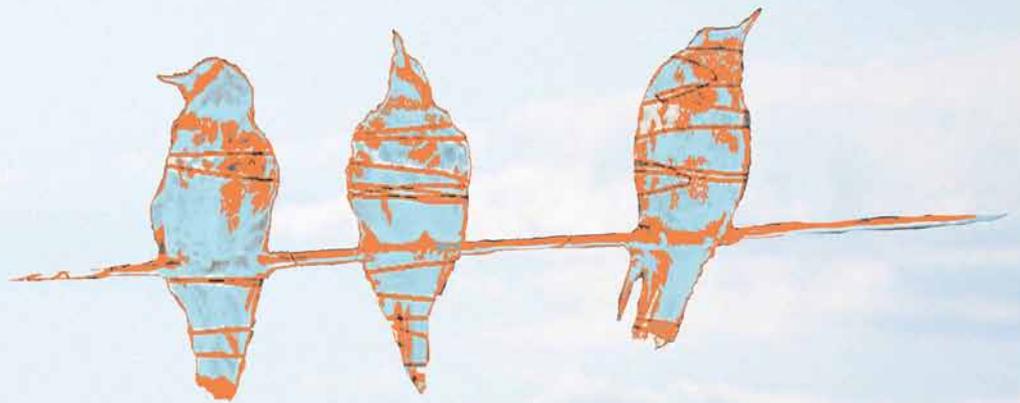


MARCH 2010

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



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 advocates 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. We promote legislation which, with the proper safeguards, entitles any adult person suffering severe pain or distress, with no reasonable prospect of recovery, to a painless, medically assisted and dignified death in accordance with his or her expressed wish and direction.

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# when the end is nigh: it's best to avoid hospital

Professor Ken Hillman

Many of us will spend the last few days of life in an intensive care unit. For many, it will be a painful and futile experience, causing unnecessary suffering for the patient and loved ones.

Once death was treated as a relatively normal and inevitable experience. It is now a highly medicalised ritual. Now, when someone who is old and near the end of their life suddenly or even gradually deteriorates, the ambulance is called. The paramedics cannot be discretionary, even when it is against the wishes of the patient. The role of emergency rooms is to resuscitate and save lives, and package the patient for admission to hospital, whether active treatment is appropriate or not.

It is difficult to get off this conveyor belt. The reasons why are many and complex. Unreal expectations of what modern medicine can offer, reinforced by everyday stories of the latest medical miracle; the inability of politicians and funding bodies to rationally limit resources for end-of-life care without accusations of neglect or even murder; the difficulty of progressing this discussion in a society with such diverse opinions; the increasing specialisation of medicine; the practical fact that it is easier for busy clinicians to continue active treatment than to undertake the difficult and time-consuming business of talking to relatives and patients about dying.

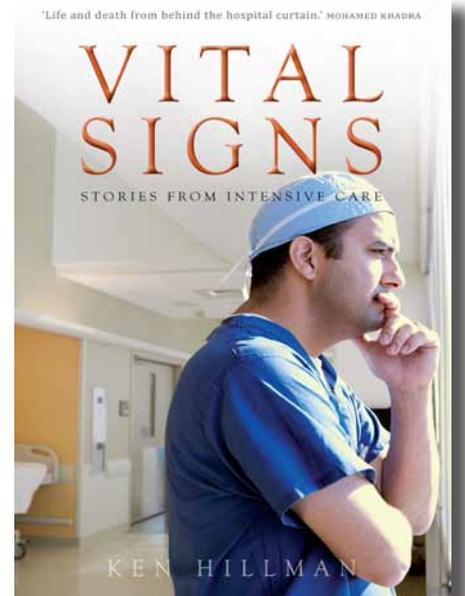
All of this is exacerbated by a health system driven by fees for services, with little incentive to embark on the difficult business of managing dying. There are the ethical issues and the fear of litigation from a predatory legal system.

All these factors mean it is increasingly likely that a patient will not be plucked off the conveyer belt until everything medical has been administered and the last few minutes of life squeezed out.

There are limited provisions for rescuing these people and providing more appropriate care. My specialty of intensive care often acts as a surrogate end-of-life service at unsustainable cost to society.

It is difficult to discuss this elephant in the room. If patients were not given every life-saving therapy, politicians and bureaucrats could be accused of wanting to save money. Community and even medical expectations of medicine are unreal, and we see a patient surrounded by high technology as meaning there is a high chance of recovery.

Then there is the complex issue of just how many resources should be used to manage the seriously ill at the end of life, and who should make decisions



community & even  
medical expectations  
of medicine are unreal //

about resource allocation. Any perceived criticism of medical practices here is about the systems within which clinicians work and is not directed at the individuals who work there. In my career, most doctors I have worked with have been hard-working, diligent, caring and proud of the privileges and satisfaction that practising medicine brings. I have never witnessed a doctor discriminate against any individual patient based on their wealth, class, religion or culture.

But much of the hospital system seems designed to fail. Hospitals have been pieced together over centuries. For example, patients are treated in high-technology areas such as an intensive care unit, where they have access to skilled clinicians, and are surrounded by machines which can support life.

These areas have been grafted onto general wards, where the nursing

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



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

levels and ways of monitoring have not changed much over centuries.

It is not surprising that patients rarely die in an unexpected way in intensive care, compared with the high incidence of potentially preventable deaths on the general wards. With the push for shorter stays in hospital, it can be assumed patients are in hospital because they are ill and need complex care. They are now rarely seen walking around in dressing gowns and slippers. However, hospital systems are still built around admitting senior doctors who may see their patients for 10 minutes each day and have observations recorded by hand on a chart at the end of the bed.

In larger hospitals, the admitting doctor is often a single-organ disease specialist and patient health issues are rarely confined to single organs. However, the system of a senior doctor being ultimately responsible for an individual patient is probably infinitely better than a health administrator calling the shots, as they cannot help ultimately serving their own bureaucracy and funding bodies; managing up, not down; coming in on budget; and trying to stay out of the media.

That system would also be designed to fail patients. New systems built around and judged by meeting the needs of patients would profoundly change the way we deliver health care.

### Vital Signs: Stories from intensive care

Ken Hillman  
ISBN 9781742230955  
UNSW Bookshop (Ph: (02) 9385 6689)

This gripping collection of stories about the experiences of intensive care patients, their families and carers, is about ordinary people facing terrible tragedies and the ways they cope with them.

The author, an experienced intensive care clinician, takes the reader on a journey inside an intensive care unit and reveals to the public, for the first time, what really happens inside ICU. The book traces the personal experiences of ICU patients and their families and the struggles of staff providing care in this critical environment. It also offers a searing critique of the way modern healthcare can fail those in greatest need.  
<http://www.unswpress.com.au>



Not only are hospitals not safe for those with a treatable condition, they are not safe for those who are dying. My grandfather died at home

in 1959, managed by a wonderful GP. Most of my friends' grandfathers died at home. Gradually, as medicine could offer more, it was not a case of whether we should but whether we could.

The health system is geared to actively treating patients, not to recognising the dying. Medical specialists are often uncomfortable with patients who are dying. They can usually think of something more to be offered. Finally, as patients become even more ill, they are often admitted to intensive care. Up to 70 per cent of people now die in acute hospitals surrounded by well-meaning strangers inflicting all that medicine has to offer, often resulting in a painful, distressing and degrading end to life.

Ken Hillman is Professor of Intensive Care at the University of NSW. This is an extract from his book, *Vital Signs* and appears with his permission.

The same system of specialisation of medicine means many patients fall between the cracks and, as a result, hospitals have become dangerous.

# DWDNSW CHARTER



Dear ....

I am writing to seek your endorsement of our Legislative Charter.

The Charter sets out our aims for changes to NSW legislation on end-of-life choices. We are seeking reforms to current law that recognise the right of terminally and incurably ill people with profound suffering to choose medically assisted dying.

Under current Australian law it is illegal to assist a person to die, even if they are hopelessly ill and suffering, and have clearly expressed the desire to hasten death. This is despite numerous opinion polls that consistently show that over 80% of the Australian population support the rights of a terminally ill individual to seek and obtain medical assistance to end their life. In a recent Newspoll (October 2009), 87% of people living in NSW endorsed this right. Clearly, current laws lag significantly behind the will of the people in this matter.

Medically assisted dying has been legalised in a number of countries, including Netherlands, Switzerland, Belgium, Luxembourg and Albania, in addition to three North American states – Oregon, Washington and Montana. It was also briefly legalised in the Northern Territory in 1996; however, the legislation was overturned the following year by the Federal Government. While the provisions of the legislation vary between countries, in all cases individuals with a terminal illness are able to obtain assistance to achieve a peaceful and painless death, under very strict safeguards and conditions.

The Charter has been sent out into the community to seek endorsement. (See this page for text of the letter and insert for the Charter.)

We have clarified our vision – our mission statement is clear and easily articulated:

*The aim of Dying with Dignity NSW is to promote legislation which, with the proper safeguards, entitles any person suffering severe pain or distress, with no reasonable prospect of recovery, to a painless, medically assisted and dignified death in accordance with his or her expressed wish and direction.*

We have developed a brand that can be easily understood and related to – Dying with Dignity NSW. And we are ready to establish and develop new supportive relationships as part of the process of the drafting and promotion of the DWDNSW Bill.

As the ability to make laws on this issue is a state responsibility, our legislative goals are directed to the NSW legislature. (While the Federal Parliament has the power to override Territory legislation, it cannot do so in relation to state laws). Our aim is to lobby NSW parliamentarians to reform state laws in line with the expressed views of the majority of the population.

Since 1973, we have been advocates for legislative change on the rights of terminally ill people. We do not provide information on euthanasia methods, but focus on influencing law makers through strategies such as writing letters to MPs and the media, making submissions to parliamentary inquiries, commissioning opinion polls, sending press releases to the media and providing information for consumers via our website (including information on how to make an advanced health care directive).

In order to influence the political process we seek the support of various groups within NSW, including your own. We hope that by demonstrating a strong base of support among key community and professional groups, members of parliament will become more responsive to public opinion. We therefore urge you to consider adding the name of your organisation to the list of community groups that are prepared to stand up for the rights of the terminally ill by endorsing our Legislative Charter. If you are willing to do so, please complete the enclosed form and return it in the envelope provided to DWDNSW.

If you would like to discuss this or any related matter with us, or if you would like any further information about the activities of DWDNSW, please call our office on 9212 4782, or visit our website at [www.dwdnsw.org.au](http://www.dwdnsw.org.au)

Yours sincerely

Professor Peter Baume AC Patron  
Dr Robert Marr President

Dying with Dignity NSW  
Dying with Dignity NSW



# the dying of the light

## the drawn-out indignities of death

It's January, and with the holidays behind us, here in Minnesota the deep psychosis of winter settles in. The cold has a sharper edge; the darkness of night seems more penetrating and brittle. We'll take the ornaments off the tree but leave the lights on and keep watering it until it gives up its photosynthetic ghost. The green must be cherished until life returns in earnest in the spring.

I'm a physician in a large hospital in Minneapolis, where I help care for patients struggling through the winter of their lives. We've got a lively spring unit, an obstetrical ward where fresh-faced tulips are popping up at all hours, but that's not my specialty. As a hospitalist, I see adult patients of all ages and complexities, most of whom make good recoveries and return to life as they knew it. But taking care of the thread-worn elderly, those facing an eternal winter with no green in sight, is definitely the most difficult thing I do.

That's because never before in history has it been so hard to fulfil our final earthly task: dying. It used to be that people were "visited" by death. With nothing to fight it, we simply accepted it and grieved. Today, thanks to myriad medications and interventions that have been created to improve our health and prolong our lives, dying has become a difficult and often excruciatingly slow process.

Take one of my patients. She started dialysis six months ago at the tender age of 85, and the diabetic vascular problems that put her kidneys in the tank persist. One leg has been amputated above the knee, and several toes on her remaining foot have succumbed to gangrene. Robbed of blood, they appear dry, black and tenuously connected, like an ash dangling off a cigarette.

This patient was brought in for a decreased level of consciousness and low blood pressure, but she has been having periods of nausea, and her appetite seems to have died with her kidneys. The initial workup revealed little, perhaps a low-grade bladder infection, but treating it and her low blood pressure doesn't seem to make much of a difference. She is withdrawn; food goes into her mouth, but she won't chew and swallow unless her children instruct her to. She intermittently refuses pills. There's a language barrier, but her children are there to interpret for her. Translation: She feels exhausted and weak, and she feels that way most of the time.

Dr Craig Bowron

▲▲ ...when I enter his hospital room he seems like a giant oak felled into a hospital bed, stiff & rigid.//

This woman is suffering from what we call "the dwindles," characterised by advancing age and illness. Although dialysis is a miraculous technology -- she'd be dead without it -- it exacts a heavy toll from someone her age or with her medical problems. Three days a week are spent in dialysis, and the other four are spent recovering. It is extending her life, but she's miserable.

Her family has designated her "full code," meaning that if her heart stopped or she were to cease breathing, we would do CPR to revive her, even though there would be a very slim chance of success -- and even though it would be God's or the universe's way of giving her an easy way out.

Another patient is in even worse shape. He's 91 and still a very big man. When I enter his room to

To be clear, everyone dies

examine him, he seems like a giant oak felled into a hospital bed, stiff and rigid, with swollen arthritic joints. A stroke four months earlier paralysed his right side and left him bed-bound and nearly helpless, with pressure sores on his heels. He is mildly demented, and the pain pills aren't helping. He was brought to the ER because he was thought to be having another stroke, though these new symptoms quickly resolved.

Talking with this patient, I recognise his face and the Cajun accent; I'm certain that I took care of him sometime in the past, but he is not the man he was then. Staring at his 230 pounds stretching the length of the bed, I wonder how difficult it must be to care for him. To transfer him to a toilet or a chair requires the use of a Hoyer lift, a gigantic sling that's wrapped around the patient and attached to a mobile mini-crane. Fully suspended, he looks like a massive baby being delivered by a giant stork. The contortions and gymnastics of getting him slung up and moved must drive him wild with arthritic pain.

Though I reviewed the patient's chart before going into his room, I can't recall seeing what nursing facility he had come from. So I ask the nurse. She tells me, unbelievably, that he has come from his home, where his son cares for him. Later in the day I place a call to this Clark Kent, this Superman in disguise.

The son answers with soft echoes of his father's Louisiana brogue, and I ask him how in the world he manages to take care of his dad. He replies that for one, it's all he does, a full-time job, and moreover, his experiences in Vietnam numbed him to some of the intimacies of caring for another human being. "Once you've shoved some guy's guts back into his stomach, you know, you can get used to the rest of it," he says. He tells me that his father is wearing out and that it's hard to watch. The arthritis has become quite painful, and sometimes his dad just weeps. Some nights he needs a couple of Vicodin to be able to sleep through the pain. The old man is also spending a lot more time thinking about his wife, who passed away before him. His son thinks he may be ready to die.

Nothing in my medical training qualifies me to judge what kind of life is satisfying or worth living. Many would say that if we were to become paralysed in an accident, just let us die. But many quadriplegics, once they've gone through an initial period of adjustment, find their lives very satisfying. Patients can and do make enormous efforts and fight precipitous odds to get back to life as they knew it, or even just to go on living. But the difference for many elderly is that what's waiting for them at the end of this illness is just another illness, and another struggle.

Another patient of mine has 86 years behind her and was brought to our hospital from a nursing home in the wee hours of the morning. Her diabetes has become very brittle and difficult to control; the day before, paramedics were called because her blood sugar had dipped so low that she was becoming unresponsive. She also has dementia, and a couple of months ago, she fell and broke a hip. Although it was repaired and she completed rehabilitation, she has wound up essentially bedridden. Strictly speaking, losing your mind won't kill you: It's the falling, the choking, the weakness, the bed sores.

This patient was brought in because the nursing home staff thought that she might have aspirated some food or secretions and developed pneumonia. She thinks it's 1982 and is, as we say, "pleasantly confused." She denies any and all symptoms, and her breathing looks comfortable. A review of her chart shows no fever and a normal white blood cell count. Her chest X-ray shows perhaps a subtle pneumonia but also a compression fracture of one of her vertebrae, which has gone from being 50 percent to 90 percent collapsed. Her dementia has mercifully spared her a lot of pain from the fracture, but it also keeps her from recognising members of her extended family. Sometimes she doesn't recognise her own son, who drove to the hospital to be with her at this early hour.

He and I discuss what brought her in, and then we talk about her code status, which he confirms is Do Not Resuscitate. "She wasn't supposed to be brought to the hospital in the first

place," the son tells me, and puzzled, I ask him to say that again. She was never supposed to be hospitalised: Whatever troubles arrived, the plan was to deal with them in the nursing home. His mother had made that decision herself, several years prior to this hospitalisation, before the dementia really set in.

Later that day, I meet with the son and a few other close family members. They want to continue the medications that would bring their mother comfort and discontinue all the rest. They aren't looking to end her life, but they aren't looking to prolong it, either. They can see that she is moving away from them in both body and mind, and they are ready to let her go.

To be clear: Everyone dies. There are no life-saving medications, only life-prolonging ones. To say that anyone chooses to die is, in most situations, a misstatement of the facts. But medical advances have created at least the facade of choice. It appears as if death has made a counter-offer and that the responsibility is now ours.

In today's world, an elderly person or their family must "choose," for example, between dialysis and death, or a feeding tube and death. Those can be very simple choices when you're 40 and critically ill; they can be agonising when you're 80 and the bad days outnumber the good days two to one.

It's not hard to identify one of these difficult cases in the hospital. Among the patient-care team -- nurses, physicians, nursing assistants, physical and occupational therapists, etc. -- there is often a palpable sense of "What in the world are we doing to this patient?" That's "to" and not "for." We all stagger under the weight of feeling complicit in a patient's torture, but often it's the nurses who bear most of that burden, physically and emotionally. As a nurse on a dialysis floor told me, "They'll tell us things that they won't tell the family or their physician. They'll say, 'I don't want to have any more dialysis. I'm tired of it,' but they won't admit that to anyone else."

This sense of complicity is what makes taking care of these kinds of patients the toughest thing I do. A fellow physician told me, "I feel like I am participating in something immoral." Another asked, "Whatever happened to that 'do no harm' business?"

If we can be honest and admit that we have no choice about dying, then the only thing we do have a say in are the circumstances. Like many nursing home patients, Dorothy was on the cholesterol-lowering medication Lipitor. Why? So that she wouldn't die of a heart attack or a stroke. But don't we all die of something?

Everyone wants to grow old and die in his or her sleep, but the truth is that most of us will die in pieces. Most will be nibbled to death by piranhas, and the piranhas of senescence are wearing some very dull dentures. It can be a torturously slow process, with an undeniable end, and our instinct shouldn't be to prolong it. If you were to walk by a Tilt-A-Whirl loaded with elderly riders and notice that all of them were dizzy to the point of vomiting, wouldn't your instinct be to turn the ride off? Or at the very least slow it down? Mercy calls for it.

This isn't about euthanasia. It's not about spiralling health care costs. It's about the gift of life -- and death. It is about living life and death with dignity, and letting go.

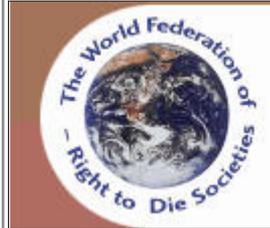
In the past, the facade of immortality was claimed by Egyptian kings, egomaniacal monarchs and run-of-the-mill psychopaths. But democracy and modern medical advances have made the illusion accessible to everyone. We have to rid ourselves of this distinctly Western notion before our nation's obesity epidemic and the surge of aging baby boomers combine to form a tsunami of infirmity that may well topple our hospital system and wash it out to sea.

At some point in life, the only thing worse than dying is being kept alive.

*Craig Bowron is a hospital-based internist and a writer in St. Paul, Minnesota, USA. This article appears with his permission.*

## World Federation of Right-to-die Societies (WFRtDS) Conference 2010

The conference is to be held in Melbourne from 6th to 10th October 2010 and will be held at Rydges on Swanston in Carlton, a short stroll away from the social and dining precinct of Lygon Street.



A number of discussion sessions will address a range of topics, covering world's best practice and the latest thinking around assisted dying for the terminally ill. An exciting list of highly respected and credentialed national and international speakers is growing.

The panel discussion public day will provide for some 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 we expect the remainder to go quickly.

Tickets include morning and afternoon tea, and a light lunch. Non-members will receive with their registration a complimentary one-year membership of DWDV. Ticket sales will open on DWDV's web site in late February. [www.dwdv.org.au](http://www.dwdv.org.au)

### Program:

- Wed 6th: Australian delegates day; with cocktail reception for all WF delegates in the evening.
- Thu 7th: WF delegates meetings
- Fri 8th: Panel discussion public day
- Sat 9th: WF delegates meetings
- Sun 10th: Relaxing social, unique 'Australiana' event for networking.

#### Prices for the public day forum:

- DWDV member-pensioner: \$60
- DWDV member non-pensioner: \$90
- Non-member pensioner: \$80
- Non-member non-pensioner: \$130

## Research on Euthanasia from the Netherlands

Two decades of research on euthanasia in the Netherlands have resulted in clear insights into the frequency and characteristics of euthanasia and other medical end-of-life decisions in the Netherlands. These empirical studies have contributed to the quality of the public debate, and to the regulating and public control of euthanasia and physician-assisted suicide.

No slippery slope has occurred. Physicians seem to adhere to the criteria for due care in the large majority of cases. Further, it has been shown that the majority of physicians think that the euthanasia Act has improved their legal certainty and contributes to the carefulness of life-terminating acts.

Medical end-of-life decision-making is a crucial part of end-of-life care. It should therefore be given continuous attention in health care policy and medical training. Systematic periodic research is crucial for enhancing our understanding of end-of-life care in modern medicine, in which the pursuit of a good quality of dying is nowadays widely recognised as an important goal, in addition to the traditional goals such as curing diseases and prolonging life. *J Bioeth Inq.* 2009 September.

## AUSTRALIA

Kevin Rudd does not believe federal parliament will be asked to make a conscience vote on euthanasia any time soon. And if it was, he would vote against the right to die. The prime minister was responding to a question (during the Seven Network's *Sunrise* program), requesting his personal view on euthanasia.

How disappointing to hear Mr Rudd dismiss the opinions of over 85% (*Newspoll*, 2009) of the Australian community who don't want patients to suffer unnecessarily at the end of their lives. Professor Michael Cousins said (in the *Sydney Morning Herald*, 12 Feb, 2010) that nearly half of all cancer patients experience unrelieved pain—with 80% affected in their final stage of life. Professor Cousins, director of the Pain Management Research Institute at Royal North Shore Hospital and a pain medicine and palliative care specialist, said that disturbing numbers of cancer patients are experiencing unrelieved pain, with many having to be sedated for the last week of their lives to free them from suffering.

"It's amazing that we have this in a civilised country, which you would think would be pretty focused on human rights," he said.

Australian Greens leader Bob Brown's private bill to restore the NT law is still before parliament with no sign of anything happening anytime soon.

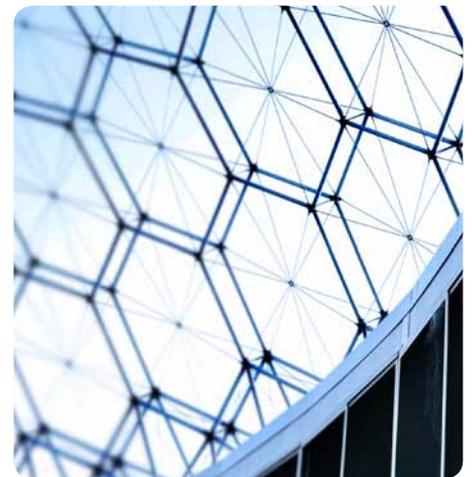
A recent Four Corners episode found that a cultural failure to confront death—and an increasing faith in doctors' ability to cure - meant governments are spending millions on acute care beds when the money would be better spent on palliative care. Dr Richard Chye, the director of palliative care at Sacred Heart at St Vincent's Hospital in Sydney, agreed that the failure of some doctors to accept they cannot cure all patients means death is not well-managed.

"From a doctor's perspective, I think a lot of doctors find it very hard to say you are dying, because ... one, they don't believe in palliative care, and two, they see palliative care as a failure. They see a patient's death as a failure," Dr Chye said. "I think all doctors should be able to do palliative care."



DON'T FORGET TO CHECK OUT [www.dwdnsw.org.au](http://www.dwdnsw.org.au)

- South Australia's parliament rejected the Australian Greens' bill. But the author of the bill, Mark Parnell, still believes voluntary euthanasia laws will be passed in SA "one day". His voluntary euthanasia bill was defeated in the Upper House by a vote of 11 to nine, with one politician abstaining. "To have the bill voted down is such a big disappointment," Mr Parnell said. "Yet to come so close is a sure sign that one day, very soon, the South Australian parliament will pass death-with-dignity laws. Mr Parnell said he would now work with voluntary euthanasia advocates with a view to presenting a revamped bill after the state election in March.



## AROUND THE WORLD

- The WA Greens MP Robin Chapple has introduced a Private Members bill to parliament pushing for voluntary euthanasia to become legal. Mr Chapple says a draft version of the legislation has been well received by MPs and he hopes the Government will allow it to be debated soon. The Premier Colin Barnett says he'll grant Liberal MPs a conscience vote on the bill but doesn't think it will succeed. Those with internet can find out more details via Chapple's own website at [www.robinchapple.org.au](http://www.robinchapple.org.au).

- Google refused to bow to a request by the Australian government to censor videos on YouTube, saying the move would stifle public debate on important issues such as euthanasia and drug use. Stephen Conroy, the communications minister, asked the search engine to "voluntarily" censor videos that fall within the government's broad new "refused classification" category. However,

Google said blocking access to videos in the category would lead to the removal of many politically controversial, but essentially harmless, clips. Google said it would not voluntarily censor videos on these subjects because exposing the topics to public debate was vital for democracy.

### UK

One devoted mother helps her sick daughter to end her life with tablets and morphine walks free from court with a suspended sentence. Another is jailed for murder, to serve a minimum of nine years, after injecting her brain-damaged son with a lethal dose of heroin. The two contrasting cases have reignited the right-to-die debate in Britain and whether those who assist a loved one to end their suffering should be subject to criminal law.

- Frances Inglis' self-confessed mercy killing of her 22-year-old son Thomas,

who doctors said would live the rest of his life in a vegetative state after a catastrophic accident, made headlines when courts ruled her act was murder and sentenced her to life in prison. Inglis injected her son with an overdose of heroin. But nurses resuscitated him -- and she was charged with attempted murder. One year later, while out on bail, Inglis successfully administered the heroin overdose and killed her son. The jury reached their verdicts by a majority of 10 to two after deliberating for more than six hours.

- Kay Gilderdale was cleared of attempted murder after helping her daughter, Lynn, to commit suicide. Ms Gilderdale admitted aiding and abetting her 31-year-old daughter, who had the chronic fatigue syndrome ME, to take her own life and was given a 12-month conditional discharge.

- Author Terry Pratchett, who has Alzheimer's, says he's ready to be a test case for assisted suicide "tribunals" which could give people legal permission to end their lives. In a keynote lecture, *Shaking Hands with Death*, the best-selling author said that the "time is really coming" for assisted death to be legalised.

- And Ray Gosling, a veteran BBC presenter and documentary-maker, admitted that he had smothered a lover with a pillow as he lay in his hospital bed, after doctors said they couldn't help relieve his suffering. He claimed he had previously made a pact with the man, whom he did not name, that he would help him die if his pain became unbearable. He was arrested and is currently on bail. His claims come just weeks before a landmark set of guidelines will be published by the Director of Public Prosecutions, Keir Starmer, which will be seen by many as legalising assisted suicide by the back door. The final guidelines are due by March and are not expected to differ greatly from the earlier draft, despite opposition from the medical profession, legal experts and religious leaders. Last week the Archbishop of Canterbury, Dr Rowan Williams, warned that creating a right to die would be a "moral mistake".

- Scottish politician Margo MacDonald, a leading right-to-die campaigner who has Parkinson's Disease, has introduced a physician assisted dying Bill into the Scottish Parliament. Her Bill proposes

that anyone over the age of 16 should be able to request medical help in dying if they have been diagnosed as terminally ill or are physically incapacitated and find life intolerable.

Edward Turner, of Dignity in Dying, said that the proposed law also risked



Ray Gosling (Top left), Kay Gilderdale, Frances Inglis & Terry Pratchett

changing society's views of the disabled. Mr Turner, who travelled to the Swiss clinic Dignitas with his dying mother four years ago to allow her to end her life, said that Ms MacDonald's inclusion of people who had been physically incapacitated raised troubling questions about the value of the lives of the disabled. Dignity in Dying recommends that only those who are terminally ill and have six months or less to live should qualify for the right to an assisted death.

## CANADA

A new poll shows that three-quarters of British Columbians support VE and more than half recommend decriminalising assisted suicide. Nationally, 85 per cent of Canadian respondents (as do Australian), believe legalising VE would allow an opportunity for suffering people to ease their pain, in addition to establishing clearer regulations for doctors with end-of-life decisions. Further, two-thirds of Canadians agreed that legalising VE would not send the message that the lives of the sick or disabled are less valuable.

- And a recent poll of Quebec medical specialists reported that 75 per cent of those who answered the poll were "certainly" or "probably" in favour of legalising VE, as long as the practice was strictly regulated.

## US

- New Hampshire has defeated a bill that would have allowed the legalisation of assisted suicide for terminally ill patients. The House voted 242-113 on Wednesday against the bill, which would have allowed the terminally ill to obtain lethal prescriptions, with safeguards to prevent abuses.

- Residents of the USA State of Montana have now joined those of Oregon and Washington in being able to access medically assisted dying, a right just confirmed by Montana's Supreme Court. Whereas Oregon and Washington's laws were created by public ballot, Montana's was declared a constitutional right.

- Two studies published in The New England Journal of Medicine have found that many elderly Americans in nursing homes are suffering from futile care at the end of their life. Distressing symptoms and burdensome interventions are also common among such patients. **Patients with health care proxies who have an understanding of the prognosis and clinical course are likely to receive less aggressive care near the end of life.**

- Al Pacino will play the role of Jack Kevorkian, the enigmatic pathologist known as "Dr. Death" who assisted in more than 130 suicides with his "mercy machine." The flamboyant doctor, who served eight years in prison on a second-degree murder charge, was released from a Michigan maximum security prison in 2007 with a parole pledge that he never kill again. The made-for-television movie is titled, "You Don't Know Jack".

## 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 50 per cent of the electorate votes in favour, it could become law.

It looks like being a very busy year on the Central Coast.

On February 19th they had a full house for a workshop on Advance Health Care Directives led by Dr Tomika Barrett, a geriatrician from Wyong Hospital. She was an excellent speaker and led a lively session.

On the evening of Monday 22nd March, Gosford Uniting Church will be hosting a community forum on *Dying with Dignity – the Issues*, which the CC Branch are supporting.

And on Wednesday morning 24th March, DWD CC is convening a follow up meeting at the same venue. Ian Wood of South Australia will be the guest speaker talking on "Christians Supporting Choice for Voluntary Euthanasia."

The next general meeting will be held Friday April 16th at 10:00am – at the usual meeting place – Gosford Senior Citizens Centre, Albany Street, Gosford.

Rosemary Long, a lawyer, will give the talk and lead the discussion. The title is yet to be finalised.

## ACT

The ACT Branch has an active program for this autumn.

On March 16, they will sponsor a public meeting to be addressed by Senator Bob Brown on '**DYING WITH DIGNITY**', with reference to his bill ('Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2008') seeking rescission of the Andrews Act, other legislation put forward by Greens MPs in Victoria and Western Australia, and on the Senate Inquiry into Suicide.

Time: 7 pm.

Venue: the ACT Legislative Assembly, London Circuit, Civic.

On March 25, as part of Seniors' Week the ACT Branch will have a table at **Seniors' Expo** at the Old Bus Depot at Kingston, 10am to 3 pm.

On April 15, the speaker for the first General Meeting of 2010 will be Emma Awizen, Coordinator of 'Respecting Patients' Choices', which is based at the Canberra Hospital. This program records patients' advance directives, and other wishes, when they enter hospital. The computer record is available to other hospitals in the ACT. We would like to see this program extended nationally.



ACT members (& others)  
– hear Senator Bob Brown

### dying with dignity

When: Wednesday, March 16 @ 7 pm.

Where: ACT Legislative Assembly,  
London Circuit, Civic.

# 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 gift by Will, 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.



**Administration Assistant/Membership Secretary required to provide support to the Co-ordinator.**

Responsible for the provision of confidential administrative, clerical, and membership services. The position requires someone with initiative, self-motivation and the ability to communicate well with others.

Experience in MYOB, database maintenance (ACCESS), payment and receipting functions, as well as general office administration required.

A sympathetic ear, common sense as well as a commitment to DWD principles is essential. If you are interested please call or email Annemaree for Position Description and Duty Statement.

This is a part-time position: 3 days per wk.  
p: 9212.4782 / e: [dwd@dwdnsw.org.au](mailto:dwd@dwdnsw.org.au)



## AGM Meeting

When: 2.00pm **SATURDAY** 17 April 2010

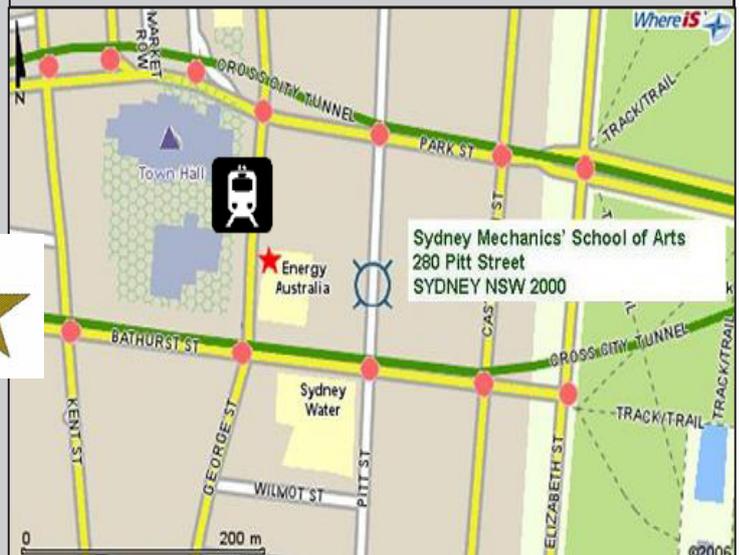
Where: SMSA 280 Pitt St Sydney  
(Sydney Mechanics' School of Arts)



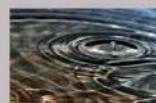
**DR DAVID LEAF**

## Doctors & PAD

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.



### Advance Health Care Directive



Completing this form gives you the best chance of ensuring that you will not be given unwanted medical treatment at the end of life. It can also make it easier for your family and health care providers to understand and respect your wishes.

### Available from office



#### Appointment of Enduring Guardian

Appointing someone to make decisions on your behalf.

**What is an Enduring Guardian?**  
An Enduring Guardian is someone you can appoint to make decisions on your behalf about your health-care and other personal matters if you are no longer able to do so. The person must be over 18 years of age and needs to agree to the appointment; they should be someone you trust, who is prepared to carry out your wishes as far as is possible. Most people appoint a close family member or friend as their Enduring Guardian.

**Appointing an Enduring Guardian**  
Every competent adult has the legal right to accept or refuse any recommended health care. This is relatively easy when people are well and can speak for themselves. Unfortunately, during severe illness people are often unconscious or otherwise unable to communicate their wishes – at the very time when many critical decisions need to be made. If you have not yet appointed anyone and you wish to do so, you will need to complete an Appointment of Enduring Guardian form.

**What happens if I have not appointed an Enduring Guardian?**  
If you do not appoint your own Enduring Guardian, the law provides that someone called the Person Responsible can make health care decisions for you if you lose the capacity to make your own decisions. The Person Responsible is the first, in order of authority, of the following people:

- Your spouse or partner (including same sex partner).
- If you do not have a spouse or partner:
  - Your carer (this is the family member or friend who provides direct personal care to you (eg. showering, housework, shopping, or arranging for someone else to do that, or who most often comes to visit you and looks after your needs.) This does not include someone who is being paid to care for you but it could include someone who is receiving a Carer's Pension.

If there is no carer:

- A close relative or friend of yours. Sometimes there will be more than one person in this category and if they cannot agree about what treatment you should receive, the doctor or hospital staff may have to organise mediation to solve the dispute.

Note: The Person Responsible is not necessarily your Next-of-Kin.

Enduring Power of Attorney (for money or property)  
You may also wish to give someone Enduring Power of Attorney for financial matters in case you need someone to manage your property or money. If you wish to do that, you will need to complete a separate Enduring Power of Attorney form.

Note: Enduring Power of Attorney does not give the appointed person the right to make decisions about your health-care or other personal matters.

DWD now thanks Professor Colleen Cambridge and AS2APC for permission to utilise this form.

**respect for the right to choose**