



## DR RODNEY SYME RALLY ADDRESS: PART I

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### Given at the Steve Guest Day rally, 20<sup>th</sup> June 2007

Thank you all for attending this rally to honour and respect Steve Guest, and his courageous advocacy for choice and dying with dignity over the last two weeks of his life.

On July 11 2005, he phoned Jon Faine on ABC radio and told him he was dying. Jon was astonished and the usual 1 minute talkback call lasted ten minutes, and listeners swamped the station in response.

I was first aware of Steve when I responded to his phone message that evening. After talking to him for over 30 minutes, I felt compelled to visit him at his Point Lonsdale home the next day.

Steve was 59. His first symptoms were about twelve months earlier when he noticed difficulty swallowing. He underwent an operation three months later—cancer of the oesophagus was causing obstruction to swallowing, and was so advanced it was infiltrating his aorta and chest wall. The cancer could not be removed so the surgeon placed a tube into his stomach through which he could feed himself. Subsequent chemotherapy and radiotherapy produced no benefit. He lost 35 kg over the next nine months.

Steve was being given excellent care by his GP, and support by his family and local community. His very significant pain was being controlled to a reasonable extent by liquid morphine, but he described its effect as like a 'shot of lead in the brain'. It impaired his ability to think and create. For a while after he took it, it was as though he ceased to exist. While his pain was reasonably controlled, his weight loss and extreme and progressive exhaustion could not be altered. He would very soon be unable to care for himself at home—he would be forced to submit entirely to the care of others. Such a loss of independence was abhorrent to Steve, akin to the loss of cognitive ability due to his medication. These losses, of independence and cognition, form part of what is meant by existential suffering.

But to me his most significant suffering was both existential *and* psychological—he felt he had no control over the end of his life. The circumstances as to how he died were of enormous importance and great meaning to him. He had enormous anxiety, fear, even terror, of losing control, being placed in some sort of care, and merely eking out an existence without meaning and purpose, as his body and mind disintegrated as he was drugged to death.

He had contacted me in the hope of gaining control. I explained that palliative care could provide him with continuous medication by injection of sedatives and morphine—called terminal sedation—that would allow him to sleep through the last days of his life. He rejected that categorically. Such an ending had no dignity for him. I formed the conclusion that the best palliation I could provide was to give him advice about barbiturates, their effects, how to use them, and the dose required. I provided him with medication. Advice without medication would have been ineffective: a Clayton's palliation. It would have meant the abandonment of Steve to intolerable suffering, and I could not do that.

I believed that giving Steve control over the end of his life would dramatically relieve his existential and psychological suffering and improve the quality of his remaining life, and even possibly extend his life. It was the best palliation I could provide for him.

*Dr Rodney Syme  
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