Submission into the Voluntary Assisted Dying Bill 2021

Submission No.:	192
Submitted by:	john gregan
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Comments in relation to:	Other
Attachments:	See attachment
Submitter Comments:	

To Members of the Health and Environment Committee – Queensland Parliament

I understand that that your Committee is conducting a consultation on the proposed *Voluntary Assisted Dying Bill 2021* of the Queensland Parliament which will be considered in September and appreciate this opportunity to make this submission to the Committee. I had previously submitted the attached document (Euthanasia 2 - with minor edits) to the initial public consultation process of the issue leading to a report issued by the Queensland Government, which I subsequently received. The submission below to your Committee is the same as I made to MPs following the recent report arising out of the initial consultation process.
Note: On the two occasions in the original submission where I have referenced two attachments – viz: "Euthanasia 2 - with minor edits" and "capital punishment" I assume it is not possible to include them as separate attachments to this document to the Committee, so I have incorporated them as addenda to this document.

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As a retired health professional (clinical pharmacist in hospitals) and an old person (born 1941) I cannot for the life of me understand why, after several thousand years, legislatures in Australia feel the need to legalise suicide. I have also contributed to pre-legislation considerations on this issue in the various jurisdictions. Since the introduction of human euthanasia into legislation in Victoria, Western Australia and more recently Tasmania I have noticed that it also seems to be legal for cohorts other than the elderly? I sense that this initiative has come about as a result of sociologists and others wanting to classify members of the community into distinct groups and then prescribing controls for each group. After WW2 I grew up in a seamless society of grandparents, relatives, parents, other adults, and children. No special identities were assigned - you were born, lived and died as part of this social group. As an old person I have become alarmed at some of the recent suggestions by some political actors, e.g. old people above a certain age should not be allowed to vote, something must be done because there are too many humans on earth who have become a threat to planetary health, the cohort of "baby-boomers" are beginning to reach retirement age and this presents a great financial burden on society, etc. It's a strange feeling for me to think that I am now a "victim" and a "burden" just because I am old. In writing this letter I would like you to know that it is done as an individual Australian citizen. I do not belong with any activist group, particularly one of those which is well funded to promote human euthanasia.

I read the Queensland report and associated documentation last year as well as a more recent report on the same issue from the South Australian Parliament. I have to say that the South Australian report, while it made many of the same points as the Queensland one, was more balanced. In the Queensland report many quotes appear be emotional statements from younger people (supporting euthanasia) about their elderly parents and pro-euthanasia statements from medical practitioners, but very little from old people themselves. The report seemed to have excluded a lot of views opposing euthanasia and as a result appeared quite biased in favour of it. For instance, I did not see a credible case made to show that the existing system that we have had in Australia for generations, namely end of life palliative care , was a giant failure, thereby

necessitating legalised suicide. Indeed the only basis that I could detect from the report was summed up in the following statement by a Belgian doctor who practices euthanasia:

Prof. Deliens: *The largest challenge for our healthcare system across the globe in all developed countries—you all know it but do not come forward with solutions—is the ageing of our society. The number of people who will die in the coming 50 years is going to increase substantially. The models that we have developed with specialist palliative care services are not sustainable and you do not need these services for a good death. We have to rethink our concept of palliative care and always use the 95 per cent rule, meaning who is going to take care of you all when you are going to die?*

Apparently the push for euthanasia all boils down to financial concerns. How sad. It has been a tradition for generations in many families, including those of myself and my wife, that the children share looking after their parents until they die in their own homes or that of one of the children or after family home care are transferred for a short period near the end to a dedicated palliative care facility and die there. The other alternative is that parents themselves choose to go to an aged care facility with graded levels of care ranging from self-care to end of life palliative care or in some cases children with power of attorney place their parents in such facilities. On paper this looks like a good idea, but the recent Royal Commission has revealed the dark side of such places. My wife, a retired nurse, spent part of her career working in aged care facilities and noted the big difference in not only the quality of care provided by these commercial enterprises, ranging from excellent to pathetic, but also in the attitude of the children of the inmates, many of whom never or rarely visit their parents. In such worse case scenarios she says it is akin to taking their old people to the tip. With these attitudes it is not surprising that euthanasia appeals to some in the community.

In the recent South Australian report I noted the following comment: "*Dr Michael Sorokin encapsulated the parameters of the debate: The wondrous challenge of the medical profession is to balance the need for the relief of suffering with the dictum to do no harm. Those who work on the principle that life is a Divine gift and must never be voluntarily surrendered are entitled to do so but those who consider that Compassion is the guiding principle on which the practice of Medicine is based are equally entitled to a less rigid view on the gift of Life and its surrender. A modern Society should be able to encompass within its law the expression of both points of view*."

I agree that "*The wondrous challenge of the medical profession is to balance the need for the relief of suffering with the dictum to do no harm."* But I have not come across many in the profession "*who work on the principle that life is a Divine gift."* Most of us health professionals irrespective of one's religious beliefs or absence thereof work on the secular "*dictum to do no harm*" (which includes deliberately causing the death of a patient) combined with compassion for the patients. We leave the "Divine" to those to those trained in theology. Also in the above report (as well as in your Queensland report) there was a discussion on "the slippery slope". In the South Australian report the experience of an American state is quoted to show that it is not a possibility, but experience in other countries, e.g. Belgium, indicates that the "slippery slope" is alive and well. I have covered this aspect in the attached document "Euthanasia 2" where the "slippery slope" is demonstrated in relation to nicotine products. The activists or commercial interests trying to achieve their goal know they will meet stiff resistance from the community and/or governments and strive to get it legislated initially with massive caveats, just to "get a foot in." Once it is "over the line" they gradually chip away over many years to achieve their original goal.

As mentioned earlier, the Queensland report dealt extensively with communications from relatives of dying persons who were so traumatised by the experience that they indicated support for human euthanasia. One justification put forward by pro-euthanasia activists is to use these personal trauma experiences to justify euthanasia and claim that the majority of the population support euthanasia and therefore it should be legislated because it would be undemocratic if such survey results were ignored. This misses the point that sometimes Governments make decisions that do not accord with survey results. One such decision was removing the death penalty for murderers in Australia. At the time, the majority of the population were in favour of the death penalty, especially the loved ones of the persons murdered. Yet Governments went ahead and abolished the death penalty. Another more recent example was the Government mandated removal of guns from households after the massacre at Port Arthur. The majority of law abiding citizens who owned guns and many others did not agree with that decision, yet the governments went ahead and eventually the decision was seen as sensible.

In my comments below the basis of my arguments derives from secular principles observed over a working lifetime as a health professional working in an ethical environment centuries old. I understand where the strategy of the activists is coming from, namely that people feel compassion for people who are dying. As mentioned above, health professionals share that compassion but people at the coal face of healthcare often face enormous problems that only politicians and lawyers have the power to address but they often fall short because they look at such problems from different perspectives, leaving the health professionals to keep putting up with serious ethical dilemmas. Human euthanasia is one such issue for us. I worked for a good while as a clinical pharmacist in hospitals (both in Australia and overseas) where I was involved in looking after dying patients where we made their last days as comfortable as possible. That has been the approach as I said for several thousand years and it is even better these days with more effective drugs to alleviate the pain and other issues. "Homi-cide" means killing a person by someone else. "Fratri-cide" means killing of a brother by a brother. Sui-cide means killing self (sui) by self. All these “cides” until recently have been considered “murder” and people assisting these murders to happen were classed “accessories to murder” and in trouble for breaking the law. Now health professionals have become “legal” accessories to murder in Victoria, WA, Tasmania and soon Queensland and possibly in New South Wales but they are still accessories to murder – in reality nothing has changed. And we don’t like it. The activists, and the parliamentarians they convinced, used faux or misplaced compassion for old people to get this legislation up, but in reality it is applicable to all age groups and down the track it will be done on an industrial scale – the genie is out of the bottle.

As indicated above my objections to euthanasia are mainly based on my experiences as a health professional. It is horrific that doctors and others are now used as instruments of the State to be directly or indirectly involved in the killing of its citizens. That is not their role. What they have done since the dawn of civilized society is to minimise the clinical effects associated with the dying process, and that has been accepted by the general community, most of whom see death as part of life and accept it, albeit with great sadness as they see a loved one in their last stages. Deliberately killing a patient is false or mistaken compassion. It is incongruous that government agencies and charities undertake campaigns on encouraging young people of working age not to commit suicide whilst at the same time suicide is being endorsed for the group they considered to be economic burdens. Mass murderers in prison are economic burdens but they are not killed. The history of state approved killing of citizens such as hanging, beheading etc is one where the State over time has deemed such practices to be barbaric and unlawful. To illustrate where we have come from as a

civilized people in relation to State sponsored legislated killing of citizens I have attached another document in which I have outlined the history of such practices in our own society showing the progressive changes that have taken place, some of which even in my own lifetime. In view of this historical progression I find it incomprehensible that we are going against the tide of history by allowing human euthanasia.

Capital punishment - another State sponsored killing of citizens - was eventually stopped in Australia in relatively recent times for many reasons, but the main one was that an innocent person could be executed. I grew up in [redacted] NSW after WW2 and like many Australians in the 1940s and 1950s, despite my youth, I still thought capital punishment was OK. We had read about the hangings of bushrangers and escaped convicts who had committed murder and my grandfather told me how his father had told him about the public hangings outside Darlinghurst jail in Sydney when men, in their Sunday best suits, would go to watch the hangings. At the time I could cope with the idea of hangings in private but the thought that public hangings were OK was over the top. It was late in 1964 when working in London that I was walking around central London on a freezing cold night on my way home to an unheated rented bedsit and noticed a cinema that was showing a movie version of a play ("The Quare Fellow") by the Irish playwright Brendan Behan. I had read a bit about Behan that he was a hopeless drunk and was controversial so I decided to go in and see it, especially because cinemas were heated. I went in believing in capital punishment and walked out being completely against capital punishment. It was a very powerful movie that made the point that sometimes if people are executed for murder the real murderer is discovered later on. Even now in NSW and other jurisdictions, there have been cases in recent times where people jailed for murder have subsequently been found to be innocent – but at least they still have a life to lead. A similar issue is pertinent to euthanasia, in that once it occurs to the patient there is no coming back. I saw a letter in The Australian newspaper some time back from a physician in an American State where euthanasia is legal. He had diagnosed a patient for cancer and she became so depressed that she requested to be euthanased when she was told of the diagnosis. In his clinical opinion she had a very good chance of survival with appropriate chemotherapy. In the end, he managed to convince her to undergo chemotherapy treatment and she survived and had many happy and productive years of life after the treatment and was glad she had not chosen euthanasia.

Below are several comments I have made in relation to arguments put forward by elected representatives when discussing human euthanasia. Points 1 and 2 deal with comments (in italics) made by Senators in debating the proposal of Human Euthanasia in the A.C.T. Point 3 is an earlier comment on a report on the matter issued by the Queensland Parliament.

1. I agree with his comment that *"The assisted suicide issue is not just about our beliefs or religious principles".* It is about the role of health professionals in relation to a dying patient and the relationship between the doctor and patient that has served us well for centuries. The idea that *"some of us will find ourselves powerless to manage our own suffering"* seems to ignore the fact that apart from minor ailments people rely on trained health professionals to manage their serious suffering. It's not a "do-it-yourself" thing done by looking up the Internet.

2. *"We have more compassion for animals than we do for people. If an animal is in pain or is suffering, we have it put down. That is compassion, yet we do not have that same compassion when it comes to people."* If a horse breaks a leg and is in pain or suffering it

gets shot or otherwise “put down”. If a human breaks a leg and is in pain or suffering they do not get shot. They go to hospital where they are cared for by health professionals and are restored to health. That is our job and there are many other situations where humans experience pain or suffering and we take the same approach in trying to restore them to health. With dying, there is similar pain or suffering but we cannot restore them to health, only assist them to die peacefully and pain free. It will be very hard for health professionals with their long history of caring for human beings to now have the direct or indirect responsibility for their death.

3. Thank you for sending me a copy of the report. One thing I noticed appeared to be an absence of the "Do not resuscitate" option. Whilst I am totally opposed to euthanasia, euphemistically defined as "assisted dying", I have no problem with a patient, clearly at the end point of dying, wishing to not be resuscitated if they lapse into a coma as part of the dying process. Experienced clinicians and nurses are aware of this stage of the dying process and can comply with the patient's wishes. Another thing in the report I did not see was a reference to a point I made in my submission is that in some cases when the medical staff have determined that the patient is in the final stages of dying, the family of the patient insist that the staff employ "heroic" methods to keep the patient alive. It is an understandable reaction in the circumstances, but in the present ultra-litigious climate in Australia it is possible the staff could be sued if they do not conform to the relatives' wishes. This is an issue that could be addressed.

In summing up, I would exhort you and your parliamentary colleagues not to support the passing of any proposed euthanasia legislation and instead recognise that dying is part of life and should be accepted as such by governments and society in general and that more funding should be allocated to palliative care because palliative care is the civilized way of dealing with naturally occurring death.

Yours sincerely

John Gregan

Euthanasia – A personal view

By John Gregan

A person's view of the end of life process changes as they move from one age to another. My earliest brush with another's death was in September 1944 when at the age of 3 years and 4 months I accompanied my grandmother, my mother and her sister to the funeral wake of one of my grandmother's older brothers in [redacted] Sydney. I remember it vividly. All the women were dressed in black and I was confined to the kitchen where a relay of pots of tea and cakes to the dining room was being initiated. The group was predominantly women because most of the menfolk were away at the war. At that age, my understanding of death was problematical but I could recognise the grief that was occurring. About the age of 8 years I was staying with the family on holiday at my grandparents' house in Sydney and their neighbour "Uncle Bill" was in his home next door dying from liver cancer. He was being looked after by his wife and his GP who in those days did house calls. At one point my grandmother suggested that I go next door and say my last goodbyes to Uncle Bill. I remember going into the bedroom and sitting next to the bed and chatting with him. His skin was quite yellow and he had lost a lot of weight and his eyes were sunken and he had difficulty breathing. At that age I had a better understanding what was happening and was grateful to my grandmother for sending me to see him for that last time. He died several weeks later, after we had returned to the country town where we lived. In the 1950s some of my mother's older cousins died and as a teenager I accompanied her with my sister to their funerals, but again I had no experience of witnessing the actual death. The closest I came to understanding it was at a "Mission" given by a Redemptorist priest at the Catholic Church at Lilyfield in Sydney in 1954. His oratorical skills were such that as he described in great detail a typical deathbed scene as part of his sermon some of the women in the congregation began to weep at the recollection of their own experiences at the bedside of a dying loved one.

After leaving school in 1957 the dying process was still a relatively abstract concept. As a Uni student the idea of euthanasia was tossed around hypothetically in the 1960s but without the immediacy of impending legislation as today. I lost interest in it when I heard a Bellocian type "cautionary tale" on the issue which was based around the banks of a large river where a five year old was playing at the water's edge and saw his father dragging down a large wicker basket. The child asked his father what was in the basket and what was he doing with it. The father replies that it is your grandfather who has become very frail, can no longer work and was another mouth to feed and had become a burden on the family so I am going to throw him in the river. The child then requests his father not to throw the basket in as well because one day he will need it. My sister at the time was training as a nurse and she was witnessing the dying process through the eyes of a health professional. One of her stories remained with me. It concerned an old man in his late 80s who was dying in the ward. She described the symptoms – the laboured breathing, the death rales and so on. The

young doctors strove to keep him alive using all their new found knowledge and he was obviously uncomfortable with all the tubes and cannulas stuck into his body. After a day or so of this treatment a much older specialist was called in to see the patient and recognised the signs immediately that the man was in the final stages of dying, so he told the young doctors to remove all the tubes etc, make him comfortable through administering regular pain relief and let the man die a decent death, surrounded by his loved ones, instead of giving them false hope. It is very hard for the relatives and close friends of a dying person to accept the reality because of their love for that person and because a bit of themselves dies with the death.

In 1962 one of my grandfathers was hit by a car and broke his hip and was admitted to hospital. When it became obvious there was nothing they could do for him and he was dying, he was transferred to the St John of God hospital/hospice at Burwood. I was working in Burwood at the time and used to visit him daily during my lunch hour, and after work with my father. He could no longer recognise us due to dementia and was asleep much of the time under the influence of the opiate analgesia. I watched as the death rales began and he slipped away peacefully. This was my first experience of a loved one dying and it was a very emotional experience. The thought of someone killing my grandfather never occurred to me as an option. It was his life to live and his life to die at the times appointed by nature.

In 1964 I found myself working as a hospital pharmacist in London. One day a nurse from a ward dealing with the terminally ill (usually cancer patients) brought down a prescription and a 100 mL injection bottle for a refill. It was for diamorphine hydrochloride, the technical term for heroin, which was still used in Britain at the time, but only for pain relief for patients who were in the final stages of dying. The new dose on the prescription was higher than the previous doses and it could be seen that there had been an increase in the dose each time a new bottle had been made in the pharmacy. The Chief Pharmacist explained that heroin was quicker acting than morphine but highly addictive and that the increasing doses was a result of “tolerance” developing to the drug. The hospital had determined a conservative maximum dose allowable and we could not exceed that dose, because anything higher could be fatal to the patient and it was not our job to kill patients. If the patient reached the dose limit of the diamorphine – very rare because it was only ever given in the final stages – other types of analgesia were used to supplement the diamorphine. It was also difficult to set an upper dose limit because patients have different thresholds of tolerance. This was my first exposure to the secular medical ethics surrounding the treatment of dying patients. Since that time I have worked in the area where patients are treated in their last stage of life as well as witnessing the final days and weeks of my own family loved ones. In all cases, the palliative care was such as to allow them to die a decent death surrounded by their families and friends. They were real people, not objects to be killed. There is a well established body of knowledge held by experienced people who are experts at caring for the dying in a compassionate and dignified way.

The recent public debate on this issue (pre-October 2016) had been dominated by arguments by "'progressives" and media celebrities giving reasons favouring euthanasia. This lasted up until October 1st (2016) when Paul Kelly's article appeared in the Australian giving very good reasons why legalising euthanasia is a bad idea. He quotes overseas experience showing that once euthanasia is approved for terminal illness it then moves on to be used in other situations, despite the claim that strict safeguards will be put in place to prevent such a progression. He is right and I know of a parallel situation that I came across as a pharmacist. It involved the introduction in the 1970s of a pure nicotine medical product to be used to replace the smoking of tobacco products. Initially, permission to market it in Australia was contingent on its getting approval from the nation's peak public health regulatory body at the time, the National Health and Medical Research Council (NH&MRC). The Council recognised that the use of such a product would reduce the incidence of lung cancer from the inhaled smoke of tobacco products but nicotine itself has the potential for toxicity, both acute and for the vascular system. The Council also recognised that, because nicotine was addictive, simply replacing one form of nicotine by another would not remove the potential for harm to the vascular system if used over a long period, and consequently did not approve of the product's use. The manufacturer then provided a very responsible reassurance, saying that it was intended to available only on a doctor's prescription, so that the doctor could monitor the patient's progress and taper off the dose so that the patient would in a reasonably short time not only be free of smoking but also of nicotine. If used this way such therapy was found to be very effective. On the basis of that reassurance the NH&MRC agreed to its marketing. Other formulations followed. This state of affairs lasted for a few years after which the status changed so now the products were to be available only in pharmacies and whose sale was to be managed personally by the pharmacist who would give the same advice as previously given by the doctor. The rationale, I presume, was that more people would have access to nicotine products and hence more would get off smoking. Pharmacists were provided with counselling leaflets which stressed, *inter alia*, that the product was not intended simply to replace tobacco products as another form of nicotine addiction but to wean patients off smoking as well as nicotine. The danger of chronic use of nicotine leading to harm to the vascular system was also emphasised. At this level of public access, advertising the products was not permitted. Their use was still in the hands of a health professional. Despite the rationale for removing it from control of the doctors, pharmacists found that a percentage of patients were obviously using the products simply as a substitute for smoking to maintain the nicotine effect. Later on, the access level was reduced to being available only in a pharmacy, could be sold by an unqualified shop assistant without counselling (with the option of asking the pharmacist to intervene in the sale if necessary), and could be advertised directly to the public. This situation lasted a few more years and now you can buy these products in supermarkets without any controls, apart from the legally worded package insert. There is nothing to stop a person using such supermarket products merely as another source of nicotine. Tobacco smoking may be

down, but is chronic nicotine usage also down? There is no way of knowing. So, the "slippery slope" of euthanasia which Paul Kelly correctly identifies is a real possibility, if the example above is anything to go by.

Another more recent example is the legalisation of marihuana. This started off in the USA as a faux compassion for its use for sick people, despite the fact that the sicknesses were already catered for by medicines of proven safety and efficacy. Marihuana and its smoking can give rise to serious side effects, including depression, schizophrenia, memory loss, aggressive behaviour, lung cancer etc. Its sale was not by health professionals and there appeared to be a very low "sickness" bar to allow its purchase. This situation has now morphed into its sale in some American States for "recreational" use, but still in the raw form. The next stage will be mass marketing of factory-made products, available in supermarkets. "Medical" marihuana has been taken up by Canada and soon in Victoria and in Queensland.

How would the above examples translate if euthanasia followed the same path? Initially it would be legalised as claimed in Victoria with strict safeguards and equally strict guidelines for eligibility criteria. So far, so good some would say. But legalising it makes it a "legal product" like tobacco products. Once it becomes a legal product it becomes subject to market forces. Someone will set up a clinic where the use of injectable drugs will be used to kill the "clients". Over time, sales will increase to a point where there is room for another entrant into the growing market. However, in order to gain a bigger share of the market and make his product more attractive, the newcomer needs to differentiate his product, so he decides instead of using needles they will use an odourless gas with a similar effect – i.e. the client initially goes to sleep then never wakes up. What could be more humane? Once the gas method is established, the owners notice that the needle group have dropped their price and sales are flagging, so they reason if they can achieve economies of scale they can beat the needle group's price. Hence, instead of gassing clients one at a time in a cubicle, they invest in a large custom-built room that can take 5 or more clients at a time and using less gas (sounds familiar?) which allows them to drop their price. This proves a winner and because of these efficiencies they become more competitive and claw back market share. The above scenario reflects the reality – you can't sanitise killing people, even if you get them to press the button themselves.

If euthanasia gets up, apart from the "slippery slope", certain groups will benefit whilst others will lose out. Those who will be winners are:

- **The children (or relatives of the clients**). At present such people, if they have power of attorney, can sell their elderly parents' property and install them in a nursing home and operate their bank accounts. This has been known to be abused and that is just one aspect of what people call "elder abuse". If parents are suffering from

dementia and in terminal pain, why wait for the inheritance? Are children then able to exercise their power of attorney and have them euthanased? Dementia would also rapidly become another "eligibility criterion".

- **Businesses to benefit.** This would include hospitals and clinics offering euthanasia as well as the drug companies providing the means of killing the clients. Media would gain more advertising revenue as competing methodologies advertised heavily on prime time TV. Such ads would complement the funeral insurance ads so fashionable on TV today.

- **Investors.** This growing market would attract investors, big and small. New IPOs would be all the rage, as we saw recently with medical marihuana. The big investors behind legalising marihuana would pile in, knowing that mental health issues, such as depression and desire for suicide, arising from marihuana and other illicit drug use/abuse would eventually become eligibility criteria.

- **Lawyers.** The reality of life is that if you pass legislation of any sort, it provides fresh fields of endeavour for the legal profession. It is axiomatic that euthanasia legislation has enormous potential for litigation.

The losers in the legalisation of euthanasia would be as follows:

- **The Taxpayer**. Being euthanased won't be cheap, so there will be a substantial cohort of citizens who cannot afford it. But as euthanasia has now become the citizen's human right, governments will fund their killing in much the same way as they fund "legal aid". The drugs used will be listed on the NHS. The Commonwealth will be expected to subsidise the States in this noble endeavour because the States (nominally responsible for the Health head of power) will develop innovative cost-shifting strategies to ensure that the Commonwealth pays.

- **Insurance Companies** . Euthanasia poses a problem for those selling Life Insurance. These policies traditionally pay out a large lump sum if the person dies from natural causes or an accident before the agreed policy expiration date. If someone is euthanased before the due date are the companies liable for the payout? If they are, then this would encourage those who financially benefit from the person's death to accelerate the process through euthanasia. Also, would private health insurers have to pay for euthanasia as part of their "Extras" package"?

- **Murderers and other serious criminal offenders**. If euthanasia is enacted it would be a green light to bring back the death penalty. If the State does not agonise over

killing an honest citizen in the name of compassion, why would they not extend this activity to persons who commit horrific crimes, particularly if suicide and other non-terminal conditions become eligibility criteria, as is looking a possibility in Belgium - according to Paul Kelly's article. The Americans are finding it difficult to source drugs to execute convicted criminals because of human rights concerns. How will they source the same drugs for euthanasia which is human rights approved?

- **Doctors and other health professionals.** In his article, Paul Kelly's quote of AMA's Paul Gannon's statement is a cry for help. The quote basically says medical ethics dictate that doctors do not get involved in treatments designed to kill patients and this has been the case for 2000 years. In the past, the medical ethics were respected by legislatures who relied on advice from experts in the medical field when designing health policies. These days health policies are often influenced by a mish-mash of sociologists, economists, lawyers, feminists, drug-abuse activists and media celebrities, all estimable in their own fields of excellence, but hardly a good basis for coal face health policies.

- **Charitable Organisations with a Health focus.** One sees more and more on TV advertisements exhorting viewers with a particular ailment or problem *to ring this number.* One of the most prominent is directed at people contemplating suicide. At present they try and talk the caller out of committing suicide. If suicide becomes an eligible criterion for euthanasia will such organisations – for legal and "inclusive" reasons - be expected to offer both options, or would another euthanasia specific organisation be needed?

Conclusion

Some readers may find the above views outlandish or exaggerated and even cynical and lacking in compassion and feel it would not happen here in Australia. People said the same thing about Germany in the 1940s – how could a civilised place like Germany with their equally civilized traditions and achievements do what they did. It was because they were subject to human nature and "let the bad guys win" and we are no different in allowing euthanasia.

I hasten to add that the reference to the "bad guys" in the "Conclusion" above is not a reference to Parliamentarians. That is far from the case, as I have a high regard for such persons who have given up a lot to represent their electorates and are passionate about their country and its people. The "bad guys" to me are those outside Parliament who stand to gain unethically from legislation. George Soros and his activities spring to mind. An example of such unethical behaviour was the thalidomide crisis in the 1960s. It was

marketed initially as a sedative in Germany in 1957 and its use was soon extended to cover morning sickness in pregnancy, as the post-war “baby boom” was in full swing and this indication represented a huge market. Between 1957 and 1965 serious side effects, including birth defects, were identified but questioned and resisted by the company. In 1965 the evidence was overwhelming and in Australia the States ceded their Health power relating to assessment of new drugs to the Commonwealth who enacted the Therapeutic Goods Act in 1966 using the Commonwealth Head of Power in the Constitution relating to “Imports”. In Australia thalidomide was marketed from the beginning as being able to be prescribed by pharmacists without a doctor’s prescription. At the coal face, we pharmacists were prescribing thalidomide for morning sickness, based on the information provided to us by the company. When we became aware that we had been unwittingly complicit in this disaster, pharmacists were outraged, **not** at the NSW government in my case but at the company who had deceived the Government.

And so it is for me in relation to euthanasia which I believe could also be subjected to unethical behaviour, particularly as the impending deaths of the baby boomers represents a huge market for death related products and services. I believe that the current system where there is a traditional professional relationship between the doctor and the dying patient is the best model of care. Doctors are answerable to the community through being registered and subject to ethical standards determined by a Registration Board established by legislation.

Brief History of Capital Punishment in the Anglo-Australian Context

1534 – In 2002 I worked for a year in Canterbury, UK. My wife and I rented a flat that was situated on what had been the estate of the husband of the daughter of Sir Thomas More, Margaret. The locals told me that she had gone to London to look after him during his imprisonment in the Tower and after his beheading had bribed a gaoler to give her the head of her father to take back to Canterbury, instead of putting it on the end of a pike for display on London Bridge. That was done in those days "pour encourager les autres" to behave. Nearby was the Parish Church of St Dunstan which I planned to visit because it was very old. The locals advised that for 10 pounds donation to the church I could be taken down to the crypt and view the head of Sir Thomas More preserved in a large glass jar. I visited the historical church, made a donation but declined the crypt invitation.

1660 – I always wondered about the origins and function of Charing Cross when working in London in the 60s. It was only recently after reading Geoffrey Robertson's book "The Tyrannicide Brief" that I realised it had at one stage been a place of execution. One of the most notable was that of John Cooke who had been involved in prosecution and judgement resulting in the beheading of King Charles 1. After the Restoration of Charles the Second, Cooke was sentenced to be hung, drawn and quartered. I thought that the beheadings of Sir Thomas More and Charles 1 were barbaric but the following description of H,D & Q by Robertson beggars belief. "*John Cooke looked up at clouds heavy with rain, and stepped into thin air. The rope pulled tight around his neck and he briefly blacked out, but the hangman quickly cut the rope and his body crumpled on to the ground. The assistants took the tongs and pincers and one held a flaming torch. John Cooke was quickly stripped and held backwards, as his genitals were cut off with a sharp knife. He was held up, conscious, while they were held in front of his goggling eyes before the hangman threw them into a bucket. ……. His assistants pulled on the halter that brought the judge forward; the hangman inserted the burning corkscrew and expertly twisted out the lining of the inner bowel; Cooke was bent backwards again to watch as his entrails were put to the torch. The executioner would normally at this point end the excruciating suffering by cutting out the heart but this executioner wanted Peters to observe Cooke in conscious agony for as long as possible. The stench became sickening as the yards of bowel were slowly burned – ladies clasped scented handkerchiefs to their noses as the wind carried the smell to residential apartments overlooking the gallows. Eventually Cooke expired: his heart was cut out and exhibited, still pumping, to the approving crowd, the executioner holding it high around the scaffold on his knife before casting it in the bucket. Then the body was beheaded in dumb show, the dead head falling at the stroke of the axe and held aloft by an assistant shouting: 'Behold the head of a traitor!' It was thrown in separate bucket…. And then the body, laid out on a trestle, was expertly chopped with a cleaver into four pieces – lengthwise and then horizontally – to provide four 'quarters' – two arms and two legs each with a torso base, for impalement on the spikes of the city gatehouse."*

1789- I read somewhere that a Catherine Murphy of London, who had been found guilty of counterfeiting coins, was the last woman to be burnt at the stake in England, after due process of law.

1852 – This was the year of the last public hanging outside Darlinghurst jail.

1907 - The last hanging inside Darlinghurst Jail, out of the public gaze, was held in 1907.

1967 – The last person to be legally executed by hanging in Australia was Ronald Ryan at Pentridge Prison in Melbourne.

So you can see from the above there has been a steady progression of civilised behaviour over the centuries by Governments in relation to State sponsored killing of citizens to the extent that here in Australia it no longer exists, apart from Victoria, Western Australia and Tasmania. After all the hard work that has gone into reaching this point, why reintroduce the same concept into legislation, albeit for another reason?