

DYING WITH DIGNITY^{nsw}

PATRON: PROFESSOR PETER BAUME AC FRACP FRACGP

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Yes, we changed our name to Dying with Dignity NSW (DWDnsw). If you didn't know then most likely you're not connected to the Internet – or you haven't provided your email address. Not having an email address means you miss out on updates about important matters that might require your attention.

In October DWDnsw commissioned a Newspoll survey based on the question:

If a hopelessly ill patient, experiencing unrelievable suffering, with absolutely NO chance of recovering asks for a lethal dose, should the doctor be allowed to provide it, or not?

The poll showed an increase in the number of Australians who said yes. In fact, 85 per cent of them said yes. A minority of 10 per cent were opposed, with 5 per cent undecided.

In NSW the percentage was even higher with 87 per cent support. It's obvious that the Australian community does believe in the provision of assistance to die in dignity.

October also saw the State and Territory VE societies meeting in Adelaide for a National Conference.

The conference was organised and hosted by SAVES (South Australian Voluntary Euthanasia Society) and was attended by over thirty delegates. Amongst the topics discussed were: the Law (in particular recent bills); overcoming barriers: palliative care and medicine; religion; funding issues and motivating the masses. An update regarding the Clem Jones bequest was very informative.

A number of parliamentarians both past and present, including SA Greens MLC Mark Parnell, former NT Chief Minister Marshall Perron, WA Greens MLC Robin Chapple and VIC Greens MLC Colleen Hartland discussed their legislative initiatives and shone some light on the shadows within the parliamentary system.

Several highly respected medical specialists including Dr Roger Hunt, (Palliative Care), A/Professor Chris Doecke,

(Pharmacy), and Emeritus Professor John Willoughby (Neurology), addressed the conference.

It was a united and successful conference with all the Societies agreeing to support each other in the push for dying with dignity legislation. A motion was passed that in principle we form a coalition of the States and Territories. The conference was in agreement that once a bill gets through in one State there would be a domino effect with pressure from residents of the other States.

There have been some important court decisions. The WA case concerning Mr Christian Rossiter emphatically upheld the common law right to refuse unwanted medical treatment, even if refusal of such treatment will cause death, (in the case of those who still have decision-making capacity).

This decision recognises the right of a competent adult who has received advice about the consequences, to refuse treatment, even if that includes nutrition necessary to sustain life. And it clarifies the position for the health professionals. For those of you interested in the court decisions I have included a paper compiled by Dr Rodney Syme in this newsletter.

It is frustrating that with ongoing polls of 80% upwards support for physician assistance dying, this issue is still described in the media as a minority issue.

We need to become as noisy as the 'vocal minority' in the ears of politicians and others. I am encouraged by the response of members who write to the papers and their local MPs etc. Thank you to those many members who respond to my call for action.

Why not become part of this group and add to the momentum? It's just a matter of time! If you haven't already given us your email address please do so on your membership renewal form. If you're interested in getting connected TADAust (<http://www.tadaustconnect.org.au/>) is the Internet Service Provider that provides an exclusive Dialup Service for People with Disabilities, the Aged and Veterans. (Ph: 1300 735 439).

- Annemaree Adams, Coordinator.

DYING WITH DIGNITY:

conscientious objection, conscious voting & refusing the unconscionable



Dr Leslie Cannold

What this talk is about

Our understanding of the proper role of conscience in the lives of individuals is murky. What is conscience? In a liberal democratic society, like Australia, what claims in its name are justified? What limits can be imposed on an individual's, a doctor's and a politician's liberty to follow their conscience? And what does the range and limits of the conscience rights available to doctor and politicians tell us about our rights as citizens, and the success of future legislation enshrining a right to die with dignity?

My argument

I believe that all of us—patients, doctors, politicians—have consciences and are entitled to act, or refuse to act, on the basis of them. All consciences are created equal and none have claim to particular privilege or respect. I understand the right to act on conscience, and to refuse to do so, as a subset of the larger moral entitlement we all have to autonomy. Autonomy, which in Greek means self-rule, is the entitlement of all individuals to live their lives according to their own beliefs values, not those of others. Autonomy is the central political value in liberal, plural and democratic societies like ours, and the pre-eminent ethical principle governing modern medical decision-making (replacing the paternalism dominant in days of yore).

As anyone who has followed my work over the years would know, I am a fan of autonomy. Here, I am not alone. Autonomy is a central moral principle in key and diverse moral theories, including utilitarianism (Peter Singer) and deontological or Kantian theories. But like all rights – and this is the main point I wish to make in this talk – the right to autonomy has limits. It is not absolute. No right is. In particular, the right an individual, a doctor or a politician to act, or refuse to act, on his or her conscience is limited. It is limited by the conscience rights of others and by the obligations (duty of care) professionals have to those they serve. In particular, a doctor's autonomy rights are limited by the obligation he has as a professional to treat his patients fairly and protect them from harm. Where there is a clash between the right of professionals and others, the rights of professionals don't trump the parallel rights of those they serve. Rather, an imperative exists for a balance to be achieved – a balance between the legitimate conscience rights of the professional and the equally compelling ones of their patients and a balance between the rights of the professional and his obligations to his patients/constituents.

All a bit heady and abstract, I know. So let's take it down to brass tacks and ask what all this tells us about what doctors and politicians should do when a patient

it is wrong –
hypocritical in fact –
for a politician to use
right of conscience
to deny conscience
rights to others //

asks for help to die, or a piece of dying with dignity legislation comes before parliament?

Medicos

I think it means that when (not if, but when) a law is passed that articulates the rights of individuals to determine not just the direction of their life but the timing and manner of their deaths, it must acknowledge that in this medical engagement, like all others, medical staff have a right to conscientiously refuse to be directly involved. They have the right, all things being equal, to refuse to accede to a terminally ill patient's request for assistance to die. But this right is not absolute. A doctor's right to act on his conscience must be balanced against the parallel autonomy rights of his patients to act according to the dictates of their consciences. The conscience of the physician does not stand above the

what are the ethical limits?

conscience of the patient. Rather, some accommodation or compromise must be made. What does this cash out to in the real world.

In the real world what it cashes out to is an obligation on a doctor refusing to provide care on grounds of conscience to:

Disclose his conscientious objection to patients as soon as possible (preferably, prior to the formation of a therapeutic relationship). This can be through the posting of signs in a surgery or direct disclosure to all new patients. This disclosure must be accompanied by;

Referral to another practitioner or source of information (eg a hospital switchboard, a medical helpline) who/that does not—as far as the physician is aware – have a conscientious objection to providing information about dying with dignity, referring the patient to a provider that offers the service or who will himself assist a patient to die, within the boundaries of the law.

The ethical limits on physician conscientious objection in situations where such action will harm patients or treat them unfairly means it is never justified for a doctor to refuse to provide a treatment necessary to preserve a patient's health or her life. Indeed, I find it extraordinary and disturbing that I should even have to say this. I mean "der". I note that none of the ethical textbooks which detail the above, widely-accepted limits on medical rights of conscientious refusal feel any necessity to spell this obligation, an integral part of physician's duty of care, as spelled out clearly in law.¹

I am making it explicit, however, because doctors themselves and the organizations represent them seem confused. In particular, I was very disturbed by assertions made at a conference entitled "Conscience Laws in Healthcare". Promoted on the AustralianChristianLobbywebsite it was held a few weeks back in Melbourne, with the usual range of male suspects as speakers: Martin Lavery from

Catholic Healthcare, Senator Julian McGuaran and the AMA's Francis Sullivan. The conference was a thinly-disguised attack on Victoria's recent removal of abortion from the Crimes Act and the conference brochure, populated by photos of pregnant women and babies asserted - with absolutely no sense of irony or shame - that "everyone" was entitled to "freedom of conscience." It described the requirement that doctors must act to save the lives of their patients by, where this was required, performing an abortion, as illegitimate "coercion"



to "act contrary to their consciences and their deeply held ethical, moral and religious convictions."²

Politicians

Politicians get a conscience vote on the personal issues that some church hierarchies define as of high moral concern. (Some say the fate of the environment, the universality of healthcare and the equity of access to education are also critical moral issues about which Christian politicians ought express concern and be free to vote with their consciences, but this is a discussion for another day).

There is a dismaying lack of theory and guidance for politicians facing a "free" vote. In practice, according to my observations, each is left to decide for themselves, within the context of their party's culture around dissent, how this liberty should be used. Some follow their leaders or other powerful folk in the party, either because they can't or won't decide for themselves, so as to ingratiate themselves or to obtain political cover - or all three.³ Some survey their constituency and vote the way dictated by the majority, others come to a considered view after

listening to argument from colleagues and constituents while the final group vote according to long-held and/or faith-based views and beliefs.

If you really want to get a polli'e's dander up, try telling them that there are right and wrong ways for them to use their conscience vote. I can tell you from personal experience that they don't take kindly to it. Finally free from the dictates of their party or faction, they can be highly resistant to any suggestions that other obligations ought constrain their exercise of

power.

But politicians are professionals and if we return to the idea that professionals have obligations to those they serve – in the case of polli'es, their constituents – and consider those in the context of a liberal, plural democratic society, I think logic delivers this unavoidable conclusion. That in a democratic plural society those elected to serve are obliged to give their support to laws that enhance their constituents' autonomy. For the same reason, politicians are duty-bound to reject legislation that would have the effect of imposing the moral beliefs of one part of the community on the rest, even if they personally endorse those moral views.

The reasons why should have a familiar ring. That is because they are, in essence, the same reasons I gave for my view about the range and limits of medical conscientious objection. And they are this: that it is wrong –hypocritical in fact – for a politician to use right of conscience to deny conscience rights to others, little less the conscience rights of those s/he is bound to protect.

What that means as far as a dying with dignity bill goes, is that when such legislation comes before state or federal parliament and, as is likely for the major parties at least, a free vote is given, that it would be wrong for any politician to vote against it.

Now, that's a controversial thing to say so I want to take you through the logic that brought me to that conclusion.

The first step was to recall the grounding principle that all consciences are equal. This makes wrong for one person's autonomy to be purchased at the cost of another's. This wrong is compounded when the person elevating his conscience over that of another is actually duty-bound, as a professional, to defend the other's autonomy. Acceptance and use of a free vote is implied consent to the importance of individual autonomy, but to make such acknowledgement by casting such a vote only to deny the identical right to others is both hypocritical and unconscionable. Thus my conclusion, that those who use their conscience vote to deny freedom of conscience to others do something unconscionable.

Of course, politicians may believe that patients ought never give up on life or that legitimizing a right to die will lead to it being abused or that only God has the right to take life or whatever they believe. They have a right to these

beliefs and luckily, in contrast to those of us who have different views, the freedom to live according to them. What they don't have is the right to use their professional power – power granted to them by the constituents – to compel those constituents to live by them, too. If they can't bring themselves to vote for such legislation then they should at least abstain. But voting against the right of others to live and die according to the dictates of the conscience is more than wrong. It is inequitable, irresponsible and hypocritical. Unconscionable.

Conclusion:

Getting the Balance Right

We need to get the balance right. Indeed, if you read medical textbooks on the subject of conscience, what stands out most strongly is the stress on good faith efforts of all those involved in such matters to not assert their rights as absolute and use them truncheons against everyone else, but instead to work to find a balance between the rights and obligations of conscientious actors and the rights of those conscientious actors are duty-bound to serve.⁴

Sadly, such efforts are not always made. The doctors group asserting a conscience right to let women die rather than terminate a life-threatening pregnancy is one example of an improper absolutist approach to conflicts of conscience. More illegitimately absolutist conceptions

of conscience and religious freedom will likely be found in any draft human rights legislation offered by the National Human Rights Consultation, which is chaired Catholic Priest, Father Frank Brennan. My prediction is that Father Frank's charter of human rights may wax lyrical about the right of doctors to refuse treatment on grounds of conscience, but be less forthcoming about the conscience rights of pregnant women and the terminally ill who want medical assistance to die. Yes, the entitlements of MPs and medical professionals to follow the dictates of their consciences are part of the autonomy story. But with rights – always and forever – come obligations. Medical and political professionals who assert their right to vote or to refuse care on grounds of conscience must take their responsibilities to foster the autonomy of those they are bound to serve—we citizens and patients—just as seriously.

They can do this by recognizing that it is unconscionable for someone to defend the right to follow his conscience, then deny that very same right to someone else. When it comes to conscience, the golden rule applies. Do unto others as they would to you.

•Dr Leslie Cannold is an author, bio-ethicist and commentator. She is in high demand as a public speaker.

GETTING THE BALANCE RIGHT

(Endnotes)

- 1 See: Kerridge, Lowe and McPhee (2005) Ethics and law for the health professions. Federation Press: 472-3 and Beauchamp and Childress (1989) Principles of Biomedical Ethics. Oxford University Press: 386-394.
- 2 http://www.acl.org.au/pdfs/load_pdf_public.pdf?pdf_id=1358
- 3 <http://www.aph.gov.au/library/pubs/cib/2002-03/03cib01.pdf>
- 4 See, for example, Beauchamp and Childress, op cit: 390.



THREE AUSTRALIAN LEGAL DECISIONS

1. Supreme Court of NSW 6 August 2009

Judgment of McDougall in *Hunter and New England Area Health Service v A* [2009]

Mr. A was a Jehovah's witness, who had created one year before, while mentally capable (competent), an advance directive which refused "procedures involving the medical use of [his] own blood". Mr A developed septic shock and respiratory failure, and renal failure and his life was being sustained by mechanical ventilation and renal dialysis. The hospital sought a declaration as to whether the advance directive compelled the hospital to withdraw treatment. "This case is concerned, at the level of principle, with the right of a capable adult to refuse medical treatment, and, at a particular level, with the question of whether the advance care directive ... was a valid exercise of that right".

The judge determined that it was. He said "If an advance care directive is made by a capable adult, and is clear and unambiguous, and extends to the situation at hand, it must be respected", and "it is not necessary, for there to be a valid advance care directive, that the person giving it should have been informed of the consequences of deciding, in advance, to refuse specified kinds of medical treatment". This decision was based on common law, there being no statute law regarding this matter in NSW.

He stated "I accept that the result of withdrawal of dialysis will be to hasten Mr A's death. That is a consequence of the decision that he made [in advance] ... What my orders did was recognize his right to make that decision".

In the course of his judgment, McDougall J cited decisions from a variety of other Australian and international courts (including the UK, Canada and USA).

Cardozo J (New York, 1914). "[e]very human being of adult years and sound mind has a right to determine what shall be done with his body".

King CJ (SASR 1983). "the paramount consideration that a person is entitled to make his own decisions about his life".

Robins JA (1990). [a] competent adult is generally entitled to reject specific treatment or all treatment, ... even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. ... it is the patient who has the final say on whether to undergo the treatment". This encompassed the right "to make choices that accord with their own values regardless of how unwise or foolish those choices may appear to others".

Lord Donaldson (1993). Where there was a conflict between a competent adult patient's right of self determination and the interest of society in the preservation of life, the individual patient's right was paramount. "The patient's right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent".

Butler-Sloss CJ (1993) "A decision to refuse medical treatment by a patient capable of making a decision does not have to be sensible, rational or well considered".

Staughton LJ (1993) "[a]n adult whose mental capacity is unimpaired has the right to decide for herself whether she will or will not receive medical or surgical treatment, even in circumstances where she is likely or even certain to die in the absence of treatment".



CHRISTIAN ROSSITER

Robins JA (1990). "[i]ndividual free choice and self-determination are themselves fundamental constituents of life. To deny individuals freedom of choice with respect to their health care can only lessen, and not enhance, the value of life".

Lord Goff (Bland 1992). "the principle of the sanctity of life must yield to the principle of self-determination".

McDougall J concluded that "recognition of the right to reject medical treatment does not depreciate the value of life. In a free and democratic society those attributes [of life] include the right of autonomy or self-determination.

He indicated that consent was vitiated if (1) the individual was not capable, (2) consent was obtained via duress, (3) consent did not extend to the particular situation, (4) there was ambiguity or uncertainty.

McDougall J indicated that the absence of adequate information at the time of completion of an advance directive did not invalidate the directive. He also observed that "not all those who execute advance care directives are legally trained", and indicated that excessive legal scrutiny or speculative analysis should not be directed at the words of the directive.

The judge did state that the decision was NOT a recognition of a "right to die". This is clearly true in law, if not in logic.

2. Supreme Court of WA 20 August 2009

Judgment of Martin CJ in Brightwater Care Group v Rossiter [2009]

Christian Rossiter is a very high quadriplegic since 2004, maintained with a tracheostomy and a PEG tube. He is totally dependent. He is neither terminally ill nor is he dying. He could continue to live for many years.

He has stated on many occasions that he wishes to die. Because of the limitations upon his movements he lacks the physical capacity to bring about his own death. He has therefore directed staff to discontinue the provision of nutrition through the PEG. Mr Rossiter is aware that he will die from starvation if hydration and nutrition is no longer administered. The court determined that Mr Rossiter has full mental capacity.

Martin CJ determined that Mr Rossiter has the mental capacity necessary to make an informed decision in respect of future provision of treatment ... and could do so with a full appreciation of the consequences of that decision. Martin CJ recognized the well-established common law principle of the right to autonomy or self-determination. He also recognized that an individual with full capacity is not obliged to give consent to medical treatment, even if the failure to treat will result in the loss of the patient's life. This principle applies without regard to the reasons for the patient's choice, and irrespective of whether the reasons are rational, irrational, unknown or even non-existent.

Martin CJ also referred to the relevance of advance directives (established by the Acts Amendment (Consent to Medical Treatment) Act).

Martin CJ cited a number of cases from other jurisdictions, including the UK, Canada, New Zealand and the

USA, which have established these principles in common law.

Martin CJ was asked to determine the legality of providing palliative care to Mr Rossiter following the withdrawal of nutrition and hydration. He confidently asserted three principles.

First, that the legal rights and obligations relating to the provision of palliative care are unaffected by the circumstance that the occasion for the provision of that care comes about as a consequence of Mr Rossiter's withdrawal of consent to the continuing provision of other medical treatment, namely, the provision of nutrition and hydration. His treating doctor's rights and obligations are no different to the obligations which attend the treatment of any other patient who may be approaching death. Second, if palliative care is administered with the informed consent of the patient, it does not have the intention of causing or hastening death. Third it is unlawful for a doctor to administer medication for the purpose of causing or hastening the death of another person.

3. Supreme Court of ACT 28.8.09

Judgment of Higgins CJ in Australian Capital Territory v JT

JT is a 69 year old man suffering from chronic paranoid schizophrenia for many years, and who was not responding to maximum therapy. He was obsessed, for 4 years, with the belief that starvation would bring him closer to God. His self-starvation had become life threatening – he was physically resisting naso-gastric feeding. Physical restraint had been employed in order to feed him. He was mentally incompetent and the Public Advocate was his guardian. His medical carers (geriatrician, psychiatrist, and GP) described his 'artificial feeding is likely to be resisted and, save in the short term, likely to be ineffectual, unless delivered... by PEG'.

His carers did not recommend PEG feeding and sought the Court's

declaration that it not be employed, and that "a simple palliative approach" be adopted. The judge commented that meant "avoiding euphemisms, to allow the patient to starve to death whilst easing the suffering associated therewith"

Essentially this was an argument based on futility, but not put strongly and simply in those terms. The argument was complicated by an opinion from the Canberra Hospital Clinical Ethics Committee that "as JT was accepting of death, his mental state indicating capacity to consent should be ignored and his 'wishes respected'". The public Advocate did not oppose JT's physicians request to refrain from artificial feeding.

Higgins CJ cited precedents from other Australian states, NZ and the UK. Higgins CJ that, in this case, provision of nutrition and hydration "will provide a benefit, in the sense that life will be maintained, albeit, that it will to an extent derogate from the patient's dignity". He quoted Bland – "though the patient's best interests were in being kept alive, that objective had disappeared due to the hopelessness of his condition. Efforts to maintain life were ... futile".

Higgins CJ concluded "If JT were competent to refuse treatment the situation would be otherwise. He is not. Thus the Territory is no more entitled to refuse treatment to JT than any other person in its care who is unable to refuse it. It remains, of course, a matter of clinical judgment whether any proposed course of treatment would be medically feasible".

Thus Higgins CJ seemed to find in this case that the argument for futility was not sufficiently made to allow withdrawal of feeding, and was suggesting that PEG feeding be provided if feasible ("on the evidence so far presented").

One wonders what the outcome would have been if the matter had been brought to court by the Public Advocate, who would presumably have had the authority to refuse treatment, supported by the

physician's strong statement that further treatment was highly likely to be futile.

CONCLUSIONS

Because the Justices in all three cases cited precedents from other jurisdictions, both Australian and international, it can be accepted that these decisions have significant impact in other Australian states, and potentially, other English-speaking jurisdictions.

The principle of autonomy and self-determination, to determine what happens to one's own body, even if such decisions result in death, is paramount. Autonomy trumps sanctity of life.

An advance health care directive, created by a capable individual, must be respected if it applies to the situation at hand.

Doctors must provide palliation of symptoms caused by the refusal of treatment, even if that refusal of treatment will be likely to result in death.

A person does not need to be terminally ill or dying to make a decision to refuse treatment which will almost certainly result in his death.

The court did not seem to regard a decision to refuse treatment thus precipitating one's own death as suicide. It did not seem to regard medical assistance (palliation) to achieve that end as criminal.

Such a decision, if made by a capable person, need not seem to be rational, nor did the person have to be fully informed (in the case of an AD) about the consequences of refusal.

- Compiled by Rodney Syme, and checked for validity by Professor David Kelly, former chairman of the Victorian Law Reform Commission.



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.

The principle of autonomy and self-determination, to determine what happens to one's own body, even if such decisions result in death, is paramount. Autonomy trumps sanctity of life. //

ADVANCE HEALTH CARE DIRECTIVES

Do you have time on your hands and have library/archive experience? We need someone who can come in and help us in the office. Must be computer literate and would probably need own transport as access to public transport is limited around Wattle St, Ultimo. Please contact Annemaree: 9212 4782 or email dwd@dwdnsw.org.au

SOUTH AUSTRALIA

Greens MLC Mark Parnell's voluntary euthanasia bill passed a second reading in the Upper House 11 votes to 10 in a conscience vote On Wednesday night 28 October, 2009.

Independent MP Anne Bressington's vote was key, and while she has not committed to supporting the bill, she did vote in favour of it progressing to the next stage of debate.

Discussions are ongoing and if some agreements can be reached soon it would be in time for a third reading vote on mid November.

If passed, the bill then goes to the state's Lower House for a vote to determine if it becomes law.

Mark Parnell's bill stretches existing laws on medical treatment rather than create new stand-alone regulations.

He says he will now negotiate with Ms Bressington to find a way through the current differences. In two weeks time the Bill will go to another vote.

TAS

Bad news about Greens' leader Nick McKims' *Dying with Dignity Bill*. Tasmania's Parliament voted it down.

Despite MPs being allowed a conscience vote, they voted largely along party lines. All Tasmanian Greens members supported the motion, while all Liberal members opposed it. The bill was defeated 16 votes to seven

WA

Christian Rossiter, a 49-year-old former stockbroker had suffered from series of injuries that had combined to make him a quadriplegic and he described his life as a "living hell".

He had asked the Brightwater Care Group at least 40 times to stop feeding and hydrating him through a tube to his stomach before the matter was taken to court.

In his decision the Chief Justice recognised the tragedy of Mr Rossiter's circumstances, and noted that he was totally dependant on others, unable to take nutrition orally and had to be



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fed through a PEG, and although not terminally ill he has been advised that his condition would not improve.

Dr Simon Longstaff of the *St James Ethics Centre* said about the case that it is important to distinguish between the right to refuse treatment and the likely outcome of refusal. This kind of distinction is routinely drawn in the field of medical ethics and involves the application of the principle of double effect. In essence, this principle says it is allowable for a person to act with a noble intention and in pursuit of a good outcome even if in doing so they



AROUND THE WORLD

might reasonably expect to cause a second (double) effect that is bad.

USA

Montana Supreme Court to Tackle Physician-Assisted Suicide.

Having a physician's help in dying will be declared a constitutional right in Montana if the state's Supreme Court upholds a December lower court ruling, according to the New York Times. The state would be the first in the nation to declare it as a constitutional right, though Washington and Oregon also allow physician-assisted suicide.

WASHINGTON

Eleven people used medications to end their lives during the first six months of Washington state's assisted suicide law. Another five patients received medication but died without using it.

CONNECTICUT

Two New England physicians are taking on a state law they argue interferes with their ability to prescribe life-ending doses of medication to terminally ill patients who request it.

Gary Blick, MD, an HIV/AIDS specialist in Norwalk, Conn., and Ronald M. Levine, MD, an internist in Greenwich, Conn., in October filed a legal challenge to the state's assisted-suicide statute, saying the threat of punishment prevents them from prescribing lethal doses of medication.

CANADA

Doctors are "in sync" with most of Quebecers on euthanasia, the Quebec Federation of Medical Specialists says.

In a survey of its members, about 84 per cent of respondents said they are ready for a public debate on

euthanasia and 74 per cent “would certainly favour or probably be favourable” to euthanasia within a legal framework.

Quebec doctors issued a cautiously worded policy suggesting Criminal Code changes to protect doctors who follow an “appropriate care logic” to end the life of suffering patients facing “imminent and inevitable death.”

The change would protect doctors who withhold treatment or boost painkillers to end suffering and hasten the end, according to Yves Lamontagne, president of the college.

UK

On 30 July 2009 the House of Lords allowed an appeal by Debbie Purdy and required the DPP to promulgate a offence-specific policy on prosecuting cases of assisted suicide.

In other words, UK Law Lords have forced the Director of Public Prosecutions to publish the criteria he would use to

determine whether or not to prosecute someone for assisting a suicide.

The judgment is significant for two reasons. Firstly, it will mean that sufferers and their family/supporters can make an informed choice as to whether somebody can accompany them abroad to die. Secondly, it gives greater protection to those who may have been considered vulnerable to coercion

If you have a personal reason for supporting Dying with Dignity and would be willing to share your story on our website or speak to the media, we would really like to hear from you.

SWITZERLAND

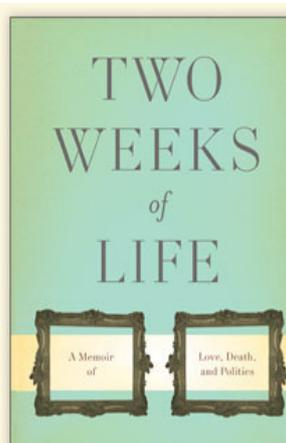
The Swiss government is considering restricting or even banning organised assisted suicide in an attempt to reduce so-called “death tourism”.

Swiss authorities want to ensure euthanasia is a last resort for the terminally ill, amid fears their current laws on assisted suicide could be open to abuse. A study last year suggested more and more people seeking help to die in Switzerland did not have a terminal illness.

Two Weeks of Life:

A Memoir of Love, Death, and Politics
 Eleanor Clift
 Basic Books
 ISBN: 046500251X

Author and *Newsweek* contributing editor Eleanor Clift tackles one of the most important issues facing the modern world: how we deal, or fail to deal, with dying. She provides a very personal narrative as she alternates between the much-publicized death of Terri Schiavo and that of her own husband.



What has become known as the Schiavo affair—the death of a brain-damaged woman in Florida in 2005, and the controversy that surrounded it—was a revelatory moment in American society. For the first time, the nation got a clear view of both the fanaticism gripping the religious right and the political power it could bring to bear even when the vast majority of the country disagreed with it. But it was also a turning point: a moment when America seemed to glimpse a dangerous radicalism, and began to pull back.

Eleanor Clift witnessed this event from a unique vantage point. At the same time that Schiavo was dying in her Florida hospice, Clift’s husband, Tom Brazaitis, was dying of cancer at home; the two passed away within a day of each other. *Two Weeks of Life* alternates between these two stories to provide a moving commentary on how we deal, or fail to deal, with dying.

Membership of DWDnsw is not just about death & dying. Many members support VE because of their passionate belief in protecting & championing the rights of others.

Dignity is crucial to any discussion of human rights.

Why not consider extending your DWDnsw status to a Family Membership adding younger voices to fading ones?

The broader our support base – the more our politicians are forced to heed the community’s wishes.

ACT NEWS

The ACT Branch has had three excellent speakers at its General Meetings this year, and the AGM in November will be devoted to general discussion and planning. Dr Kris Klugman, President of Civil Liberties Australia, presented useful ideas in 'Yes we can ... decide for ourselves' and provided statistics on surveys of public opinion on voluntary euthanasia. (We note the recent survey on behalf of DWDNSW, confirming increasing public support for VE.) Brian McLeod, Deputy Public Advocate of the ACT, spoke on 'Autonomy of choice in health and associated matters' and provided updated documents on Enduring Power of Attorney and Health Directions in the ACT. Dr Brian Furnass, a medico for many years with wide experience of health and environmental matters, spoke on many aspects of Death and Decisions.

A public forum on 'Death and dying in multicultural Australia' was arranged in Canberra in October by various Palliative Care organizations and Calvary Health Care ACT. All panel members represented some form of religion. Their avoidance of the issue of voluntary euthanasia disappointed those of our members present, but the issue was raised in general discussion. Panel members' opposition was largely on two grounds, 'the danger of abuse' and 'who will be asked to inject the needle?'. These are views which we need to know how to address and refute.

We continued our lobbying activities. The ACT Greens (3 members of the Legislative Assembly out of a total of 17) are well disposed, but seem not to have VE in their formal platform, contrary to what many of us believed before the last ACT election. We have made a submission to the Inquiry into Suicide in Australia being conducted by the Senate Community Affairs Committee of the Australian Parliament. The terms of reference do not embrace our interests, but we have said that whilst we do not seek to minimise the problems of suicides occurring in high risk groups such as indigenous youth or rural communities we wish to draw attention to problems of the ageing and the afflicted. We also referred to recent court cases which revealed the inadequacy of our legislation to guide the judicial system in requests for assisted suicide and the protection of civil rights.'

Central Coast Convenors Pip Preston and Doris Hart would like to hear from you if you are a CC member.

Their work is made so much easier if they can contact people regarding activities—or any changes.

You can either send your details to: Pip Preston, C/O Post Office, Woy Woy NSW 2256 or call Doris: 4368 1687

CENTRAL COAST NEWS

Although we had fewer members at our last meeting on 21 August, 2009 – perhaps because of the change of venue to Narrara – we are optimistic attendance will be greater for our final (Christmas) meeting at Gosford Senior Citizens' Centre on Friday, 18 December, 2009 at 10am.

The new Committee feels we can but try to meet the high standard of our hard-working Romaine Rutnam. A unanimous vote of thanks for her sterling efforts was passed at our meeting, and also best wishes for her speedy return to good health.

Activities for 2010 centre around local matters, and the upcoming World Federation of Right-to-Die Societies (WFRtD) to be held in Melbourne in 2010.

NEW MEMBERSHIP FEE STRUCTURE

DWDnsw membership fees have remained constant for many years now. The Committee has decided to instigate a new membership structure along with an increase in rates. The basic Ordinary/Pensioner/Couple remains the same (apart from the fee increase), but we now offer the option of Bronze, Silver, Gold and Platinum (Bequest) Memberships.

All members will receive a DWDnsw Membership Card on renewal of their 2010 membership but for those who feel able to contribute that bit more on a regular basis and just never get around to doing it – there are the options of premium memberships.

DWDnsw is a self-funded, non-profit organisation and we rely on membership fees, donations and bequests to continue its work.

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.

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

Members' Meeting

When: 2.00pm **SATURDAY** 28 November 2009

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

WENDY ROGERS

When is the organ donor dead:
challenges in diagnosing death



Wendy Rogers is Professor of Clinical Ethics at Macquarie University. Wendy trained in medicine at Flinders University and specialised in general practice in the UK before returning to further tertiary studies, culminating in a PhD in medical ethics.

Her current research interests include health research ethics, public health ethics, issues raised by organ donation and the ethics of innovative surgery.

She is the co-author of *Practical Ethics for General Practice* (Oxford University Press, second edition 2009) and has published widely in ethics and medical journals. In addition, Wendy is a regular commentator in the media on a range of bioethical issues.



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President: Dr Robert Marr, Vice-President: Dr Sarah Edelman. Other committee: Geoff Taylor, Jan Burnswoods, Dr Giles Yates, Tom Kelly, Ian Macindoe, Dr David Leaf and Richard Mills
Coordinator: Annemaree Adams / Membership: Jennifer Dustmann