GERARD HENDERSON

Gerard Henderson is a newspaper columnist and executive director of The Sydney Institute

My response is (Question 1) "For" and (Question 2) "Yes". Without qualification. My (late) dogs Laddie, Tigger, Kanga and Ranger all had the benefit of a dignified exit at a time of terminal illness. I fail to see why, in similar circumstances, such a death should be denied to me and/or my (human) loved ones.

Bossy-booting moralists have a right to preach at large. But they have no right to regulate how others should die.

HARRY HERBERT

Rev. Harry Herbert is General Secretary of the Uniting Church Board of Social Responsibility in the NSW Synod. In that role he deals with chaplaincy, community service and social justice issues on behalf of the Uniting Church. He is also President of the NSW Council of Social Service and a member of the Legal Aid Commission of NSW.

I am opposed to the legalisation of euthanasia for a number of reasons, one basic and some secondary. My basic reason stems from my Christian belief in God whereby I believe that all life is under the sovereignty of God. It is not appropriate for humans to usurp the role of God in deciding when our life is finished. This is the reason why Christians are opposed to suicide. It is not lack of compassion or understanding for the person involved, but a strong conviction that we must not take life into our own hands. So, although I am aware of the reasons why some people with incurable illness want to have a doctor give them a lethal injection, I think that to legalise such a practice would mark a fundamental change in the way in which we understand life issues generally.

People who support voluntary euthanasia will argue that I have a perfect right to hold my beliefs, but that they should also have the same right and have access to a lethal dose at the time of their choosing. They will say that Australia is not a Christian society, and therefore Christians should not impose their beliefs on the rest of the population. I don't disagree with that argument in some cases. However, in this case I want to stress that I also oppose euthanasia on the grounds of what it would do to the perception of life issues in the community generally. In other words, apart from my Christian beliefs, I think that to legalise euthanasia would be bad for our society. And it is worth noting that the fundamental principle of the sanctity of human life is not restricted to Christians. It applies in most other religious systems, including Islam and Hinduism and is included in Article 6 of the International Covenant of Civil and Political Rights. In addressing the wider impact on society, I need to raise some of my secondary reasons and questions.

What will it do to the medical profession if it is understood that they also have a role to administer death as well as to support life? Will elderly people who have had strokes, start to fear their doctor because they think (probably even wrongly) that he may have formed the view that death is the best option? Will we really be serious about addressing palliative care issues if euthanasia is legalised? While it is always promoted as a voluntary matter, won't it start to put pressure on people who are incurably ill to take that option? And will it shift our perception about people who are incurably ill and how we deal with them?

While I don't have all the answers to those questions, I am seriously concerned that in some cases the legalisation of euthanasia will have implications far beyond giving permission to a small group of people to do something they have requested.

Then, of course, there are all the practical issues of obtaining informed consent. It is easy to speak about living wills and powers of attorney etc, but how can a person be realistically held accountable for actions taken years previously when they lacked appreciation of the real situation in which they later found themselves? It is not surprising that opinion polls indicate

public support because people often answer the question before they fully appreciate the issues. For instance, many people answer the question in the context of not wanting to suffer unbearable pain, but don't appreciate that such situations are very rare.

Again, some people support voluntary euthanasia for other people, but have they really thought about themselves? On a talk-back radio program on this topic, after I had given my reservations, one caller said that she would "just like to have it as an option". I tried to get her to give her reasons, when I soon realised that she was not talking about herself, but about her mother. I am very suspicious of the many claims that voluntary euthanasia is so widely supported.

Also, many people confuse active euthanasia with passive. There is certainly wide community support for not actively working to maintain life when natural forces are against it. Lots of elderly people in nursing homes express the wish that they not be resuscitated if they stop breathing or not receive antibiotics if they have pneumonia. But, when we are speaking of voluntary euthanasia we mean a doctor would administer a lethal injection, or use some other means, to kill a person.

Voluntary euthanasia lobbyists give great stress to the rights of the individual in this matter. They argue that if people want this, why can't they have it? I don't think it is nearly as simple as that, and that legalisation of euthanasia would herald profound and unwelcome changes to the way in which the whole community understands life and death issues.

Of course, I must emphasise that the views expressed here are my own, as the Uniting Church has as yet no official view on the matter. However, I do stress that the church cannot simply pontificate on this issue, but the Christian community must be active in seeking to help dying people and to help the community address the palliative care needs of such people.

I would also want to add that despite the views I have expressed here I would want to be open to continue to hear the arguments in favour of euthanasia. By all means let us have a good community debate. Churches and Christians and people like myself need to be ready to see the issue from the perspective of others, especially terminally ill people. For Christians, this is a theological issue and all theology must be informed by the real situation in a society. I must admit that it is easy for me to write an article setting out all the reasons why I think the legalising of euthanasia would be wrong, but I might have another perspective if I were terminally ill myself. Finally, euthanasia is not a black and white issue, even though I have argued against its legalisation. When it comes to specific legislation, it may well be that Christians will be able to find some areas of agreement with those seeking voluntary euthanasia legislation.

JOHN HINDE

John Hinde is the ABC's television film presenter. He has a long history as a journalist, a newsroom editor and a war correspondent for the ABC and the BBC.

When my friend Andrew went into hospital a few years ago and found he had cancer that couldn't be treated, he said to his doctor "You'll help me out when it gets bad, won't you?" He

knew what we all thought we knew: that doctors don't let you suffer for too long after it gets so bad that you have to ask. Back when we were kids ... right back when our mums and dads were kids ... it was part of the human kindness of the world. Or that's how our mums, and sometimes our dads, told it.

But Andrew's doctor said "I can't do that! No doctor can do that! We'll do all we can to make you comfortable. But ..." and he gave Andrew a lecture on medical ethics. Andrew was appalled. Times had changed. He was alone. And he felt it. Badly.

Yet perhaps he wasn't. He went much more easily and in much less misery than he might have. Some of us thought his doctor had helped. Perhaps he just wasn't willing to be, in his own mind, a paid agent of death. Perhaps he wanted to be allowed, instead, to be mediator between Andrew's ultimate misery and his own conscience.

And there's the problem. It's hard for many of us, perhaps most of us, to quarrel with the individual right to court death and meet death as she or he wants to, or needs to.

It's inhuman to condemn the medico who's willing to face his own ambivalences and suffer from them (as anyone must however cool he thinks he is) when he must decide whether or not to help a patient escape from terminal misery.

To do it she feels, if the decision is yes, will be to add as best she can to the fuzzy logic of human kindness in the world. But because the real world does work by fuzzy logic, something changes when you give a legal blessing (and inevitable legal rules) to this dark, dangerous, life destroying and life enhancing, human decision to turn a life off.

Who needs to dwell on the effects of blanketing that secret sledgehammer of awareness and anxiety that makes the conscience of the kind ring like a bell and race through the whole register of possibilities in that moment of decision to end the suffering? Or on the story-book certainty of "euthanasia murders" for gain or to get rid of unwanted people?

Of course we have the right to end our lives. Of course we have the right to ask someone to help. But the logic of "helping" is too fuzzy to identify with "rights". Perhaps the Northern Territory experience will penetrate the fringes of the fuzz.

ELIZABETH JOLLEY

Elizabeth Jolley, novelist, teaches part-time in the School of Communications and Cultural Studies, Curtin University, Perth. She has three children and four grandchildren and shares the universal concern about issues of health and the quality of life in the future.

On February 7th 1766 Parson Woodforde, then curate of Castle Cary, Somerset, England describes, in his diary, how his sick mother sent for him and his brother Jack to come up to her room where she *very solemnly took her leave of us; therefore I do not believe she can exist very long in this world ...*

And on February 8th he writes "It pleased almighty God of his great goodness to take unto Himself my dear good Mother this morning about nine o'clock, out of this sinful world, and to deliver her out of her miseries. She went out of this world as easy as it was possible for anyone..."

There are many deaths and burials recorded in Parson Woodforde's diaries. These are mentioned as an ordinary part of life but with full recognition that death is a deliverance from the unendurable. Similar thoughts are expressed in many writers' works, perhaps in particular, some of Wordsworth's poetry.

A slumber did my spirit seal;
I had no human fears:
She seemed a thing that could not feel
The touch of earthly years.

No motion has she now, no force;
She neither hears nor sees,
Rolled round in earth's diurnal course
With rocks, and stones, and trees.

Thomas Traherne, earlier than both Woodforde and Wordsworth, celebrates the miracle of birth. He is said to have shown, in his poetry, *the earth with the dew on it* as during the sunrise in summer. His poem *The Salutation* opens with these lines:

These little Limmes,
These Eys and Hands which here I find,
These rosie Cheeks wherewith my Life begins,
Where have ye been? Behind
What Curtain were ye from me hid so long!
Where was? in what Abyss, my Speaking Tongue?

and

I that so long
Was Nothing from Eternitie,

Did little think such Joys as Ear or Tongue,
To Celebrat or See:
Such Sounds to hear, such Hands to feel, such Feet,
Beneath the Sides, on such a Ground to meet.

Traherne's poem is a long one. In it he regards each newly born infant as a gift containing, in its tiny body, more wealth than is to be found in the whole world. Birth is a gift. Death is another gift, an inevitable one. It is our destiny from which there is no turning aside.

During my years of training as a nurse (from 1940 onwards) I understood that many patients were helped by prescribed medication to sleep on peacefully into death. Nurses, in those times, sat with dying patients. Often nurses would kneel by the bedside and pray. As a young nurse I felt the responsibility heavily and prayed, one time, that the patient with a lung haemorrhage, would stay alive till the relieving nurse arrived. A night sister, with 30 years of night duty to her credit, reprimanded me as if she knew what was in my prayer. She told me that I was not God and that the patient would die, in spite of what was being done for him, when it was the given time for his death. I have never forgotten that this responsibility was, in this new understanding, lifted from me.

A certain ambivalence persists and invades the thoughts on the proposal under discussion. I know that if I should be in a distressing and painful condition in old age or a terminal illness I would like to be helped to die. There are difficulties in that there has to be the person to carry out this wish. Another difficulty is the thought of the mysteriousness and the celebration of the given time from birth to death and our not knowing why we were born at a particular time. We do not know why we have had certain experiences and why we made decisions, and why we met the people we met and why we gave birth to more lives and why we recovered from certain illnesses and why life should be so hard and sorrowful and so on ...

It is all this, in this given time between birth and death, not knowing why we have lived, yet being conscious of following certain directions in our lives as if following a laid down pattern and being, at the same time, watched over and cared for and directed as if in answer to prayer (even when prayer is forgotten or discarded), which causes feelings of ambivalence towards this very important question.

I feel that I am not capable of giving the best answer. I will say that after being beside the patient who, after his unendurable sadness and pain, sleeps on peacefully into death I would choose for all to be able to do this if they wish it.

On further reflection, in spite of the above ambivalence, I think a patient with a severe incurable terminal illness should be allowed to ask for death.

And naturally, in these circumstances, doctors (with legal impunity) should be allowed to actively assist those people in their request to have their lives ended. We do at present govern lives with advanced medication and operation to advantage.

ALAN JONES

Alan Jones is one of Australia's most popular broadcasters and newspaper columnists. He has worked as a teacher, a political adviser, a rugby league and rugby union coach. His contribution was originally published in the Sunday Telegraph on 23rd April 1995.

There are a few human realities which better demonstrate the inadequacy of present law than the ongoing debate over euthanasia. When a number of Melbourne doctors recently described the present laws as hypocritical and admitted helping terminally ill patients to die, they highlighted again the extent to which the law seems out to step with reality and the public's expectations.

A Morgan poll on euthanasia, conducted in August 1994, found that 78% of Australians believed a doctor should be legally able to administer lethal treatment at the request of a terminally ill patient. A similar survey of NSW doctors established that 50% of them would be willing to help the terminally ill to die if such action were legal.

Certainly, allowing doctors to make decisions in consultation with terminally ill patients and their families may, to some extent, be enabling them to play God. But doctors have always enjoyed a very large degree of trust and respect in the community - a trust the present law may not properly recognise.

Last week demonstrated clearly how slavish adherence to legal principles can lead to the very opposite of justice when a drug trafficker walked free after the High Court determined that police had acted illegally by infiltrating his drug ring. It is easy to see how similarly rigid principles, which fail to take account of context, circumstances and outcome could lead to convictions of doctors for mercy killing - convictions which most Australians would consider unjust.

There's nothing wrong with principles *per se*. But the logic of principle can sometimes be as misleading as it is convincing. It is, for instance, simply inadequate to adopt an inflexible principle that all premeditated killing is murder when the ordinary person's perception of what constitutes murder is affected by circumstances such as mercy killing.

None of this is to deny that statistics revealed by the Netherlands 1990 Rummelink inquiry into euthanasia are pretty startling. Voluntary euthanasia has been legal in the Netherlands since the 1980s. According to some commentators, the Rummelink inquiry statistics show that Dutch doctors killed 19,275 patients in 1990, many of whom had not given consent even though they were capable of doing so. The sheer volume of these numbers is disturbing.

On the other hand, it is easy to be shocked by figures in isolation when they cannot be compared with other figures simply because no comparative studies on euthanasia have been carried out in the Netherlands or anywhere else. In other words, there's nothing to indicate how many assisted killings, voluntary and non-voluntary, occurred in the Netherlands before the introduction of voluntary euthanasia legislation there.

For all we know, there could have been more. So it isn't fair to use the Rummelink inquiry to condemn voluntary euthanasia legislation without any evidence of what the statistics were

before the inquiry. Before the Rummelink numbers are examined closely, some of the various categories of euthanasia should be distinguished.

Voluntary euthanasia occurs where a patient has expressed a wish to die - as opposed to non-voluntary euthanasia where he or she has expressed no such wish. Active euthanasia occurs where a doctor takes active steps to bring on death; passive euthanasia is where the doctor simply agrees not to administer treatment which will prolong life.

Another distinction is made according to whether a doctor administering active euthanasia does so by means of a non-therapeutic drug, which would be a toxic substance designed specifically to kill, or by means of "life-shortening pain relief".

It's worth noting that of the 19,275 Dutch patients in 1990, 7,875 died as the result of doctors withholding treatment; 8,100 from life-shortening pain relief; and only 3,700 from taking a non-therapeutic drug.

Those who argue against the legalisation of euthanasia have made much of the Rummelink inquiry's findings, which established that while 27% of the 8,100 who died from life-shortening pain relief were capable of giving consent, 60% of them (1312 patients) were not asked for that consent. Naturally, this failure to obtain consent would make the killing of those 1,312 people a criminal offence. But it's also easy to understand how distinctions might become blurred in circumstances of enormous pain and suffering.

Indeed, AMA president Dr Brendan Nelson, who has himself admitted helping two patients to die during his 11 years in practice, has distinguished between treatment used to alleviate pain, which still could end a patient's life, and euthanasia. Dr Nelson's point was that a doctor does not necessarily administer such treatment with the intention of causing death, but rather of alleviating pain. When looked at from this perspective, consent may not, at the time, seem necessary as the alleviation of pain - rather than causing death - is the doctor's primary concern.

It would be dangerous to adopt a cavalier attitude towards euthanasia. Life is humanity's most precious commodity and must never become expendable. But it is also precisely because life is so valuable that the last moments of life ought to be afforded, in extreme circumstances, some kindness and dignity by highly trained and highly trusted professionals, without fear of legal consequences.

Northern Territory Chief Minister Marshall Perron's private Member's bill to legalise voluntary euthanasia, and the courageous public admissions of a number of doctors, have once again placed this issue firmly on the public agenda.

Euthanasia deserves debate and legislative response. There is no doubt that legislation is a delicate balance between imposing and reflecting public mortality, and there are always good reasons for caution. But there are also good reasons to begin to recognise that principles, including legal principles, ought to be flexible enough to reflect human reality and realise human expectations.

MICHAEL KIRBY

*Justice Michael Kirby AC CMG is President of the New South Wales Court of Appeal.
Chairman, Executive Committee, International Commission of Jurists.*

It is a curse, being a lawyer. You find it so hard to respond spontaneously to any question. Should people in a terminal condition experiencing outrageous pain be given help to stop the intolerable suffering? Of course they should. But that is not what the question asks.

"Are you for, or against, a proposal a person with a terminal or incurable severe illness should be able to have their request granted that their life should end?"

Whose "proposal" is this? Who is the "person"? Is the person of full intellectual capacity or so riven with pain and distraction that an informed decision cannot be made? Who says that the illness is "terminal"? How many doctors are needed to certify that it is "incurable"? How can we ensure that those who do so are completely neutral in the assessment? In any case, some terminal or incurable illness, although severe, are not immediately painful. What procedures must one put in place to ensure against snuffing people out prematurely upon their ill-judged, spontaneous and possibly temporary desire that this should be done?

We are living through an age of economic rationalism. It has taken control of everything - from the monarchy and the courts through to the healthcare system. To be perfectly blunt, I would not want such people to have any say whatever in the decision to end a human life. They might, just, be tempted occasionally to look at the problem from a purely economic point of view. Thank God, human lives are not mere statistics. They are not simply economic units.

Above all, who is it who will "grant" their "request"? The very idea that there is this Granter of Requests is a trifle worrying. Bet your bottom dollar he or she is wearing a white coat. In the past, we have usually involved the symbolic representatives of the whole community in formal decisions to stop a life before nature is ready. There was a time when Judges in black coats were the great Terminators - donning a black cap when they pronounced the awful sentence to symbolise its terrible significance.

The question therefore makes many assumptions. Persons, with or without a terminal illness, can bring their lives to an end even now. They commit no crime. If there is the will, there will usually be a way. So the question appears to be addressed rather to protecting doctors and other healthcare workers if they give a hand than protecting the patient. In this sense, the first question is just a softening up for the second which is about legal impunity.

Why should the impunity be restricted to doctors? What is "euthanasia" - a rather self-serving word? What is the difference between actively assisting and simply withdrawing heroic intervention? What precautions are introduced to ensure that the "people" involved are able to make an informed choice? What assurance is there that their "request" is fully informed, carefully thought out and removed from the pressure of an avaricious family or other beneficiaries keen to advance their bounty'.⁷ What happens when they are in a coma and cannot chose for themselves?

I have said enough to show that my concerns are mainly those about procedures and

safeguards. The great social advantage which our current embargo upon active assistance to ending a human life secures is this. It recognises the integrity of each human life, no matter how futile and worthless it may seem to others. It protects the old and the sick, who are vulnerable, from those who might have motives to hasten their departure. It sets the standards of respect for human life that we would usually wish to be observed for ourselves and those whom we love most dearly. It respects the most important human right of all - the right to live.

But if, by proper procedures, it is clearly shown that a condition is terminal, accompanied by pain and the life in question has made an informed decision the case for being enabled to seek help to bring suffering to a close is strong. Relief of pain which has become unendurable is a proper imperative, for such pain makes a mockery of 'life'. Everyone knows that some painkilling procedures carry risks to life. At the moment, this is how we muddle through with our inconsistent objectives of defending life and relieving insupportable pain. A lot of relief will ease the pain. But it may shorten the life. So I would not oppose a facility of skilled medical assistance in certain cases. But separating the patient from the beneficiaries is an absolute prerequisite. And one would hope that the assistance would be provided by a reluctant and cautious medical profession. Not by enthusiastic specialists in "euthanasia".

HELGA KUHSE

Helga Kuhse is a doctor of philosophy, working in the area of bioethics as the Director at the Centre for Human Bioethics at Monash University in Melbourne - She is the author of numerous articles and books on various topics in bioethics, including the ethical issues raised at the end of life. Two of her books are of particular interest in the context of this book -- The Sanctity of Life Doctrine in Medicine - A Critique (Oxford UP 1987) and Willing to Listen - Wanting to Die (Penguin Books, 1994.) Dr. Kuhse is the Past President of the World Federation of Right to Die Societies, and of the Voluntary Euthanasia Society of Victoria.

Four of five Australians believe that incurably ill patients, whose suffering cannot be relieved in any other way, should be able to request direct help in dying from doctors who are willing to provide it. I am one of these Australians and have therefore welcomed the passage of the Northern Territory Rights of the Terminally Ill Bill, which decriminalises voluntary euthanasia and medically assisted suicide.

Why do I hold this belief? The answer will emerge, from my criticism of recent events. As I am writing this - three days after the passage of the historic legislation on May 26, 1995 -- I have just learnt that Catholic and Anglican church leaders are launching a campaign to thwart the spread of voluntary euthanasia legislation to other states. It would not have perturbed me if I had learnt that these Church leaders were reminding members of their faiths that voluntary euthanasia, assisted suicide and even suicide are, according to traditional Christian thinking, always morally wrong. But Dr. Harry Goodhew, the Anglican Archbishop of Sydney, has done much more than that. In a letter sent to the clergy and people of the 272 parishes of the Sydney diocese, to be publicly read in all Sydney Anglican churches the following Sunday, he says "that if euthanasia legislation does come before the NSW parliament, Sydney as a diocese should oppose it strenuously." In urging this, the Archbishop goes beyond his religious brief, steps into the public policy arena, and seeks to impose a particular religious morality on *all* citizens of the state.

Australia is not the Anglican or the Catholic Church writ large. Rather, it is a pluralist, multi-cultural society made up of people of very different faiths, and of no faiths at all. There is a diversity of moral viewpoints, quite different, for example, from the more uniform set of moral beliefs that characterises present-day Islamic states, or that was prevalent at the time when the great Roman Catholic Thomas Aquinas thought that heretics should be killed.

Living together peacefully requires respect for autonomy and each other's moral and religious values and beliefs. This entails that we must learn to be tolerant and guard against moral absolutism and self-righteousness.

As John Stuart Mill has so aptly put it in his great essay *On Liberty* "The only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others Over himself, over his own body and mind, the individual is sovereign."

The belief that we must never - not even in the face of unbearable terminal suffering deliberately cut short our lives makes sense from within a system of beliefs that holds that our lives are not our own to be disposed of at will, but the property of God, which only He has a right to reclaim. But not everyone shares this religious view. Moreover, even some religious thinkers, such as the eminent Roman Catholic theologian Hans Küng, believe that even though life is a gift from God it has also "been made by God our own responsibility". As Küng puts it in his recently released book *Dying with Dignity*: "For people who are at the end of their lives and for whom the approach of death is irresistible, this responsibility extends to the when and how of their dying."

It is, of course, widely recognised that partialist moral or religious beliefs are an inadequate foundation for public policy. In light of this, opponents of voluntary euthanasia will generally look for other more universally shared grounds for rejecting the practice. These grounds are often found in so-called "slippery slope" arguments: the claim that decriminalisation of voluntary euthanasia will lead to non-voluntary euthanasia, and to harm to others.

Such slippery slope arguments are generally extremely vague and are intended to appeal as much to people's pre-reflective thinking as to their considered judgments. Moreover, because these types of argument rely on claims about potential or hypothetical harm, they are difficult to state accurately and hence difficult to refute. All of them do, however, have one thing in common: the claim that any hypothetical harm will far outweigh the actual harm now experienced by people who are denied the right to die with dignity.

The harm experienced by these people is, however, real and should not be disregarded on the basis of unsubstantiated claims. I believe it is not beyond the capacities of societies such as our own to devise laws that will safeguard the practice of voluntary euthanasia. Our laws already recognise the right of patients to refuse medical treatment, even if this results in their death. The recognition of that right has not sent us down a "slippery slope" and neither will, I believe, the decriminalisation of voluntary euthanasia.

It is in light of reflections such as these that I have long argued for the decriminalisation of

voluntary euthanasia. After all, as the eminent legal scholar Ronald Dworkin argues when he writes:

"Making someone die in a way that others approve, but he regards as a horrifying contradiction of his life, is a devastating odious form of tyranny."

It is time that we as a society end this tyranny.

TERRY LANE

Terry Lane is an ABC broadcaster, writer and columnist with the Sunday Age in Melbourne. He was a Churches of Christ clergyman before becoming well-known through his daily radio programs on the ABC. He has written extensively on assisted suicide in his books Hobbyhorses, More than meets the ear and God:the interview. He contributed to the collection of essays on the subject: Willing to Listen: Wanting to Die.

In March 1995 seven Melbourne doctors wrote an open letter to the Premier, Mr Kennett, in which they all admitted to helping patients end their lives. One day many of us will have reason to be grateful to the seven, just as we have reason to keep alive the memory of Dr Bert Wainer.

Remember Dr Wainer, the doctor who virtually single-handed exposed the hypocrisy of Victoria's anti-abortion law by defying that law and at the same time forcing the prosecution of the corrupt police who profited from the discrepancy between what the law prescribed and what the people wanted?

As far as I am aware the law prohibiting abortion in Victoria has never been repealed, but a combination of open defiance and a liberal interpretation of the law by a judge has created a situation in which it is unenforceable. The law prohibiting assisting suicide must also be considered archaic and unenforceable if the state does not prosecute the seven doctors who have provided the Premier with specific instances of breaking it. The law, as it stands, is cruel, discriminatory and stupid.

It is stupid to have a law which forbids a doctor to assist with a suicide when the act of suicide itself is not illegal. If it is not against the law for me to take my own life then how can it be immoral or illegal to ask someone else, with better knowledge and equipment, to help me do it? The law is discriminatory because it gives one class of person -doctors -- a suicide advantaged. As one of the seven, Dr Rodney Syme, has said, doctors have the knowledge and the chemicals to end their lives in a quiet and dignified manner. Their patients, on the other hand, must slash their wrists, shoot themselves, throw themselves from windows or under trains or gas themselves. In Victoria you are permitted to commit suicide provided you do it in the most violent manner possible, guaranteed to cause the maximum distress to your family.

The Health Minister, Mrs Tehan, was reported as saying that 'better pain management and palliative care' is her preferred course for treating terminally ill people. Which is all well and good. She can exercise her choice in the matter. She doesn't have to commit suicide if she doesn't want to. But the very choice that she says she 'prefers' is the one the present law

makes obligatory for everyone. Mrs Tehan should be able to make her own choice in this matter. And so should the rest of us. And how I choose to end my life is none of her business, nor the Premier's, nor any politician's nor the mealy-mouthed AMA's.

Having said all that I think that the politicians are in a bind. It is simply not possible to write legislation to deal with the matter of assisted suicide. It is far too personal and ad hoc to be dealt with in iron-clad, apply equally-to-everyone laws. In the end it might be better to let the law stand as it is. If the seven doctors are not prosecuted then the matter is more or less settled. It will be permissible to ask your doctor to help you kill yourself and the doctor will be able to do it, knowing that if it is the clear wish of the dying person and her immediate family that he will not be prosecuted.

Perhaps all that needs to be done is to simply repeal the law forbidding assisted suicide. There is no need to write a euthanasia law that tries to anticipate every permutation of circumstances that a doctor might encounter in her practice.

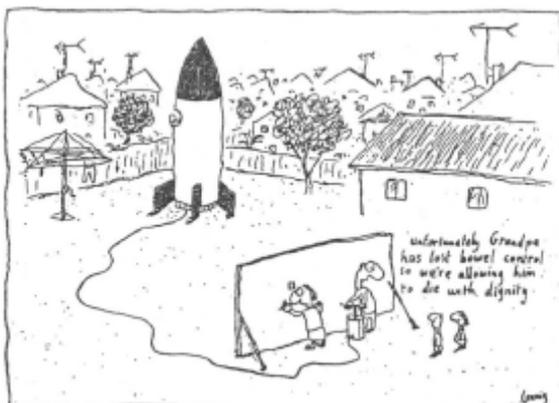
The magnificent seven doctors have concentrated on the end of life, but doctors also face moral dilemmas with the new-born. Again the law is too blunt and inflexible an instrument to apply to the difficult choices that parents and doctors must make when a baby is born with miserable life prospects.

There are spaces and events in life which are so private that the law must not intrude. Bit by bit we have repealed those laws which are most obnoxiously intrusive in the private sphere -- particularly laws controlling sexual behaviour. Well, life and death are more private than sex. What happens between a doctor and patient is, in its way, as intimate and personal as what happens between lovers. They must be left to do what they agree together is right for them in those circumstances.

Thank you Dr Norm Roth, Dr Darren Russell, Dr Rodney Syme, Dr David Bernshaw, Dr Andrew Buchanan, Dr Pat Scrivener and Dr Sam Benwell. Your patients are lucky people.

MICHAEL LEUNIG

Michael Leunig is one of Australian's most acclaimed cartoonists.



A dear friend in his seventies was dying of cancer and had decided to 'end it' with the help of his doctor. We made our farewells a few hours before the chosen time of death and this, for me, was a most disturbing and perplexing experience. For the first time in my contemplations of euthanasia I felt that it was clearly wrong. The next day, to my amazement and consternation, I learned that my friend was still alive, having somehow survived a massive dose of the drug which was meant to end his life. He lived for about another six weeks and during that period I had good contact with him.

It is now my conviction that this final period was one of profound and immense significance to him and to me - in spite of his continued suffering. I think he achieved something within himself - a sort of 'completion' by going in his own time. I am thankful and grateful that he had those final significant days.

I feel it is worth considering that sometimes the wish to 'end it' might not in fact be the desire to end 'something' – perhaps an emotional - psychological encumbrance which is standing in the way of the final, vital phase. I am aware that this statement may sound arrogant to some but I feel obliged to pass on my thoughts which have arisen from a real experience.

NORELLE LICKISS

Norelle Lickiss is a cancer specialist who has worked in palliative care for the last ten years. She is an associate professor in the Faculty of Medicine at the University of Sydney and director of palliative care at Sydney's Royal Prince Alfred and Prince of Wales Hospitals.

In the face of a frontier (moral, ethical, legal, medical, political, social, and personal) I am on the side of the explorer. We are neither monads nor lemmings rushing over a cliff but in the present debate we are in danger of looking like both. We need to stop, pause and think again in the midst of this debate, for it concerns not whether or not we have the right to be put to death, but who we are and what kind of community we wish to become.

There is much confusion, and many issues to be explored, and only a few can be touched on in the quest for realistic responses to the current questions. Incidentally, the terms "terminal illness" and "incurable illness" are obscure, for both are compatible with being active, at work or at home, driving cars (patients sometimes drive to palliative care clinic) or to being actually close to death ... and everything in between.

First of all, it is rather odd to be arguing about a right to die for we all must die one day. What is less understood (sadly) is that we already have the right to influence a great deal about our own deaths. We can influence, though not wholly determine, not only how we live, what sort of persons we become, the illnesses we are likely to develop, but also when, how and even where we will die. Dying is probably the most personal act of our lives and we have a responsibility to give it shape. It is clear from caring for many hundreds of patients (several thousand actually, over 25 years) that, if precise palliative medicine is practiced, even the actual moment of death may be chosen by the patient. Dying can become a personal act, not an expression of passivity. People put to death by a lethal injection, rather than through illness, do not, as far as we know, die in such an active and self determined fashion.

It is essential that all of us understand the real potential (as well as the limitations) of high quality palliative care, which is not yet available for all. Good palliative care involves the creation of an environment of freedom where unique personal issues can surface, appropriate decisions facilitated, relief of major symptoms achieved and care taken of the patient and carer. One of these elements often predominates. All this may occur in a crisis situation in an acute hospital, or an emergency department and make it possible for a patient to return home and resume activity. Or it may restore dignity and calm as we die. Or it may occur over a longer period at home with a family doctor (helped by palliative medical or nursing consultants if need be), always with the aim of improving the quality of life.

Major symptoms for the majority of patients with serious and progressive illness can be much relieved. There is now need no for anyone to die in unrelieved distress, except in unforeseen emergencies. In our palliative care service with over 1,000 new patients referred each year, we become involved in the last days and deaths of about 400 patients each year. A few times each year it is necessary and appropriate for a sedative to be given in ordinary, not lethal, doses to ensure that the patient sleeps as he or she dies. This is not, repeat *not*, euthanasia. On the contrary, euthanasia involves the deliberate intention to put a patient to death by means of lethal doses of drugs -- a very different thing indeed. Any competent doctor, especially with understanding of contemporary palliative medicine, and broad experience of many patients close to death, well knows the difference -- for it is fundamentally in the intention, as well as in the instruments used (different doses and usually different drugs from those used to induce simple sleep). Also, it is simply incorrect to confuse the withdrawal of futile treatment (say, a respirator) in the midst of care with good control of symptoms, with euthanasia. The public as well as conscientious doctors must not be confused by such nonsense.

Euthanasia must be correctly defined. It involves a deliberate intervention undertaken with the express intention of ending a life on, of course, compassionate grounds. It is essential that this be clearly distinguished from the theoretical and rarely practical possibility that life may be shortened by drugs used to control symptoms. Incidentally, correct use of morphine as one of the drugs involved in relief of pain does not shorten life, despite popular misconceptions which even feature on the writings of scholars.

There is enormous potential in good palliative care to improve dramatically the condition of most patients in the last phase of life and when actually dying. Dying with dignity is already possible. However, it is essential to recognise the limitations even of the best palliation and care. No medical measure nor the best care can take away all the distress associated with grief in the face of loss, caused by family conflict, by a sense of personal failure, or by loss of meaning. For these things concern the core of the self. Suffering has been defined as a sense of disintegration of the self. We speak of "going to pieces". The reintegration of the self, which we all know is possible even in extremity, is an interior matter influenced and facilitated by the care of others once major matters like severe pain and other impediments to dignity and freedom have been removed as far as possible.

It is clear then that I consider that a person's wish to die must be heard and his or her personal priorities and objectives understood and respected. Such listening appears not be occurring enough in these times. A person may express a wish to die for several reasons, each of which requires a different response, for example:

* because of unrelieved major symptoms - relieve them.

- * because of feeling a burden - we must share it properly.
- * because of a sense of completeness ("a good innings"), sometimes combined with a wish to make resources available to others - ensure that nothing is done to prolong the dying phase or to obstruct death.
- * because of true depression - treat the depression.
- * because of a sense of, or fear of loss of control, of powerlessness, and loss of self worth, of fear of trusting or surrendering power to another person, and sometimes requesting euthanasia, an apparent paradox in the midst of great distress - opportunities for choice and control need to be gently explored, quite apart from the issue of being put to death.
- * because of despair, a loss of sense of meaning and other spiritual, though not necessarily religious matters - skilled pastoral care may help.

It is worth noting that whereas it is not uncommon for sick patients to express a wish to die, in the experience of cancer and palliative care specialists it is rare for patients to request to be put to death: the difference in the frequency reported in media reports is enormous and misleading. Those who do request death often change their minds.

All of the above issues are involved in the apparently simple first question. The second is equally complex.

Those who request that their lives be ended by euthanasia certainly need the assistance of a doctor. But it is absurd, offensive and misleading to apply the words "assistance" or "helping" to the intentional putting to death of a patient, willing or unwilling. Palliative care has nothing to do with euthanasia, and when competent palliative medicine and palliative nursing consultants are called to assist distressed patients, the patient and their families need not fear euthanasia. The debate about euthanasia is in fact not about palliative care but about the limits of autonomy in a post modern society.

There are many arguments against being put to death deliberately by doctors, even with "safeguards" against abuse. Some of these arguments are simple -- like the manifest failure of safeguards. Others are profound, and raise complex issues.

The phenomenon of people -- even those not yet ill -- in Australian society pleading for the right to be put to death in certain circumstances requires the close scrutiny of society, as do the individuals so concerned, and the intellectuals driving the debate. What is wrong with us? What has gone wrong in the 20th century? Why such obsession with self-determination, even at the expense of each other? And why such fear of weakness? Why do we have such great fear of vulnerability here in Australia, away from the madness of war and deranged dictators? Why can we not trust each other or our doctors to listen hard when we say we want to be allowed to die? Is there no other response than the setting up of structures to put each other to death, on the presumption that we will thereby reduce the burden of suffering in each other and in our community?

If we can trust no one with our weakness, nor anyone in power, how can we trust safeguards supposed to regulate someone putting us to death? And if we feel we may not be listened to when we want our views about different treatment options taken seriously (so that we are not "kept going" in a state we don't want), why are we prepared to trust people to hear us correctly when we try to talk about being put to death? They might get it wrong!

It is certain that once a line is crossed deliberately by doctors intending to put people to death, however competently and efficiently (and one winces at the notion of efficiency in putting persons to death) -- once this line is crossed, and it is crossed by a change of intention, then issues of consent become of far less importance. This is demonstrated by recent history in the Netherlands and information available from doctors in Australia who admit to having ever deliberately and directly taken life. On such (rare) occasions, consent was often lacking. It is inevitable that euthanasia without consent would occur if the deliberate taking of life is sanctioned. The sporadic euthanasia already (if rarely) occurring, both voluntary and without consent, requires examination, and a sympathetic search for other solutions, not mere regulation. The repugnance of doctors to kill is a core attribute. If this is weakened, or worse, abolished, society is in great danger. The greatest safeguard for the people -- and the people in Sydney are already expressing fear (especially those whose language is other than English) -- is the refusal of doctors to ever intentionally kill a patient. This refusal, together with a commitment to listen more carefully and to improve both our decisions and our care, may save us.

The fabric of society is under threat if we have the right to put each other to death. Civilised societies are abolishing capital punishment, and increasing numbers of citizens in societies where life is valued, repudiate war as a means of solving human conflict. Even the slightest risk that medically sanctioned killing would devalue life and harm society should be reason enough to ensure that the practice is not in any way legitimised, or worse, facilitated in our midst.

None of us should die a "treatment failure", wanting mere elimination from our ranks, nor as "losers" in a battle with cancer or AIDS or heart disease, nor as an unbearable burden. We should die as people given a chance to make a positive achievement even of the last phase of life, like the last lap of a marathon, even in difficult circumstances. The facilitation of dying naturally, with a person in control of his or her own dying, requires superb palliative care, not a lethal injection, which would be the ultimate medicalisation and disowning of death.

Every Australian needs a chance to make something of the last bit of life, even if what has gone before has been rather regrettable. Each of us, however frail, enriches society somehow, and we need to come to understand this, even as we are dying. We are, each of us, a profound mystery, and in our dying, we enter into our own mystery, into our dreaming, in a way we cannot understand. We all fear suffering, and we all have the obligation to relieve the suffering of others. We may all some day welcome death, and may have the courage to shape the pattern of ourselves and the death we shall die, within a liberated caring society, but not by asking others to put us to death.

We should take note of, and study at a community level, the lengthy Report on Medical Ethics (1994) of the House of Lords and the Hansard (March 1994) reporting the debate. After two years of exhaustive work (which included a disturbing visit to the Netherlands) the inquiry recommended unanimously that the legalisation of euthanasia should not occur, but that the care of the people must be improved by other means. But we Australians must define for ourselves what sort of society we wish to become. Euthanasia is a touchstone issue.

The present debate is necessary, for it offers an opportunity for rethinking who we are, the desired shape of our society, our meaning (even in the cosmic process), and the substance of our hope. We are all interconnected -- we are not monads -- and we must accept limits to our

autonomy, if the exercise of our autonomy puts our fellows at risk. There will always be differences of opinion on profound matters in a free society, but being put to death even with one's consent is not a private matter, for it strikes at the foundations of what we are, and affects not only the one put to death but the one who carries it out. Our acts shape us, and the act of putting another person to death must change us. If we are doctors, it strikes at the core of what we should be in society: bringers of life, of hope, of healing, of comfort, sometimes bringers of bad news, companions on the way. But not bringers of death. This is my current response to these profound questions.

MILES LITTLE

Miles Little is Professor of Surgery, University of Sydney at Westmead Hospital. He is the author of books and articles on surgery, the philosophy of medicine. He has also published poetry. His latest book is Humane Medicine published by Cambridge University Press.

The ethical debate over the issue of shortening life continues without resolution in most countries. Even in the Netherlands, the practice is not strictly legal, and claims are made that lives are being shortened without consent. The debate is complicated by such issues as 'passive' euthanasia. This withdrawal of life support is accepted as morally reasonable, even desirable, and will not be further discussed. 'Active' euthanasia is a complex issue, made more complex by pluralism. Pluralism inhibits consensus on the subject, as it does on most important matters. Requests for euthanasia are quite common in clinical practice, and many doctors have helped to shorten periods of suffering. Nevertheless, the common-sense view held by many that doctors ought to shorten suffering as one of their duties does not fit the beliefs of many others.

A person seeks euthanasia for himself because he experiences intolerable suffering, or, more strongly and more broadly, recognises the cessation of life worth living. Space is contracted to a bed and a room, and time is a burden and a medium for suffering. 'Quality of life' is meaningless; the life has no quality. Autonomy is reduced to a choice of when to have the next injection for pain relief. The last autonomous act available may be a decision to die. In this context, a request for death is always rational. But it is always necessary that the request be made by the sufferer in a time of rationality. No one else can make that decision, even a near relative, who is sure that a patient with Alzheimer's disease would not wish to live on under such restricted circumstances. A decision to stop life-support when there is evidence of brain death is a different matter. The decision to take a life that is not conditional on extraordinary measures - beyond, say, washing and feeding - cannot be so easily condoned, since it is open to arbitrary decision and the persistent doubt that there may still be life worth living.

It takes little training to teach someone how to end a life mercifully. It is technically simple to give a lethal injection. But the power is alarming. When doctors undertake to treat, they do so with the end of care or cure. Providing death in these circumstances may well seem to be the ultimate care, but the doctor caring for the patient is *not* the person to decide when the time for death has finally arrived. Personal involvement transfers personal values in many subtle ways. The desire to have the distress of the patient over and done with may express the desire of the doctor to resolve her own distress. The decisions which end life would need to be taken by people whose skills and knowledge were specifically directed toward judging that the suffering patient had reached the point of *knowing* that there was no longer a life worth living. Such a person would need to possess the medical virtues in high degree - wisdom, endurance,

knowledge, judgement, compassion and prudence. Only the wisdom of training and experience, and an unusual degree of commitment can equip someone with the capacity to combine belief, desire and evidence in this ultimate decision to act. The treating doctor may argue for her patient's decision to end life, acting as the patient's advocate, and may actually terminate the life, if that is the wish of the patient. It is the final decision that needs to be taken out of the 'normal' medical transaction.

The medical relationship begins in trust. Groups that advocate euthanasia claim that legalisation of euthanasia will *increase* trust. The decision made between patient and doctor, they say, must be based on the greatest trust one person can bestow on another. The issue is less simple. The fundamental function of medicine is care or cure. Active killing is not easily accommodated within a healing profession. There are many people who detest the idea of euthanasia on religious or other ethical grounds. If they wish to be kept alive in states of illness, how can they trust their doctor who practises euthanasia to enter their realm of intersubjectivity and make decisions that are 'right' for them? This is further reason to suggest that the practice of euthanasia would have to be in the hands of a specifically skilled group of practitioners, while the generality of doctors preserve their ancient embargo on ending life.

Finally, the immense problems associated with money need to be examined. The thought of payment for termination of life seems obscene, and neither patient nor family should be burdened with its responsibility. Third party payment seems to be the only way to separate the intrusions of the System from the emotions of the Lifeworld at so sensitive a time. There are other implications of money, and opponents of euthanasia point out how easily it may open the door to fraud and accusations that inheritors unduly influence autonomous decisions.

Defining criteria for ending life is not too difficult. Matters of method can likewise be resolved. The personal qualities, the virtues, of the doctor who decides, are paramount if the process is to be practised more generally. I do not believe that the treating doctor can make the decision, whatever his part in the final action. Not every doctor should be licensed to prescribe euthanasia if the prior condition of trust is to be preserved. If all scruples against euthanasia one day disappear, this principle may change, but it must be observed while there are religious and ethical convictions in pluralist societies that no one should take the life of another. The special content and meaning of the language that must pass between the patient and the deciding doctor mandate special training. Intersubjectivity is the essential quality in determining how beliefs, desires and evidence combine to produce the 'right' decision. Finally, money has to be kept out of the whole process. Lifeworld values must predominate if the process is to remain free from a materialist stigma, and accusations of convenience rather than compassion.

ROBERT MARR

Robert Marr is a Sydney general practitioner and a founding and still active member of the Doctors Reform Society.

I strongly support the proposal that a person with a terminal illness should be able to request and receive medical assistance to end their life. I have come to this decision as a result of two main experiences:-

- 21 years as a doctor, seeing many patients suffering in their last few months of life
- My experience of my father dying from motor neurone disease

Both of these experiences of people suffering have led me to believe that we must all stop running away from the idea of death and face the fact that everyone dies and when this important time comes in a person's life they should not have to suffer unnecessarily. I believe doctors should be legally allowed to actively assist terminally ill people, who request their lives be ended through euthanasia. I have been asked on several occasions by dying patients to help end their life. I know that the decision to help a terminally ill patient die is one of the most stressful and difficult decisions a doctor faces. However, I believe all patients must have this right at the end of their life to request and receive medical assistance to end the suffering.

It has been argued that palliative care is sufficient for terminally ill patients but I know there are many illnesses in which pain is not the main cause of suffering. In their illness, patients are experiencing great suffering that cannot be relieved by more palliative care (for example, motor neurone disease, inoperative brain tumours etc).

Some doctors may not be willing to assist these patients end their life. I respect the right of doctors to refuse to help patients end their life. But I expect those doctors to respect the belief of the patient and refer such patients to doctors who will assist them.

Euthanasia is being carried out in Australia today. As a young hospital intern 21 years ago, on night duty, I was woken up at 5am to administer a large dose of morphine, ordered by a hospital specialist, to a terminally ill patient already on morphine intravenous infusion. The patient dies within hours of the injection. I realised then how some cases of euthanasia were carried out in our hospitals.

I have sat with dying patients including my father as they have suffered their last few days of life and I know that every patient should have the option to request medical assistance to end their suffering.

It is important to bring euthanasia into the light of day by legalising it because only then can real safeguards be introduced. These safeguards could include the written request of the dying patient to receive medical assistance to end their life. This request should be made in front of at least 2 doctors who have no financial interest in the patient's death.

The debate about euthanasia is similar to the abortion debate several years ago. It is mainly the same groups of people opposing euthanasia as those who opposed legal abortions. We all know backyard and secret hospital euthanasia is going on. It is now time to bring it all out into the open and give all terminally ill patients the right to euthanasia with appropriate safeguards.

Euthanasia is really an issue about patients' rights. It is time to decide if the patient, the doctor, or the church should have the right to decide what happens to the patient when they are dying.

JIM McCLELLAND

Jim McClelland has written a column for the Sydney Morning Herald since 1986. He was a Labor Senator for NSW between 1971 and 1978 and Chief Judge of the Land and Environment Court between 1980 and 1985. He has written three books. This contribution was originally published in the Sydney Morning Herald in 1995.

When you are only a few weeks off turning eighty and have already had a brush with death, the question of euthanasia is not an academic one. For me it is a real, practical question to which I have given plenty of thought and come up with an emphatic answer: When what I have left of life is not, in my opinion, worth having 'and I am assured I have no chance of recovery, I will expect the doctors attending me to help me to die.

In the present (in my view wrong) state of the law I will not expect them to do anything to incriminate themselves. The seven Victorian doctors who recently and courageously owned up to having assisted terminally ill patients to die are, in my view, the tip of the iceberg. When I visited my sister in hospital a few years ago when she was terminally ill with lung cancer, she was, a couple of weeks before her death, extraordinarily calm. 'I have,' she assured me, 'an understanding with my doctor.' I have long believed that those who practice medicine and have witnessed a few deaths, with a very few exceptions, take it for granted that a terminally ill patient's wish to die should be respected.

Those, mostly religious people who speak of the sacredness of life as an impassable barrier to the acceptance of euthanasia, totally miss the point. Life is more than just the capacity to breathe. It involves a certain minimum level of sentience, cognisance and capacity to interact with your fellows. When a human being's capacities fall below that line, a life worth preserving, no longer exists.

In fact, to persist in trying to preserve it is an offence against those whose lives are still worth preserving. We are assured by the statisticians that by the year 2026 some 20 percent of the population will be over sixty-five years of age. Inevitably, even with the anticipated advances in preventive medicine, this will involve a considerable increase in the number of people

requiring medical attention, drugs and hospital space. Even in the most advanced societies, there is a limit to the availability of those palliatives of inevitable physical deterioration. The deployment of these scarce resources on preserving lives no longer worth living must subtract from their availability in keeping viable lives going a bit longer.

As for those who believe that life on earth is merely a preparation for the experience of the beatific vision, it has always been a matter of some perplexity to me that they take such pains to delay this consummation. Why postpone the soul's leaving the mortal body and finding its resting place in paradise or delay the start of its waiting period of a millennium or two in heaven's ante-room, a place called purgatory? As to eternal damnation, I doubt if anybody any longer believes that their merciful God has this in store for anybody and that its commencement should therefore be postponed as long as possible.

The opportunity to die with dignity and without pain is a benchmark of a civilised society. To watch on TV the obscene circumstances of the demise of thousands of innocent people in

third world countries is to appreciate the superiority, not only of life, in the countries where we are fortunate enough to live, but also of death. The right to death is a logical corollary of the right to life.

For a long time the law has turned a blind eye to unspoken and unadmitted medical attitudes to euthanasia. There are those who advocate that, in the light of the widespread medical practice of assisting terminally ill patients to die, there is no need for amendments to the law to spell out the legality of such conduct. The same argument is also advanced in the matter of abortion, about which there is no absolute legal permissiveness, despite its widespread availability.

I believe the time has come to put an end to the under-the-counter attitude to the termination of human life through euthanasia. As the law at present stands, those seven brave Victorian doctors are liable to prosecution. The very fact that that is unlikely to happen testifies to the widespread community acceptance of euthanasia. It is time that the law caught up with reality in this as in other spheres where it is dragging its feet.

COLLEEN McCULLOUGH

*Dr Colleen McCullough is retired from her career as a neurophysiologist at the Yale Medical School after she wrote her second novel, the bestselling *The Thorn Birds*. Her experience with the terminally ill extended over a period of twenty years.*

Having worked in hospitals and medical schools for over twenty years, I find myself now in two minds about euthanasia. To witness the suffering of others carries a pain which often proves ineradicable; to be the one suffering is a fate too awful to bear thinking about.

At first glance euthanasia seems a welcome solution for those who do genuinely desire an easier swifter and far less painful end to suffering. In an ideal world it would already be accepted practice.

But, alas, our world is far from ideal, far from perfect. Therefore I have grave misgivings about legalising euthanasia for persons afflicted with terminal or incurably incapacitating diseases. My reasons are grounded in human nature, and chiefly concerned with the human propensity to think of events in terms of money. Gain of one kind or another.

Is it moral or ethical for a government to contemplate legislative action which inevitably incorporates an element of saving large amounts of the taxpayers' money when it simultaneously deprives other taxpayers of life? Is the motive, genuinely founded in humanitarian principles, or is it the result of coldblooded economic necessity?

A look at the Australian Constitution reveals that most of it is concerned with protecting the rights (and skins) of politicians, not the people they are elected to represent. It is therefore highly unlikely that in the aftermath of legislation authorising euthanasia, those who framed and passed the laws dealing with it could be held culpable. Culpability will devolve upon those who perform the act. And how watertight would such legislation be? Could *any* government unconditionally guarantee legal impunity to the persons performing what is actually an act of murder? Governments do not interpret laws, they make them. Courts interpret laws, and

courts are supposed not to be susceptible to governmental pressures.

One of the Ten Commandments says Thou shalt not kill. Is that Commandment to be deemed a religious shibboleth or a flat statement that life is sacred? Euthanasia is an emotional and a religious issue, and emotions and religions make a poor substrate for laws. Laws govern the conduct of collections of individuals who have differing emotional responses and differing religious ideas.

I am also haunted by the fact that scum rises to the top of a pond. Once a euthanasia law is on the books, what kind of people will enforce it, interpret it? One must never, never, never forget the example of Adolf Hitler and Nazi Germany. Millions upon millions were subjected to genocide. No, it was not called euthanasia, nor was it merciful. But a law authorising legal murder is a beginning. Can any, Australian truly say that a Nazi Germany situation could not happen in Australia? Surely that depends on the quality of the scum on top of the pond - in other words, it depends on the quality of the politicians who rule us far more than they represent us.

I have to say that prudence, common sense and a considerable experience of human nature dispose me to think that euthanasia is an unattainable, if humanitarian, dream. It wouldn't work because it couldn't work. I wish it could.

PADRAIC P. MCGUINNESS

Padraic Pearse McGuinness is daily columnist for The Sydney Morning Herald and The Age. He is a former editor-in-chief of the Australian Financial Review. He has degrees in economics from Sydney University and London School of Economics, and has taught at universities in Sydney, London and Paris. At the time of writing, none of his immediate family or friends was suffering from a terminal or painful illness. His contribution was originally published in the Sydney Morning Herald and The Age on 31 May 1995.

The churches and the Christian "ethicists", who often confuse faith with ethics, seem to be deliberately muddying the debate over euthanasia, though they have some very strong points to make. The most essential and basic distinction they blur is that between suicide and euthanasia.

Whatever religious people may believe, they have no right to deny to an adult who does not share that belief system the right to end his or her own life. However our law is riddled with relics of the time when legislation was made at the behest of those who denied the right of suicide. If a person wishes to end his life at any time and for whatever reason, there are a multitude of means available. However, most of the easiest, cleanest, surest and least painful means of suicide have been made very difficult of access. This is objectionable and a denial of the individual's freedom of decision. In effect, the law says that if you want to commit suicide you are going to have to choose the crudest means unless you can persuade someone else, usually a medical practitioner, to supply you with the means - and the law forbids that.

That is, a medical practitioner who you may or may not respect has been given power to block the exercise of your free choice as to the means, as well as the end, of suicide. No wonder doctors tend to think they are on the right hand of God. But the debate about euthanasia is

much wider. "Euthanasia" has become a weasel word. It can be applied to a very wide spectrum, from supplying an able and conscious adult with the means to suicide, to administering those means, to administering them in accordance with the recorded but not currently expressed wishes of the person (in the case of incapacitation or unconsciousness) through to administering them according to their supposed wishes, and on to killing a person without any authorisation or even implicit consent. In the last case it is simply murder.

The really powerful arguments against euthanasia spring from the way in which good intentions can slide over into something very like murder. "Euthanasia" administered for the good of the victim can never be justified, even if that person is unconscious and has little possibility of recovery, or is conscious and in extreme pain but does not request assistance to die. When a person has become unconscious there is a case for passive care, that is allowing the patient to die without artificial life-support. There is even some debate about that, but most of the religious casuists have agreed on it.

There is a particular danger for our society at present in considering euthanasia. This is the rapid aging of the community and the inevitability of generational conflict. The average age of the population is rising, the proportion of the aged is rising rapidly, and the life-expectancy of the aged is also increasing. The medical costs of the aged are very high. The cost of superannuation and pensions paid to the aged is also increasing, and the baby-boomer generation has ensured that these will be a heavy burden on the present and future young working population. The rise of puritanical moralism about the use of substances like tobacco and alcohol has already led to suggestions that those who suffer from supposedly self-inflicted ills should be denied care.

But it is simply not conceivable that the maximum level of medical services and care, and life-prolonging procedures, should be available to every person. The community is not and never will be willing to pay for such care. Already many medical practitioners are performing involuntary euthanasia by denying people who want them expensive procedures which they believe should go to more deserving cases.

Voluntary euthanasia in clear cases simply means that a person has requested assistance in ending his life. Dr Jack Kevorkian, "Dr Death", in the United States has invented a rather macabre, but simple, device which allows a person to administer without difficulty a fatal injection. He can leave the person with this device, unattended, to kill himself. Instead of being treated as a public benefactor, he is denigrated. Of course even in such a case, when assistance is offered there is always the danger of pressure being put in various ways on a person contemplating suicide. (For example, by grown children tired of giving care or in a hurry to inherit.)

Despite the possibility of abuse, the availability of such a device or an equivalent is the right of any person. Where distinctions get difficult is in the cases where a person is incapacitated such that he cannot commit suicide without help. If he is conscious, the situation ought to be clear - he is entitled to die by his own will at any time without being pestered by doctors and particularly not by moralists and do-gooders who want to impose their own beliefs on him. The notion of a "living will", whereby a person can as a form of insurance provide that he wants to be assisted to die if he is not in a position to express a wish at the necessary time is a good one. There should be some protections in such a case, but not such as to become obstacles. And that is about as far as one can go.

But what about the facilitation of suicide instead of effective medical and palliative care? This is usually a deliberate red herring. It is true, of course, that an apparently stable person in good health might be suffering from clinical depression, but it is rarely that such a person will not have sought some kind of medical or therapeutic help. His situation is usually made more difficult by the barriers which exist to the self-administration of effective palliatives except with the interference of do-gooders.

It is, again, purely the right of the individual to determine what ails, physical or mental, he is prepared to tolerate and for how long. That is, the argument that a person might commit suicide in a fit of depression if access to the means were too easy is merely an excuse for interference.

This does lead to the problem of those who are genuinely mentally ill or unstable, as well as those who make suicide attempts as a call for help. But such cases never justify interference in the liberty of most. And the treatment of adolescents, children and babies of course all raise special issues.

The Northern Territory legislation is objectionable not because it permits assisted suicide, but because it has too many obstacles built in to the making of conscious decisions by adults. It is part of the apotheosis of the medical practitioner which has gone much too far in our society, and which has given rise to its own backlash.

GEORGE NEGUS

George Negus is a prominent journalist and commentator. He has hosted the ABC's Foreign Correspondent since its inception.

As we stumble our way through this morass of both instinctive and wilful neuro-emotional responses we laughingly call life, there are probably only a handful of issues that can be seriously termed "life and death".

War is clearly one, famine and disease two more. But, among the touchiest are at the very extremities of human existence - abortion at the beginning of things and euthanasia at the end. Both are guaranteed to stir emotions, raise hackles and provoke argument. And rightly so. Given that the question *why* is the ultimate imponderable where life is concerned, if we don't have a view on *when* and *how* the damned thing begins and ends, it's possible we will go through it equally ignorant of the sense of the bit in between, those legendary on-average "three-score-years-and-ten."

As for "the end", seeing that we have absolutely no say whatsoever in how and when we shuffle onto this proverbial "mortal coil", surely it's reasonable that we should be able to determine -- or at least have an in-put into -- when we shuffle off it?

As for whether or not we are capable of knowing when our personal plug should be pulled, we somehow manage to get through life itself without really knowing much for sure, so why should there be a demand for absolute certainty where death is concerned? Shouldn't we have a right to be as wrong about that as we probably have been about the bit that goes before it?

Having said all of this, my only area of ethical concern, indeed doubt, is the impact of my being

euthanased on those left behind. In death, I would never want to hurt loved ones who have put up with me in life. If it's OK by them for me to shove off into the ether of the post-life, then I would. If they would like me to put up with the pain and the indignity for a while longer so I can be with them, I would be delighted. That would actually prove that I'd got something right in between not being aborted in the first instance and being euthanased in the last. But, if my sons and their mother thought it was best for me -- and for them -- if I buggered off, then bugger-off I would!!

BRENDAN NELSON

Brendan Nelson is a general practitioner and immediate past president of the Australian Medical Association. He was recently endorsed as the federal Liberal Party candidate for the seat of Bradfield in Northern Sydney. His contribution is an edited version of an article he originally published in Australian Medicine on March 21, 1994.

A recent correspondent to *The Australian* called on the AMA to "stop dodging the issue of euthanasia". If you are a doctor treating patients, you cannot avoid the issue of dying.

It is my view that much of the push for euthanasia and assisted death is driven by fear of dying in pain or without dignity. It is important that Australians understand terminology and exactly what it means.

It is equally important they understand what doctors think, why we believe what we do and that there is diversity of opinion on this and other issues. A recent survey found that just over a quarter of doctors had administered treatments intended to cause death.

How many of us with reasonably long careers in clinical medicine have not found ourselves in circumstances where it would seem reasonable to accede to the requests of dying patients and their families? The professional must, I believe, continue to hold the view that doctors should not assist patients to die. Equally important though is the need for us to recognise that we will not ever have a set of principles or a law that will cover all the situations we find ourselves in as doctors, and, eventually as patients.

Although there are well intentioned people in Australia pushing for laws to cover the dying process, in my view judgements about death and dying are better covered by ethics, morality and common sense, than they are by laws. Attempts to legislate the dying process will create more problems than it will ever resolve. Laws place doctors and patients in a situation where each may see the other as a potential adversary, which is not in the interests of patients.

Every death is different. Patients are individuals and that is how they must be treated.

FRED NILE

The Rev Fred Nile is a Call to Australia Party representative in the NSW Legislative Council. He is founder and national president of the Call to Australia Citizen's Movement. His contribution was written by Dr Kevin Hume KSG, FRACGP and is fully endorsed by the Rev. Nile.

My answer to question 1 is that I am not unequivocally against the proposal that a person with a terminal or incurable illness should have their request granted that their life should end. At first reading the question appears to be simple and straightforward, but it is not.

The question could be interpreted as a prayer -- that God should grant the suppliant's request. In His own time, but please God, sooner rather than later. For the believer, that is a perfectly legitimate prayer. It violates no law of God and respects Him as Author of life, Who alone grants life and Who alone may take it away.

A further interpretation is that the patient may be requesting that futile treatment be ceased and that the disease be allowed to take its normal course so that he/she may be allowed to die. Again this is a perfectly legitimate request. No one is obliged to be the recipient of inappropriate treatment.

A final interpretation of the question is that the proposal is that such a person should have his/her request granted to be killed. I am unequivocally against granting such a request. I am certainly not opposed to proper management of such a person by those skilled in palliative care whose services are now available in abundance, even though the person's life may be inadvertently shortened in the course of this treatment.

But deliberate killing, no! No matter how much suffering has to be endured by the person's nearest and dearest and how much their pocket books are depleted by the continued existence of the sick one. If I sound cynical, then let me say that I speak from experience.

And who is to carry out the execution? A doctor who knows little or nothing of modern palliative care and cares less, as it is so much simpler to kill than to care? Speaking to nursing staff at a nursing home I visited recently I was aghast to learn that a large proportion of visiting doctors had no knowledge of even the availability of effective pain relief for the terminably ill, much less of how to initiate it.

Finally let me say that such requests are unknown in well run institutions for the dying where every care -- medical, spiritual and psychological -- is given. The answer to question 2 is that legal clarification of medical responsibilities should be forthcoming where it does not already exist. Euthanasia means easy death and that is everyone's entitlement. It is the obligation of every doctor to ease the passing of his patient, but not to kill him or her. Doctors were never intended to be executioners. Good medical training would ensure that students are instructed in the principles of modern palliative care. Assisting patients to suicide is a mark of medical inadequacy.

Sir GUSTAV NOSSAL AC, CBE, PresAA, FRS

Sir Gustav Nossal has been Director of The Walter and Eliza Hall Institute of Medical Research in Melbourne since 1965. He was President of the International Union of Immunological Societies from 1986-89 and is President of the Australian Academy of Science and Chairman of the Victorian Health Promotion Foundation. He has published 480 scientific articles and five books, the latest being Medical Science and Human Goals, and Reshaping Life: Key Issues in Genetic Engineering. He was knighted in 1977 and made a Companion of the Order of Australia in 1989.

Dying with dignity and in peace should be everyone's right, particularly in an industrialised country with high standards of health care. Nevertheless, I am against the formal legalisation of euthanasia. A well-ordered society is a very fragile thing, as recent history (Hitler, Pol Pot,

Rwanda) shows. I believe there are grave dangers in a society giving to anyone, no matter how well intentioned, the right to terminate a human life. However, I do believe that those who are terminally ill should come to the end as free of pain as possible and with as tranquil a state of mind as possible. This may necessitate the use of strong drugs in doses that imperil life. I certainly do not believe that fear of possible fatal consequences should limit the dosage of narcotics, tranquillisers or other medications in such circumstances. It seems to me that the crucial thing here is intent. The intent to relieve pain and suffering is good, the intent directly to kill breaches what I consider to be societal norms. Enshrining a right to terminate life in legislation would, I believe, do more harm than good, although I totally support the right of others to disagree with this view.

SIR MARK OLIPHANT

Ellen Fanning (EF): Sir Mark, What do you think of Bill Hayden's views on euthanasia?

Mark Oliphant (MO): I'm completely in agreement with him. I'm very glad that he has said those words. That a man in that position should advocate euthanasia .. the end, not of physical suffering only but of mental suffering too. The realisation by the old that they're losing their marbles as it were and that they forget and do silly things. It's time then for the active man ... for the active man or the woman who has led an active life, to be assisted to die.

EF: He said that he views his final days with apprehension. Now, you're 93 years old. Do you have these concerns?

MO: I do and it's foremost in my mind now. I realise my days are numbered and I do not want to go into a home and just be one of those being looked after and kept alive unnecessarily. I do not want to suffer pain and that is beginning to show itself with me. And I do not want to be a nuisance to any other people. I think there are too many people who are no longer part of humanity as it were, still being kept alive and even in their own homes by their relatives. I think the objections to euthanasia are completely wrong. The remarks made by that great medical man just now [here he refers to a previous interview with Dr Brendan Nelson] represent a carry-over as it were of the more or less religious attitude towards life.

EF: What about the fact that ... you've talked about being a nuisance .. what about the fact that many old people may feel they're being a burden on their carers and feel obliged to end their lives. Should they feel that obligation if euthanasia were legal?

MO: It's a personal question I mean some people like being looked after .. there's a great scientist that I know in Cambridge who should be dead and he's not -- he just loves to be alive. He's just a nuisance to all his friends and relatives.

EF: And that's his right too, isn't it?

MO: No I don't think he is ... he's cluttering up the world and he should not.

ENDS

DAVID PENINGTON AC

Davis Penington has been Vice-Chancellor of the University of Melbourne since 1988. He has worked as a medical practitioner, teacher and researcher and was Professor of Medicine at the University of Melbourne from 1970 and Dean of the Faculty of Medicine from 1978 to 1986. In 1988, Professor Penington was awarded a Companion of the Order of Australia for services to medicine and to the community. particularly in the fields of medical education and health care. His many appointments have included Chairman of the body which came to be known as the 'AIDS Task Force' (1983-87), Chief Adviser on Health Policy and Programs, Health Department Victoria (1986-87), and member of the Boards of the Royal Melbourne Hospital, the Walter and Eliza Hall Institute, the Cancer Institute and the Ludwig Institute for Cancer Research (Melbourne Branch).

Care of the dying is one of the most critical functions of medical practice. Such care has to be viewed with the outmost sensitivity. The circumstances vary from patient to patient and from family to family. It is very difficult to ensure that generalisations will be appropriate to cover this wide range of circumstances. The passage of legislation in the Northern Territory adds yet a further dimension to the problems, in that attitudes to the medical profession or to the individual practitioner on the part of the dying patient may be coloured by the legislation when the patient has doubt as to the expectations of the doctor or of the patient's family once they are critically ill.

The tradition of the medical profession, which goes back at least to Hippocrates, is of respect for life. For a medical practitioner to be perceived as taking actions to terminate life presents a major problem with respect to the confidence with which members of the community may place in that practitioner. Nonetheless, the practitioner has an overriding responsibility to ensure that no patient suffers unnecessarily in the course of a terminal illness. They also have a duty to see that no processes are undertaken which will artificially prolong life when the chance of recovery to an independent existence reasonably free from suffering is slender indeed. The medical profession is familiar with the challenge of making judgments taking into account probabilities as to survival and as to possible outcomes. Balancing these probabilities is a critical aspect of decision-making in every individual case. The decision should rightly be shared with the patient whenever this is possible and with the relatives of the patient.

Under legislation in States and Territories other than the Northern Territory, the commitment to relieve pain and suffering, even if it may marginally shorten life, is something which leaves significant discretion to the medical practitioner. The proposed changes to legislation in Queensland would safeguard this situation and allow for active development and expansion of palliative care facilities for patients suffering terminal illness. I believe this is the direction in which legislation should move.

The more common problem is that of life being needlessly and inappropriately extended by the use of life support systems. Patients should have the right to request that this does not occur. To date, common law in this country has not interfered with medical decisions to terminate life under these conditions. Only if this were to occur, as is the case in some jurisdictions in the United States, would I see the need for legislation.

Legislation in Victoria was introduced in 1988 to allow patients to establish a continuing

authority for their lives not to be extended needlessly in the event that the chance of recovery is slight. I strongly supported that legislation at the time it was introduced and commend it to other States.

The issue of drawing a line to limit decisions as to where life can be actively terminated presents many difficulties. Shortening life slightly by the administration of analgesia seems to me to present few problems and is, in fact, common practice in the medical profession. Such action is unlikely to be challenged in the Courts except where grossly abused, as in the Bodkin Adams Case in the United Kingdom. The adoption of legislation similar to that introduced in the Northern Territory creates problems for patients suffering from terminal illnesses who may be reluctant to submit their families to sharing with them in their suffering. Intervention of this kind is needed in communities which do not provide adequate palliative care but I believe the need is only slight where effective and widespread palliative care is available.

The review of The Netherlands experience of similar legislation by the House of Lords Select Committee on Medical Ethics (London: HMSO, 1994) indicates that there are major difficulties in setting limits to the operation of euthanasia practices. Whilst my concerns are in no way based in formal religious beliefs, I have a strong instinctive concern that the principle of *respect for life*, which is so fundamental to moral values in our society, could become seriously eroded by widespread practice of euthanasia. Such widespread practice has evolved in the Netherlands, as borne out by the findings of the House of Lords Enquiry.

The strong religious condemnation of suicide is a position which I do not support. Rather, I have a profound concern for those who suffer depression. I believe that every step should be taken to avoid or minimise its effects. The desire to end life in the presence of prolonged suffering is an understandable desire on the part of the individual. However, with modern medicine, suffering in the form of pain can be largely alleviated even though there may be significant shortening of life. Actions to alleviate suffering are entirely supportable and morally defensible. I have concern, however, that actions aimed at shortening life represent a major departure in terms of fundamental ethical principles - a departure which I am not willing to accept as appropriate for our society.

RONALD PENNY

Ronald Penny is professor and director of clinical immunology at St Vincent's Hospital in Sydney. He is chairman of the NSW Department of Health Committee on AIDS strategy. His contribution was originally published in the Canberra Times on 18 November 1994.

Society has witnessed one of the greatest revolutions in medical technology in recent years. This has generated a high level of public interest and knowledge with a high level of expectation of health and well-being, and improvement in the quality of life.

With increased information within the community, greater participation and cooperation between patient and health-care provider has developed in areas such as surgery, drug treatment and the use of alternative therapies. Now the same principles are being applied to the area of death and dying.

Just as the important issues of choice and consent apply to decisions related to health and living

well, there has become an increased focus on dying well, with more consideration to the dignified manner of death, where death will take place, such as at home or in an institution and other concerns.

The AIDS Council of NSW is to be commended on its recently released booklet, *Choosing to Die*, a booklet for people thinking about euthanasia and those asked to assist. Much public criticism of this publication has been generated, but on a very careful perusal of the booklet its contents provide an exceptionally informed and balanced approach regarding a crucial decision for patients, their loved ones and health workers. Its contents are in no way constricted to those dying from AIDS but could be equally and informatively read by patients dying from cancer or other degenerative diseases.

The AIDS epidemic has catalysed a remarkable community response to a well-informed constituency who are generally of a much younger age than those dying from other diseases. Most have seen first-hand loved ones or friends dying from an extraordinarily distressing syndrome, often with profound wasting rapid aging and overwhelming failure of various body functions. Many having confronted these scenes do not wish to see it replicated in themselves. Many also may be alienated or isolated from family and many have no current same-sex relationships with whom their dying can be shared.

In addition, pain, or more frequently fear of it, profound emotional distress, loss of function and quality of life lead many to see euthanasia as a more palatable solution to their problem. Some even see this option at their HIV diagnosis despite the fact that they may have a decade or more of health ahead of them, yet would sacrifice their relatively short-term life potential. Such difficulties confronted by patients with HIV/AIDS may be exaggerated by lack of support from their health workers.

The whole debate on euthanasia has been propelled by both increasing public debate and by a number of key legal decisions around the world. The first development was the legal definition of brain death so that termination of life support in unconscious patients was clarified. The more difficult current debate is the conscious decision of individuals who wish to terminate their life in the face of a terminal medical condition and who may ask assurance from important others, or specifically their doctors.

Euthanasia carried out by patients is not against laws around the world. In Holland since 1993, assistance by others within certain constraints is not illegal. Elsewhere, in the United States and Britain, decisions have been made where medical doctors involved with assisting euthanasia have not been charged.

The law as it stands in Australia does not permit this nor does support come from the reports of the World Medical Association or the Australia Medical Association. The Royal Australasian College of Physicians has recently, without apology, released a paper addressing the issues involved in the case for and against voluntary euthanasia. The NSW Department of Health in its interim guidelines on management, *Dying with Dignity*, addresses what currently takes place.

These guidelines as well as others highlight a significant area and that is the abandonment of futile medical treatment. Some consider this equal to euthanasia, others believe that this is a correct clinical decision to abandon what really represents unjustified life-support. In addition there are circumstances where a doctor can prescribe drugs to ameliorate symptoms but this

might be in such dosage that it represents a risk of shortening life.

It is important to note that the provision of quality palliative care which must never be abandoned, averted a specific decision on euthanasia in many instances. Extrapolation from a Dutch study this study indicates that perhaps only 1,800 deaths a year were the result of voluntary euthanasia, out of some 9,000 who explicitly sought assistance to die.

In Australia, where there are more than 18,000 patients with HIV infection and many more patients with cancer and degenerative disease, doctors will be confronted with this issue with increasing frequency and increasing pressure by patients. In a recent survey, some 60% of Australian doctors wished the law to be changed to allow them to assist in voluntary euthanasia. The debate in Australia as elsewhere is heating up.

Doctors will continue to practice as they have, some providing assistance, some patients assisting themselves in euthanasia, currently receiving advice from the Voluntary Euthanasia Society and other sources. One does not know how many of the more than 3,500 patients who have died of AIDS have followed this path.

High-quality palliative care at both an emotional and therapeutic level will reduce yet never eliminate demand, but "choosing to die" will increasingly become recognised as a patient's right.

MARSHALL PERRON

The Northern Territory's Chief Minister, the Hon. Marshall Perron, MLA is the first leader of a government in Australia to personally endorse the need to decriminalise the practice of voluntary euthanasia. In February 1995 he introduced a Private Member's Bill to the Northern Territory's Legislative Assembly. The Bill was passed 15-10 at 3.15am on 26th May 1995. Mr Perron sent us the following contribution before the Bill was passed and before he resigned from the Northern Territory government.

"The law as it stands actively ensures that many doctors will not intervene to assist patients to end their suffering because of fear of legal action. The law should be changed to formalise and decriminalise a practice which occurs now but a practice for which some patients regrettably cannot find sympathetic doctors prepared to risk their careers and liberty.

This Bill is about personal choice. it does not provide *carte blanche* for euthanasia.

It contemplates no externally imposed end of life decisions for the aged, the disabled or for anyone else. in simple language it provides mentally competent, terminally in patients with the right to choose to shorten their agony peacefully and with dignity.

It is restricted solely to adult patients who are terminally ill and able to make a judgment for themselves after advice from their doctor."

- Extract, Second Reading Speech, The Rights of the Terminally Ill Bill, Northern Territory Legislative Assembly February 22 1995 by The Hon. Marshall Perron MIA, Member for Fannie Bay.

Voluntary euthanasia is a human rights issue which Australia's politicians must eventually confront. It is an issue of social and legal reform that legislators will face up to because of pressure of demand from their constituents. The practice occurs in our society, illegally, and public opinion favours change. Politicians should have no fear that they will lead public opinion in reform. The question is: when are the legislators going to catch up with what the people want?

I began preparing my Bill following searching thought about the rights of those who face a distressing, undignified and possibly painful death and the dilemma confronting them and their medical advisers on the question of whether or not to actively terminate life.

Through the laws in place today, society has made an assessment for all of us that our quality of life, no matter how wretched, miserable or painful is never so bad that any of us will be allowed to put an end to it. I am not prepared to allow society to make that decision for me or for those I love.

I am keenly aware that in other forums this issue has been debated for many years, and usually such debate has been inconclusive because it has split the medical community, drawn opposition from some religious leaders and as a consequence the emotion generated within the community has caused the politicians to back away.

Since I publicly announced my intention on February 1st 1995 the elements of this debate began to unfold in the Northern Territory. At one end of the spectrum I was damned as an agent of death and at the other I was painted as a champion of global change. The truth is the Bill I brought before the Northern Territory Legislative Assembly was based on a relatively simple principle, that if there are terminally ill patients who wish to end their suffering by accelerating inevitable death, and there are sympathetic doctors who are willing to help them die with dignity, then the law should not forbid it. There are such patients, and there are such doctors, but the law does forbid.

My Bill proposed the decriminalisation of voluntary euthanasia for a very specific group in our community under a very specific set of conditions. A person asking for assistance to accelerate their death would be in total control of the process and that person must:-

- * Be an adult
- * Be terminally ill and diagnosed to die within 12 months.
- * Be of sound mind.
- * And must make the request in writing.

The patient must also be advised about the nature of the illness and its likely course, and the medical treatment, including palliative care that is available. The patient must be experiencing severe pain, or suffering or distress with no medical treatment reasonably available and acceptable to the patient to offer relief.

My pleas for the debate to be rational failed. The opponents "forgot" that there was no compulsion in the Bill. They "decided" it was the start of the slippery slope which would lead to

the horrors of Hitlerian Germany and they "ignored" any logical comment about the rights of those who desire a better death. For good measure they claimed I was setting out to legalise murder.

These strident claims told me that my opponents had no interest in considering the rights of others, but they had every interest in forcing the entire community to adhere to a set of views and beliefs to which they subscribed. They hardened my resolve.

The need for reform is not only real, it is long overdue. Eight out of ten Australians want voluntary euthanasia decriminalised, as indicated in public opinion surveys.

They do not regard voluntary euthanasia as a step into the unknown. They merely desire sanction with due safeguards to a practice which occurs now behind closed doors and a practice which most in the community condone.

The first dilemma under present law

Citizens dying in agony who cry out for help do not all receive assistance from sympathetic doctors. Those doctors who assist do so at some legal ask, and others refuse assistance for fear of prosecution. In some cases family members resort to manslaughter, or murder in the minds of some, to help a loved one. The law as it stands forces some of our citizens to assist in suicide. All who participate in this practice -- the dying person, a doctor or nurse who takes some action to accelerate the death, or a relative who helps a loved one to die -- all of them may offend under the Criminal Code.

Section 169 says that anyone who attempts to kill themselves is guilty of a crime and is liable to one year in gaol. Section 168 provides a penalty of life imprisonment for anyone who aids another to kill themselves. This penalty can even apply to anyone who gives verbal advice, as well as those who assist a person to commit suicide.

These circumstances do exist. Surely they should not be part of a civilised humane society? Surely it would be far better to guarantee the choice of a humane and dignified end for those who desire it and to free medical carers from the fear of legal sanction?

The second dilemma under present law

In some circumstances life can now be shortened for the terminally ill. They can refuse medical treatment, operations, life support systems and resuscitation and thereby bring about an earlier death. The Northern Territory's Natural Death Act even allows a competent adult to designate that others can make a decision to accelerate death for them by switching off life support equipment.

So Territory law dictates to the patient who is dying in agony: end your life if you like but you are going to have to do it slowly, no-one can legally help you. We can legally *let* them die, but it is illegal to *help* them die. Thus far we have not had the compassion required to give them relief even when they ask for it.

Voluntary euthanasia is not for everyone

The will to live is probably the strongest living force of all. Patients will hang on while their quality of life is acceptable but if the pain and distress of terminal illness become insufferable they should have the right to die at the time of their choosing. Most people simply want the reassurance that if their situation becomes desperate they can get help to die.

A recent two year study of terminally ill patients at Daw House Hospice in South Australia has shown that 6% of patients asked medical staff for a speedier end. The report on that study describes these requests as spontaneous expressions by the patients, 21 people in all out of a total of 331 in the study period 1991-93, asked their carers: "Please, do something now." They sought voluntary euthanasia.

Society needs legislation to give unfortunate individuals and only those individuals the right to choose a more humane end to their life if they are terminally ill, near death and find the pain and stress beyond their capacity to endure. Opponents should not pretend that it opens the door to the practice of widespread state-sanctioned death in our hospitals.

The major concern of the medical profession is patient care. In some cases care means the option of final release and doctors admit this is so. I am certain that once reform occurs doctors will abide by its provisions in the best spirit of the medical tradition.

No compulsion

There is no compulsion in my Bill. There is no requirement that every terminally ill patient or indeed any terminally ill patient must consider whether or not to hasten their death. The claim that it will inevitably lead to non-voluntary euthanasia as was practiced in the politically corrupt Germany in the 1930s and 40s has long been a major tactic of those opposed to voluntary euthanasia. This scare is repeated by opponents at every opportunity in the world wide euthanasia debate. It is in my view an obscenity to associate this practical legislation which has popular support with the shadow of the Third Reich. It is also an insult to Australian doctors to seek to pretend that the profession would be associated with such a wicked scenario.

Palliative care

Even with the best medical care some people will always demand a speedier end, and that is understandable when you contemplate some of the most dreaded forms of death. As an example consider this advice from a palliative care specialist:

"Pain, particularly that due to infiltration by cancer of extremely sensitive nerve rich areas such as the brain, head and neck, pelvis and spine, is commonly episodic and excruciating, aggravated by movement, and may be likened to a dental drill on an unanaesthetised tooth nerve. As such it is not capable of adequate control by palliative medicine. 5-10% of cancer pain may be of this type and can only be "palliated" by producing a prolonged unconsciousness, coma or 'pharmacological oblivion'. This may last for days until death occurs by dehydration and circulatory collapse or retention of bronchial secretions ('the death rattle') pneumonia and

pulmonary collapse."

Add to the pain intractable vomiting, gastrointestinal haemorrhage, air starvation and massive loss of weight and it is easy to picture that this is not a dignified process.

Opponents of voluntary euthanasia, including the U.S. campaigner Dr. Robin Bemhoft, who toured Australia this year admit that palliative care is not the answer for every patient. Regrettably, they refuse to address the issue of what is to be done for such patients.

I have found nothing in the religious arguments, which demand the imposition of a belief on others, to alter my resolve to work towards ensuring that patients' wishes are sacrosanct. Neither the doctor, the family, nor the church should be allowed to over-ride the patient in regard to the right to die.

Public support

If you believe that only God can give life and only God can take it, actions available under my Bill are not for you. I aim simply to give those who desire a choice the right to make it.

I am certain from support I have received, and the public debate so far, that many who consider themselves Catholic, Protestant or whatever also support the concept of voluntary euthanasia. For example, *The Sunday Territorian* asked the question "Should euthanasia be legal in the Northern Territory?" On February 12th it reported that 576 people had registered a vote with 80% voting Yes. *The Australian* newspaper on February 15th published findings by the respected pollster Newspoll, which showed 81% in favour from a nationwide sample of 1200 people. The question asked by Newspoll was:

"Thinking about euthanasia, where a doctor complies with the wishes of a dying patient to have his or her life ended, are you in favour or against changing the law to allow doctors to comply with the wishes of the dying patient to end his or her life?"

Eight in ten from this statistically sound sample agreed they would support a law to allow voluntary euthanasia. I think we must accept that some respondents who favoured euthanasia in both polls would be practising Christians or members of other faiths.

Personal tragedy

Soon after I announced my intention to introduce my Private Member's Bill I spoke with a doctor who described how and why he killed his suffering mother in the presence of his father. I also received a signed letter from a Darwin woman who was forced to kill her father after a long battle with a particularly insidious cancer. During the last six months the father was slowly dying of starvation and in such a wretched state of pain that he and the family prayed constantly for him to die.

This woman was very close to her father and in the end she could no longer stand to watch the man she loved who gave her life continue to suffer so horribly so she personally fulfilled his wish to die. She told me her only regret is that she did not do it earlier. At least one similar experience was relayed over Darwin Talkback Radio in the opening days of the public debate in

the Territory.

When considering my Bill, I appealed to my colleagues in the Territory Assembly in these terms:

"If we as legislators wring our hands and turn our backs, we are compelling suffering citizens to beg their loved ones to take the law into their own hands by whatever means they have available because current laws forbid the medical profession to do what is humane. The frightening prospect of an inexperienced family member botching an assisted suicide and its effect on the family thereafter is an awful thing to contemplate."

Ultimately politicians throughout the country are going to have to confront the issue on these grounds.

John Stuart Mill's famous essay *On Liberty* observed:

"The only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others ... over himself, over his own body and mind, the individual is sovereign.... The only freedom which deserves the name, is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or *impede* their efforts to obtain it."

CHRIS PUPLOCK

Chris Puplick is currently the president of the NSW Anti-Discrimination Board; Chair of the NSW Privacy Committee and Acting Chair of the AIDS Trust of Australia. He has served previously as a Liberal Senator for NSW and a member of the Shadow Cabinet. He holds an MA degree from the University of Sydney and is the author of several books.

In the late twentieth century there is no shortage of social critics and commentators ready to tell us that the problem with modern (western) society is that people will not take sufficient responsibility for their own lives. We are told that the welfare state, the government, interest groups, big business, the international money markets or whatever else have become so powerful that we are no longer in control of our own lives and indeed that we have accepted this situation passively and are prepared to go along with it. As Dostoyevsky in *The Brothers Karamazov* and Erich Fromm in *Fear of Freedom* told us, nothing is more terrifying for human beings than the concept of personal freedom.

What is urged upon us is that we should fight back, that we should reassert control of our lives and accept a greater degree of personal responsibility for who we are and what we do.

I agree with this proposition - it is important in liberal democracies such as ours, and indeed in all societies that people should take responsibility for their lives and actions, and should be held to account for what they do. To me, it follows logically that taking personal responsibility for our lives means that we should also take personal responsibility for the very end of our earthly lives - our deaths. How we live affects other people - for good or for evil; so does how we die.

As a society we are hypocritical about death. We canonise the priest who substitutes himself for another at the mouth of the gas chamber; we respect Lawrence Oates as he walks off into

the Antarctic snow; we are touched by the true love manifest by Sydney Carton as he mounts the scaffold. They are people sacrificing full lives.

How then do we get to the point when an apologist for pain like C S Lewis (*The Problem of Pain*) excoriates the suffering for offering up to God "our own, (life) when it is no longer worth keeping"?

Surely in so doing we are making a number of statements. In the first place a belief that God does not intend us to be wretched and to so demean His gift of life as to eke it out in utter despair and worthlessness. Secondly a sense of concern not just for ourselves but for others - our family, the ones we love, our carers, including the professionals who make every effort to keep us alive. Our decision to shuffle off this moral coil is perhaps the last and most loving thing we can do for them - we put an end to their suffering no less than to our own.

Our sense of moral responsibility tells us to do what we can to overcome injustice and suffering - to relieve others and ease their burdens. Do we have no less responsibility to ourselves - and who is better to judge than we?

Finally, who do we wish to make accomplices in this final act? By their consent it should be either those who love us the most or those who are the best trained and whose whole existence is predicated upon preserving life whenever that is a viable option.

I for one would count it as an act of supreme love were my family or those closest to me, knowing what my views are and what I regard as the essential elements of quality in my life were to authorise the withdrawal of treatment or the pulling of the plug at the point which they know in their hearts and souls is the right point if I were not able to do that for myself.

I would hope that the medical practitioners to whom I might turn to seek just such help were sufficiently full of human compassion to give me the help that I have requested. I would hope that the legal arrangements in my country would recognise this for what it is - my decision - a taking of responsibility for the final act of my earthly life just as I hope I have for all my conscious life that has preceded it.

I have seen enough suffering and dying. I have lost too many friends. If any one of them had asked me for assistance, out of love, I would not have refused them. If and when my turn comes I hope I can count on no less.

MARK ROSENTHAL MB BS, FRACP

Mark Rosenthal is a medical oncologist who completed his medical Degree at the University of Melbourne in 1983. He completed his oncology training in 1992. He is currently researching the genetic basis of colon cancer as well as practising as a consultant medical oncologist.

I am steadfastly against the proposals that patients should be killed at their insistence and that doctors should be allowed to perform this task.

The argument for active euthanasia is patronised by newspaper editorials, lawyers, civil libertarians, ethicists, bereaved relatives and a relatively small group of doctors who have

limited experience and training in the provision of palliative care. In contrast, those who care for the terminally ill, including medical oncologists, psychiatrists, palliative care physicians and palliative care nurses have laboured the point that active euthanasia is an inappropriate and unnecessary manner with which to deal with a terminal patient's physical symptoms or psychic pain.

Proponents of active euthanasia are generally non-medical and have a minimal understanding of terminal care. They cite extreme but mythical case scenarios which they say justify euthanasia. I have never seen such a case. Almost inevitably patients who receive appropriate care in the terminal phases of their life do not want to die. Almost inevitably physical and psychological symptoms can be controlled.

Perhaps there is the rare instance of a patient making a rational and existential decision to commit suicide. Enacting legislation to assist such suicides will never adequately isolate these cases from those who make decisions through pain, grief or despair. Furthermore, employing doctors as executioners is an anathema to the practice of medicine.

For those proponents of euthanasia who have a medical background, I believe that claims for active euthanasia exposes their own medical inabilities and their personal inadequacies. Far from being a courageous stand, these doctors take the easy option of removing the patient from their care. Active euthanasia is a hopeless, cowardly and ignoble response to a patient's cry for help.

I am dismayed by the attention directed towards legislating active euthanasia. In contrast, calls for establishing adequate palliative care services are muted. Concerned community members should be clamouring for the provision of these services rather than expelling their energies on a polarised view of terminal care that has its basis in ignorance.

BRUCE RUXTON

Bruce Ruxton is national vice president and Victorian state president of the Returned Services League.

I believe the right to live far exceeds the right to die. This could be termed as being a simplistic attitude, however human life is by far the most important single entity we have.

The medical profession is too important to be placed in the same category as government executioners, and that is what they would become if legislation gave them the right to press the button and extinguish a human life.

If a person is in such pain and anguish that he or she feels that life cannot go on any longer, the decision to terminate that life rests with the person concerned. If an individual decides to play God, so be it.

Doctors cannot be expected to be God one moment and an executioner the next. Who in our community would want to see a legalised form of murder appearing on the statute books? No profession is perfect and there are bound to be some rotten apples in the medical barrel.

The western world recoils in horror when a criminal who has committed some of the most diabolical crimes known to mankind is sentenced to death and is subsequently executed. I suspect there are many who reject capital punishment but call for the legalisation of euthanasia.

We are not here to play God and we should leave decisions like the right to remain alive or to die to Him.

B.A. SANTAMARIA

B.A. Santamaria is president of the National Civic Council, editor of New Weekly and A.D. 2000, author of four books and since 1976 a weekly columnist for The Australian. His contribution was originally published in The Weekend Australian on 1st April 1995.

The campaign for the legalisation of euthanasia is in full swing throughout the country. The ideological foundations were originally laid by Professor Peter Singer and his associates at Melbourne's Monash University. After months of active "consciousness-raising" (or propaganda), this was followed by Chief Minister Marshall Peron's private member's bill in the Northern Territory Legislative Assembly; and then by a similar Bill introduced into the South Australian Legislative Assembly. Finally seven Victorian doctors have jointly signed an open letter to the Victorian Premier, stating that they have actively assisted a number of their patients to die.

They did not attempt to hide the fact that, in an effort to rally public opinion to force the Government to change the law, they are deliberately breaking the existing law by assisting suicide which, in all Australian States, is a criminal act.

The seven doctors present their case as that of persons willing to terminate the sufferings of individuals who would be exceptions to the normal process of dying, who ask for final relief from their suffering. Their motive is compassion. I do not question their sincerity. What we have to determine, however, is not what we think of their motives but whether we want the kind of society which will actually evolve if the law is changed in the way they desire. Fortunately or otherwise, there is a precedent in Holland, a country quite as civilised as Australia, which has - *de facto* - legalised euthanasia.

In 1990, the Dutch government appointed the Rummelink Committee to investigate the aftermath of the Dutch legislation. It established that in 1990, 129,000 people died in the Netherlands, of whom 2,300 (or 1.8%) were actually "eliminated" by their physician at the patient's request. An additional 400 were assisted by their doctors to commit suicide. Another 1,000 were put to death without any request. Another 8,100 were killed by being given pain-relieving drugs, not with the primary intention of relieving pain, even if the treatment might hasten death, but of deliberately bringing it about.

Of these, 60% were at no stage asked for their consent. Since 1990 the situation has become worse. Death certificates are falsified, actual killing being reported as "death by natural causes".

Dr Helga Kuhse's recently statement published in the *Australian Financial Review* - that as there are no earlier records, there could have been as many killings in Holland before the Dutch legislation was passed - is nonsense. The merest tyro knows that, within the past 40 years,

there has been a complete collapse of religious belief in Holland, which explains both the new law and the conduct of society, doctors and patients.

It is therefore reasonable to anticipate that what is happening in Holland would inevitably happen in Australia if Australian law were to follow the Dutch precedent.

The euthanasia proposal comes at a most critical moment in the history of public health legislation in Australia. As a result of the collapse in the birthrate, in all Western societies population are rapidly ageing, unless replenished by migration. The pressure to change the law to legalise the killing of those whose lives seem no longer to have any meaning, and who would otherwise occupy precious hospital beds, will in time become overwhelming.

The Singer ideology would provide the necessary justification. And since probably a majority of doctors, like the mass of society, no longer believe anything, there is no deeply ingrained moral obstacle to stand in the way of this development. This is precisely what has happened in the matter of abortion.

The issue, of course, is not primarily about euthanasia at all. Euthanasia is about the ending of life. At the other end - the beginning of life - lie all of the procedures associated with IVF, surrogacy and foetal experimentation, ultrasound procedures followed by abortion, and so on.

Like abortion and euthanasia, IVF procedures were originally introduced in the name of "compassion". However, the result was clearly forecast.

In 1984, the late Professor Bede Morris, head of the Department of Immunology of the John Curtin School of Medical Research at Australian National University - who in 1979 had headed the team of veterinary researchers which developed a then revolutionary procedure to produce two entirely different species of cattle from the same womb - pointed to the consequences if those techniques were applied to human beings:

"The social and political climate has evolved to the stage where society is able to accept with a good deal of equanimity propositions about human reproduction that would have been unthinkable a short time ago ... They have irrevocably changed society's moral attitude towards procreation".

These genuinely revolutionary developments do not simply happen. They arise as the result of the assertion of new claims by a new class of scientist which believes that it is the repository not merely of superior skills, but of a superior morality.

So, back to our seven doctors. On the basis of the evidence they have themselves deliberately provided, they should be prosecuted, tried and convicted. the nature of the sentence is secondary, even if what is originally imposed is merely a suspended sentence. this, however, should be accompanied by a warning that if the offence is repeated by themselves or others, the next sentence will be drastic.

It is reported that Premier Jeff Kennett and the Victorian police do not intend to prosecute. If that is true, it can only mean that in practice they are condoning euthanasia and changing the law without referring the issue to Parliament or the people. Each member of the Kennett

Cabinet should be held personally responsible. Silence indicates consent.

DOROTHY SIMONS

Dorothy Simons is vice president of the Voluntary Euthanasia Society of NSW, and its former president. Since the 1960s she has been variously president of the Council of Australian Humanist Societies, the Family Planning Association of NSW and Preterm. She edited the Womens' Electoral Lobby newsletter for 14 years.

When I was twenty, one of my main concerns was not to have an unwanted pregnancy. The slogan of the 1970s, 'A woman who cannot control her fertility cannot control her life' rang a very clear bell, but I already knew that in the 1930s.

Now that I am over eighty I have very different concerns: I am afraid of losing my memory, my ability to look after myself, or lose control of my bodily functions through disease. In short, I do not want to become a burden to myself or to others and therefore wish to control the way my life ends.

It made sense for me to join the Voluntary Euthanasia Society of New South Wales when it was founded in 1973. The founders chose this rather cumbersome name for a specific reason. 'Euthanasia' means 'a good death' and linking it with 'Voluntary' is crucial. Our opponents, by omitting this word, are guilty of a philosophical furphy. They want to imply that such deaths are involuntary, or against the patient's wishes. Many people are unclear about what voluntary euthanasia involves. It is not the withholding, or withdrawing of treatment, a practice which is now generally accepted. It is either doctor-assisted suicide or a quick and peaceful death carried out by a doctor at the request of the patient.

Nowadays death is rarely easy. The use of antibiotics prevents pneumonia being the 'old people's friend'; technology also plays a part in keeping people alive irrespective of their wishes or their quality of life. Suffering can be both physical and mental, it's not just a matter of pain. For example, being doubly incontinent or totally dependent on others may be unacceptable for some. Who wants to be alive only in the sense of not being quite dead?

The past president of the Australian Medical Association (AMA), Dr Brendan Nelson, takes a curious position. While stating he has helped patients to die, he adds in the same breath that there should be no change of the law because 'doctors would then be told what to do. Also, there are bad doctors who would abuse the system.' It is not clear whether Dr Nelson's attitude reflects that of the AMA membership. The seven Victorian doctors who recently laid their careers on the line by calling for law reform might well be more representative of what the medical profession actually thinks.

In connection with voluntary euthanasia, almost no one in New South Wales has so far been convicted for 'aiding and abetting', murder or manslaughter. The unfortunate survivors of murder-suicide, when charged, have been treated leniently. So the judiciary seems to be in tune with public feeling. This is admirable as far as it goes but it would be preferable to amend the law so that people would not be driven to commit desperate acts.

Public support for voluntary euthanasia has increased considerably. To the question put by the

Roy Morgan Research Centre in Melbourne 'If a person who is terminally ill, or injured with no chance of recovery, asks for a lethal dose so as not to wake again, or asks for some other help to die, should the person be helped to die or not?' In 1962 47% answered 'yes'. In 1993, that figure had increased to nearly 80%.

Public opinion polls show that, in comparison, abortion has never achieved this level of acceptance. Only those who are 'unlucky' and get pregnant against their wishes have to consider abortion. This is a problem only women in their fertile years have to face.

We all have to face death.

PETER SINGER

*Peter Singer is a professor of philosophy and Deputy Director of the Centre for Human Bioethics at Monash University. Best known for his book *Animal Liberation*, which is credited with starting the modern animal rights movement, he is also the author of several other books, including *Practical Ethics*, *How Are We to Live?* and *Rethinking Life and Death*. At the next Federal election, he will stand for a Senate seat as a candidate of the Australian Greens.*

I support the proposal for two distinct reasons.

Firstly, I support the general principle that the state should not interfere with the decisions made by its citizens, other than to prevent them harming others, or to obtain the resources needed to work for the benefit of the community as a whole. This principle, which was most forcefully stated by John Stuart Mill in his celebrated essay *On Liberty*, does have grey areas, where people make decisions without reflection, or where the decisions they make may throw a significant burden on the community. But when an adult person of sound mind makes a carefully considered decision on a matter which does not harm others or the community as a whole, then the state ought not to interfere with that decision, or invoke criminal penalties to stop the person acting on it.

It follows that if the person who has made this decision needs the assistance of another to help her carry it out, and that other person is also an adult, of sound mind, who after careful reflection is willing to assist the first person in carrying the decision out, the state also ought not to invoke criminal penalties against the person who assists.

The second reason why I support the proposal is that I think it is a mistake to believe that life is always good. Life is normally very valuable because it is the basis for everything that we value, whether it be happiness, appreciation of beauty, creativity, love, or the exercise of our rational faculties. But there comes a time in the lives of many people when life can no longer support these things we value, or else is so racked by pain, discomfort, nausea or other forms of suffering that it has more negative value than positive value. An individual who is adult and of sound mind is the best judge of when his or her life has lost what is positive about it. If in the case of a terminal or incurable severe illness it is reasonable to believe that these positive qualities can never be recovered, then it can also be reasonable to regard the days, weeks or months that are left as being of no value, or even of negative value.

The argument from individual liberty and the limited right of the state to interfere might be enough to support the case for the proposal. We should also be free to do things that are unreasonable. But in this case, people who are terminally or incurably ill, who find their condition unbearable, and who want to end their lives, are doing something that is entirely reasonable. Neither they, nor those who help them, should be considered criminals.

SIR NINIAN STEPHEN

Sir Ninian Stephen was Governor General of Australia from

You ask my views on voluntary euthanasia, seeking them by reference to two specific questions. May I say at the outset what a good thing I think it is that you should undertake an enquiry of this kind. However, I have some difficulty with your first question. In explaining that difficulty my views on voluntary euthanasia will, I think, at the same time become clear.

The problem that I have with that first question is that it is silent regarding both pain and quality of life, two factors which I believe to be critical in answering any question concerning euthanasia. Instead, the question seems to treat as critical two other factors - that an illness is terminal or that it is incurable and serious.

That an illness is terminal (and most of us who die from natural causes will, I suppose, ultimately suffer a terminal illness) surely cannot in itself be much of a ground for euthanasia so long as we regard suicide as conduct not to be encouraged. Likewise with an illness which is incurable, (still often the case despite the advance of medical knowledge), or is severe; these factors in themselves do not seem to bear greatly on the euthanasia debate. Only when coupled with pain or grossly depreciated quality of life do they seem to me to be significant.

Considering pain, proper palliative care should in many cases dispose of, or at least greatly reduce, the significance of pain. However, where it is severe and also incapable of being relieved I would regard the case for voluntary euthanasia as strong. So too if illness reduces a person's quality of life to that of severely miserable existence.

The difficulty with these two factors, especially the latter, is how subjective they are, how personal will be the judgment about intolerable, unrelievable pain or about one's quality of life.

Any suggested policy on euthanasia always seems to involve criteria, whether they be yours of "terminal or incurable, severe illness", mine of unrelievable pain or grossly depreciated quality of life or some other quite different criteria. There always seems to be a felt need for the judgment of a third party, presumably a doctor, as to whether the criteria are met.

This brings me to the second question. In my view doctors should be able to assist in euthanasia but only subject to stringent safeguards. For instance, confirmation by a second and wholly independent doctor as to the meeting of criteria, the two medical opinions being perhaps expressed in the presence of and recorded by, say, a magistrate. It should be accompanied by a clear expression by the patient of his or her will to die, attested in some way by witnesses as being expressed with no question of duress or influence exerted by anyone else.

If all this were possible, then I believe that the patient's will to die should be respected; the doctors could then lawfully assist the patient to his or her death.

However, I would not tolerate euthanasia without all these safeguards. That great care is needed in formulating appropriate legislation is, to me, emphasised by the form of your first question. Obviously, care has gone into its formulation; yet to me it omits the two critical factors of pain and quality of life. If a statute took the form of your question I would regard it as so defective that I would prefer no legislation, and hence no euthanasia, rather than what seems to be suggested by your question.

LOUISE SYLVAN

Louise Sylvan is the Chief Executive Officer of the Australian Consumers' Association. She is well known as a strong advocate of people's rights in the health system including their right to be fully informed, to participate as partners in any treatment decisions affecting them, to refuse treatment and to have access to their own medical and hospital records.

To every thing there is a season, and a time to every purpose under the heaven: A time to be borne, and a time to die...

I support the proposal that a person with a terminal or incurable severe illness should be able to request that their life be ended. It is, after all, one's own life which is at issue and, if I were in the position of deciding that I no longer wished to continue to live due to a severe illness, I would not want that choice interfered with by others. Of course, I would want to take into account the effects on family and friends; my own preference would be also to tell them, though that is a matter for each individual. Whether family or friends accept the decision, however, is not the overriding factor. The choice to end one's life in this type of circumstance has to be the person's sole decision.

My mother, who is a robust 85, may also face such a difficult choice. She is a life-loving, active woman who might want to consider her right to die if faced with a substantially diminished quality of life or with continuous severe pain from an incurable illness. I would want to respect her choice in this matter and to have help in carrying out her decision in the most painless and peaceful way possible,

Protections are needed, naturally. As a society, we would wish to have clear safeguards surrounding such decisions - safeguards that ensure the individual is making a decision in sound mind and that they have not in any way been coerced. These protections could take many forms but they must have a legal base to ensure that the individual concerned can have their wishes met and, also, to ensure that those who might assist are not criminally liable.

Doctors are appropriate people to assist those who request that their lives be ended. In many cases, an individual may want a doctor's presence but also the active assistance of a friend or relative. In both cases, it is again imperative that the legal protections be clear.

Western society is, in general, not good at dealing with death, unlike many other cultures. Apart from legal preparation to take care of the living (insurance, wills and so on) we do little to prepare for an experience that each of us will face. Other cultures have done better - in some Asian and a range of tribal cultures "choosing one's time" was part of dying with dignity. We can

learn from these cultures; enabling people to make this type of choice is one step to dealing with death in better ways.

BARBARA THIERING

Barbara Thiering, now a full-time writer and researcher, was an active member of the University of Sydney's School of Divinity for 22 years. In a 1990 documentary, The Riddle of the Dead Sea Scrolls, drew national attention to her research on the Dead Sea Scrolls and the historical Jesus. Her book Jesus the Man has been a world-wide best-seller.

Have I the right to leave my children? At the moment, while still in good health in my mid-sixties, the main argument against euthanasia that occurs to me is that if I chose to accept it, it would mean that my children had given some degree of assent, even if their part was simply not to intervene. They would normally act to care for me and preserve me (for which I thank them!). I think that if I had agreed to the putting to death, or the assisted suicide, of a loved parent, or even an unloved one, I would be left with a continuing feeling of guilt.

My father went gently into the good night, after quietly fading over some years, and he left us with intact memories of his caring life. I would hope to do the same, even if my mind had switched off for some time, as his had, or if my body had become useless. But supposing one was in intolerable pain? Or supposing one was a severe burden to others, cramping their lives? Perhaps there is a point at which one can cooperate with intolerable pain or weakness, letting them make an end, without putting the burden of choice on others. One would certainly have a right to ask that no artificial steps be taken to prolong one's life when a hopeless stage had been reached.

Because every situation is different, I would agree that there should be no legal barrier to euthanasia. There would be many cases where a doctor would be acting entirely out of mercy. Legislation permitting it would need to be surrounded by many safeguards, but there should be no law preventing an act of sheer mercy.

This is very much part of the theological question, of course. I do not think that there is an absolute morality out there. The Ten Commandments were in the Old Testament, and are better replaced by the Christian ethic "love God and love others". For my own part, loving others does not seem to me, at the moment to include handing over to others the responsibility for my existence. Loving God - that of God in oneself - seems to mean having the courage at the last to "lay my weary soul in thee", as the hymn says. I do not believe in an afterlife in any physical sense, or in the sense of the survival of one's identity. But there is "that of God", for a while in oneself, and after one's personal life, everywhere. There must be a moment when you willingly give your part of it up, for it to belong again to the everywhere.

The question of euthanasia is not the same, I think, as the question of abortion. A foetus in the first few weeks that could not survive alone is not yet a person. The decision to abort is the decision not to let it become a person. But someone who is capable of a decision about her or his own life is responsible for carrying that life rather than putting it into the hands of others.

As with most things, further experience can make you change your mind. But this is the way it seems to me at present.

BERNADETTE TOBIN

Bernadette Tobin PhD is foundation director of the John Plunkett Centre for Ethics in Health Care at St Vincent's Hospital in Sydney. Her qualifications are in philosophy and in education. Her current research focuses on a value-based approach to medical ethics and education.

Let us be precise. Forgoing futile or burdensome treatment is not euthanasia: it is good medical practice and legal everywhere in Australia. Relieving the symptoms of illness is not euthanasia: it is good medical practice and legal everywhere in Australia. As for deliberately hastening someone's death for economic or social reasons: that is not euthanasia but homicide which is and should stay illegal. If we are to discuss euthanasia intelligently, we need to be clear about what is and what is not euthanasia. It is the directly intended hastening of death which is motivated by concern for the person's suffering.

Since there is no sound way of evaluating the ethical status of euthanasia which does not involve careful attention to all the details of a particular case, let, us simply presuppose that in an individual case euthanasia may be ethically-unobjectionable.

The question then arises whether it would be wise to remove the legal prohibition on euthanasia. To my mind it would be so unwise that a society in which euthanasia is permitted could hardly be called a compassionate or humane society.

It is often pointed out that there is no sure way of building into legislation a line between voluntary and non-voluntary euthanasia. (Even if we thought that there were, we still need to be honest about whether the safeguards would work in practice: there is plenty of evidence that the Dutch 'safeguards' are widely ignored in practice.) That is a serious objection to removal of the legal prohibition.

What is not often realised is that voluntary euthanasia may itself be ethically objectionable. It depends on the details of the case. Perhaps the person who requests euthanasia is giving up too soon. Perhaps a young man wants to punish a family (or society) which has discriminated against him for years. Perhaps, having suffered from unwanted sexual advances in the past, a young woman now wants to demonstrate ultimate control over her own body. Perhaps an old man's family have made it clear to him that he really is a burden on them, and now he has absorbed their valuation of him. Only someone who worships an inflexible and wooden rule of 'respect for personal autonomy' could think it appropriate to respond in such cases by acceding to a request for euthanasia. By legalising euthanasia we would encourage doctors to respond to those kinds of cases in just that way.

In addition we would embolden doctors to ascribe 'autonomous wishes' to people not able to express any wish at all, When It was revealed in Professor van der Maas's survey of the Dutch experience that in one year a thousand people had been the subjects of 'termination of life without an express request', this shocking fact was passed off on the grounds that after all they were all 'in great distress' and that the killing was in accordance with the views of the family and the nursing staff!

Is killing the right word? Surely, it might be said, euthanasia is no more than assisting someone to commit suicide? Certainly the expression 'assisted suicide' is meant to suggest that there is no difference between 'suicide' and 'euthanasia'. There is however a clear ethical difference

between one act and the other. Suicide is an act of someone who kills himself or herself. Euthanasia is an act of a person who kills someone else. The considerations which may be thought to justify the latter are significantly different from the considerations which may be thought to justify the former. And assisting someone to commit suicide is a different human act from both suicide and euthanasia.

One last point. If we do go ahead and legalise euthanasia, doctors should refuse to do the killing. The idea that killing patients -- even at their request -- could be part of the practice of medicine is deeply mistaken. The goal of medicine is to heal. Its objectives are to cure an illness (where possible), to stabilise someone in a reasonably satisfactory condition, and to relieve the symptoms of illness. Healing does not encompass killing. So doctors should insist that the politicians find someone else to do that.

ROBYN WILLIAMS

Robyn Williams is a science journalist and broadcaster who has presented the ABC's Science Show since its inception in 1975. He is Chairman of the Commission for the Future and President of the Australian Museum. He has written more than ten books, with his latest being the autobiographical And Now for Something Completely Different.

One of my most stark memories is of my father, in 1962, pleading "Mama, Mama, let me die, please let me die!" He was enduring an overwhelming heart attack and felt humiliated by his ordeal. The hospital, when we got him there, was terribly keen to take details of religious belief etc before they would deal with him. Their heroic attempts then, repeatedly to save his life, gave Gwyn the odd extra week but left him shrivelled and demeaned.

My mother too ended her days as a bowel movement refusing to happen. Only when the magnificent nuns in the hospice (where she finally found relief) gave her lashings of heroin and got her comfortable did she return, briefly, to being a person.

Why do we insist on spending 90% of our health funds on vainly trying to extend the last couple of years that old people have left to them? Why can't we be more relaxed about a natural extinction? Is it not more humane to allow the dying person some control and comfort at the end instead of inflicting last ditch remedies?

I have a little experience of possibly terminal disease. I was aware of how many measures were being tried *just in case*. I became exhausted by the endless procedures that modern medicine seems able to offer. It was a relief to know my doctors were very able and would stop the onslaught as soon as they were sure what was up with me. I wondered at the time how I'd feel if I hadn't been so lucky and their efforts were instead withdrawn because I seemed a hopeless case. Would I not really want *anything* done in the vain hope that something might work?

I think not. There comes a time when no wants to be left alone, kept free from the machine that goes PING!, away from the invasion of the tube.

When I am due to snuff I expect it will be sudden. But if it is a long, drawn agony I do hope a kind sawbones will offer expedition. I know roughly what my span is likely to be and I'd rather

set up a pleasant wake, kick it off with a gentle farewell, then leave the participants to drink to my demise. Good funds on festivities, not cut flowers. It would be a nice way to go. I've seen worse. Far worse. It is so pointless.

There are sensible ways for doctors and patients to cooperate in making dying less miserable, even straightforward. Let us explore them.

ROGER WOODRUFF MS BS, FRACP.

Roger Woodruff is a palliative care physician at the Austin and Repatriation Medical Centre, Melbourne. He is author of Palliative Medicine: Symptomatic and Supportive Care for Patients with Advanced Cancer and AIDS. Asperula, Melbourne 1993 and chairman of the Palliative Care Group of the Clinical Oncological Society of Australia.

Acquiescence to the questions posed, that an individual has the right to request and receive euthanasia, and that a doctor performing euthanasia is immune from criminal prosecution, would require legalisation of voluntary euthanasia or physician-assisted suicide. In addressing this question, I ask four questions: *who is asking for it? Is it clinically necessary? Can it be controlled? and Is it in society's interest?*

I have worked in cancer medicine for more than twenty years and am yet to receive a request for physician assisted suicide. The much publicised polls claiming that the majority of people in this society are in favour of euthanasia mean little, for it is well documented that peoples' attitudes change when they actually have a terminal illness. I see patients daily who, despite suffering and some pain, cling to life. The published studies of the attitudes of doctors and nurses are likewise meaningless because of the self selection of the respondents.

The optimal management of patients with advanced cancer or other terminal illness requires a different approach to clinical care, known as palliative care. Palliative care employs a multidisciplinary team including doctors, nurses, social workers, psychologists, physiotherapists, occupational therapists, pastoral care workers or clergy and other allied health personnel as required. The team works in a coordinated manner to address all aspects of suffering for both the patient and family. Palliative care should not be regarded as second class care introduced when "nothing more can be done". It is intensive care, quite different from what might be seen in a hospital intensive care unit, but nevertheless incorporating excellent medical treatment in the setting of holistic care. I believe that too few of the patients whom we have all heard about, whose terminal illness was associated with much suffering, received the benefits of multidisciplinary palliative care.

Uncontrolled pain is often cited as a reason for euthanasia. Contrary to popular belief, cancer is not invariably associated with severe pain; about two-thirds of patients with advanced cancer will experience moderate or severe pain, and this can be well controlled in 95% of patients employing standard techniques as well as input from the multidisciplinary team. What is sometimes forgotten by treating doctors is that physical pain may be caused or aggravated by matters of psychosocial concern and that no amount of well-prescribed analgesia will relieve this pain until the psychological and social factors are addressed. This is the case for the majority of patients referred to me with poorly controlled pain and underlines the importance of a multidisciplinary team approach to care. I believe that too few of the patients we have all

heard about, whose pain was poorly controlled, received the benefits of multidisciplinary palliative care.

Patients with a terminal illness deserve the best possible control of symptoms. There are situations where the treatment necessary for the relief of distressing pain or other symptoms may incidentally hasten death; so be it. As a doctor, I have an ethical obligation to act in the best interests of my patients, even if the measures taken may incidentally shorten life, but this is morally and ethically distinct from premeditated active euthanasia.

Patients with terminal illness should not be subjected to unnecessary or futile treatment. It is always easier for a doctor to say "we are going to do such and such" than to sit down and explain to the patient that they are going to die. I believe some of the patients we have all heard about, who suffered a relentless series of investigations or operations, might not have consented to them had they been more fully informed.

Voluntary euthanasia or physician assisted suicide cannot be controlled, even by the most stringent legal safeguards. The Dutch experience proves that the slippery slope exists; it is documented that some Dutch patients upon whom euthanasia was performed were inadequately assessed and some hadn't even requested it. I believe that the legalisation of physician assisted suicide for patients with a terminal illness such as cancer will slowly come to be applied to increasing numbers of people with increasingly less frailty or dependence. There are numerous reports from medical and palliative care associations from around the world which, after careful consideration, advocate against the legalisation of euthanasia or physician assisted suicide.

Legalisation of voluntary euthanasia or physician assisted suicide cannot be anything but detrimental to society, now and for the generations to come. It will slowly but surely erode that most precious and irreplaceable social value - our respect for life. Christian belief in the sanctity of life is well known, but even in a completely secular society every individual has his or her own spirituality, that existential *raison d'etre*, that intrinsic value of being a human being.

For these reasons and more, I am against any legalisation of voluntary euthanasia or physician assisted suicide. I shall continue to try and improve the standards and availability of multidisciplinary palliative care for patients with advanced cancer or other terminal illness. I will continue to enjoy seeing terminally ill patients, relieved of their pain and physical suffering, peacefully coming to terms with their lives, mending fences and enjoying being with their families. And I will continue to marvel at the joy of life expressed by patients with terminal illnesses who are a long way past some people's criteria of eligibility for euthanasia.

MICHAEL WOOLDRIDGE

Dr Michael Wooldridge is shadow minister for Health for the federal Liberal Party. Dr Wooldridge responded to our request by providing the transcript of a radio interview conducted by Ranald Macdonald on radio 3LO on 3rd February 1995.

RM: I will be speaking today with the newly appointed Federal Opposition Shadow Minister for Health, Dr Michael Wooldridge. He's a doctor of medicine, practising here in Melbourne [on] his response to the Northern Territory's Chief Minister's draft Bill on Voluntary Euthanasia.

I discussed it yesterday and I want to get Dr Wooldridge's own personal reaction to it. As a doctor, you must have your own views about voluntary euthanasia, based on experience, do you support it being legalised?

MW: Well, I do have my own views. Most doctors have reasonably strong views on this. About ten years ago I worked in the Breast Cancer Unit at Peter MacCallum [hospital], so I've had a lot of experience of death, of dying, of cancer; and, as a doctor, you get a lot of pressure put on you in those sorts of situations by relatives, by friends, to end somebody's life. I think life is extraordinary precious and I think you can do a lot to make sure that a person's last days, or months, are free of suffering.

So I have to say, it's not something I could personally support, though I do understand Marshall Perron's position and I respect him for it.

RM: You do support, though, the current position, which is that drugs can be, if the patient or family, acting on the patient's wishes, want you to, to stop actual life retaining drugs?

MW: Well, I draw a distinction between artificially prolonging life, which is what that is, and doing something to actively hasten someone's death and, certainly, I think it is humane and caring, towards the end of someone's life, if they wish to do things that don't prolong it. But I think there is a big distinction between that and actively killing someone.

RM: Could, actually, the proposal from Marshall Perron is that, if the patient quite clearly wishes and it is quite clear that there is not all that much longer to go, then a doctor can administer a lethal injection - you actually believe that positive move is not something that you could support.

MW: That's correct. I have to say I've seen people who, I've written in the medical history, that they are likely to be dead in 24 hours, I've seen them walk out of hospital and have a substantial life beyond that. It doesn't happen often, but I have seen it happen. The second thing is, when doctors are put under pressure in these situations, it's always the family saying 'look, you kill them', and, as a doctor, I was very uncomfortable about that.

RM: Which is a question in that area, I suppose, Archbishop Raynor has supported this, generally, and that is the use of pain killing drugs and, I suppose, morphine is a good example, when one knows the person is under severe pain, but also the administration of those drugs could shorten that patient's life. I wonder about that - that's sort of in the middle, isn't it?

MW: Well, it is in the middle, but what you are doing there is in the best interests of your patient. As a doctor, particularly when I had most of my patients dying, I had to confront this myself and I was actually very upset for the first couple of weeks, as you might imagine, when you get close to your patients and realise that most, if not all of them, are dying. Because, by the time they get into hospital for treatment they are at the latter stages of their disease. I came to the conclusion that my job, as a doctor, was to relieve suffering, not to prolong life. But, I couldn't come to the point where I said, as a doctor, it was my job to end life.