



VESV REPORT

VOLUNTARY EUTHANASIA SOCIETY OF VICTORIA INC.

Reg. No. A0006974B

Member of the World Federation of Right to Die Societies

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Self-Determination, Courage and Activism

On January 2, Admiral Chester Nimitz Jnr and his wife of 63 years committed suicide at their retirement home in Massachusetts, leaving a note saying: *we have consciously, rationally, deliberately and of our own free will taken measures to end our lives today because of the physical limitations on our quality of life placed upon us by age.* Admiral Nimitz was 89 and suffered with congestive heart failure, severe gastrointestinal and back problems, failing vision and was losing his independence; Joan Nimitz was 86, suffered from acute osteoporosis which was causing her bones to break, and had become blind. Until the last few years, the couple led full and enviable lives of golf and gardening and socialising in their homes on Cape Cod and in Florida, surrounded by their three daughters, five grandchildren and three great grandchildren. Their age-related health problems were robbing them of their greatest pleasures, and Admiral Nimitz was terrified that he would have a heart attack and that his wife would then be unable to kill herself as they had planned. They discussed their feelings with their families, lunched with some of them on New Year's Day and spoke the next day with another daughter. The Nimitzs were found dead the following morning, having requested in their note that the staff at the retirement home not resuscitate them if they were found unconscious but still alive.

The carefully planned suicide of such a prominent and respected couple, and their clearly stated refusal to accept their impending loss of independence and quality of life, has refocused attention in the United States on the issue of doctor-assisted suicides and is likely to lead to future legislative initiatives and considerable debate.

The importance of this particular suicide to the euthanasia movement is the discussion it will inevitably generate throughout society. Popular culture has often been influential in altering the beliefs of a population, thereby leading to more rapid social change in legal and other institutions, and any extensive discussion will accelerate this change. Although public opinion consistently supports the concept of voluntary euthanasia, public activism is far more limited; in 2001 VESV was 'active' with the 'Peaceful Protest' and in doing letterbox drops and manning polling booths in the Menzies Electorate. Much more is needed if the aims of the Society are to be achieved.

At the 2000 World Federation conference in Boston, Massachusetts, the need for a broader appeal was discussed, and a number of interesting ideas presented. A sociologist, Professor Joe Bandy of Bowdin College, said that *one major reason* (for the lack of widespread activism) *may be that, unlike other movements which struggle to eliminate suffering, the right-to-die movement seeks to do so by promoting suicide as a choice, an issue that is taboo in our culture and frightening for many even to consider. The difficulty of mobilising activists, especially those who do not immediately face end-of-life decisions or terminally ill conditions is difficult, and this difficulty is compounded by the death shroud that public figures like Dr Kevorkian have placed on the movement by promoting assisted suicide in a less than tactful way.*

His recommendation for the right-to-die movement was that it *must endeavour to create a popular culture that helps a fearful public overcome its fears about death by presenting models that are more dignified---*

rather than fade into oblivion, death must be presented as the way to punctuate and give completion to a vibrant life.

The way of achieving this, Dr Bandy believes, is by end-of-life education through cultivating alliances and coalitions and by involving the services of the medical profession and the church. Suggested coalition members could include medical and health organisations, senior citizens and other community groups.

VESV Members may see an active role for themselves in one of more of these.

From VESV REPORT February 2002

Vast majority of Australians support voluntary euthanasia

AN INDEPENDENT survey that shows 76 per cent of Victorians believe doctors should be allowed to assist in voluntary euthanasia must convince politicians to take action, VESV president Dr Rodney Syme, told a special meeting of our members last month.

About 80 members, plus TV, radio and newspaper reporters, were told similar approval has been found in surveys in other states.

More than 1,200 people had been interviewed by Roy Morgan Research in Victoria, New South Wales and South Australia. The 76 per cent of Victorians in favour represent an estimated 3,016,000 people.

Victorians are not alone in their belief. Seventy per cent of respondents in New South Wales, and 79 per cent in South Australia, say doctors should be allowed to help hopelessly ill patients in unrelievable pain to end their own lives. In a separate recent independent survey in Western Australia, 74 per cent of respondents said they supported voluntary euthanasia.

The support was bipartisan with 78 per cent of Labor and 73 per cent of Liberal voters indicating they supported it.

When it was explained to Victorians that currently it is not against the law to commit suicide, but it is a criminal offence to assist someone to do so, 71 per cent said the law should be changed to allow terminally ill patients to obtain assistance from a doctor to commit suicide.

The survey reveals that, rich or poor, young or old, it matters little: Victorians from all walks of life are in agreement that the law regarding euthanasia should be changed.

“There is an enormous groundswell of opinion throughout all segments of the community, regardless of people’s income, politics or religion, which must not be ignored by governments”, Dr Syme said.

“Victorians want to see leadership on this issue from our state politicians. Premier Bracks should respond to the public’s wishes on this subject and immediately introduce legislation that reflects community attitudes.”

Dr Syme said there has been extensive public interest in recent suicides in Queensland, South Australia and Victoria.

He said nearly three quarters of Australians aged 35 – 49 (74 per cent), 25 – 34 (74 per cent) and 50 – 64 (73 per cent) said the current law should be changed to allow hopelessly ill people to gain assistance from a doctor to commit suicide. Even among the usually conservative 65 and older group nearly two-thirds (65 per cent) said the law should be changed.

Similarly, Victorians earning less than \$15,000 per year (71 per cent said the law should be changed) were nearly equally likely to say the law should be changed as those earning \$60,000 a year or more (72 per cent) said it should.

Even among Victoria’s Roman Catholic community a clear majority of respondents (61 per cent) said the law should be changed to allow terminally ill patients to obtain assistance from a doctor to commit suicide.

Among Anglicans (82 per cent said the law should be changed) and those with no religion (82 per cent) agreed.

And while women are more likely to call for changes in the law (73 per cent) than men (69 per cent), opposing changes to euthanasia laws is not likely to be a voting problem for any of the major political parties, with 72 per cent of electors saying the law should be changed.

Among ALP supporters 74 per cent said the law should be changed, while even among Liberal and National Party supporters 69 per cent have the same opinion. Among supporters of the minor parties the support for change was even higher, with the

Australian Democrats (76 per cent), The Greens (75 per cent) and One Nation (80 per cent).

In a rebuke for anti-voluntary euthanasia campaigner and Minister for the Aged, Kevin Andrews, who has claimed that palliative care is adequate, the survey reveals fewer than a quarter (22 per cent) of Victorians think that palliative care is sufficient.

The survey found nearly one-in-four Victorians (18 per cent) had personal experience in which a close relative or friend was hopelessly ill and wanted voluntary euthanasia. Dr Syme said

undoubtedly substantially more people would have requested euthanasia, if it had been legal.

The controversy based on 21 people attending the suicide of Nancy Crick in Queensland inspired a question based on when a person is hopelessly ill and commits suicide because of unrelievable suffering, anyone present may be found guilty of assisting the suicide, even if they do nothing to help. Asked whether the law should be changed so that it is no longer an offence to be present at a suicide, 77 per cent of Victorians agreed.

From VESV REPORT August, 2002

I HAVE A DREAM

*by Faye Girsh, Director, US Hemlock Society
(With apologies to Dr Martin Luther King Jnr)*

I have a dream that someday every American whose quality of life is unacceptably diminished by an irreversible physical condition will have the choice of a peaceful, assisted death.

I have a dream that if such a death is chosen, it will be gentle, quick and certain and in the caring presence of loved ones.

I have a dream that hospice care will someday be extended to include the choice of a peaceful, hastened death.

I have a dream that the law will permit even people not capable of self-deliverance to have this help if they choose it.

I have a dream that the choice of a hastened death will never be a substitute for quality end-of-life care, but that every person will be able to make an informed choice to refuse such care and hasten the dying process.

I have a dream that there will be available through churches, synagogues, mosques, humanist and atheist organizations, civic groups and medical facilities, people who will provide this kind of careful, caring assistance.

I have a dream that those whose beliefs differ from ours will respect our choices about our lives and deaths, as we respect theirs.

I have a dream that the advances in technology that enable us to live longer, healthier, better lives will be applied to relieving the anxiety, barbarism and suffering of an agonizing and prolonged death.

I have a dream that human beings will be able to retain their dignity, their personhood, their values, and their choices up to the last day of their lives.

I have a dream that the secrecy and guilt associated with hastening death will disappear and that a dying person will be able to openly make and announce this choice.

I have a dream today.

From VESV REPORT May 2002

This significant motion was passed in May this year at the Federal Council meeting of the Australian Medical Association:

“That the AMA support doctors whose primary intent is to relieve the suffering and distress of terminally ill patients in accordance with the patients’ wishes and interests, even though a foreseen secondary consequence is the hastening of death.”

AMA acts regarding patient suffering

HISTORICALLY THERE has been a general consensus that the Australian Medical Association is opposed to the concept of voluntary euthanasia. This year’s passage of the above motion can be seen as an indication of a gradual change in the thinking of many doctors with a resultant change in the official policy of the organization representing a sizeable proportion of them, the AMA.

At its May 2002 Federal Council meeting, the members debated a motion that it adopt a *neutral attitude to the question of VE*. This motion was defeated, but there was over 30% support for it which represents a significant gain over recent years. The passage of the above resolution is a positive indication of a receptiveness to further debate on the subject in the near future.

The primary intent of any act of euthanasia is the relief of suffering and distress, for without these there would be no justification for any assistance, and an integral component is the autonomy of the patient in making any such decision. Both of these are acknowledged in the AMA’s adopted motion.

It was very clear from the World Federation of Right to Die Societies Conference in Brussels this past September that successful legislation in the Netherlands was achieved because of the support of the medical profession, and we need this to happen here if any legislative change is to occur. As it is apparent that there has been an increase in the level of support within the AMA, continued pressure on them should serve to keep the issue prominent in the Australian debate and to further the inroads already made.

Medical views on euthanasia fall into three broad categories:

- The idealists who regard it as immoral and believe it is unnecessary

- The pragmatists who see a necessity for some form of assistance to the dying but do not want to disturb the status quo
- The realists who fully accept the necessity to hasten death on occasions and believe that we should openly acknowledge and regulate it.

The problem is fundamentally with the word *euthanasia* and the different meanings attached to it. The idealists regard it as bad and convince themselves that they never practise it, the pragmatists reluctantly agree that they do perform a sort of euthanasia but not publicly, while the realists freely acknowledge that they practise voluntary euthanasia and wish to change the law but are forced to practise covertly in order to stay in practice.

The AMA supports doctors who actually practise voluntary euthanasia as long as their motivation is the relief of suffering rather than the hastening of death and the term voluntary euthanasia is not used. The doctor’s role in this process is to hasten death slowly by using analgesics and sedatives to induce coma. Such a method may serve the legal and moral interests of the doctors but not necessarily those of the patient or the family who have specifically requested rapid hastening of death. A doctor may accede to the request, but would the AMA support the doctor when the hastening of death is a secondary intention rather than merely a secondary consequence?

Thus the AMA motion condones one method of voluntary euthanasia but neglects others that might be preferred by the patient. If voluntary euthanasia is defined as the deliberate termination it should be opposed, but if it is defined as *an action whose primary intent is to relieve suffering and distress of hopelessly ill patients, in accordance with the patients’ wishes and interests, even though the inevitable*

consequence is the hastening of death, then it should receive the support of the majority of

doctors and the AMA.

From VESV REPORT NOVEMBER, 2002

Cannabis for pain

IN MY BOOK *Cannabis and Cancer, Arthur's Story* (2001, Scribe Publications) reviewed in the VESV Report of October, 2001, I tell my husband's story illustrating that cannabis acted favourably where other medication failed. From a debilitated 84 year old with nil appetite, he regained some vigour, 6 kg in weight and his sense of humour, enjoying a reasonable quality of life during his last six months. I incorporated the necessary ingredient in biscuits as he was a non-smoker.

The large positive response to my book surprised me and it continues even a year later. Sufferers, desperate for relief for themselves or for others, contact me asking for help. They are prepared to break the law as I did. I point them in the right direction and, where there is feedback, the result is usually good but it does not work for everyone. Also fear of overdosing may inhibit a good result. This is highly unlikely. In all the literature, there was only one instance of death from cannabis, unlike the millions from other illicit and licit drugs. Attempt to kill a dog by cannabis overdose failed, though a cat did succumb.

The biggest problem is supply. One woman, after watching street corners in her local shopping area but seeing nothing that suggested an exchange of goods and money, proposed going to St Kilda, having a coffee at a pavement table and "casing the joint". I advised against this. Even if she found a supplier, the naïve innocent would not know the difference between the genuine herb and dried parsley. I was able to provide her with an address where a medical certificate would produce a supply of ready-made biscuits.

The opponents of cannabis use concentrate only on the recreational side, and are obviously not up-to-date with the latest research. Its medical benefits cannot be denied as shown by anecdotal evidence and in clinical trials. There is abundant evidence on the web (see www.gwpharm.com/news).

In Canada there is now an Office of Cannabis Medical Access that approves the use of cannabis for terminal illness, multiple sclerosis,

spinal chord injury and disease, cancer, AIDS/HIV, severe arthritis, epilepsy and for other serious medical conditions (medical declaration necessary). Cannabis is grown under government supervision to supply patients.

In Belgium, cannabis can be used legally to treat similar medical conditions, as well as for treatment of nausea resulting from chemotherapy and radiotherapy, and glaucoma. This softening of attitude is repeated throughout Europe and in the UK. IN Australia, laws differ from state to state; south Australia, ACT and the Northern Territory permitting personal use, with relaxed law enforcement in the other states.

Nowhere is its use actually legalised. There's a fine line, which few lawmakers wish to cross. Hypocritical, yes, but there are those who continue to press for clarification of the laws with changes to rid us of this hypocrisy, such as Families and Friends of Drug Law Reform (ACT) Inc. I have bombarded our politicians with letters and information but received little more than predictable responses which, of course, are negative. This continues despite the fact that our present Victorian government went to the last poll with a positive commitment to legalisation of cannabis use. The plant itself is not guilty, only its possession and use.

All over the world there is recognition that prohibition does not work. Rather, it encourages profiteering by illicit drug growers and places those who gain relief from devastating illness in the field of lawbreakers. If the opponents of cannabis could spend some time with AIDS sufferers and others terminally ill who gain some relief from cannabis, they might perhaps think, "there for the grace of god go I", and take action. It is only by constant hammering that we can change the law.

Anything that can be done to alleviate distress ought to be done; not by somebody else but by those of us who have compassion for those less fortunate. Who knows when we may join them.

Pauline Reilly

From VESV REPORT November, 2002

Terminal illness vs hopeless illness

HOW DO politicians view each of the above and how would they determine for themselves whether or not to support **Terminally Ill** (TI) or **Hopelessly Ill** (HI) in their consideration of legal reform on the question of voluntary euthanasia. What we need to ask is: do we really understand what TI and HI mean to a politician?

While everyone has considerable sympathy for both TI and HI sufferers, there exists a clear distinction between them - and perhaps more so in the minds of politicians than in the minds of members of the community at large. TI is finite in that a judgement has been made that a person does not have long to live whereas with HI the 'terminal' phase cannot be predicted. All TI proposed reform incorporates significant safeguards - a diagnosis of a TI, a prognosis of less than 12 months to live, a proscribed cooling-off period - none of which applies to HI. Politicians want every I dotted and every T crossed, and while they may sympathise with HI sufferers they are unlikely to vote for HI law reform because of the uncertainty of the time frame and the fact that it is a terminal **condition** rather than a terminal **illness** in the accepted sense.

And while public opinion and sentiment may support the concepts of TI and HI, it is the politicians who are the lawmakers and who must be convinced that a better form of social cohesion for older people can be maintained if those people are given the right to choose their own medical decision-making at the end stages of life.

Marshall Perron stated on 30th May 2002: *I believe it will be much harder to get legislation through a parliament with the term Hopelessly Ill compared with Terminally Ill...If I had chosen HI as the criteria in the NT, I do not believe I would have obtained half the support I did get. In my opinion the most difficult step in achieving our cause is the first one. If TI comes into law, it will only be a matter of time, and pressure will mount for HI patients to be able to access VE. By this time the fundamental principal will be accepted and legislators will be less nervous about embracing the issue.*

VESV must get a foot in the door before pushing measures and constructs we support but which are not politically viable at the present time. As a Law Reform Society, VESV knows how difficult it is to get any legislation passed in the VE area. We cannot afford to concentrate our efforts into a cause that politicians will not support.

I have been involved in politics for 15 years. I have seen how politicians operate and on what basis they serve their community. Politicians do not represent their constituents unconditionally or representatively; they represent the electorate who voted them in to represent the electorate, but they do so based on their values and beliefs.

The public supports the humane concept that an individual at the end stages of their life *has the right to determine their medical decision-making* without interference from religious institutions or pragmatism from politicians. However, religion plays a major role in society. Sensitive social issues that present themselves as an 'abomination to God's Law', such as Stem Cell Research, Physician Assisted Suicide, Voluntary Euthanasia, Abortion, Same Sex Marriages and Homosexuality are just a few of the discriminating issues on which the Church wishes to impose its values and hence to maintain social control over society.

The argument TI vs HI is all about convincing the politicians (lawmakers) that a human right cannot be overridden by a religious belief.

Noel Sanderson – VESV Secretary

From VESV REPORT August 2002

THE DIFFERENCE BETWEEN TERMINAL AND HOPELESS ILLNESS

For many years the debate about voluntary euthanasia has been focused around terminal illness. Terminal illness is a well-recognized medical concept and refers to the phase where the illness has reached an inevitable and irrevocable course to death and where the time interval to death is usually less than six months. It is accepted that the closer the patient moves towards a predictable death, the more agreement there will be among physicians that a terminal illness is present. It is a term that is particularly applicable to malignant diseases, because the advanced incurable cancer is usually associated with a fairly rapid, progressive, reasonably predictable and inevitable path to death. Cancer itself is not a terminal illness, but advanced incurable cancer is. Thus a terminal illness is defined by four basic characteristics which may or may not be accompanied by intolerable and unrelievable suffering:

- (1) no chance of recovery
- (2) certain progression to death
- (3) rapid progression to death
- (4) a short time-frame to death

Thus terminal illness could be defined as “*an incurable illness that is certain to cause death in a short period of time.*”

A hopeless illness shares one characteristic with terminal illness: there is of no chance of recovery. A hopeless illness is characterized by permanence, such that the patient will never recover, and severity leading to intolerable suffering which is incapable of being relieved. A mid-brain stroke, which causes paralysis of all movements except eye movements, together with an inability to speak or swallow, yet preserves cognition, would be considered by most as a hopeless illness. Multiple Sclerosis is a permanent, progressive illness, incapable of improvement and causing severe effects which result in intolerable suffering that cannot be alleviated. These two differ from the terminal nature of cancer as they have no particular time frame. They are both capable of causing suffering over a prolonged time, particularly if intensive treatment is provided. In mid-brain stroke, the provision of tube feeding may prolong life as a hopeless illness for an indefinite time.

It must be emphasized that a critical characteristic of hopeless illness is intolerable suffering. For example, many people find the earlier stages of MS tolerable. Stephen Hawking finds the advanced stage of MND tolerable, because his extraordinary mind, through which he lives, is unaffected. For him, the illness is not hopeless, but for most mortals, it would be hopeless. Thus the characteristics of a hopeless illness are:

- (1) permanent with no chance of recovery, and a remorseless progression
- (2) severe illness causing significant unremitting symptoms
- (3) no characteristic time frame
- (4) close association with intolerable suffering
- (5) no effective and acceptable treatment to ameliorate the suffering or to alter the course of the disease.

Thus hopeless illness could be defined as *an incurable illness of certain permanence or inevitable progression, whose severity causes intolerable suffering that cannot be relieved by treatment that is acceptable to the sufferer.*

It is clear that the worst hopeless illness will have the longest time-frame. The emotional, psychological and existential components of the illness become more significant the longer it persists. A **terminal** illness may be a hopeless illness, but it is likely to be one of short duration, and the intolerable suffering will also be shorter. A **hopeless** illness can be prolonged by treatment – for example motor neurone disease by tube feeding or artificial respiration. In these situations, the patient may end the hopeless illness by either refusal or withdrawal of such treatment. On the other hand there are some hopeless illnesses, where the treatment can be neither refused nor withdrawn, and if physical pain (as opposed to emotional pain) is not a major symptom, there is no opportunity to utilize the double effect of pain relief

and/or sedation to end the suffering of such a hopeless illness. The only remaining option for relief of suffering is deliberate starvation or dehydration.

It follows that a hopeless illness that is terminal may not cause as much suffering as a hopeless illness that is not terminal. It is the chronic, non-progressive or slowly progressive hopeless illness with little visible, audible or palpable suffering which may be the hardest to bear, but receives the least attention in the euthanasia debate. That is why the debate must be about **hopeless** rather than **terminal** illness.

Rodney Syme- VESV President

From VESV REPORT July 2002

VESV AND SUICIDE

The purpose of the Voluntary Euthanasia Society of Victoria Inc. is to secure legal reforms that would allow people who are hopelessly ill to determine, either directly or through their duly appointed representatives, the nature and time of their death. The reforms that VESV are seeking involve safeguards that are intended to prevent unilateral mercy-killing and the hasty or irrational killing of oneself.

In seeking these reforms, VESV is asserting that there is a right of choice in end-of-life decisions, and is advocating the legislative delivery of that right. However, VESV does *not* advocate suicide as such, either generally or in any individual case, and none of the material it produces should be construed as doing so.

Anyone who feels that they are hopelessly ill needs to give a great deal of thought to their end-of-life choices. They need to be quite sure that they have been properly advised and that they understand the nature and prognosis of their disease and that they are making a rational decision. They need to involve their family in all the issues, and to feel quite free of all duress from their family or carers. VESV urges anyone who may be contemplating the imminent end of their lives to seek the best available advice and support.

From VESV REPORT February 2002