



Member of the
World Federation of
Right to Die Societies

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IN THIS ISSUE:

Vale Steve Guest	1
President's message	2
Proposed name change	2
AMA policy must change	3
Book review	4
EXIT and VESV	4
Federal anti-VE legislation	5
Updating Advance Directives Refusal of Treatment Certificates	5
From near and far	6
They wouldn't treat an animal like this	7
Workshop corner	8
Member Services	8

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With a bang, not a whimper... Vale, Steve Guest

On Monday July 11th, Steve Guest rang Jon Faine (ABC radio 774) full of anger at the hypocrisy of Kevin Andrews and other "God botherers". Steve was suffering from inoperable oesophageal cancer and being unable to swallow, had been fed through a tube inserted into his stomach for nine months.

Thus began an extraordinary 15 day roller-coaster journey for Steve, a truly decent, brave and determined man who decided he would die "with a bang, not a whimper" and that through his dying he would make a statement on behalf of others caught, like him, in terrible predicaments not of their making.

Steve Guest rang me on July 11th seeking help. I saw him next day and we talked for two hours, during which time I got to know him and understand his physical, psychological and existential suffering. He was in pain (barely controlled, and the side-effects of the medication were crippling) and cachexia (severe appetite and weight loss and profound weakness).

Cachexia is a symptom that cannot be palliated.

Of greater significance was his extreme psychological suffering (anxiety, emotional lability and depression) stemming from lack of control over his illness and his future. There was also profound existential suffering (loss of role and meaning in his life, loss of independence and the prospect of a totally undignified future existence and death).

I was impressed that most of his suffering could not be palliated, although advice that would give him control over the end of his life would probably palliate his psychological suffering and empower him to make a valuable and uplifting statement during what time remained to him.

Without hesitation I gave him that advice – it was good medical practice to do so and it would have been inhumane not to. He embraced this opportunity to the full, and his improved quality of life as a result of having had this advice was obvious to everyone who knew him. Through print and electronic media, he also declared it to an audience numbering tens of thousands.

Through his radio interviews over the next two weeks (particularly with Jon Faine) he touched and impressed many, many people.

Steve eventually ran out of energy and died peacefully, securely and with dignity on the 26th of July.

Jon Faine had asked Steve why he would choose to spend his last days going public about his situation, his conviction being that he owned his life and his belief that he had the right to be humanely helped end his suffering if and when he chose.

He replied, "I don't want the issue to die with me."

We owe it to Steve Guest to ensure that his costly and magnificent effort is not in vain.

Rodney Syme

Over the last ten years VESV committees have discussed changing the name of the Society but have never reached agreement on either the need for change or an appropriate new name.

Thirty years ago when VESV was founded, the word "euthanasia" meant both active and passive help to die. Over time, passive methods like withdrawal or non-initiation of treatment have been removed from the debate because they are now in the "acceptable medical treatment" category. With this change, the term "Voluntary Euthanasia" has narrowed in meaning until it is now widely understood to mean the intentional hastening of death by lethal injection.

This has opened the way for our opponents to describe VE as "killing" or "murder".

Our Society essentially represents the original meaning of "euthanasia" which is "good death". We promote everything that contributes to a good death, and support the principles of choice, dignity and the basic human right to die when, where and how one wishes. We believe in the legalization of medically assisted dying, the actual process being determined between the patient and the doctor. It is also our position that self-administration (physician-assisted suicide) is most appropriate in terms of responsibility and safety, and that in practice, it is rarely necessary to consider lethal injection.

Describing our Voluntary Euthanasia Society as concerned with lethal injections misrepresents us, and the committee believes it hinders our effectiveness. In an article at right, Max Sutherland discusses both the reasons for a change of name and for the name we are suggesting.

We welcome your contributions to the discussion.

In planning our strategy for this year, we decided to focus on changing medical attitudes towards medically assisted dying. Until this happens, there will be little pressure on government to change the law. Significantly, the British Medical Association voted to adopt a neutral position to medically assisted dying last month. On the opposite page, Dr. Simon Benson describes our activities, aimed at achieving a similar change in this country.

A third important change will take place at the next election. Changes to the election of the Legislative Council to allow for proportional representation mean that Greens, Democrats and Independents will be elected. These groups are very likely to support legislative change and perhaps introduce Private Members' Bills for medically assisted dying.

Exciting times ahead?

Rodney Syme



Our committee has voted to recommend to members a change of name for the society to be implemented at the next Annual General Meeting of the Society. The recommended name is: **Dying with Dignity – Victoria. Promoting the right to choose.**

This recommendation was arrived at following considerable discussion and evaluation of various alternatives.

Why Change the Name? The committee believes this is a more accurate descriptor of what the society stands for. The label "voluntary euthanasia" triggers a lot of different (and often wrong) associations in people's minds.

The word "euthanasia" triggers associations of gas ovens, death-camps and killing, that can completely overshadow the "and lead to confusion and misinterpretation. It is also associated with the concept of a doctor delivering a lethal injection, whereas emphasis around the world has shifted to medically assisted dying via advice and self-administered medication.

Opponents can be quick to take advantage of this and blur and even misrepresent what we stand for.

To succeed in its objectives, the Society must be very clear in its communications with the public as well as the media and politicians as to just what we stand for and what we want.

What we want is the legal recognition of a terminally ill person's right to exercise personal choice to be able to die with dignity. Surveys consistently show the overwhelming majority of Australians support our cause.

In investigating a new name, your committee looked at what names are used by other similar organizations in the world. Of the 40 member organizations from 23 countries in the World Federation of Right to Die Societies, only Australia and three other countries (NZ, South Africa and England) still retain the word "euthanasia" in their name. This reinforces that we are on the right track in moving to update our name.

Proposed change of name?

Dr. Eduard Verhagen (Dutch paediatrician provoking debate on the Groningen protocol for euthanasia for severely disabled and suffering babies and infants): "They are children who are severely ill and in great pain. It is after they die that you see them relaxed for the first time. You see their faces the way they should be."

A number of these other organizations from various countries use some variation on "dying with dignity" (or "dignity in dying") and frequently also incorporate some mention of the word "right" (or "rights"). The committee believes that the notion of rights in the tagline is important in order for our cause to resonate with younger people as well as older people.

A common characteristic of younger people is the tendency to feel

"bullet proof". Death is not something that resonates personally with young people. But they can readily identify with, and be quite passionate about, protecting the rights of others. Indeed our 2002 survey shows that by the age of 30, more than one in ten have had personal experience where a hopelessly ill close relative or friend wanted voluntary euthanasia.

So there are four key concepts contained in the new name and

tagline: rights, dying, dignity and choice. No name is perfect but your committee believes that this change will enable us to be much clearer in our future communications and enable the society to have more impact – especially with the general public. You will be asked to vote on the adoption of the new name at the next Annual General Meeting of the Society.

Max Sutherland (Committee Member)

AMA policy must change

I am a GP who has joined the Board of VESV this year.

I work in a six-doctor suburban practice with a broad range of patients of all age groups. My work includes about six hours per week looking after residents of aged care nursing homes.

This gives me considerable exposure to death and dying, and from time to time I am faced with the situation where someone wants to call an end to their life, generally in very reasonable circumstances.

Times like these make me wish that I had trained as a vet, for whom this situation would not be a problem. Their patient could quietly and comfortably have its life ended.

For me the situation is very different.

I can explain the position clearly to the person asking for assistance, but I am not able to offer any real assistance. I am legally able to withdraw treatments on request, and to provide sedation and pain relief, but not to grant the patient's request to end their life. I am able to feel sorry for them but not able to do much about it.

I am also a member of my professional organisation, the Australian Medical Association (AMA). The AMA currently has a policy of opposition to any active involvement in euthanasia or in assisted suicide; I do not agree with this, and I believe a majority of both doctors and AMA members also disagree with it.

I consider it is very unlikely that we will get legislative change on euthanasia/assisted suicide while Australia's pre-eminent doctors' organisation holds a policy of opposition to it.

The Federal AMA has resolved to review its "Position Statement on the Care of Severely and Terminal Ill Patients" in 2006. VESV has been in contact with its sister organisations in all states to co-ordinate action by AMA members who are also members of a right to die organisation to write letters and attempt to get motions put forward, to move the AMA's policy to one of neutrality on the subject, as has recently happened with the BMA in the UK.

I have no doubt that this will also happen here – eventually – but I would like to see change sooner rather than later. I do not want to continue to see too many more patients end their days wishing they'd already died, and just waiting and hoping that their end will come soon.

And when the time comes I certainly don't want this to happen to me.

Simon Benson

\$\$\$\$SSS Help VESV save costs!

Our Voluntary Euthanasia Society of Victoria is a non-profit organisation funded entirely by member subscriptions and donations.

•
For each communication that is sent out to members, we incur paper, printing and postage costs. You can help the Society reduce these running costs by choosing to provide us with your email address for most communications.

•
If you would like to help save costs this way, please make sure we have your current email address. If you are unsure as to whether we have your current email address, simply send an email to us at vesv@vesv.org.au

•
Put your name and address in the body of the email. In addition, please indicate how you would like to receive your copy of the quarterly newsletter by typing one of the following three options into the Subject field of the email:

•
Newsletter by **email** only, please
Newsletter by **post** only, please
Newsletter by both **email and post**, please

We sincerely appreciate your support.
Rodney Syme
President

In Australia, Philip Nitschke is a household name. Anyone who has not spent the last few years hiding under a big rock knows Philip Nitschke as a passionate and, some would say, controversial defender of the "right to die".

"Killing me Softly" is written jointly by Philip Nitschke, a medical practitioner, and Fiona Stewart, a medical sociologist.

As Nitschke acknowledges, Stewart played a crucial role in the production of the book: "Fiona took a jumbled mountain of half finished papers and ideas and turned them into this book. It wouldn't have happened without her." But the result is very much Nitschke's book.

Written in the first person singular, it is a chronicle of Nitschke's work and a testimony of Nitschke, the man.

Nitschke is often painted by opponents of voluntary euthanasia (VE) as a somewhat sinister "Dr. Death" but the first chapter seeks to set the record straight. In chronicling Nitschke's life from his birth in 1947 to the present, it portrays an intelligent, goal-determined person who, rather than being driven by weird desires, is motivated by a strong sense of justice and personal responsibility.

Because VE is not a lawful option, many patients die in ways abhorrent to them, suffering more than they are willing and able to bear.

Besieged by large numbers of people seeking help and advice, and convinced that it is wrong to deny the hopelessly ill the right to die, Nitschke has devoted the last decade of his life

to finding a way of giving people that right.

There are two basic ways in which this might be done: firstly, by working towards law reform, which would allow terminally or hopelessly ill individuals access to direct medical help in dying; and secondly, by providing individuals with the practical means to end their lives, without the assistance of doctors.

The remainder of the book makes clear why Nitschke has increasingly moved from being an advocate for the first position to being an advocate for the second.

Given that strong conservative forces (what Nitschke and Stewart call the "Unholy Trinity" of Medicine, Law and the Church) have so far thwarted all attempts at law reform and are likely to do so in the near future, Nitschke now seeks to develop the means (drugs and mechanical devices) that will allow individuals to act for themselves.

Technologies such as Nitschke's "Peaceful Pill" and the "CoGenie", might one day be effective in providing a peaceful death, but any DIY approach also has its limitations. Unless people wanting to end their lives can enlist the help of others, some, (among them the sickest and weakest), will miss out.

And yet, Nitschke might reply, isn't it better that some, rather than none, have access

to a peaceful death?

Then there is the question of possible abuse. Many people think the possibility of abuse is a knock-down argument against Nitschke's DIY approach.

But this, a defender of Nitschke's position might argue, is overly simplistic – it looks only at merely possible harms and ignores actual benefits – the benefits DIY technologies bring to those who are no longer forced to die in pain and suffering. Moreover, might it not also be the case that the very way in which DIY technologies cir-

cumvent and challenge a law long overdue for reform will act as a powerful catalyst for that very reform?

But "Killing me Softly" is not a philosophical or legal tome. Rather, it is written in an easy, almost chatty style; it is rich in insight, brims with case histories and historical anecdotes. It constitutes not only an important chapter in the history of the Australian right-to-die movement but, typeset in big print, it is also a thoroughly good read.

Reviewed by:

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Centre for Human Bioethics,
Monash University.

**Philip Nitschke and Fiona Stewart:
Killing me Softly: Voluntary
Euthanasia and the Road to the
Peaceful Pill.
Penguin Group, London, 2005.**

EXIT and VESV

In this newsletter, VESV is distributing a flyer re EXIT's conference in Brisbane.

We are happy to do so, as these conferences are valuable and VESV is contributing to this one.

Nevertheless, it is known to some that VESV and EXIT have somewhat different agendas.

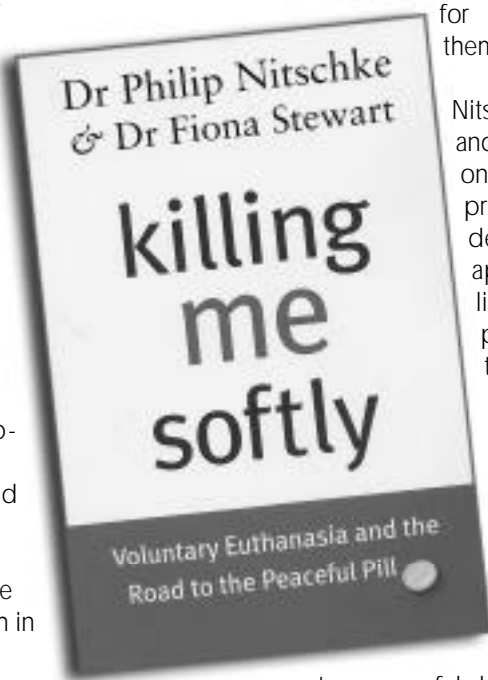
VESV is committed to law reform through public dialogue and argument with government. Our emphasis is on medically assisted dying with strict safeguards in specific circumstances. We recognize the difficulty in achieving this, but are optimistic that it will occur.

EXIT is also committed to law reform, but is pessimistic about it happening soon. Meanwhile, many people seeking assistance in dying are deprived of a dignified death.

EXIT wishes both to help these people and to push the envelope on assisted dying by developing a "peaceful pill" that would give people direct control without the need for medical surveillance.

This is a direct confrontation to government, and is perhaps why recent Federal legislation has been created.

Next Page....



VESV does not support the "peaceful pill" in principle, particularly because there is no current process to prevent it being abused.

We are sensitive that many of our members are anxious to have the control over their lives that this "pill" would theoretically bring.

That is why we provide personal advice to distressed members.

Two points need to be made. Firstly, that the "pill" places EXIT in direct conflict with government, and governments do not negotiate from positions of threat.

Secondly, the benefit gained from assistance in dying by an older person would be completely negated by the untimely suicide of a young, healthy, psychologically distressed person who

gains access to the "pill".

I believe there may be benefit in these two organizations following different paths and bringing different sorts of pressure into the debate.

This can be achieved by tolerance and cooperation.

Rodney Syme

Federal Anti-VE legislation

On 23rd June, 2005, the Criminal Code Amendment (Suicide Related Material Offences) Bill 2005 was passed by the Federal Parliament after quite a prolonged community and parliamentary debate. Although this is a thoroughly unpleasant and unnecessary piece of legislation, there has been much exaggeration as to its effects.

The Bill creates offences for the display of explicit material on how to suicide on a "carriage service" (which means via a computer, but also includes use of telephones and fax).

Let me quote from the explanatory memorandum for this Bill.

"These offences are not intended to capture Internet material that advocates or debates law reform on euthanasia and/or suicide related issues. Accordingly, the relevant subsections only apply where the person intends to use the material concerned to counsel or incite suicide, or to promote or provide instruction on a method of committing suicide. A person is not guilty of these offences merely because the person uses a carriage service to engage in public discussion or debate about, or advocates reform of the law relating to euthanasia or suicide."

Unfortunately, and perhaps deliberately, the language of this Act is so obtuse that a sensible person would find it very difficult to understand what it means. I cannot help feeling that this legislation is meant to obfuscate and intimidate – in practice, I believe it will be very difficult to prosecute anyone through this legislation due to the necessity of proving intention. However the threat of prosecution and the cost of defence will be powerful weapons for Senator Ellison and his religious backers.

The aim of the legislation is to prevent web-sites from providing specific "how to" information with regard to suicide.

As a doctor, I do not object to such an aim. While I do believe that individuals, after careful consideration of their situation with a doctor, should be able to receive information, and if necessary, medication from that doctor, I do not believe the same information should be available to anyone, regardless of context.

Placing explicit information on a web-site runs a high risk that it may be used by someone to suicide in circumstances that most people would consider regrettable.

Unfortunately, the Act includes communication by telephone or fax, but interestingly, not by letter or directly.

It has to be proven that the use of the "carriage service" for information is done with the "intention that the material be used by another person to commit suicide".

VESV does not use its website to carry any specific information as to how to suicide, and while I am President it never will. It is essential that such information be given only in the appropriate context and through a personal relationship.

VESV members are in no danger from this legislation, and this legislation will have no significant influence on the affairs of VESV.

Rodney Syme
President

UPDATING ADVANCE DIRECTIVES

During recent debate about advance directives, the President of the Victorian AMA made the rather fatuous comment that a 30 year old AD might not be reliable.

It is fatuous because it is such an extreme example, but nevertheless it highlights the sense of keeping your AD relevant. I believe it would be sensible for those who are well to reaffirm their AD(s) on a regular basis, say every 2-5 years, perhaps relating the frequency to age.

The older you are, the more frequently it should be reviewed.

However, for those who are diagnosed with a specific illness with the potential to cause death, it would be wise to reaffirm the AD in the light of this illness. If that illness is clearly progressing and is likely to cause death, it would be very important to reaffirm your AD.

No one could then claim that it did not represent your current view.

COMPLETION OF REFUSAL OF TREATMENT CERTIFICATES

Once you have been diagnosed with a terminal illness (a "current condition"), you can ask your doctor to complete a Refusal of Treatment Certificate, if you do not want any specific or general treatment.

This effectively creates a cast-iron guarantee, rather than the vagueness of a verbal agreement.

Next page...

On that certificate, you can also ask for **"maximum relief of pain and suffering"**. If that is not provided, you and your representatives have valid grounds for complaint to the Health Services Commissioner or the Medical Practitioners Board of Victoria against the doctor.

Alternatively, if you have been diagnosed with a severe but slowly progressive chronic illness (one that cannot be regarded as likely to be fatal in a foreseeable time), you can also complete a Refusal of Treatment Certificate in which you refuse treatment for a complication of a chronic illness (e.g.

for a stroke if you suffer from hypertension, or antibiotics for a chest infection if you have chronic respiratory disease or dementia), and you can (we would suggest **MUST**) request **"maximum relief of pain and suffering"**.



from NEAR and far

Columbia

Predominantly Catholic Columbia has been permitting the terminally ill to choose to die.

An opponent of euthanasia tried to block the practice by an appeal to the Constitutional Court. The court decided by a vote of 6-3 that an individual has the right to choose and that a doctor should not be prosecuted for assisting.

This has been the situation in Colombia since 1997.

A Doctor Quintana has assisted in several cases and has described how he agreed to assist a young man dying with widely spread cancer.

The death certificate listed heart failure as the cause of death.

In 1997 the Court suggested that some guidelines similar to those used in the Netherlands be established but in the past eight years nothing has been done. Now one of the determining magistrates has become a senator and will introduce a Bill to provide guidelines.

It will be interesting to see how this will be framed, given that the highest Colombian Court has already allowed choice.

United Kingdom

In an earlier report Lord Joffe was proposing to introduce legislation in the Lords along the lines of the Oregon (US) law which allows doctors to assist suicide by supplying information and prescriptions.

Lord Joffe's Bill lapsed with the election but he will re-introduce it. Meanwhile clarification of meanings and discussion of attitudes to the issues continues.

Before the annual meeting of the BMA, various branches discussed the issues, calling for more debate (Manchester), a neutral stance (Oxford) or support for assisted suicide (Brent and Islington). The Colleges of GPs and Physicians had previously adopted the neutral stance. However after protests from doctors the College of GPs reinstat-

ed their opposition.

At the annual meeting of the BMA the conference called for opposition to euthanasia and assisted suicide to be dropped and a neutral stand was adopted. Appropriate safeguards which were suggested by delegates included measures to ensure that patients were not being pressured and that individual doctors could decline to be involved where they had objections.

There were calls for better information for patients on the availability of palliative care.

These same issues arose in Victoria before our Medical Treatments Act and must always be considered. Doctors would prefer the option of assisting suicide over active participation.

The BMA result is being seen as showing increased recognition that the choice to die is a social question to be determined by the public.

For many years polls have shown public support for the choice to die, so this may be seen as progress.

France

After a five year enquiry, a French Tribunal found insufficient grounds to prosecute a doctor who had prescribed cocktail comprising an opiate, a tranquiliser and a sedative, which he admitted could have contributed to the lethal process.

However, he explained that his intention was to "attenuate the suffering" of his patients.

The judge concurred, stating that "The inquiry has shown that, far from engaging in the practice of criminal euthanasia, the doctor has in reality inscribed his action in a process of palliative care for all the patients in terminal phase for which he was responsible".

Legal hypocrisy or pragmatic good sense?

USA

In 1994 voters in Oregon, USA, passed a law that allowed people with life expectancy of less than six months to get a lethal prescription if they followed a specified procedure.

This law took effect in 1998, and since then more than 200 people have used it.

On 4th July, a similar bill in the Californian Legislature was withdrawn from the House as it was expected it would be, with only 33 of the 41 votes required.

It was introduced by Patty Berg and Lloyd Levine.

The opposition was mainly from the Catholic Church, its social organizations and Latin American residents. Their opposition was based on the religious argument that life is sacred no matter what.

However, a poll showed that 70% of Californian residents supported the bill, although the opposition disputed this figure.

Berg and Levine plan to resubmit the bill next January, and meanwhile campaign actively to get overwhelming public support. Berg is herself a Catholic; but believes that the question goes beyond political or religious affiliation.

She believes it is only a matter of time, and this will have to be recognised.

Switzerland

Assisted suicide; but not active euthanasia, is legal in Switzerland. This has led to so-called "suicide tourism" and the country has one of the highest suicide rates in Europe.

The number of people using it in 2003 was 2000. This has led to some concern that the country might get the international reputation of a world suicide centre, and a call for tighter regulation on how euthanasia is carried out, and on whom.

The Swiss parliament is considering a new law to control this. Under it the mentally ill or those with psychological symptoms should not have access to euthanasia, nor should those suffering from purely financial or social problems.

Also the groups administering it should work under strict regulations.

"They wouldn't treat an animal like this"

Alan Rusbridger describes his father's final days "clouded by his growing pain and sense of betrayal" and asks, must it be this way?

We all have fantasies of how we'd like to die. A soft trickle of Mozart, a haze of distant hills, a circle of closest friends and family around you. That, I guess, would do for most of us.

We also have firm feelings about how not to die. For myself, I would rather not die as my father recently did.

My dad was 96 and when the time came, was unsentimental to a fault. He'd had a good innings, he didn't want to waste anyone's time. To the kindly doctors and nurses assembled around his bed he spoke warmly but firmly.

"You've got much more important priorities than keeping me going," he told them. He chose the euphemisms of his generation, but his meaning was crystal-clear: he wanted them to end it for him.

I felt obliged to intervene on the doctors' behalf. "I'm not sure they can do that, Daddy," I told him. The doctors smiled knowingly and nodded agreement. My father grew irritable at their failure to understand. I did my best to argue on the side of medical reason.

But, actually, I think my dad was right. The coming days, our last precious time together, were clouded by his growing pain and sense of betrayal. He blamed me and my brother for our failure to persuade the doctors to carry out his wishes.

Instead of tranquillity there was bitterness and bewilderment.

"They wouldn't treat an animal like this," he groaned each time the ulcers in his leg threw his whole body into spasm. He was right about that, too.

It was not quite the script the consultant had gently outlined just over two weeks before my father eventually died. He had set out the options: amputation of his remaining leg or letting nature take its course. "Nature" meant anything from severe ulceration to gangrene as the circulation in his "good" leg packed up. It could be days, or it could be weeks.

We were not to worry: they could control the pain.

My father was quite clear he couldn't face another amputation. So it was simply a matter of nursing him to a quiet, dignified and painless end.

But they were wrong about the pain. My father was, so far as we could tell, quite often in agony. And my brother and I were placed in the awkward situation of begging, cajoling and in the end, demanding that he be given ever higher doses of morphine.

Different members of the medical team appeared to have different views about what was an adequate or appropriate dose. The night team countermanded the day team. The palliative care team didn't work week-ends. At one point my father weakly changed his mind.

He couldn't take this pain any more: perhaps he should go ahead with the amputation. But, of course, by now he was too frail for an operation.

This logic drove him into furious exasperation.

I had a tense conversation with one Macmillan nurse to whom I had suggested raising the dose of morphine. "We have ethical and legal difficulties with sedation," she sniffed.

"I'm not asking you to sedate him," I replied. "I'm asking you to do what he was promised; to be allowed to die without pain."

"But if we gave him a higher dose he would fall into unconsciousness," she said. "And then we couldn't tell if he was in discomfort or not."

Eventually he did fall into a deep sleep and we asked that the medical team remove the drip which could have only prolonged it. A nurse explained that, effectively, he would die of dehydration. There would come a point when his internal organs would pack up.

My brother and I visited every day, spending hours by his bedside. But, as luck would have it, the dehydration finally took its course at a time when neither of us was there. So my dad died alone.

I assume everyone involved in my father's last few days behaved as they had to. But I would defy anyone to call

his ending a "good" death, or even a particularly ethical one. Why is withholding nourishment and treatment as an old man withers away from dehydration more ethical than intervening to help him die at the time and in the manner of his choosing?

Were I ever to be faced with the same situation, I would like to have an option denied to my father. I would like to choose, well, Beethoven actually, then bid farewell to friends and family and ask that I might gently drift away under a general anaesthetic, followed by whatever would stop my heart as swiftly as possible.

It seems, from the current debate within the medical profession, that a good many doctors would be willing to help, if only they could do so without fear of prosecution.

Isn't it time we let them?

Reprinted, with permission, from
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Education & Membership

One of VESV's major roles is public education about medically assisted dying.

We have done this over the years by providing speakers to many organizations and institutions.

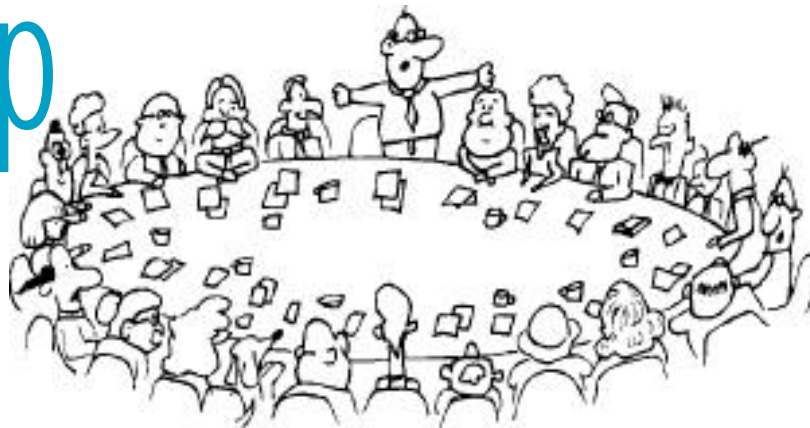
It is also through such opportunities that VESV can expand its membership, a constant necessity.

We have spoken to groups such as Rotary, Lions clubs, RSL branches, U3A, and Probus.

We are advised that even bowls clubs and other social groups are often interested in speakers.

If you belong to such a group, see if you can interest your committee in the idea of a talk on end of life issues.

Workshop CORNER



OUR NEXT WORKSHOP
is planned for
MONDAY 19TH SEPTEMBER 2005
at 10AM AT NORTHBROOKE HOUSE, High Street Malvern

VESV RUNS regular workshops on the subject "How to choose and achieve a dignified death".

These run for about two hours, and deal in depth with the Medical Treatment Act, refusal of treatment, appointing an agent, advance directives, palliative care, pain relief and sedation, and medical practice and the law.

They are limited to groups of about twenty to allow dialogue and interaction. They emphasise the importance in end of life situations of preparation, understanding and communication. Many members have attended these workshops and both enjoyed them and learnt much.

If you would like to attend a workshop, ring Rowena at the office for details. Friends who may have an interest or need advice are welcome. It is an excellent way of developing membership.

We are currently compiling a list of names of people interested in attending the workshop proposed for 19th September 2005

Comments from attendees at the VESV Workshop held in Cowes on the 28th May:

1. "Yes it was very informative and helped make a lot of issues much clearer for me. Particularly how to make my desires for my death known and how to inform my family"
2. "Extremely useful from all points of view but especially in laying out the options available under the law, and in emphasising the need to plan and communicate"

To reserve a place in upcoming VESV workshops

telephone:

Rowena Moore

Office Manager

Voluntary Euthanasia Society of Victoria Inc

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MEMBER SERVICES

VESV was formed over 30 years ago to give people the right to choose dying with dignity. To achieve this in full measure requires legislative change. We have worked to achieve this without ultimate success (but with some small victories along the way). During this time, significant legislative change has been achieved in only three jurisdictions (the Netherlands, Belgium, and Oregon). It is not an easy thing to achieve.

Most of our activity involves education of individuals, politicians and the public, but also in providing advice and assistance to our members and the public. Many of our members are relatively young and physically well – they have no immediate needs for advice or assistance but they may wish to make preparations for the future. Others have more immediate needs. Both groups can obtain information and assistance from VESV.

Our member services are as follows:-

(1) Provide and explain documents relative to the Medical Treatment Act, such as Medical Enduring Power of Attorney, and Refusal of Treatment Certificates (competent and incompetent).

- (2) Develop and provide advance directives (living wills) for a wide range of situations.
- (3) Provide workshops for groups of 15-20 people to discuss the Medical Treatment Act in detail, explain advance directives, and to help understand palliative care and medical practice at the end of life.
- (4) Provide books such as "Final Exit" and "Departing Drugs" that give specific advice about ending life with dignity.
- (5) Provide individual counselling from independent advisors for people with specific problems at the end of life.

It distresses me greatly when I hear of a VESV member who has had a bad death but who has not sought advice from us.

Circumstances may mean there may be little that we can do on some occasions, but experience tells us that being able to discuss the problem with an experienced person is usually of value.

So please get in touch with our office if you have a problem – we can probably be of help.

Rodney Syme

