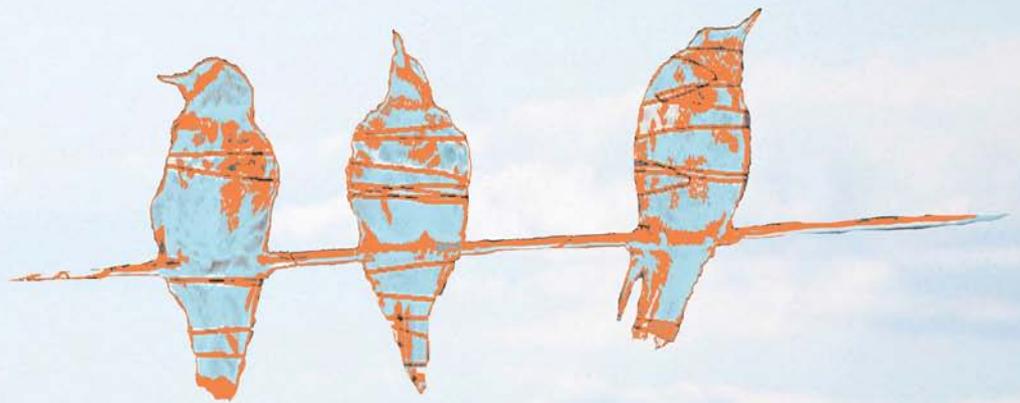


JULY 2010

# dying with dignity<sup>nsw</sup>



## respect for the right to choose

*Over 85% of Australians believe in the right  
of the terminally or incurably ill to obtain  
medical assistance to end their lives*



## Dying with Dignity NSW

ISSN 0813-5614

Dying with Dignity NSW promotes legislation which, with the proper safeguards, would entitle any adult person suffering a terminal or incurable illness to a dignified medically-assisted death. In fact, we advocate decriminalising a medical procedure which is already occurring, albeit covertly. We propose that dying with dignity become a legally accepted and protected element in medical practice – an option for patients who want it – and ask for it. And for doctors who are sympathetic and wish to participate.

Over decades our Society has shown itself to be an example of responsible and informed debate on this increasingly important issue for the Australian community.

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# CONTENTS

Doctors' attitudes to DWD/VE: a literature review

Dr David Leaf 3 - 8

NEW Community Organiser

8

DWDnsw President's Report

8 - 9

WFRtDS Conference

9

DWDnsw Treasurer's Report

10

Updates

9 - 10

ACT Branch News

11

CC Branch News

11

Updates

12

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# doctors' attitudes to DWD/VE: a literature review



I believe that part of the job of a speaker is to get people thinking – to be a bit controversial. I intend to do that – and I hope I don't offend anyone.

It strikes me as ironic that whilst we cannot attract government funding because we support something that is technically illegal, the Catholic Church is funded to the tune of millions of dollars a year and, as we all know, is guilty of the worst type of crime imaginable – the abuse of children (and the cover-up). Yet they continue to attract government funding.

Speaking of the Catholics and their current troubles – maybe we should use this to our advantage – strike while the iron is hot, as it were. Because, rather like the Third Reich, (who the Catholic Church also supported) they are busy fighting on three fronts in NSW.

Number one – the Russian Front – they're busily defending the Pope. This is the big one and it's probably going to hurt them. Number two – the Western front – where the fight's over ethics being taught in our schools.

Number three is us – DWD/VE. I think we can blindside them because of the aforementioned preoccupations.

(This is a good time to mention one of my personal heroes – Galileo. He knows a thing or two about the Catholic Church!)

Two years ago I gave evidence for the Standing Committee Hearing for the *Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill*. Senator Brown's Bill seeking to repeal the Andrews Bill which repealed Marshall Perron's ROTI Act. Apart from a second reading, Bob Brown's Bill has not been heard in federal Parliament two years down the track.

The Prime Minister has been otherwise occupied with a looming election so I don't think we've got any chance of being heard this year, but perhaps in the next term if Kevin Rudd wins.

The arguments for and against Senator Brown's Bill were very interesting. Those who spoke against the bill also appeared on the opposing panel of the IQ2 Debate: *We Should Legalise Voluntary Euthanasia*. They were Tony Abbott, Frank Brennan and a Catholic GP whom I know quite well (Dr Maria Cigolini). Bob Brown, Philip Nitschke and Peter Baume stood for the affirmative. (If you haven't seen this debate you can view it here – <http://www.abc.net.au/tv/bigideas/>)

We all know that public opinion in Australia reflects the support for DWD/VE in the rest of the world, numerous studies have proved this. In Australia, support varies from state to state – but is always upwards of 90% which is a significant percentage.

So who opposes us – apart from the obvious – the religious groups? We think we know who our enemies are – but I think there is another enemy out there – and that's the doctors.

But let me explain why I think they're irrelevant to the whole DWD/VE argument. In the event of DWD/VE legislation doctors will be needed, and they're the best

“...there's another  
enemy out there - and  
that's the doctors”

people to provide assisted-dying. But in terms of being advocates for achieving support for any legislation, they are useless, and, I would argue, counterproductive. Let me tell you why.

I would like to pose a question that I have not heard before: *Should medical practice reflect community opinions?* I say: *Yes, they should.*

The Australian Medical Establishment's positions are well known, The AMA's official position is opposed because it (VE): *...changes the nature of the doctor patient relationship*. I would like you to remember this because I am going to prove later why this position is scientifically wrong. And, as Richard Dawkins would say, I would like to bring a bit of science into the argument.

The Doctors Reform Society is supportive – but the professional colleges are opposed. How do we know that? I will tell you about that as well a little further on.

An interesting article I came across in my literature search was from the United States. This article, titled *The Patient's view about PAS and*

...it's difficult to get off this conveyor belt

VE (Graber, MA. *Journal of Internal Medicine*, 2002) looked at patients' views about physician-assisted suicide and DWD/VE.

So what do patients actually think of doctors who participate in DWD/VE or doctor-assisted suicide or about those who are prepared to take part in it? This is an important question because the AMA claims that they don't support VE as it will affect the patient/doctor relationship.

Well I say that is rot. And why it is rot? Look at this survey – two hundred and fifty people in a medical out-patient clinic in the United States were asked a number of questions and I have summarised them for you.

The question was: *If voluntary euthanasia was legal in Australia would your college support it? Guess what? We got no responses. Not one. We sent it to all the Australian Colleges that certify doctors to be specialists.*

One can only speculate on the reasons for this, but I think it's fairly obvious, and I have summarised them here: it's too 'hot' to discuss; it's a taboo subject; controversial; hypothetical (not worth considering). It's too confronting; too many cultural and religious implications.

To test this out, I started informally surveying some of my colleagues. One comment was particularly interesting. It was from an English doctor, a paediatrician and a very

So, they are saying that it's good for terminally ill patients, but I would not have it for myself.

Fifty percent of those surveyed thought that the decision should be made by the patient, which I found interesting. And, forty-six percent thought the decision could be made by the patient's family in the circumstances where the patient is incapacitated and can't make the decision themselves.

Forty-five percent thought that the patient's doctor along with two other colleagues had the right to make the decision too.

Forty-six percent said that assistance to die should be provided by an

## The health system is geared to actively treating patients, not to recognising the dying.

They were asked whether a doctor who wanted to assist a patient to die could still be construed as trustworthy, were they caring and do they think they were able to offer support to the patient and the family?

Guess what? 90% of people said: *Yes of course they can*, 5% of people said: *No – and I would prefer to see another doctor.*

This is significant because if you don't want to participate in DWD/VE then you don't. If you have a problem with your doctor and that doctor happens to be someone who can legally participate in DWD/VE, and you don't feel comfortable with that, then you have the right to see another doctor, there are plenty of us around. Just the same way as if you didn't like the colour of that doctor's tie or their accent or the fact that they were a woman, you could change doctors. No problem. (You, dear reader, are the minority).

Ninety percent of patients didn't think it affected the doctor patient relationship. The AMA chooses to ignore this. I know that is only one survey but on reading the study it seems well done and had external applicability. So I asked Annemaree to send out a questionnaire to all the professional colleges in Australia: The Australian College of Physicians; Psychiatrists; Surgeons; and General Practitioners etc.

nice fellow indeed whose wife is a palliative care specialist. I asked him: *And what does your wife think of voluntary euthanasia?* He looked at me as if I had picked up a handful of excrement and he said: *They don't like to really talk about it. It's not the 'done' thing.* I think this view is shared by the palliative care fraternity and that, in some way, VE threatens their empires. This disturbs me, as all we are offering is another option to patients who may or may not wish to take it up.

With this in mind I undertook a literature search to see what is known about doctors' opinions about DWD/VE around the world. I used a Medline database which is well established, using the key words 'euthanasia', 'doctor', 'opinions', 'attitude', and 'doctor-assisted suicide'. I found a number of studies from around the world. There were forty-seven on the database and I have summarised some of the more relevant ones here.

The first one was from Blomfontein, South Africa, (Brits, L. 1999). They surveyed 250 private medical practitioners (GPs and specialists) regarding DWD/VE for terminally ill patients. They did not survey people who want to die for other reasons. Forty-six percent supported VE which is the highest rate that I have found amongst countries surveyed. But only 35% would not choose it themselves.

independent doctor trained in assisted-dying. In other words: *I agree with it, but I am not going to do it myself.* Fair enough! But interesting that this response was in the minority.

Thirty percent thought the patient's doctor should do it. Clearly there might be some worries from the doctors that the patient's doctor might have a conflict of interest, and may not be able to engage the patient's family in support after the patient's death. But I think the previous study from the United States disproves this concern.

And there is strong opposition to prescribing drugs for the patients use 'willy-nilly' – which is something that I support. The question: *Would they allow the patient to have the drugs at home to use when the patient felt like it.* – (I would not support this statement either).

This extensive questionnaire showed there was strong support for a panel to review the cases (which is the Dutch model).

Interestingly, Italian GPs were surveyed in 1999 – interesting, because VE is not a debate that occurs in Italy. Very few Italian GPs support VE and this study showed that although eleven percent of doctors had been asked by their patients at one stage or another to help them die, almost none of them would contemplate doing it.

Of the doctors who would not participate in DWD/VE, one-hundred percent were Catholic. You would you would expect this a Catholic country

In Japan, palliative care doctors along with nurses were surveyed by the Palliative Care Association of Japan. This study, called: *Doctors attitudes towards voluntary euthanasia in Japanese Palliative Care Association*, (Asai, A. 1999), revealed that fifty-four percent of palliative care physicians had been asked by their patients to hasten their death. Five percent had acted on this request and eighty-eight percent agreed that the requests can sometimes be rational.

So there is an acknowledgement from Japanese palliative care physicians that these patients were rational and were asking for their death to be hastened. But only thirty-three percent regarded voluntary euthanasia as the ethically 'right' thing to do, and twenty-two percent would actually practice VE if it were legal – so there was an increase there. Again, most doctors would not do it, but if it became legal they would do it.

Is the profession lagging behind the rest of the world? Absolutely!

Another study from Norway, another highly Catholic country (I don't mean to belt the Catholics but every now and again I think they need it). In this study, (Meidell, NK. 1998) – thirty percent of those surveyed were pain clinics. The study didn't refer to palliative care and didn't describe these clinics further. But these were patients who were chronically in pain for one reason or another. Thirty percent of these doctors had received requests for VE. Sixty-seven percent were satisfied with the current laws in Norway (VE is illegal). So, most doctors were happy that the law did not allow it, but thirteen percent would endorse DWD/VE if it were legal, and if patients wanted it. And only five percent were willing to participate.

The numbers increased to thirty percent if the law changed. So, all of a sudden these doctors are saying: *I don't believe in euthanasia, it's illegal*, but then, if it were illegal, many of them will actually start believing in it!

The question wasn't: *Will you do it?* The question was: *Do you believe in it?* But, all of a sudden, if it becomes legal, then they say: *Sure*. This doesn't make sense to me.

In Florida, in the United States the same thing occurred. They surveyed oncologists and non-oncologists (they did not define non-oncologists in the study), looking at their attitudes towards DWD/VE. Most oncologists and non-oncologists oppose DWD/VE in favour of better patient pain control, which, as an argument, is ludicrous because, many of the patients who request DWD/VE, do so because of their fear of loss of their dignity – not fear of pain.

I think this reflects the lack of understanding these doctors have about what their patients are actually thinking. However, if DWD/VE was legalised, many, (and the study did not quantify the number), many would change their practice – and their minds. It seems they blow with the wind!

In Queensland, community members and doctors were surveyed regarding DWD/VE. This is a very interesting study (*End of life decisions making* (Steinberg, MA. 1997). Seventy-eight percent of community members and fifty-four percent of doctors agree that we should turn off life support when it is requested (whatever that means!). Sixty-eight percent of doctors thought that patients would ask for life support to be ended even if pain was well controlled. That's not a question I've found in any other study.

Sixty-eight percent of doctors thought that patients would ask for life support to be ended even if pain was well controlled. These are probably intensive care doctors. And seventy percent of community members versus thirty-three percent of doctors wanted the law to be changed. This clearly demonstrates the disparity between the community and the medical profession. In the same study sixty-five percent of community members thought a doctor should be allowed to assist a patient suicide versus thirty-six percent of doctors.

That is, 'a particular doctor' (i.e., their doctor). Seventy-nine percent of doctors and seventy-five percent of community members thought that patients would still ask for DWD/VE despite optimal palliative care.

This means doctors are aware that a majority of their terminally ill patients would choose VE.

Another Australia-wide study, (Wardell, C. MJA, 1996), studied doctor's attitudes towards patient's

wishes and change. This was a postal survey which described four scenarios, with varied illnesses and mental competences outlined in each of the scenarios. A scenario was described on four different pieces of paper and the doctor asked their opinion about each of the scenarios. The doctor's demographics were recorded against their responses. It was anonymous.

Results show that the responses against differing scenarios varied systematically – depending on the socio-demographic and training of the doctors. Doctors generally adhered to patients' and their families wishes – when they were known. But doctors did not adhere to a patient's request to die. So, they will do everything their patient's request – except help them to die (which is still the patient's request). So there is an inconsistency.

In the conclusion, and this is a direct quote from the discussion part of the conclusion of the study: *The treatment provided is significantly affected by the characteristics of the doctor and not solely by the patient's own medical problems.*

The authors conclude that the GPs participation in the preparation of advance health care directives reduces the variability for medical practice.

Another interesting article appeared in the *Journal of the Royal Society of Medicine* in 1996 (a Dutch publication) which addressed the differences between France and Holland, and the way the Dutch worked around the problem of religious obstruction. At the time (in 1996), France was on the verge of legalising DWD/VE and looked to Holland for a model.

The article said the Dutch allow the patient more autonomy and *dragged* – and that is the word they used in the study – the medical profession with them – with the provision of legal protection. In Holland, when this protection began, reporting rates but not DWD/VE rates rose. So in other words, the DWD/VE cases in Holland at the start of the legalisation process stayed the same, but more people were owning up to it.

In Belgium, another survey (Lemye, R. 2002) looked at the VE question through the Belgium Medical Association. This association existed before, during and after euthanasia was legalised in Belgium.

The results showed the medical profession spilt right down the middle. The article says they (the medical profession) were barely involved in the process, and even after legislative protection was put in place for medical practitioners participating in DWD/VE, many, including many prominent medical practitioners and professors, were still loudly worrying about litigation, patient care issues and abuse of the law. To date no data has been published as to whether their concerns were well-founded.

My question is: *Are doctors irrelevant?* This following study might suggest that they are.

An opinion piece titled (Bugarcic, M. *Journal of Law and Medicine*, 2002): *VE – why it doesn't matter what the doctor thinks and why there is no suggestion that the doctor has a duty to kill.* This article claims that, in the Netherlands, it's the judiciary that has taken the lead, which, when you think about it – it has to – it's either legal or it's not. If it's legal or illegal it has to be run by the judiciary, not by the medical profession.

But you would think the medical profession, who are supposed to be a caring profession and working for the best interest of the patients, would be at the forefront of this. But they're not – and they haven't been anywhere in the world.

They are too worried about irrelevant issues and their own threats of litigation and conjecture about patient care. I see it in doctor's attitudes towards other things. (As you can see I am critical of my own profession in some areas).

Take flu vaccines as an example. The overwhelmingly majority of science shows that the swine flu vaccine is effective, safe and cheap. However, very few of my colleagues will get the swine flu vaccine. Why? And I asked them (I have had the vaccine). They say: *Because I don't need it; Because I don't think the science is in yet; Because I did not get it last year; Because I might get sick from it.*

I pointed out that these are the sort of arguments that we criticise our patients for. Doctors should not be the ones saying these things because they are supposed to be informed. I think this kind of thinking goes on with their attitude towards DWD/VE.

So what are the implications from all these studies?

The common denominator worldwide, is that patients want the right to choose DWD/VE in the same way they want to choose all their other medical options. Everybody wants the best for themselves and their family. DWD/VE, in my view, and that of many others, is that is it just another option we can offer patients.

It does not change the patient doctor interaction. What the AMA is saying is nonsense and is not consistent with the known science. If the AMA wants to go on and do their own study in an Australian perspective, I say, more power to them.

Doctors fear the legal consequences even when they have protection available. Doctors' views (especially religious views), affect their ability to practice medicine in regards to DWD/VE, and I think that is completely unacceptable.

The practice of medicine should be without fear or favour. That is, it should be for anybody, at any time and regardless of who they are whatever you might think about that person. When I worked at Prince of Wales Hospital I would have to treat a prisoner bought from jail. On occasion I have been aware of the crime the prisoner has been convicted of. Sometimes I don't. I don't care either way. Or if I do – I bury it and just get on with the job. They are a patient on the bed. And that's how it should be. There needs to be more accountability in the way doctors practise with regards to their own personal beliefs.

Where DWD/VE is available (Holland, Oregon, USA), the evidence shows us that people often do not use the option. They feel comforted by the fact that the option is there if needed. There is no (and this is my term) 'tsunami of lemmings' because that's an argument (slippery slope) that's used by our opponents frequently. That the floodgates will open. Frank Brennan actually said: *Well I don't think we should bring about change in the law in the Northern Territory, because an Aboriginal person said to me once and I quote. 'If euthanasia was legalised again in the Northern Territory, no Aboriginal person would want to go to hospital because they think they would all be going to be killed.'*

I heard him say this at the Senate Hearing – I could not get up and tell him it was a non-argument. But this is some of the nonsense that these people are allowed to get away with.

We can make some evidence-based conclusions in regard to Australia. The pathway of DWD/VE legalisation is through the judiciary – as it was in Holland. We can't look to the medical profession to support us, which is a shame. The usual arguments made against change are outdated and motivated by other factors. The majority of the medical profession is incapable of participating in the argument, in the debate, being, as they are, motivated by self interest. Yes, I am being purposefully critical.

Once legalisation occurs many doctors will change their minds: *Oh, I always agreed with it anyway!*

And I believe I have demonstrated this using the aforementioned articles from around the world. In the end the patients are, of course, the ones who benefit from this.

I would like to end this particular part of my talk with a quote from one of my personal heroes – Amelia Earhart (1897-1937), the famous aviatrix of the 1930's, who said: *Courage is the price life extracts for bringing peace.*

I think we all need to be more courageous about this subject, both as a community and as medical professionals. We need to look at death as something that is inevitable, inexorable and in many cases horrifying.

I first became aware of the DWD/VE debate in 2002. I had a fifty-two year old patient named Ian, a businessman in my town. He owned a motel. I very rarely saw him as he was quite well, and then in January of that year he told me he had had a cough for a few months so I organised a chest x-ray which showed that one of his lungs were filled with fluid.

We made the diagnosis of Mesothelioma, a very nasty cancer derived from asbestos exposure. Ian knew all about Mesothelioma as he has nursed his dad to death twenty-two years before. In fact the reason he picked up Mesothelioma was because he helped his dad wash his boiler suit when he came home from the asbestos factory.

Ian came to me with the diagnosis and we talked about it in my office. And he said to me coldly, calmly: *David I need you to help me die. When a time comes I want you to help me die.* And I had to say to him: *Ian I can't break the law in NSW. But I promise I will be there for you.*

Over the next few months he had a lung biopsy. The cancer had decided to erode and eat its way up the tract made by the lung biopsy through his chest wall. That involved the lining of the lung, the ribs, and then the intercostal nerves which run along the sides of the ribs. The cancer was eating its way through these areas, so that every time he breathed or coughed, Ian would experience agonising pain. Even the act of breathing was uncomfortable. And it was very difficult to control his symptoms.

I was the final person to try and control his symptoms, (I felt like the goalkeeper). Before he got to me he had seen a number of pain specialists in Newcastle, a palliative care team and the oncologist looking after him.

He progressed quite rapidly and I put him on a morphine infusion, a little pump which puts morphine under his skin for twenty-four hours a day but I was unable to achieve a dose that would keep him comfortable. For weeks and weeks and weeks he was like this.

I engaged the local palliative care team nurses to help me load the pumps and attend to him. The palliative care team in Newcastle is run out of the Mater Hospital, which is a Catholic hospital. On Anzac Day they phoned me to say that Ian was out of pain and that the doses were working. And I thought: *Terrific, well done.* I got in my car and went over to see him, walked in the door with a big smile on my face only to be greeted by a man who was clearly in agony.

He was sweating, scowling, weeping with pain. He was sitting in a big reclining chair (I can still see the scene in my mind) with a blanket over his knees. I said: *Ian they told me that you were out of pain.* And he said: *That's rot, I am not. I am in agony. You get them back here and tell them to put up the dose of morphine you prescribed.*

I still remember the dose – 950 milligrams over a twenty-four hour period. He had been on 800 milligrams a couple of days before that.

However, they would not do it – the palliative care nurses would not do it. And you know why they would not do it? Because they thought the dose I had prescribed was going to kill him, and they did not want to participate in euthanasia.

I was very upset. For two reasons. The first was an egotistical reason. I thought that the nurses must have thought me so incompetent that I thought I was going to knock him off using a pathetic dose like that.

The second was that the poor man was in pain. The nurses refused to come back and see him, so I engaged a private nursing service who happily put up the dose, and higher. We ended up having him on about 1500 milligrams a day of morphine plus a couple of other drugs for the next three weeks. At that dose he was comfortable for three weeks up until he died.

There are two points I want to make about this story. One, it should not have gotten to that stage because the poor fellow wanted to go several months before that, he knew what was coming because of his experience with his father and he didn't want to go through that.

The second point is that he was lucid and mentally competent right up until the end, and should have had the right to go through assisted-dying at any stage. Poor Ian's case still disturbs me to this day.

To elaborate on my thinking about VE, I agree with the South African doctors' position.

I don't think the option to end everything should be allowed to be just 'out there' – just a drug that's prescribed and kept on the shelf for use later – because situations can change.

One of these changes may be that a patient, calm, logical, not depressed can become clinically depressed three, four, six months down the track as their disease progresses. Their situation has changed and it's a doctor's role to reassess them. Could anything else be done for the patient? Could they be made more comfortable? Are there are some easy, quick things that have to be done? And then if the patient still wants VE – after those issues are addressed – then by all means they should be able to do it. But I do think doctors are important in the process.

If Nembutal was legal I would be the first person to help you do it, if you needed it. But at the moment it is not legal. This is the real world.

Palliative care does not provide all the answers. But keeping Nembutal on the shelf? For use sometime in the future? I say: *No* – it's a bit like saying: *I'll buy a spare engine for my car in case my car engine breaks down, I'll just change it myself.*

It's not as simple a case that when the time comes, you rip it off the shelf and swig on it. There are some things that palliative care can offer that can make you live happily, comfortably for another few months.

I had a patient who was told, (not by me), that he had prostate cancer. He went home and hung himself in his barber shop. He was found by his colleague the next morning. That was terrible for his family, his colleague, his customers, me. He did not have prostate cancer. He had a raised BSA.

We need to get the science in. Patients should be reviewed by a panel of various medical professionals as part of their treatment. This is what happens when in palliative care.

They review the case as physicians. At the moment they're the guys who do it. In a lot of places GPs do it too.

This was a situation where the guy wasn't going to die – or if he was – it was years down the line.

• Dr David Leaf, B Med, FACRRM, FRACGPM, is a senior registrar in emergency medicine, training to be a specialist. He was a GP in coastal NSW for many years and has extensive experience in palliative care having cared for many dying patients and their families in their homes and hospital. David has worked in two other countries for the UN and is passionate about the rights of patients to choose for themselves, after consulting all experts relevant to their situation.

As we are currently reviewing our members' meetings structure and purpose — there will be no meeting in July.

## DWDnsw community organiser

DWDnsw is pleased to introduce Ms Diana Covell, our new Community Organiser, who began work with DWD NSW recently.

Diana comes to us with a background of many years employment experience in the non-profit community sector as an organiser, advocate, caseworker and policy adviser.

She has also contributed considerable voluntary work in the area of human rights advocacy, overseas aid and social justice campaigns and is currently Chair of the Board of the Welfare Rights Centre of NSW.

In addition, Diana has significant research and teaching experience, with a particular interest in oral history, and is close to completing her PhD on a part-time basis at the University of Sydney.

Diana's work includes preparation of a standard DWD talk for community workshops and forums, adding to existing FAQ and fact sheets on key issues, and developing strategies to help grow the membership, increase public awareness of current rights and build support for DWD's Charter and aims.

WE'D LIKE  
TO KNOW  
WHAT YOU  
THINK!

A member survey, prepared by Diana is included with this newsletter.

Please complete and post back to us as soon as you can.



Diana Covell

# 2010 a g m



## President's Report

Dr Robert Marr

It has been an honour to be the President of DWDnsw over the last twelve months.

It has been an important year in which we changed our name from VES to DWDnsw. This development of our new image or 'brand', along with new publications, logo etc have all been developed with the aim of improving our visibility and support in the community.

DWDnsw's Charter, setting out our values and principles, has been finalised, and the committee are now in the process of seeking endorsements from significant organisations in the community. This is the first stage of a much larger strategy working towards legislation that would allow medically-assisted dying. Our mission statement is clear and easily articulated.

In October we commissioned a Newspoll Survey which showed an increase in the number of Australians who support our cause. 87% of people living in NSW voiced their support.

Our Patron, Professor Peter Baume addressed the 2009 AGM. In his talk - *We Need Legislation!* - Prof. Baume talked about the hard facts involved in politicians' reluctance to support medically-assisted dying.

Twenty-two percent of people are said to oppose VE (although this amount is decreasing all the time). Of these, perhaps eight percent are regular church goers, or they're passionate opponents who might change their vote against anyone who supports legislation. Few parliamentarians have majorities that allow them to alienate up to eight percent of their electorate.

In the world of politics, there's weak support, weak opposition, strong support and strong opposition.

Much of the support for medically-assisted dying is what's called weak support, and about eight percent of the opposition is what you would call strong opposition.

So, driven by the imperative of re-election, parliamentarians vote down medically-assisted dying bills. It's not a matter of principle - just expedience.

We must change this dynamic to one of strong support for medically-assisted dying.

Another great guest speaker was Dr Leslie Cannold who discussed the immorality of politicians use of the right of conscience to deny conscience rights to others.

Professor Baume, Annemaree Adams and myself, have responded to a number of media requests for interviews and comments throughout the year, and a number of letters have been written to the dailies on matters relating to medically-assisted dying, advance health care directives, aging and nursing homes. We engaged a media consultant during the year in an attempt to cultivate relationships with journalists.

Last October, all VES/DWD organisations met in Adelaide for the inaugural national conference and agreed to form a coalition of organisations for VE/DWD. The trustees of the Clem Jones estate also attended the conference to familiarise themselves with the issues and challenges, and listen to the strategy 'wish-lists' of the groups.

The GFC has affected our finances and we hope you will remember DWDnsw in your will or consider making a donation. As a not-for-profit organisation we rely on membership fees, donations and bequests to continue our work.

Later this year, in October 2010 the World Federation of Right-to-Die Societies Conference will be held in Melbourne. Everyone is welcome to attend the public day and details are on this page. (see box). The conference is being run by DWDV with funding and other assistance from DWDnsw.

South Australia, Tasmania, Victoria and Western Australia all have bills before their parliaments. There is great hope that one of these bills will be passed soon. DWDnsw has contributed substantially to support our sister societies with advertising and other costs. There is hope that when legislation is in place in one part of Australia – the pressure will build into a national issue.

NSW and Queensland seem to be the most difficult states to achieve DWD/VE legislation due to opposition from conservative religious members of both the major parties and the general dysfunction of the current political situation.

There has also been a significant change in the recognition of advance health care directives.

In NSW, Mr A, a Jehovah's Witness, had been admitted to the emergency department in a critical state with a decreased level of consciousness. Mr A developed septic shock, respiratory and renal failure. His life was being sustained by mechanical ventilation and renal dialysis.

The hospital later became aware of an AHCD prepared one year earlier, which indicated that Mr A had stated that there should be no "procedures involving the medical use of [his] own blood" i.e. that he would refuse dialysis.

Because ceasing the dialysis would undoubtedly hasten his death, the hospital sought a declaration as to whether the AHCD compelled the hospital to

withdraw treatment.

The Supreme Court, in its decision of 6 August 2009, declared the AHCD was valid.

Until this decision we had not had a Common Law case in Australia and had to rely on case law from the UK. There is now no doubt that advance health care directives are legally binding in NSW. •

“...87% of people living in NSW supported medically-assisted dying legislation.”

### World Federation of Right-to-die Societies Conference 2010

The conference is to be held in Melbourne from 6–10th October 2010. The panel discussion public day (Fri 8th) will allow up to 300 people to hear views from some of the sharpest minds both for and against physician-assisted dying, and to ask questions. Anyone may purchase a ticket to this event. A quarter of the public day tickets are already accounted for, and DWDV expect the remainder to go quickly.

Tickets include morning and afternoon tea, and a light lunch.

Ticket sales are open on DWDV's web site: [www.dwdv.org.au](http://www.dwdv.org.au)

Prices for the public day forum are:  
DWD member-pensioner: \$60  
DWD member non-pensioner: \$90  
Non-member pensioner: \$80  
Non-member non-pensioner: \$130

## BEQUESTS

Many people would like to help in the fight for legalised assistance in dying but feel – because of advanced age, infirmity, distance or time constraints – that they cannot contribute as much as they would like.

Or perhaps feel that they cannot afford to make a gift to the Society today.

A bequest is one way you can provide a legacy for others in the future.

A bequest may take several forms. It can be a specific sum, a percentage of your estate, or the remainder of your estate after expenses and gifts to loved ones.

If you plan to make a bequest please think it through carefully. Then, meet with your solicitor to discuss and update your will. Tell him or her exactly what you want to do. Be as clear as possible in describing what you want to give.

We hope you'll tell us if you have named Dying with Dignity NSW in your will.

WE WOULD VERY MUCH LIKE THE OPPORTUNITY TO THANK YOU FOR YOUR GENEROSITY.

...everyone dies

# Treasurer's report for year ended 31/12/2009

Treasurer Geoff Taylor

Financially, 2009 was a better year than 2008. For the 2009 year a small profit of \$901 was achieved, compared to a loss of \$177,532 the previous year. As you may recall from last year's report, there was a drop in the market value of investments of \$157,089 which accounted for the majority of the 2008 loss. Fortunately, this year there was a turnaround, with the market value of investments increasing by \$52,308.

A short-form copy of the financial statements is included with this newsletter.

The Balance Sheet shows a net asset position of \$564,655 which equates to the total of our investments and cash at bank, less our liabilities.

The Profit and Loss Statement shows a profit for the year of \$901, which includes a change in the market value of our investments as mentioned at the beginning, (\$52,308). This means we had an operating loss for the year of \$51,407 compared to a loss of \$20,433 for the previous year. (Statements available from office).

Income for the year rose by \$3,630, offset by an increase in operating costs of \$34,596. (During the year we received bequests of \$29,333 compared to only \$3,000 the year before. Unfortunately this additional income was offset by a drop in investment income of \$21,466.)

Increases in the following expenses contributed to the increase in operating costs:

- Consultants fees \$3,300. A media consultant was engaged during the year to assist the committee in promoting our aims via a number of press releases.
- Employment expenses increased by \$16,184, due in part to the position of Membership Secretary being expanded to three days a week to provide further assistance to the Coordinator. The Coordinator's salary was also increased to reflect the additional responsibilities assigned to the position by the Executive Committee.
- Costs relating to the Australian Association of Voluntary Euthanasia Societies first national conference, held in South Australia last October \$2,875.
- Rent increased by \$3,292, being additional rent associated with the move to new premises in January 2009.

The committee anticipates that there will be a further operating loss for 2010, as the present income from investments and membership subscriptions will not be sufficient to cover costs. However, this loss will be reduced by any donations and bequests that may be received during this year.

• DWDnsw thanks Geoff Taylor for the considerable contribution he has made as Treasurer. Our new Treasurer is Mr Barry Hill.

## AUSTRALIA

• The state of Tasmania is set to become the first Australian state to legalise DWD/VE after the surprise announcement by the Deputy Premier, Lara Giddings of a new bill.

This is exciting news with the bill to be moved in co-operation with Greens Leader Nick McKim.

Nick McKim's private member's *Dying with Dignity Bill* went before the 25-member Lower House last year but was defeated 15 votes to seven.

McKim, now a member in the Labor Cabinet, went to the state election promising voters to continue to fight for the right of gravely ill Tasmanians to die with dignity.

He says there are a number of new members of parliament he believes would support the legislation. He is now a minister in the government.

There is to be a long consultation process so it is unlikely to be tabled until



Spring 2011 but reports from our sister organisation in Tasmania (DWD Tas) say that the chance of it being passed in the Lower House are now very good.

It will be a Private Members Bill but the announcement has given it almost a "government" imprimatur and it will be drafted by the Parliamentary Counsel's office.

Ms Giddings was one of few Labor members who, in an open conscience vote, sided with Mr McKim. She told



Parliament she was committed to helping Tasmanians faced with terminal illness die with dignity, pledging to work co-operatively with McKim on a new law.

Cont'd on back page...

# BRANCHES NEWS ACT

The forums announced in the last newsletter were both very successful, and as a result our numbers are growing.

At our June meeting we were delighted to have Annemaree and to welcome Diana Covell, new community organiser for DWDnsw. We are all enthusiastic at the prospect of working closely with her especially with workshops for those willing to give talks to community groups - a task which is essential to harness the goodwill we feel to be out there.

Our next meeting will be at 10am on Friday, August 20th at our regular venue - Gosford Senior Citizens Centre, 217 Albany Street, Gosford.

Our guest speaker will be from the Greens and the subject will be - "Dying with Dignity - the Greens Voluntary Euthanasia Policy"

The Greens are the only political party to support DWD/VE. We look forward to a stimulating meeting. •Doris Hart, Convenor

This has been a busy autumn for the ACT Branch, with Senator Bob Brown's public meeting on March 16, Seniors Week March 22-25, and our General Meeting on April 15.

Sen. Brown addressed a packed audience at the ACT Legislative Assembly on various aspects of dying with dignity. The meeting was supported by the ACT Greens.

On March 24 we had a stall at Seniors' Expo, where information leaflets and membership forms were available.

We are discussing putting together a 'sample bag' with other useful material next year. One suggestion is that we provide a reading list of items (articles, novels and other books) which some members have found useful and interesting on end-of-life options.

At our General Meeting in April, Emma Awizen, Coordinator, 'Respecting Patients' Choices', based at The Canberra Hospital, spoke on the program whereby patients' advance healthcare directives and other wishes are recorded when they enter hospital.

We continue to lobby politicians on DWD/VE matters. We are anxious that Sen. Brown's bill, 'Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2008', does not languish in the Australian Parliament for lack of Government initiative to allow it to be brought forward for further discussion. This bill has special implications for the legislative autonomy of the ACT, seeking to give ACT citizens the same rights as citizens of the states to propose and debate legislation on any form of DWD/VE.

We are also concerned at the narrow terms of the Senate's *Inquiry into Suicide* and the continued extension of its timetable.

The ACT Committee is beginning to put together a list of reading which some members have found useful and interesting in thinking about the complexities of DWD/VE and end-of-life options. It is still a draft list, and will be updated as we receive more suggestions.

We think that such a list would be useful to have available whenever we have other material to distribute to members and the general public.

DO LET US KNOW ABOUT ITEMS YOU WOULD LIKE TO ADD!

SEE SUGGESTIONS IN BOX BELOW.

Information about recommended reading list is also available on the DWDnsw website: <http://www.dwdnsw.org.au/ves/index.php/index/books/>

*Two Weeks of Life: A memoir of love, death and politics*

Eleanor Clift

Basic Books

ISBN 046500251X

*Vital Signs: stories from intensive care*

Ken Hillman

UNSW

ISBN 9781742230955

*Euthanasia: Choice and Death*

Gail Tulloch

Edinburgh University Press

ISBN 9780748622474

DWDnsw Newsletter Nov. 2008

*A Good Death*

Rodney Syme

Melbourne University Press

ISBN 0522855032

DWDnsw Newsletter July 2008

*A Social History of Dying*

Allan Kellehear

LaTrobe University, VIC

ISBN 9780521694292

Newsletter March 2008

*Freedom to Choose: how to make end-of-life decisions on your own terms*

Dr George Burnell

Baywood Books

ISBN 9780895033406

Newsletter March 2008

*Killing me Softly*

Philip Nitschke & Fiona Stewart

Penguin Group

ISBN 014300303 8

DWDnsw Newsletter July 2008

*Good Life, Good Death: memoir of how a writer became an euthanasia advocate*

Derek Humphry e-book on PDF

ISBN 0976828332

<http://www.goodlifegooddeath.com/good-life-good-death-book.html>

Two novels:

*The Spare Room* (2008)

Helen Garner

Text Publishing

ISBN 9781932351396

*Headlong: A Novel* (2009)

Susan Varga

UWA Press

ISBN 9781921401237

CENTRAL  
COAST

## DYING WITH DIGNITY NSW JULY 2010 NEWSLETTER

...Cont'd from page 10

The Tasmanian Premier, David Bartlett, has defended his Attorney-General's decision to use public money to develop right-to-die legislation.

- Recently, Kevin Rudd drew on the words of the 18th-century Christian theologian John Wesley to explain his international view saying: *The world is my parish* (as Wesley is said to have proclaimed).

Both he and Opposition Leader Tony Abbott answered the bidding of the Australian Christian Lobby to address church leaders just before Rudd's ousting.

How quickly things can change! We now have a new prime minister, in Julia Gillard, who has openly proclaimed herself an atheist.

- A South Australian court ruling that refusing food, water and medication is not suicide has correctly interpreted a woman's right to die, SAVES president Frances Coombe said. Whilst applauding the decision that will ensure carers were not prosecuted for complying with the patients' wishes, she said people should not have to end their lives by starving if they were in unbearable pain.

The decision by Supreme Court Justice Chris Kourakis stated that a competent adult was not under a duty to take life-sustaining medication and a refusal to do so was therefore not suicide.

- Another attempt is being made to legalise euthanasia in South Australia.

Independent MP Bob Such introduced a private member's bill in the House of Assembly.

Last year a similar bill proposed by the Greens in the Legislative Council was narrowly defeated eleven to nine.

- A NSW man whose wife had overdosed on antidepressant pills twice in twenty-four hours has been charged with her death. When the drugs seemed to fail, David Scott Mathers did what he believed he should.

Mr Mathers told police he suffocated his partner of 22 years, Eva Griffiths, with a plastic bag to release her from the constant pain of osteoarthritis, a condition for which doctors had told her nothing could be done. He is now accused of her murder and will face court in August.

- A Melbourne cancer patient (Ann Leith) who imported the euthanasia drug

Nembutal has avoided conviction after a court heard she was motivated only to relieve the suffering of others.

### GERMANY

Germany's Supreme Court has issued a landmark ruling that an assisted suicide cannot be punished if it is carried out based on a patient's prior request.

The court acquitted a lawyer who had counselled his client in 2007 to cut the tube feeding her mother, who had been in a non-responsive coma for five years. A lower court had handed the lawyer a nine-month suspended sentence.

### SWEDEN

A Swedish woman who was paralysed died in May after her respirator was unplugged, in the country's first case of euthanasia since the law was relaxed this year.

### HOLLAND

A new poll shows that three-quarters of euthanasia cases in Holland have increased by 13% in the past year, figures show.

Some 2,636 Dutch people administered euthanasia during this time, with 80% dying at home after their doctors administered a lethal dose of drugs. This compares to 2,331 reported deaths by euthanasia in 2008.

The rise in cases has prompted the health ministry to launch an inquiry into the law and it is due to open its investigations by the end of the month.

### US

- Psychiatrist Dr. Stuart Weisberg from Portland, Oregon is about to do what no one has dared do before.

He plans to open a home where terminally ill Oregonians can end their lives under the state's Death with Dignity law.

Dr. Weisberg said he felt compelled to act after watching a TV interview with Dr. Jack Kevorkian, who pioneered assisted suicide. He decided there are too many barriers in Oregon's law.

Dr. Weisberg believes there is a need in the community.

- The organisation Final Exit Network in the USA has announced that they plan to put up billboards along highways

in California, New Jersey and Florida, promoting what president Jerry Dincin calls "the last civil right of the 21st Century" — the right for a person to determine his or her own death in certain medical situations.

- In the first nine months of Washington's Death with Dignity Act, sixty-three terminally ill patients received lethal medication to end their lives. Thirty-six – or more than half – died from ingesting it. Complications while taking the medication occurred in three people.

### SWITZERLAND

- In an attempt to discourage so-called 'death tourism', patients who travel to Dignitas in Switzerland to die could face a 50,000 Swiss franc (\$53,000) "death tax".

Right-wing Swiss politicians want groups such as Dignitas to pay large fines for helping anyone who has not lived in Zurich for at least a year to die. A referendum on the proposal will be held in November. If more than fifty per cent of the electorate votes in favour, it could become law.

- Meanwhile the Swiss government has put forward two draft papers on assisted suicide, one of which would ban the practice altogether, and a second - the more likely to be approved - which would limit the practice to the terminally ill.

Patients would have to provide evidence from two independent doctors that their illness is incurable and that they are likely to die within months. They would also need to show that they have made an informed decision, over a period of some time, to end their lives.

All these conditions would effectively end or fundamentally change the practices of Dignitas, whose foreign patients typically arrive in Switzerland, see a Dignitas doctor and die within twenty-four hours.



DYING WITH DIGNITY NSW

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