



# VOLUNTARY EUTHANASIA SOCIETY OF NEW SOUTH WALES (INC)

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## NEWSLETTER

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### Rights of the Terminally Ill: Bob Dent Memorial Forum

On 21 September VES members and parliamentarians gathered in the Legislative Council of Parliament House, Sydney at a forum co-hosted by Ian Cohen, MLC (The Greens) and Jan Burnswoods, MLC (Labor) to mark the 5th anniversary of Bob Dent's death, and to introduce Ian Cohen's *Rights of the Terminally Ill Bill*. We viewed a video of the Channel 7 'Witness' program which documented the agonising, slow death of **Max Bell** who was prevented from using the Northern Territory's *Rights of the Terminally Ill Act*, 1995 because local doctors refused to see him



and provide the required signatures. As a consequence, Max Bell was cruelly denied the legal assistance he had travelled from Broken Hill to Darwin to receive. We also heard inspiring speeches by our co-hosts and by Marshall Perron, former Chief Minister of the NT and architect of the 1995 Act; Professor Peter Baume, our Patron; Dr Philip Nitschke, Director of the Voluntary Euthanasia Foundation; and Dr Rodney Syme, President of VES(Vic).

A World First? Max Bell's grave in Broken Hill has a website - [www.maxwellbell.net](http://www.maxwellbell.net)

*Editor's Note: Extracts from these speeches will be published in the Newsletter next year.*

## Right To Die Law

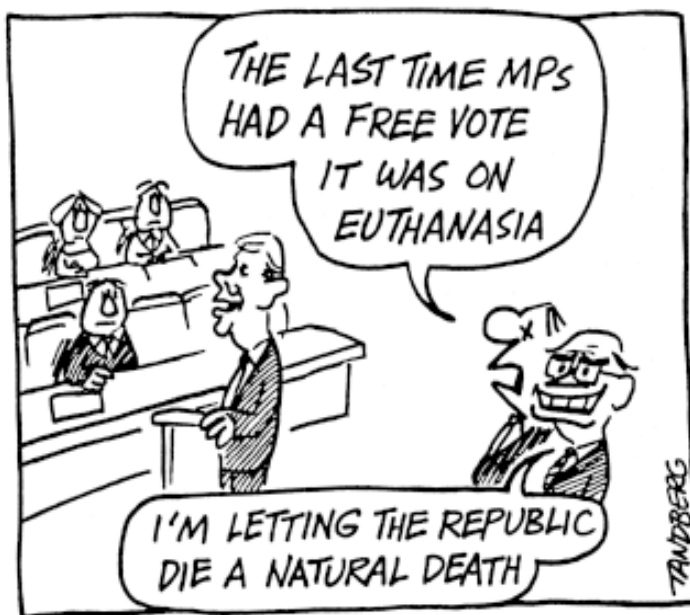
Joseph Kerr wrote this account of Ian Cohen's proposed law in the *Sydney Morning Herald* on 23 June:

A law which would let doctors help terminally ill people commit suicide has been proposed by Greens MPs in the NSW Parliament. Backed by Dr Philip Nitschke, NSW Greens Upper House member Mr Ian Cohen released a draft of the *Rights of the Terminally Ill Bill* yesterday, saying the issue was unanimously supported by his party. Mr Cohen said the Federal Government would not be able to overturn the new Bill - if it passed - as it did in the Northern Territory in 1997, because NSW was a sovereign State.

The Bill faces several hurdles if it is to become law, with a spokeswoman for the Premier, Mr Carr, describing euthanasia as 'difficult to codify'. A spokesman for the Opposition Leader, Mrs Chikarovski, said she opposed euthanasia, but would allow a conscience vote on the issue.

Mr Cohen said: 'Once they start to recognise there is immense and very volatile public support for that out there in the community, then perhaps we will slowly chip away and get a change of mind.' The exposure draft of the Bill sets out stringent conditions on euthanasia, including:

- The assisting doctor must be satisfied that barring 'the application of extraordinary measures', the person will die from their illness;
- There must be no medical treatment 'acceptable to the patient' which could cure the illness and doctors are left with relieving pain;



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- A medical specialist in the patient's condition and a psychiatrist must both have examined the sufferer, confirming the prognosis and clearing them of treatable depression;
- There must not be acceptable palliative care options available and the patient must have the right to change his or her mind.

## Keynote Address by Marshall Perron

Delivered at the Voluntary Euthanasia Research Foundation Inaugural National Conference: *Dying in Australia - Taking Control*, in Broken Hill on 3 August 2001



Marshall Perron, during his term as Chief Minister of the Northern Territory, was the initiator of the World's first euthanasia legislation

We are all familiar with the story of a man whose slow, painful and humiliating death two thousand years ago became a symbol for a more caring and compassionate society.

In a grave here in Broken Hill lies another man whose slow, painful and humiliating death will, in time, become recognised as a crucial turning point in our quest to reduce needless individual suffering today. I met Max Bell in the Royal Darwin Hospital. His request to meet me sounded like a summons. I confess a little apprehension on my way to meeting a dying stranger - one who had driven his Holden taxi 4,000 kilometres across Australia to take advantage of the Northern Territory's new Voluntary Euthanasia Law. Max was a fiercely independent and determined man whose mind was sharp. He appeared to be in

terrible physical condition. To their eternal disgrace, none of the 60-odd doctors approached by Philip Nitschke to confirm that Max had terminal cancer would even see him.

We cannot imagine the shattering disappointment, the agony, the frustration which compelled this proud, sick man to check himself out of hospital against advice, and endure an epic drive back to his home town of Broken Hill to die an awful, lingering death. On his return journey he fell out of the car at Coober Pedy when he stopped for fuel and was too weak to get up. Someone lifted him into the driver's seat and he drove on. Max Bell simply wanted to die with some dignity. He never achieved his objective. He was crucified by inaction. Crucified by a community that insists some die a tortuous death, which did not want to be involved, which could not cope with change. Max Bell was an

unwilling catalyst for others to get help. It took his cruel death to break the barrier.

The theme of this conference invites the question: 'Who does have control of dying? Do we seek the unattainable? The absolute certainty of dying sometime is for me the reason why I am more apprehensive about the process than I am of death itself. I want control of when and where I die, of who is present and I want control of the dignity of the occasion.

Once I and other Territorians had control of these four principles of dying but now, thanks to our Prime Minister and other paternalistic federal politicians, we have lost control of the two most important of these principles. We do not seek the unobtainable. We seek what is simply denied. Denied by those who are elected to office and paid to represent us. What

## FOR YOUR DIARY 2001 - 2002

### Meetings

- **Associate Professor Helga Kuhse**, Director of the Centre for Human Bioethics, will speak about **Legislation and the Situation in Belgium** at 2pm at the **Sunday 18 November** meeting at the Dougherty Centre, Chatswood.
- Kep Enderby, who was the Attorney General in the Whitlam government, will be speaker at the Annual General Meeting which will be at the same Chatswood location on **Sunday 24 March 2002**. He will speak about **Suicide and the Law** – is being present when someone commits suicide a human right or aiding and abetting?
- **Central Coast** - A meeting of the Central Coast branch of VESNSW will be held at **10 am on Mondays 3 December** at the **Gosford Senior Citizens Centre, Albany Street Gosford**. **Contact: John Doyle on (02) 4384 6676**. If you would like a lift to these meetings, ring **Debbie Mastin on 4975 2732** and she may be able to help.
- **Confidentiality**: VES(NSW) does not provide information about individual members or give the membership list to any person or organisation under any circumstances. However, if you would like your name to be added to a VES(NSW) 'telephone tree' - so that members can respond quickly when VE is raised on radio talk-back sessions - please let Carmel know. The Society will provide helpful advice on how to get the message across.
- **Fee Increase** - subscriptions have not increased since 1997 and because of added costs, including the GST, from 1 January 2002, the new fees will be:

Subscriptions	Standard	Pensioner	Life
Single	\$20	\$14	\$230
Couple	\$35	\$25	\$350

Kevin Andrews and his colleagues in Federal Parliament did was barbaric. In the four years since his Bill became an Act, about 40 Territorians have died who would, like Bob Dent and others, have used the *Rights of the Terminally Ill Act* to end their suffering on their own terms. In addition to these 40 Territorians, an unknown number of other Australians who would have travelled to the Territory, (like June Mills did), also endured bad deaths. We can only imagine the misery and anguish experienced by all those who have suffered unnecessarily, along with their families.

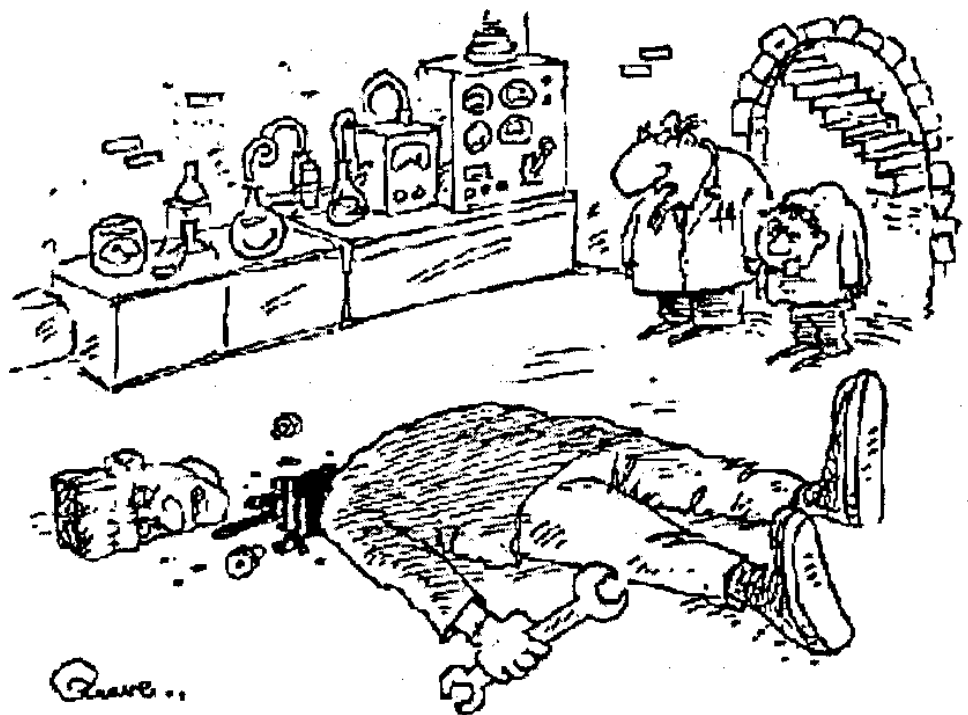
We should remind those who voted to overturn the *Rights of the Terminally Ill Act* of the misery they perpetuate. We need to show the politicians that those who suffer so much that they seek release through death are not mere statistics. They are mothers, fathers, sisters, brothers, parents, grandparents and friends. Their wishes in death should not be dismissed as an unpleasant aberration, to be ignored in the hope that palliative care has all the answers. Taking control is the objective, **but how** we take control with the law as it exists today is the issue. Some who are very ill are fortunate to have the attention of a sympathetic, compassionate doctor who is prepared to take risks and help. Others who want control are left without information or assistance and feel compelled to die earlier than they would wish, using whatever means they have available.

Those of us who believe we have a right to some dignity when dying won't find very much of it in the methods chosen by elderly Australians who take their own lives. During the last decade, hundreds of the elderly chose to die by hanging themselves. Not much dignity in that. The next largest group used firearms and explosives. Certainly a very quick way to die, but again, not very dignified and most unpleasant for those who find the body or have to clean up. Third most chosen method has been carbon monoxide poisoning. Poisoning by the likes of analgesics,

barbiturates, agricultural chemicals, corrosive and caustic substances was not uncommon. If you could lay your hands on enough of the right barbiturates you might die peacefully; however there is no dignity in the effects of swallowing corrosive or caustic substances. Drowning is probably not difficult if you are elderly and no one is around. Although not dignified, it is not quite as undignified as the last two categories I will mention: jumping from a high place and the use of cutting and piercing instruments. Around 40 Australians over 75 died from self-inflicted injuries with cutting and piercing instruments in the last decade.

We can only speculate why the elderly take their own lives. Born before Penicillin was invented, having made it through to their late seventies, eighties or nineties - through wars, natural disasters, the great depression and no doubt personal and family crises - one could be forgiven for thinking that **nothing** would faze such hardy souls.

Our opponents would say that the elderly take their



'HE'D BEEN DEPRESSED FOR SOME TIME...'

own lives because not enough government money is spent on services to care for them and that those driven to take their own lives are depressed. I am sure they are depressed. Depressed that the growing burden of illness and disease has robbed them of the pleasures which once made life worth living. Depressed at

having to die while they still have to control but before they want to. Depressed at not having access to drugs which provide a peaceful death. Depressed at not being able to die with loved ones close by. Unless the elderly suddenly stop doing what they have done for the past ten years, 2,200 Australians aged 75 and over will take their own lives violently in the next decade. More than four per week, every week for the next ten years. Some of them will be close to 100 years old. These are people who believe the life they live, or face, is worse than the method by which they choose to die. They will not die with dignity.

How many will take their life before they really want to? Probably most of them. How many will die secretly and alone? - All of them. How many will say goodbye to loved ones? Not many, although some will express their feelings in writing. How many will leave behind them trauma, guilt, anguish and regret? - We cannot even conceive the dimensions. Is it any wonder that the patience of many in our movement is wearing thin? The frustration is growing with every bad death, with every failed legislative initiative. With every medical advance which extends the dying process. How many more must die without the dignity they so desperately seek before the lawful option is restored in this country?

The pursuit of NuTech alternatives in the face of parliaments dominated by political wimps and religious zealots is understandable. After all, it is not as if we are proposing a new social experiment. Euthanasia in all its forms has been and is practiced daily around the world - doctors surreptitiously administering death, (not always upon request), to end the suffering of a hopelessly ill individual. We know that palliative care does not have the answers for every dying patient. We know that adequate safeguards can be devised. We know the broad community support for what we are trying to achieve (I sometimes wonder if we would get more attention if we were a minority group - perhaps we should become the Royal Society for the Prevention of Cruelty to Humans). Our movement should be under no illusion. The pressure to bypass the legislative solution we all started out seeking, stems directly from insensitive, incompetent and in some cases, ignorant politicians who have had ample opportunity to address this issue responsibly - particularly politicians in South Australia and Western Australia where voluntary euthanasia Bills have been

introduced and rejected. If those legislators felt the Bill before them was deficient, they should have proposed amendments. That's their job. Politicians amend legislation every day parliament sits, but not *Death With Dignity Bills*. These need to be given a wide berth, in order to not upset the clergy or the AMA, avoidance tactics are necessary.

A Parliamentary Committee stacked with colleagues having a fundamental objection to voluntary euthanasia usually does the trick. By referring the Bill to people to whom no suffering would change their minds will avoid Parliament having to debate the issue. Good examples of this ignorance can be found in the Hansard of Debates during the passage of Kevin Andrews' *Euthanasia Laws Act*. It is clear that many of the speakers in the House of Representatives and the Senate had not even casually perused the Northern Territory *Rights of the Terminally Ill Act* they were about to overturn. The Member for Richmond in NSW, Larry Anthony, said 'The old, the poor, the disabled and mentally disadvantaged are gravely at risk of being euthanised'. The Member for Braddon in Tasmania, Christopher Miles, claimed the Act opened up the possibility of 20-year-olds who feel depressed going to doctors to take their lives early. The Member for Moore, WA Paul Filing, did not know the Act was limited to competent adults. The Member for Mitchell, Alan Cadman, said 'There is no such thing as voluntary euthanasia because for disabled people and infants it becomes an involuntary process'. The Member for Lowe, Paul Zammit, said 'It has been estimated that some 25,000 Australians could be yearly candidates for voluntary euthanasia'.

I have pages of this rubbish from Hansard. That's what we are up against. That's what is driving the pursuit of NuTech alternatives. We will just have to move some politicians out so we can move some others in. The plain fact is you either change their minds or you change the member. Until one of these two things happens, death in Australia will remain the cruel lottery it is today. I urge each State VE Society to open a file on every Member of State Parliament and devise a strategy to get each of them to declare a position on supporting the electorate's view on voluntary euthanasia. Then devise a further strategy to undermine those politicians who refuse to accept the rights our community wants enshrined in law. Obviously, one would start with the most marginal

electorates. Political campaign skills may have to be learnt to use our limited resources most effectively. An objective should be to have at least one politician in each state committed to introducing and re-introducing a responsible Private Members Bill for as long as it takes. It appears, thanks to Sandra Kanck and Dr Bob Such, that South Australia has achieved this.

Two other States may not be far behind with Ian Cohen having announced his intention to introduce the first Bill in NSW and Robin Chapple building on the work started by Norm Kelly in WA. We should all hope these new champions of our cause will liaise with each other to share information and experience on how to expand the circle of support which exists in each State Parliament.

For those of you who disagree or are apprehensive about emerging strategies for self deliverance - I believe the search for new methods of taking control will continue even when voluntary euthanasia legislation is eventually adopted. The narrow eligibility criteria and complex procedures which are a feature of existing laws and draft Bills will fuel the drive for alternatives. To legally access a doctor's help to die in The Netherlands, one must be in a state of 'unremitting and unbearable suffering'. The Oregon legislation required the patient to be 'terminal and dying within six months'. The briefly-appearing NT Act stipulated that assistance could only be given if the patient was 'terminally ill and suffering to an extent unacceptable to the patient'.

All those laws require a doctor to make a judgement on whether the patient is 'suffering enough'. That is the same situation as exists now. To protect themselves, doctors who intend using the convenience of 'Double Effect' must decide if the patient is suffering enough to ensure there will be no undue interest in his or her administration of drugs. If we wait a little longer, the patient will beg more desperately for death and so will the family. Then, the doctor hopes, everyone is so relieved it's over that no one will complain. In addition to reaching the required level of suffering, current and proposed laws demand one to endure a variety of hurdles like cooling-off periods, second opinions, repeated questions. In Oregon, one must self-administer and only oral drugs are permitted.

Of course there is good reason why those jurisdictions that have laws allowing dying patients

some control are very restrictive. It is a classic example of politics being the art of compromise. If those restrictions were not in place, there would be no laws. The hundreds of thousands who draw comfort from the existence of a legal option in The Netherlands and Oregon, would be denied. The point is this: our primary objective is compassionate, safe legislation which gives the competent individual control over the dying process. However, the failure of politicians to accept (or even debate) responsible law reform and the restrictions imposed when they do, is motivating a search for alternative means to take one's own life with more dignity than is now the case.

I do not share the fears of those who believe that information about new innovative ways to take your own life must lead to more deaths. There could be no more accessible aid today than a plastic bag but no one argues that plastic bags have increased the suicide rate. The fact is, if your arms or legs work, there are a hundred ways you can kill yourself. Although the suicide rate in Australia has fluctuated over the decades, the rate in 1998 was similar to that in 1921. It seems that the assumption that numbers of suicides are related to the available methods may well be wrong. The traumatic ways often resorted to seem to imply that motivation to suicide is so strong that method becomes a very secondary consideration.

As a politician seven years ago, I was not aware that voluntary euthanasia societies existed in every state in Australia and there were similar organisations in other countries and could not describe what a hospice was. Today, despite a high level of ignorance about the detail, 798 State and Federal Politicians around Australia not only know our movement exists, many of them have been compelled to think about voluntary euthanasia, determine a position, and in some cases, publicly declare what that position is. These politicians know VE is on the agenda, inching higher with every Max Bell, Esther Wild and Norma Hall - with the actions of doctors like Philip Nitschke, Rodney Syme, Roger Hunt and others - with the invaluable research efforts of people like Colleen Cartwright and Helga Kuhse and the persistent lobbying by VE societies. Our objective has dramatically cranked up the public agenda with every new Bill that is introduced. For these we thank John Moore, John Quirke, Ann Levy, Norm Kelly, Sandra Kanck, Dr Bob Such. Soon we hope that Ian Cohen and Robin Chapple will join in

this list. And, of course, decriminalisation in Oregon and The Netherlands have helped our agenda immeasurably.

Last year Lenore Taylor wrote an excellent article on changing attitudes to death and dying in the *Australian Financial Review*. She claimed that baby boomers who questioned and challenged most of society's moral taboos about sex, marriage and drugs, are now forming their own views about death and dying rather than mimicking their parents' death-denying attitudes. A few years ago, an example of this new approach was reported from Alice Springs - former nurse Pattie Mead decided she would refuse treatment for cancer and was determined not to spend her last days in hospital. To help her friends 'lighten up' about her decision not to seek treatment, Pattie invited everyone to a coffin-building party. She broke out the champagne, cracked jokes and got down on her hands and knees alongside her friends as they set

about coffin assembling. A coffin-painting party was the next step but Pattie's condition deteriorated and her friends had to do this without her. She was certainly one of the generation Lenore Taylor was talking about.

As they age, large numbers of baby boomers will want control and they will not be preached to. One way or another, I believe they're going to get it. We are making progress - it's just too slow and we are justifiably impatient as we witness too many of our near and dear endure a miserable lingering death or die violently by their own hand. While I remain a staunch advocate for legislative reform, faced with a bad death, I could never let cowardly politicians and religious bigots deny me control. Perhaps, if enough of us feel the same way, we could have the Australian Bureau of Statistics add a new description to the list of ways Australians take their own lives: peacefully.

## Suicide (Peaceful) Pill: The Issues

The Suicide Pill (or Peaceful Pill), if developed, would be a recipe for a lethal mixture that people could mix themselves from commonly available ingredients. Swallowing the mixture would bring about a quick, painless and certain death. The September meeting of the VES(NSW) Committee vigorously debated the question of whether VES(NSW) could or should support the development of a Suicide Pill. Serious reservations and grave concerns were expressed about the likelihood of unintended tragic outcomes if the recipe is made publicly available.

Here are extracts from two recent press reports on this issue. You may wish to let the VES office know your views.

● The first report, 'Euthanasia Groups Cool on Suicide Pill', by Brett Foley appeared in Melbourne's *Age* on 3 August:

Plans by euthanasia advocate Philip Nitschke to develop a suicide pill appear likely to be dismissed by other interest groups this weekend as the Democrats and the Greens renew plans for private members' bills to reinstate the Northern Territory's right-to-die legislation. Dr Nitschke could face opposition in his plans from the state-based Voluntary Euthanasia Societies, who fear the plan would damage their efforts to lobby for political and community support to enact euthanasia legislation in each state. Dr Nitschke ... said rational people wishing to end their lives would be given the recipe for the pill, which would effectively bypass current laws.

Voluntary Euthanasia Society's Victorian president, Dr Rodney Syme, said the society's main focus was legislative change through a private member's Bill by Democrat Sandra Kanck to be debated in the South Australian Parliament next month. 'The pill is not really within our ambit because it is technically outside the law and there is a large element of irresponsibility about it. For example, it would fall into the wrong hands, such as someone with mental illness,' Dr Syme said. However, he said one benefit of the suicide pill would be to force policy makers to deal with the issue or face a situation similar to 'the bad old days of backyard abortions'.

Dr Nitschke said the pace of legislative change meant the suicide pill had to be developed to help people in the interim. The pill had to be safe, reliable and able to be made from simple ingredients so it could be available to any rational person wanting to end their life, he said. It would also have to be taken somewhere to be tested before use. Dr Nitschke conceded that the issue of how to distribute the suicide pill recipe while ensuring it did not fall into the hands of the young or the mentally ill was yet to be resolved. He has received a grant of \$58,000 from the US-based euthanasia organisation the Hemlock Society, but said further financial support would be needed for the suicide pill to be developed.

- This second report was published as an opinion piece in the *Sydney Morning Herald* on 17 August:

- Teaching people to make a suicide pill is one thing. The hard part, concedes Philip Nitschke, is restricting the know-how. Last week in Broken Hill, 95 of 100 delegates from around Australia attending the first conference of the Voluntary Euthanasia Research Foundation put their hands in the air to support development of a Peaceful (Suicide) pill. Their average age was 70.

Dr Nitschke informed delegates [that] 'a Peaceful Pill would be an answer to the unresolved voluntary

euthanasia question that does not depend on the political process. The idea is to develop a way to use available unrestricted ingredients to make an ingestible substance or drug that would provide those who are suffering with a peaceful death. Because the person who takes the drug also makes it, the process is legal. The medical profession's involvement would then be optional - doctors could explain what medical and palliative interventions are possible but it would then be the rational individual's decision whether to proceed. Dying would again be a private matter. However, along with the benefits of such a technical solution come new difficulties. The biggest concern is how to restrict use of the pill. One model has proposed that all people over a certain age (adults) who are not depressed or otherwise psychiatrically impaired should have access to the recipe. ... Others would restrict its use to the terminally ill or those chronically suffering. There will always be arguments over who should get access to such information and how it should be controlled. And, yes, restricting access to such information will be difficult'.

Nitschke continued, 'Many fear that such initiatives could aggravate the tragedy of youth suicide and some have argued that I have blurred the clear distinction between voluntary euthanasia (where the rational dying simply speed the process) and suicide (where irrational behaviour tragically cuts short a productive life)... One model (which I favour) proposes restricting the pill to terminally-ill members of voluntary euthanasia societies who have undergone medical and psychiatric assessment. ... Others argue [that] as rational adults we should have the ability to give that life away when we choose, with or without terminal illness. ... My organisation plans to proceed with the research and to adopt a restrictive model if useful results become available. What we want is an open and inclusive public debate to establish useful guidelines before this theory becomes fact'.



# When is Terminal, Terminal?



Dr Fran Boyle, MBBS, FRACP is a medical oncologist at Royal North Shore Hospital. She is frequently quoted in the press about her work on breast cancer

Here is an abridged version of the talk given by Dr Fran Boyle at the VES Meeting on 22 July 2001.

Cancer formation usually starts fairly slowly with a small group of abnormal cells underneath the surface. They are invisible at first and may remain dormant until the right conditions come along. The early cancer won't make a person sick but, by the time it increases significantly, most people start to feel unwell. This single cell kind of cancer is easy to remove. Breast cancer can often be detected at this phase because mammograms detect things under the surface. Cancers that are inside the body are not picked up until they start to become quite large or produce secondaries. The process might take twenty years - it is only the last phase of cancer that progresses quickly.

You can liken cancer to a game of chess. If you imagine your body like a chess board, the important body parts are like the Queens and Knights and Bishops on the back row but you can continue if you lose front row Pawns, such as breasts and prostates. But once vital organs fail, you reduce your chances and start getting into Check. If enough of these organs go, you end up with the Check Mate of death.

In the early phases of treatment for a localised cancer, cure is often possible - but, if some cancer cells remain, they may spread to other organs. Testicular cancer may still be curable if it spreads, but most other types of cancer are not curable once

the spread is confirmed. Lung cancer may only show up at this later phase. Although not curable, late-stage cancers are usually treatable and, with chemotherapy, hormone treatments, radiotherapy or surgery, the patient may be quite well for a while. But there comes a point when death is inevitable when important parts of the body begin to fail - vital organs such as the brain, lungs, bone marrow, liver, and kidneys. The two functions of the pancreas can be replaced reasonably well, as can the gut, with artificial feeding. But we would not consider a patient to be terminal if the vital organs were not affected very much, eg if the cancer was only in the bones.

People with advanced cancer may have pain or other symptoms that need specialist assistance. There has to be a trade-off between getting better pain relief from doing something actively, and making the side effects of the treatment manageable. Over the past decade we have improved this, with better chemotherapy drugs, better analgesics, and better drugs to control nausea. But there are people having chemotherapy or radiotherapy who tolerate that very poorly and we can predict some of the reasons for this. If the cancer is already affecting the bone marrow, the ability to tolerate chemotherapy is much less. If it is affecting the liver and making you nauseated, then the additional nausea of chemotherapy is much harder to tolerate. Some of the side effects of chemotherapy can collide with symptoms of the cancer and there can be a short-term worsening of those things before the cancer comes under control. We have to weigh up the treatment knowing that somebody might get worse before they get better. If a patient has other diseases, this will also affect their ability to tolerate treatment.

Women with breast cancer generally live longer than people with other cancers, partly because breasts are on the surface, partly because they are not vital organs, and partly because breast cancer may respond to hormone treatments as well as

chemotherapy and radiotherapy. To treat breast cancer we use drugs such as Tamoxifen to block hormones entering cells, and new drugs called aromatase inhibitors (Letrozole, Anastrozole) which stop the hormone oestrogen being made. These are not going to cure breast cancer but, in advanced disease, have given us extra treatment options, where, on average, a patient might live another six or twelve months. The National Breast Cancer Centre ([www.nbcc.org.au](http://www.nbcc.org.au)) has recently released a guide for patients with advanced breast cancer.

The shift from active treatment to a purely symptom or palliative phase is called 'end of active treatment'. We teach a lot of communication skills in medicine these days, but this is recognised as being very difficult; it is hard for doctors, who have known the patient and seen them relapse and do well again, to say we have now come to the end of the line. Doctors tend to avoid it and sometimes patients and families avoid it too. Palliative care physicians, who specialise in symptom control, would like to begin their involvement well before this moment. Ideally, their role would start as our work diminishes.

Treatment usually plays a role in the early stages of cancer but once the vital organs fail, treatment may do more harm than good. Then we normally stop active treatment and concentrate on relieving symptoms rather than controlling the cancer that is causing them. Usually, the time between ending treatment and death is between one and three months - it may be longer for some cancers and shorter for others such as brain tumours.

A recent study in the US looked at patients at this point whose doctors had discussed continuing active treatment or transfer to a hospice for terminal care. Roughly half of the patients chose active treatment and half chose palliative care. Both groups lived 29 days on average but the people who continued treatment were more likely to die in hospital, not from the cancer but from complications of their treatment. People who work in cancer are reasonably good at judging when that stage has been reached. We often fear that cancer will mean a long period of unrelieved suffering and pain. I have learnt that once the game is up with cancer, the time from then to death is usually fairly short.

## NSW Wills Register

Many members responded to information about the emergency necklace in the July Newsletter. Here is more information which may be helpful. A Will can only be used if it can be found. The NSW Government's *Wills Register* will make it easier for a Will to be found when needed. The Registry enables a user to record where the Will is kept, who made the Will and who is the executor named in the Will. Registration is free and voluntary. The *Wills Registry* does not need to see a copy of the Will, nor does it store the Will. Details can

be lodged for no charge at <http://www.bdm.nsw.gov.au/cgi-bin/WillOrder.cgi>. The user receives written confirmation of this with a registration number. If details change, simply lodge the information again. The number can be quoted at the time of a Will search, but searches can be activated without a number. If a Will is stored with a solicitor or professional trustee, they may make the registration. Details of all Wills deposited at the NSW Supreme Court will be included in the *Wills Register*.

## Deadpan Humour

'I detest life-insurance agents. They always argue that I shall some day die, which is not so'.

Stephen Leacock (1869-1944), English-born Canadian economist and humourist in *Literary Lapses*, 1910.

'It's better to die than become a victim of the whole dying industry - religion, morticians, politicians'.

Timothy Leary (1920-1996), US hippy leader, quoted in *The Guardian*, 2 December 1995.

'Either he's dead or my watch has stopped'.

Groucho Marx (1895-1977), US comedian in the film *A Day at the Races*, 1937.

'Oh well, no matter what happens, there's always death'.

Attributed to Napoleon Bonaparte (1769-1821).

'He had been, he said, a most unconscionable time dying; but he hoped that they would excuse it'.

Charles II (1630-1685), quoted in Volume 1, Chapter 4 of Macaulay's *History of England*, 1685.

'He's gone to join the majority'.

The Roman satirist Petronius (1st century AD) referring to a dead man in *Satyricon: Cena Trimalchionis*, 42.

## Swiss Assisted Suicide Branching Out

by Derek Humphry, founder of the Hemlock Society.

Switzerland is now setting the pace for the practice of assisted suicide on a wider scale even than The Netherlands. Today there are four 'right-to-die' organizations in a country with a population of seven million. Two of them offer help with hastened death to both terminally-ill and chronically-ill, be they resident or foreigner. One group will even visit a dying patient in another country if there is no alternative. Switzerland has not had a law forbidding assisted suicide since the criminal code was revised in 1937. The relevant

law - para.155 - is interpreted to mean that anybody - doctor, nurse, family or friend - can assist a suicide of a physically sick person, provided it is done for altruistic reasons. If assistance is given out of evil motives, or financial gain, then it is a crime - but there are no known cases of prosecution.

Estimates in recent years have put the number of hastened deaths at between one and 200 a year. No official statistics kept because it is not an offence. But such is the growing worldwide interest in assisted suicide that what was ten years ago a quiet, compassionate, national practice in Switzerland has recently spilled over into an

international context. Because most nations (except the Netherlands and one American state, Oregon) will not legalise assisted suicide, desperate persons who believe in the freedom to die at a time of their choosing are looking to Switzerland.

Assisted suicide is not euthanasia. Assisted suicide means helping the patient find the lethal drugs, giving advice and moral support, but leaving the patient to decide whether to ingest the potion. Some call it 'assisted suicide up to the final, self-release stage.' Euthanasia is a doctor giving a

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lethal injection on request. Only The Netherlands permits both procedures, under strict guidelines. Neither The Netherlands nor Oregon will accept non-residents for help in dying - the Dutch require that the physician has known the patient for several years, while Oregon law has a 'residents only' provision. The more flexible law in Switzerland, together with four proactive organizations, means that interest has mounted from persons with intolerable physical health problems in surrounding countries which will not change their prohibition.

EXIT - German speaking. With 50,000 members, this powerful Zurich group is the most active in helping Swiss citizens to die in appropriate cases. It does not help foreigners. The Pentobarbital is obtained from the patient's doctor, but the EXIT helper usually makes all the arrangements but leaves just before death. EXIT always informs the local police of what happened, they check it out, and the death is officially recorded as 'suicide'. This organization gets just over 300 calls a year from people wanting help to die, with 120 actually getting assistance in an average year. Swiss professional

medical groups as a policy discourage doctors engaging in assisted suicide and persons with mental health problems are not helped. Any doctor who writes a lethal prescription for no acceptable reason is unlikely to be prosecuted but will lose his or her medical license.

NoPhysiciansEXITInternational is a breakaway from the Zurich organization run by a doctor of philosophy, the Rev Rolf Sigg. The group is apparently well funded and willing to travel throughout Europe to help people die, though for the time being only German-speaking persons are assisted because of language problems. Sigg claims to have helped more than 300 people die so far - double Dr. Jack Kevorkian's total. Dr. Sigg has been particularly active in Germany because, while assisted suicide has not been a crime for hundreds of years, hardly any doctors will practice it because of the country's shame over the Nazi 'Euthanasia T-4 Program' during World War Two. Law enforcement authorities in Germany have several times pressed charges against Dr. Sigg for bringing Pentobarbital into the country, secured convictions, but on appeal they were dismissed. Appeal judges warned him not to continue

importing narcotics but at the same time praised his humanitarianism. Lacking narcotics, Dr. Sigg nowadays mostly uses the plastic bag technique if he cannot persuade the patient's own doctor to prescribe barbiturates. He is opposed to doctors carrying out any form of euthanasia, believing that the task is more suited to specially trained operatives.

DIGNITAS was formed three years ago with a motto of 'To Live With Dignity - To Die With Dignity'. It is headed by attorney Ludwig A. Minelli in Forch, Switzerland, and has helped about 30 people to die so far. It has a cautious and law-abiding approach but does help foreigners. They must first be members for an annual fee of 25 Swiss francs. The member must get a prescription from a Swiss physician for the lethal dose of Pentobarbital after examination of physical symptoms and case documentation. The case must fit Swiss law. DIGNITAS issues its brochures in German, French, Italian, and soon English. Contact: DIGNITAS.-Postfach 9, CH-8127, Forch, Switzerland. Email: [dignitas@dignitas.ch](mailto:dignitas@dignitas.ch). Web site: <http://www.dignitas.ch/>

Read more on the Swiss situation at: <http://www.finalexit.org/pract-swiss.html>

### **VOLUNTARY EUTHANASIA SOCIETY OF NEW SOUTH WALES**

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Many loyal friends have found that a bequest is one way they can make a significant gift to further our Society's efforts to change the law and to educate the community. A bequest form is available from the Society's office.