Five Last Acts

Chris Docker

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The safe and dignified ways that people use to end their own lives when faced with unbearable and unrelievable suffering

Chris Docker

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'The chloroquine controversy'
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Dedicated to Virginia Woolf, (1882 – 1941)

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Foreword

By David Donnison and Kay Carmichael

Readers in the pride of their youth may wonder why anyone would write a book about methods for killing oneself. Well, here's why.

A hundred years ago, when death approached, three-quarters of our people would be lying in their own beds, close relatives nearby, and visited occasionally by friends, a nurse or a doctor who could do little more than make the patient as comfortable as possible. Later, their bodies would be laid out and the neighbours would come to pay their last respects. Death was a domestic event; its timing decided by nature.

Today, three-quarters of us will die in hospitals or other institutions, surrounded by strangers and tended by people in white coats with the technology to keep us alive for long periods. Death has become – and will increasingly become – a medical event; its timing often decided by doctors.

Patients are increasingly demanding that their voices be heard when that decision is made. Armed with information from the internet about the likely course of their diseases, supported by pressure groups speaking for the people who suffer from these diseases, and more prepared than their grandparents were to take legal action to enforce their rights, their voices are indeed more often heard. Doctors are less tempted to act as 'sage on the stage', seeing themselves more as 'guide on the side', helping patients to make their own decisions so far as nature permits.

If you want your life prolonged as far as possible, the doctors can do their best for you. But if you ask them to help you bring it to a decent end you will run into all sorts of legal and professional obstacles.

Assisting a suicide is a crime which may get professionals struck off. Middle-class patients, with doctors among their close friends and relatives, often get help in drawing things to a close. But too many people find themselves helpless victims of pain or humiliating dependence on strangers, watching their loved ones buckle under the burdens they unwillingly lay on them. Meanwhile many more fear this may become their fate.

So it's not surprising that, for years, every survey of the British has shown that large and growing majorities of our fellow citizens – now about 80 per cent – would support the legalisation of voluntary euthanasia in the kinds of cases most of us would regard as reasonable – subject to the safeguards that more civilised nations like the Dutch have worked out to protect us from unscrupulous relatives and people like Dr. Shipman.

But politicians, who were prepared to introduce family allowances, abolish the death penalty, take us into Europe and into the Iraq disaster – all widely opposed by many of their people – are not prepared to accept the views of this massive majority. That's probably because well-funded and strident spokesmen of some faith groups oppose such a reform; and because the dead and dying have no votes.

Stuck in this impasse, a small but growing number of courageous patients, their carers and doctors, are going to the courts to seek permission for one form or another of assisted suicide. Some succeed and some fail – but all have to go through a ghastly process in a public arena that was never intended to deal with such complex, personal and painful issues. Eventually, one of the Parliaments or Assemblies of the United Kingdom will enable doctors to respond more humanely to patients approaching the end of their lives. Perhaps the Scottish Parliament, already innovative in so many ways, will give a lead?

The argument for a legal, civil right that enables people facing intolerable circumstances to gain professional help either to prolong life as far as possible or to bring it to an end has long been won. The opinion polls repeatedly show that. While we wait for our politicians to gain the courage to respond to that majority we are morally entitled to find an exit for ourselves in ways that are as secure, painless and dignified as possible.

For that, no-one is better equipped to help than Chris Docker who has won widespread respect for the work he has done on this question for over fifteen years. This book brings up to date his publications of earlier years for which many people have been grateful. Even if they never feel the need to use his advice, his readers will be better equipped to discuss in a relaxed and rational way the decisions that have to be taken towards the end of our lives.

David Donnison is Professor Emeritus in the University of Glasgow. He was Convener of the Voluntary Euthanasia Society of Scotland, and took a leading role in the biggest opinion survey on euthanasia yet made in Britain[1].

Dr. Kay Carmichael, writer, broadcaster and social worker, has also played a leading part in the movement for legalising voluntary euthanasia.

[1]Donnison D, Bryson C, Matters of Life and Death: Attitudes to Euthanasia, in: Jowell R, Curtice J et al (eds), British Social Attitudes 13th Report, Dartmouth 1996:161-183

Introduction

Death is the big unknown. Several ancient civilisations based their whole culture on trying to be as certain as possible about death, to cover all the possibilities when the moment arrived. From this they developed a psychology of dying which also gave them insights into living.

The advance of medicine gave greater life expectancy but also, in many ways, made death a more complex affair. With prolongation of life came uncertainties about living on into an intolerable state in the period before dying. In a society where individuals are accustomed to be able to exert control over their lives, these very uncertainties are unwelcome. The sense of control is something we cherish as our power to do nearly everything else slips away from us. We may live to be a hundred or more, and die peacefully in our sleep, but if it should it not go that smoothly we want to know what to do about it.

Why this book?

There is a consensus among ethicists and the law for exceptional cases, that when life starts, and a child has no prospect of any enjoyment of life whatsoever, it would be cruel and inhuman to continue. (In all other cases we strive for life.) For instance, for an infant that cannot speak, taste, see, has zero chance of improvement or adulthood, and is entering a world where pain will be its only experience: we allow that life to end.

At the end of life things may not be so simple. Palliative care is so advanced in the developed world that most pain can, given the right drugs and equipment, be controlled; but ability to control pain is not 100%, and neither is ability to control distressing and degrading symptoms. Our right to life and our desire for life is so strong that we need extreme circumstances to convince us it should end.

When it is a child's life, a doctor has to decide, using the most stringent – if arbitrary – rules to make that decision. In the case of an adult, that competent individual is the only one who can decide, but the law ties their doctor's hands. Simply stopping treatment will not necessarily result in death. The law in most countries does not allow a medical person to provide a kind, reassuring and safe injection, on request, to draw the final days a close, even with suitable safeguards. This leaves the person with the more complex option of taking matters into their own hands. Failure can bring even more suffering to an already unbearable situation. If someone has rationally decided to end their life a little earlier, in the face of unbearable and unrelievable suffering, is it not a blessing if they can do so without further unnecessary pain? This book does not encourage anyone to take that final decision. But if the decision is taken, it aims to provide the most scientific knowledge available by which further unnecessary pain may be avoided. Experience has shown that having this knowledge will often give people the courage to face misfortune and live longer.

The 'least worst options' explored in this book should not be put into effect before all other possibilities have been examined. Palliative care is continuously changing and should not be discounted simply because you knew someone it failed to benefit some years ago or with different ailments. On the other hand, it is counterproductive to leave all but a skimming through of the text until the last minute. The book holds an escape route, a key to a door marked 'exit', a way out. Like many journeys, considerable planning and familiarity with the route, the accessories you will need, back-up plans and so on, are all sensible precautions.

"What is the best method?"

This is a question I have been asked many times, especially at the workshops around the country demonstrating the techniques explained in these pages. My answer is always the same: "It depends." My

preference is to have access and familiarity with *at least* two or three methods: it is much harder to learn how to use them successfully if you leave it until you are already ill, but the point often overlooked is that *your circumstances may change* before you seriously want to end your life. Your mobility may be affected; you may or may not be hospital- or nursing-home-bound; you might otherwise find yourself not at home with all the equipment you planned on using; or someone may have discovered your drugs cache and removed it.

Hopefully none of these things will happen, but do you want to chance your luck? To be as foolproof as possible, the best planning will probably take the unexpected into consideration – that way you are easily within your abilities, not stretching them or putting all your eggs in one basket. Rather than just choose a method you like 'best' – you might decide the wisest course is to study them all and master as many as you can. Then you can practice (safely) until you *know* what you would do – and without referring to this book! When you have that secure knowledge, even if you never use it, you will have gained something that is of inestimable value: being in control.

Make it part of a big picture

Focussing on the act of ending one's life alone makes it all too easy to overlook essential details. You're driving a brand new car on a clear road at 70 miles and hour and everything's fine. Suddenly there's a downpour. You realise too late that the controls for the windscreen wipers are not where they were on your old car. You manage to get the car under control and onto the hard shoulder.

It might have been different. There might have been a passenger who could have pointed out the relevant switch. (They might also have felt traumatised until everything was ok!) Things don't always happen the way we plan them. The section on moral and legal issues is based on many case studies – real life examples. It highlights some of the not

uncommon contingencies. Examples where all the planning, confidence and foresight had to be modified rapidly at the last minute with potentially serious consequences, either for the person ending their life or for their nearest and dearest. By taking the time to get into a habit of thinking through these and similar scenarios, you can avoid problems at the most critical time in your life – your death.

You might want to consider making it as if it were a memory, something you could imagine looking back on. For those that you leave behind, the memory of everything you did in your life (including how you died) is the most valuable thing you can give. In your own mind, write your own life story, continuing the story up to, including, and after your death. Fill in all the details you want, include all the wonderful things. From that vantage point, look back along your timeline at the various endings and possibilities, the possible causes of death, last chapters, conceivable last acts, how you handled it. Are there any details in the final scenario you want to change? When all the details are as perfect as you can make them, return to the present. Make a clear picture of all the things you need to put in place so that, whatever eventuality should arise, you can take your last curtain call with dignity, so that it fits your life story.

The English language, for all its richness, doesn't really have a suitable word to denote suicide that is the result of a careful and rational choice in the face of unbearable suffering. The phrase 'self-deliverance' has long been used in Scotland, and is used frequently in this volume.

Finally, my apologies in advance for any shortcomings, whether of layout, typos or omissions. Time and cost were limiting factors.

Chris Docker
M.Phil (Law & Ethics in Medicine)
Director, Exit

Five Last Acts
is based on the EXIT Self-Deliverance workshops and accumulated research.

My thanks to all the people who helped directly or gave inspiration in the writing of this book, including:

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Is it all right to think about

. . . our own death . . . ?

Since you have made the decision to obtain and read this book, it may come as no surprise that you are about to explore the last taboo. Surprisingly, many people who come to the workshops believe at first they do not need to do this. That if they get the necessary 'recipes' that they can leave any deeper consideration until later. Yet thinking about our own death is not so terrible once you start, and it is *absolutely essential* if you plan to cover as many eventualities as possible.

Perhaps you are glancing through this book while the TV is on or just before you have to do something else. That's fine, but the following section will require your full concentration, so make a mental note to come back to it again when you are undistracted, and with no pressing concerns.

First of all, given that it is going to happen one day, how would you like to die? Picture yourself in the future, shortly before death. What would be your ideal way to go? Probably lack of pain and suffering will feature highly. What else? Suddenly? In your sleep? Picture the circumstances – fill in as many details as possible – where you are, what you can see, hear, feel, touch, taste, even smell. At the end of your life, you are about to experience death the way that you would want. From that point in time, look back into the past, through all the time that has passed since the moment when you read this book. See the things that you did, the preparations that you made, that have put you now in this position of being in control, of knowing that your death will be in a manner of your choosing. It may include some initial periods of uncertainty, areas that you will explore using this book, doubts that you will put to rest.

When you have finished reading the book, you may choose to go back and do the exercise again, to check that there are no 'blank spots' in the knowledge that gave you this feeling of confidence near the end of your life.

Next, I would like to invite you to try imagining different circumstances, one at a time. If you were not, for some reason, to have your 'first choice' preferred death, what would the next choice be? Play the scene out in your mind's eye. Take a few minutes to do it, then clap your hands or stand up to bring you back fully alert to the present moment.

As you gain confidence in the methods outlined in this book, go over the scene carefully, adding difficulties of your own imagination to see how you cope with them. You might want to try imagining that you were hospitalised, or in pain and unable to concentrate well, if you had limited strength in your muscles or if you were taken very ill while away from home or in another country. What are the least worst options? Have you researched the methods outlined sufficiently to manage the situation? After each time you do this exercise, stand up or do something to shake yourself out of that frame of mind. The intention is not to dwell on these things in a morbid kind of way, but simply to picture the situation fully enough to test your plans of action. After learning the techniques in this book, picture the situation again until you are sure you can cope if all else fails and things are pretty bad. Your plan should include all traditional options, including getting a full and balanced idea of your condition (not rushing off at the first diagnosis), knowing how to find (and even demand) the best possible palliative care, but also making sure you can pull the plug and end things yourself peacefully and competently should you decide to do that after due reflection.

Once you become practiced at this, it loses its power to shock and it is not in the least morbid. (People attending the Exit workshops are often surprised at how much good cheer and laughter there is as we get to grips with such serious issues.) More importantly, your sense of confidence grows, and death becomes less frightening.

Death has been called many things – including a journey or an adventure – and if these images or metaphors appeal to you, maybe think of this book as your travel guide . . .

Further reading

- How We Die, by Sherwin B. Nuland (Chatto & Windus 1994) contains detailed descriptions of the stages of various common fatal diseases.

Moral and legal issues

What you need to know in advance . . .

We tend to think that knowing how to end one's life with dignity, to achieve a 'self-deliverance' is all about having the correct formula or technique.

Experience shows that not only do the best laid plans sometimes have to be modified unexpectedly, but often that the idea of acting just on one's own frequently runs into unchartered waters. Self-deliverance can be a fulfilling and very special act, a lasting testament to one's life, or it can be a traumatic experience both for the person at the centre of it and for those left behind.

Wrestling with complicated moral, emotional and legal questions at a time when intense feelings are pressing down on us is not only distressing but can interfere with our concentration and ability to do all that is necessary, especially if one is very ill.

What began as an add-on in the workshops soon proved one of the most popular devices, bringing self-awareness and dramatically improved perspectives. There follow three scenarios. Each one is a composite based on real-life events and draws together key points. If you are skimming through the book at this time, or are otherwise distracted, please make a point of coming back to this chapter to do the exercises with your full attention.

Read through each scenario carefully; then take a few minutes - perhaps with a pen and paper - to write down your thoughts. There are no trick questions about the methods or drugs used - this is purely to focus on the legal and moral problems raised. What should the people

involved have been asking themselves and each other? What are the moral dilemmas? The legal problems? List the key, or underlying, factors as you perceive them, write down the possible courses of action. Who is affected and how? If you need more time, just put your bookmark where you are in the chapter and come back to it.

Scenario One

> A woman is desperately ill. She has a terminal illness and her suffering is increasing and cannot be relieved. She is bedridden and is too weak to effect her own self-deliverance. At first she persuades her ten-year old child to fetch pills for her and help to grind them up but she spilt them and was unable to end her life.
>
> Now she has asked her husband to help. He does not know what to do. He is a prominent person in a small town where questions are likely to be asked. She says to him, "I would do it for you . . ."

You may want to use the space below to jot down your thoughts or maybe use a separate piece of paper.

When you have resolved the problems in your own mind (and bear in mind not everyone's analysis will be the same, and there may be more than one 'right answer'), turn to the notes at the end of the chapter for further questions that may come up.

Scenario Two

> A gay man has decided to help with the suicide of his partner (who is terminally ill, with unbearable and unrelievable suffering) to make sure 'nothing goes wrong.' He knows he is breaking the law but plans to leave the country before anyone finds out.
>
> 1) He helps him study the literature and grind up some tablets and promises to stay with him "till the end."
>
> 2) After taking the tablets, his partner has difficulty positioning the elastic bands to hold a plastic bag in place. Reluctantly, he goes one step further and offers a second pair of hands. All seems to have gone well.
>
> 3) After a short period however, the now unconscious man starts struggling wildly. In tears, his partner tries to restrain his arms, but the unconscious man claws at the bag and breaks it. His partner realises that the only way to complete the act in time will be to suffocate him using a pillow.

You may want to use the space on the next page to jot down your thoughts or maybe use a separate piece of paper. When you have resolved the problems in your own mind, turn to the notes at the end of the chapter for further questions that may come up.

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Scenario Three

> A close friend has a terminal illness with only weeks to live. They are not eligible to apply for the self-deliverance booklet *Departing Drugs* (which requires a three months' membership of Exit and is issued for private and personal use). They know you have a copy and ask you to let them use it.

You may want to use the space below to jot down your thoughts or maybe use a separate piece of paper. When you have resolved the problems in your own mind, turn to the notes at the end of the chapter for further questions that may come up.

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Notes on the moral and legal dilemmas

Scenario One – some points to consider

Presumably she has asked the child thinking that it is too young to be prosecuted. But what of the lasting psychological effects for that child? Is it fair for her to grow up realising that she was the one who unknowingly gave her mother the means to end her life? How is this different from a knowledgeable decision taken by a competent adult?

She says to her husband, "I would do it for you", yet it seems they have not discussed it in times of health - is this emotional blackmail? If the husband is pressured into it, how will that take its toll on him? Are the wishes of the dying person the only ones to consider? What about the feelings of the surviving relatives, who must live with their actions for the rest of their lives. Quite separately from how you judge the action to be right or wrong, how will it affect that surviving person psychologically and emotionally if it was *not* a decision entirely of their own choosing or one that they feel comfortable with.

It is quite possible that he will not escape detection. If he is charged and convicted, it may also affect the child, who could be left parentless. Does this affect the rights and wrongs of the mother's request? Does it affect how he should respond? Who should be responsible for making the final decision on whether to assist, the mother or the husband? Should we view the rights of all the persons concerned equally?

Could the couple have avoided heartache by sounding out each other's views on such a situation at a time when they were in good health? Could it have resulted in them acting differently when the

situation arose? Even if it did not affect the outcome, would it make their emotional relationship different, would it make the decision easier to make, and would it make the decision easier to accept (and for the husband to live with)?

Not all couples share the same views on assisted suicide – some, even when they love each other very much, agree to differ on key issues and having different beliefs is not any indication of less affection felt. How does discussing feelings in advance make a difference? Does it allow a space to 'agree to differ'? Does it also perhaps increase confidence in the future, knowing how one's partner feels and might react, and make plans accordingly?

Over and above the moral question, some couples would be prepared to break the law for each other, some would not. How important is this?

The dying woman had also failed to plan properly – the method she had kept in reserve had its shortcomings and there was no back-up plan. Her 'dress rehearsals' had also been inadequate.

Does this perhaps affect your feelings about mastering several techniques, rather than just relying on one?

Scenario Two – some points to consider

Does the fact that the couple are gay make a difference and, if so, what difference? If they were not openly gay and in a less than tolerant community, could the threat of exposure and the emotional fall-out be a factor? Some gay networks, especially among people with HIV, exchange information on drugs for suicide or even pass on drugs illegally. Could they have relied on unverified information from sources that do not evaluate their recommendations rigorously?

How are the three acts different emotionally? Legally? Is agreeing to grinding up tablets and agreeing to stay with a person while they take them very different to actually taking part physically with the apparatus (the bag and elastic bands) that directly cause the death? The assistance has moved from preparation and passive presence to actively helping to cause death. If it goes as far as holding a pillow over the person's head, the survivor has been the main agent – not in assisted suicide but in euthanasia.

In view of the developments, how competent was the decision to help and how much of it was due to pressure of circumstances? Does the intention to leave the country before discovery indicate a willingness to go as far as necessary or not?

Scenario Three – some points to consider

You have obtained the booklet on the condition that it is for private and personal use, and so are breaking your agreement with the organisation that supplied it – not very important perhaps, you might think, in view of the circumstances. But the agreement is not just there to protect *Exit.* What other reasons could there be?

How long did it take you to absorb the information in the book, and practice it until you were confident. Several readings? Days? Weeks? Perhaps attending a workshop and reading through the newsletter literature as well. Stockpiling drugs. Did you do this in good health when your mind was alert? How will the terminally ill person fare by comparison? Will they take the information in and be able to use it? Or is there a chance that they will make mistakes? If it goes wrong, how will you feel about that?

What about if you help them and it turns out that they were not as ill as they thought they were, but ended their life anyway?

If you give them the booklet, will they be building up their hopes, as if it will give them a simple 'answer' at first glance? If their hopes are then dashed because they cannot apply the information, will they be in a better or worse state?

People's dying experience varies greatly – often depending on the quality of palliative care they manage to receive. The degree of pain and symptom relief can, unfortunately, often depend on how much fuss someone makes and how loudly they make it (ironically, having a television crew on hand, if possible, often guarantees a prompt and high quality response!) If a person puts all their energies into finding a perfect method of self-deliverance – and fails – have

they used up valuable time with which they could have been helping themselves in other ways?

When you have fully considered the arguments as they apply to *Departing Drugs* (which is harder to obtain than *Five Last Acts),* ask similar questions in relation to this book.

The main rationale behind the 'three months' wait' (based on information from several top consultant psychiatrists) is that acute suicidal intentions become less within that time. These are those that come suddenly, usually due to something like the loss of a job or spouse or exam failure – or an initial diagnosis of a disease which may be fatal (but often isn't). If a person is very depressed, they may still feel 'suicidal' after three months but they will probably be less inclined to put the idea into practice. So the three month wait is a safeguard – not a perfect one, but better than nothing. It is a legally binding condition that was written into contract at that time.

The books are purchased without any screening, but the minute that you make a personal decision to give the information to someone who wants to use it, you become personally involved. You also become involved legally. The books are supplied generally without breaking the law. Of the many thousands sold, only a tiny percentage of purchasers use the information to commit suicide. Most people want it as a sort of insurance. There has to be something else that happens between the sale and the suicide that causes the latter event. In Scots Law this is called *novus actus interveniens* (a 'new act intervening'). If you give the book to someone who specifically asks for it in order to end their life, on the other hand, you are directly participating in assisting their suicide and far more culpable legally. You might infer that you are also more liable morally.

The main rationale behind selling *Five Last Acts* without the three months' wait is that, due in part to the restricted nature of sales of *Departing Drugs,* there are many books more readily available that do not give the same information with the same scrutiny and checks. People following poor information are more likely to suffer failed attempts and serious complications. *Five Last Acts* is therefore available without a waiting period. The same considerations apply if you think of passing the book on however. And if you give it to someone with the express knowledge that they intend to use it to end their life in the coming period you have similar legal and moral liability.

Further reading on dilemmas involved in relating to a person who is dying:

- Jamison S, Final Acts of Love – Families, Friends, and Assisted Dying, Tarcher/Putnam Books, NY 1995.
- Jamison S, Assisted Suicide – A Decision-Making Guide for Health Professionals, Jossey-Bass, California 1997.

For an introduction to decision-making analysis using philosophical ethics in everyday settings (without complex philosophical terms!):

- Kallman E, Grillo J, Ethical Decision Making and Information Technology, McGraw-Hill USA 1996.

Practical aspects of dying, for patients, families, caregivers and professionals, including case studies, useful conversations and a decision to stop eating and drinking:

- Lynn J, Harrold J, Handbook for Mortals – Guidance for People Facing Serious Illness, OUP 1999.

For further case studies:

- Battin M, Lipman A (eds). Drug Use and Assisted Suicide, Haworth Press 1966:291-342.
- Ogden R, Euthanasia Assisted Suicide & AIDS, Peroglyphics Publishing, Canada 1994.
- Cases in Biomedical Ethics in: Beauchamp T, Childress J, Principles of Biomedical Ethics (4th ed), OUP 1994.
- Crigger B (ed), Cases in Bioethics, St Martin's Press 1988.
- McLean S, Britton A, The Case for Assisted Suicide 1997 HarperCollins

Understanding health and dying through the arts:

- Downie R, The Healing Arts - An Oxford Illustrated Anthology OUP 2002

For an insight into managing dying by a registered nurse who worked in both the right-to-die movement and palliative care:

- Seguin M, A Gentle Death, Key Porter Books, Toronto 1994.

Other useful references:

- Seinberg A, Youngner S, End-Of-Life Decisions – A Psychosocial Perspective, American Psychiatric Press 1998.
- Docker C, Smith C, et al, Departing Drugs, Exit 1993

Last Acts

The next chapters detail five principal methods. Please become familiar with at least two or three. Reading alone is not sufficient. 'Dress rehearsals' will make you confident by showing up weak points in knowledge or practice ahead of time, so that they can be safely corrected. In the course of each chapter, the material is approached from different angles so that you will have a thorough knowledge of the method. You may be tempted to skip through and just jot down the 'essentials' but this would be a mistake: you will ultimately save time by going through the material methodically and, when it comes to ensuring that your last act in this life is done properly, you will surely find it makes sense to have as comprehensive an understanding as possible so that you can react appropriately to any unforeseen developments or last minute concerns.

Some chapters have a short story or dramatisation to help you visualise the scenario. Research has shown that considering a 'three-dimensional' scene in this way is far more effective at anticipating and solving problems than merely using a checklist of instructions. Please adapt each story to your own lifestyle or circumstances or make your own story so you can picture each stage in some detail. As you never know when things might change unexpectedly, familiarise yourself with all the methods rather than just picking a 'favourite'.

1. Helium
2. Compression
3. Drugs
4. Plastic Bags
5. Starvation and other means

Helium

Story – what you need – main features – general description – what is the evidence for helium? – how quickly does it work? – are there any unpleasant side-effects? – checklist – references & diagram

Frank's story – a typical scenario

Frank had made his preparations well ahead of time. In the garage was a cupboard that was always kept locked. He and Miriam had always had their own hobbies, part of their lives they kept separate, and no-one ever asked what it was that he had behind that door. Miriam knew he believed in 'self-determination', in the right to end life at a time when it felt right . One evening he had brought the subject up over dinner.

"I'm going to this Exit workshop next Thursday," he mentioned casually. He had been a member for many years now. "You have a good day out", she replied. "You might want to stay over – I'm playing bridge that night anyway."

Frank enjoyed the workshop – it was not only a chance to find out the details he needed to know but he was able to chat to like-minded people. The next day, he discussed some of the ideas he had formed with his wife so that she would not be shocked if the fateful day ever arrived. He also wrote a 'last wishes' statement that he could leave in the event of his death, saying how everything was by his own hand and that it was what he had wanted. Then he went on the Internet and ordered what he needed. It was easy to find companies that supplied party balloons and the disposable helium tanks to fill them. He ordered two, just to make sure. Then he made a shopping list – plastic tubing,

some hose clips, a 'T-junction' connector. He checked in the garage to make sure he had a flat screwdriver. In the kitchen were some strong scissors he would use to cut the tubing. The first hardware store he went to didn't have any poly tubing, but the larger one on the edge of town supplied him with everything he needed. It was all in the 'home-brewing equipment' section.

The following week, it was Miriam's turn to play bridge at her sister's, so Frank set aside the evening to put the equipment together and familiarise himself with it. The tanks of helium were quite light and could be lifted with one hand, but they would still need somewhere to be stored, so he cleared out the large garage cupboard. He unscrewed the valve from each tank then checked the tap on each, releasing just a small spurt of gas so he knew how much strength was needed to open and close it. Then he fitted a length of tubing to each – he had bought more than he needed in case he made a mistake, but it was quite straightforward. He connected the tubes from each tank by means of the T-junction – they were a good tight fit – leaving the third opening for the tube that would go to a plastic bag.

When he had been in the store, Frank hadn't been quite sure if the poly tubing he chose would be a good fit for the outlet on the helium tanks. He had bought the diameter of tubing (and matching T-junction) that seemed the closest, but also purchased half a dozen hose clips to make them extra secure if need be.

Frank had obtained a sturdy transparent plastic bag, and he fixed the end of a longer piece of tubing to the inside of it using adhesive tape. This tube was long enough to lead comfortably from head height (when he was seated in a nearby chair) to the T-junction.

Before making the final connection, Frank tested the bag for comfort. He had a couple of sturdy rubber bands which he fitted loosely around

his neck, then placed the bag over his head and tucked the edges under the rubber bands. It wasn't a tight fit – it didn't need to be, as air would have to escape from the bag as the gas pushed it out. He checked that the last piece of tubing, the one attached to the inside of the bag, was plenty long enough to easily reach the T-connection. He also checked he could reach the helium taps from his seat. Then he removed the bag and the rubber bands.

When it came to the final part of his dress rehearsal, Frank knew he must take care. Helium acts very quickly, so he could not open the taps while the bag was over his head and all the tubes connected, but he had gone through all the separate stages. The taps worked fine, the bag was comfortable in use (he particularly liked the clear plastic) and the tubes were all the correct length. He made the final connection, fitting the tube from the bag to the T-junction securely, then carefully pushed the assembled equipment into the garage cupboard and locked it.

Each year or so, Frank would re-read the literature, get the equipment out and remind himself of how he would use it. One year, he found that with advancing age he had less strength in his hands for turning the gas taps. Always keen on gadgets, he and Miriam had a couple of devices for turning taps with ease. The one he liked had a good firm handle with an easy grip. It fitted over any tap (like the small one on the helium tank) and made it easier to turn them. It was easy to get a spare one and keep it the cupboard.

It was some years later when Frank realised the time was getting near. He and Miriam had discussed dying many times and understood each other's wishes. Under English law, even if a person ends their life with their own hand, a loved one cannot be in the room at the same time. On the day, Miriam spent the afternoon walking in the park.

When he was alone, Frank pulled the equipment out and got himself comfortable. It took a bit longer these days as it was less easy to get about than it had been. He had only had a very light breakfast, wanting to leave his departed body in a way that would cause minimum mess. He sat in the chair for a little while, contemplating his decision and with some of his favourite Chopin playing softly in the background. A book of his favourite poetry lay in his lap. He also knew that, although this was the perfect opportunity, he could change his mind if he wanted to. But he didn't. His illness was too far advanced and at his last check-up he had asked enough explicit questions to know that, even if he could be kept comfortable in hospital, it was not possible to prevent further deterioration. He left a last loving note to his wife, and also a note to whoever it might concern explaining his actions, how they were entirely his own and well-considered. A book of poetry rested on his lap. He put the last nocturne on 'repeat' then placed the rubber bands around his neck, the bag over his head, and tucked the edges under the rubber bands. As the gentle piano music rose, Frank reached across and turned on both helium taps quickly in succession. Within seconds he experienced a light-headed floating sensation as he started to faint. The last thing his eyes took in were a couple of lines from Walt Whitman . . .

What you need

- A tank of helium - or preferably two
  (about £45 each from party balloon supply companies)
- some poly tubing
- an 'equal-T' connector
- Five hose clips (clamps)
- A screwdriver to fit the clamps
- Some fairly sturdy scissors to cut the poly tubing
- A sturdy plastic bag
- Adhesive tape and rubber bands

Helium – you can find companies on the Internet by searching for 'helium balloons' or in yellow pages under headings such as *Parties* or *Balloons.* (As companies change from time to time, there is little point in giving addresses but they are certainly not difficult to find.) If you order by credit card over the Internet, it also avoids the need to speak to anyone personally but these companies generally are not suspicious of people buying kits of helium and balloons. Some companies have two products – disposable tanks which are lightweight and sold; and larger, heavier tanks for bigger parties that are only rented. Buy the disposable ones. They will be sent by courier. When the tanks arrive they have a valve to make it easier to attach balloons while inflating them. On all the tanks I have come across, this valve can simply be unscrewed, but if this isn't the case you need to remove it forcibly. Once the valve is off, the helium can be released from the tank simply by opening and closing the tank.

Poly tubing – this is sold for various purposes including home brewing, aquariums and garden water systems. It comes in various diameters and you need some that will fit fairly snugly over the outlet on the helium tank. The first time I bought some, I didn't want to walk around the home-and-gardens store carrying helium tanks and hadn't measured it, so I judged it as closely as possible and bought two different diameters and matching T-connectors. When I got back, I found one was a good tight fit (but needed a bit of pressure to fit), whereas the slightly larger one would need hose clips to secure.

An 'equal T' connector – this is simply a hard plastic piping connector with three outlets. It's sold at the same place as the tubing so you can get a T-connector of the right diameter made specifically to fit.

Five hose clips – if the tubing is a good fit, you won't need these, but if it is even slightly loose they are a good precaution. You place them on the tubing *before* you fit the tubes over the outlet or T-connector then tighten them with a screwdriver. If you think you might want them, maybe get slightly more than you need in case you damage one – they can be slightly fiddly to tighten. Someone at a workshop suggested using strong adhesive tape to secure the tubes once they were fitted. If you do this, do check it from time to time in case the tape has deteriorated and needs to be replaced (the same goes for any tape holding the tubing to the bag).

Plastic bag – the bag you use with helium does *not* have to be very large. It is simply a way of ensuring the helium stays around your mouth and nostrils for a few moments. A sturdy one will ensure you don't accidentally damage it on the day. A transparent one is pleasant as you can see out, and looks less morbid to those finding you. (The bag is very different in size to the one usually used for the *Plastic Bag and Drugs* method.)

Adhesive tape and rubber bands – tape is needed to prevent the smooth poly tubing from slipping out of the bag. Rubber bands for securing the bag in this method should be sturdy and quite large – the bag does not need a tight fit around the neck and the bands are simply to keep it in place. Using two guards against breakage.

Main features

Helium provides a totally painless and reliable way to end one's life. Some preparation is needed, as well as basic skills and physical mobility to put the equipment together. Additionally, it requires a safe place to store the assembled kit until time of need and sufficient privacy to put it into effect. In the unlikely event that the person was disturbed and 'rescued' at a critical moment after losing consciousness, some brain

damage could have occurred (as with any other method of asphyxiation, such as drowning). So make sure you *won't* be disturbed!

General description

Helium gas is released into a small bag over the head, displacing the air inside the bag. Breathing continues normally, but the lack of oxygen means the brain is rapidly starved and shuts down, causing death. The presence of helium in the body (for instance in post mortem) is very difficult to detect. Unconsciousness is swift, and there is little discomfort from the carbon dioxide build-up that would normally occur from use of a plastic bag alone.

What is the evidence for helium?

Helium is an odourless, tasteless, colourless, non-toxic gas that is lighter than air and fairly readily available. The 'helium method' was developed by researchers in Canada and the United States and has become an increasingly common method of choice in 'rational suicide' or 'self-deliverance' over recent years. It is impossible to survive without oxygen, and helium simply provides a way of displacing oxygen while simultaneously providing a comfortable environment.

How quickly does it work?

Loss of consciousness occurs very rapidly, as with any other method of asphyxiation such as drowning, choking, or hanging (though without the unpleasantness of those methods). Inert gas is used by vets for putting animals to sleep. In experiments, animals (dogs, cats, rabbits, mink, chickens) showed little or no evidence of distress from inert gas asphyxia, become unconscious after 1-2 minutes, and die after about 3-5 minutes. Make sure you will not be disturbed for 30 minutes, just to be sure.

Are there any unpleasant side-effects?

None known.

Checklist

- o Check that assembled equipment is in good order and that you can operate the helium tank taps. You should be familiar with their action, so you can turn them easily, quickly, and to an extent that achieves a steady flow rather than sudden, high-pressure gas.
- o Check that you will not be disturbed
- o Leave a note for whoever finds you explaining your last act
- o Exposure to atmospheres containing greatly reduced oxygen (increased
  helium) can bring about unconsciousness without warning; for the sake of those who may find you, ensure the room is well ventilated.
- o Variations on the method (instead of using a plastic bag) include use of a gas delivery mask (such as used in hospitals) or a sealed tube tent. If an oxygen mask is used, this is designed to mix the gas with air, so must be modified. Nitrogen, or any other inert gas, could be used instead of helium, but is harder to obtain. Rubber tubing could also be used instead of poly tubing. Body bags or mountain survival bags (some with clear view panes are also adaptable options and can be purchased online.

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Extra information – you may want to read the sections on asphyxia in the *Appendix* to get an even fuller understanding of the physical process.

Compression

Story (tourniquet method) – ratchet tie-down – other variations (continuous looping; suspension) – finding the carotid arteries – a word of warning – what you need – main features – general description – what is the evidence for compression? – further stories from the medical literature – how quickly does it work? – are there any unpleasant side-effects? – checklist - references

There are a number of variations on the 'compression technique' depending on personal preferences and availability of equipment. Marjorie's story illustrates the Tourniquet Method (which is the most common method in this category). The other major variation is the Ratchet Tie-Down, which is explained in detail afterwards. All the various compression methods involve compression of the carotid arteries without interrupting the breathing.

Marjorie's story

It had happened quite unexpectedly. What had seemed like a routine trip to hospital suddenly developed into something serious. They would do everything they can, but Marjorie was not expected to recover. Her careful plans to make sure the end was at a time of her choosing were not going quite as expected. In hospital, she had no access to pills or helium. She lay awake for a couple of nights making her plans, going over all the possible materials and making her choice. It didn't take too much to ask the nurse to bring her handbag for her so she could get one or two small items. She wanted her mirror and her lipstick, but most importantly she knew that in the inside zipped compartment were a pair of stockings. She had also managed to hide a spoon from dinnertime – a good metal spoon, proper cutlery, not like the stuff you got in some of the places she had been in.

Marjorie made sure her 'implements' were in a place where she could get at them easily, without making any noise that would attract attention, and not somewhere the nurse might find them and wonder what on earth this quiet little lady was going to do with them. She waited until the early hours of the morning when the ward was quietest until she made her move. Under the cover of the bedclothes, she made her preparations. This was where all the dress-rehearsals would now come in handy! If she hadn't practiced many times beforehand when she was fit and healthy, working it all out now may well have been beyond her: but she knew what she was doing. Taking one of the stockings, she knotted it loosely but comfortably around her neck. She wanted to allow about three or four inches when the loop was pulled and the elastic of the stocking was at its full stretch. Too much and the process would be cumbersome. Too little and the stocking would be uncomfortable even before she started. She tied it in a good knot that couldn't slip – a 'reef knot' I believe they called it, she reminded herself.

She remembered the many times she had practiced the technique, using her thigh at first so she could see what she was doing. If you started with the stocking looped around your thigh, one end in each hand, then knotted it – right over left and tuck it under, that was the natural way to do it. The second knot, the one that made it so it wouldn't come undone, started the opposite way: it went, left over right and tuck it under. (If you did two 'rights over lefts', you ended up with a 'granny knot' or slipknot.)

Carefully she positioned the loop around her neck so it was high up, well above where a man's Adam's apple would be. She knew that having it low on the neck would cause discomfort, since pressure lower down would compress the windpipe, which was not her intention. Marjorie decided to slip part of the pillowcase under the loop as well – not strictly necessary, but when the nylon was tightened it could

dig in to the skin a bit so might as well make it comfy with some padding. Next she slipped the spoon between her neck and the nylon of the stocking. Then she tightened the nylon loop as if tightening a tourniquet. In the practice sessions she had used a variety of implements that came to hand, some were a bit longer, some the length of a spoon. She had experimented turning the spoon in one direction and then the other to see which suited her best. After several turns she could feel it was quite tight – not far to go now. The spoon would not unwind itself – it tended to catch on the jaw or collarbone – but Marjorie would be lying down so there was also the bed there and she could be sure that, once the desired pressure had been achieved, it would remain.

Marjorie spent a few minutes lying quietly and pausing. Once more, she warmly reviewed all the wonderful things she had enjoyed in her life. She thought of her loved ones, and the sealed letter she had placed in her bag addressed to them, making sure they knew she was ending her life in the way she wanted, and that it was her decision alone, her wish.

Then she tightened the tourniquet another few turns until the woozy feeling started to come over her. One more turn. The pressure was compressing the carotid arteries. Marjorie lay on her side, inclined downwards, breathing calmly as she fainted. No fresh blood reached her brain. Five minutes later, Marjorie was dead.

Diagrams showing the correct and incorrect way of tying a knot that doesn't slip

Reef knot (correct)

Granny knot (wrong)

Ratchet Tie-Down

The ratchet tie-down is a main variation on this method. What Marjorie achieved with a handmade tourniquet is here achieved with an easy-to-obtain, inexpensive piece of equipment.

You might want to purchase one and familiarise yourself with it before deciding if it is to be one of your methods of choice. You will find them at various retail stores such as those that stock materials for home improvements or car accessories. The usual purpose is for such things is securing luggage on a car roof rack or holding items securely on garage walls; the load stays secure because the webbing tightens and stays locked in place with every pull, until you release it by pushing the thumb lever.

Some people find working the ratchet tie-down comes quite naturally and also like the aesthetic appeal (it looks nice and neat once in place). Although it comes with full instructions, others may find it difficult to use or worry about whether they can operate the release mechanism once it is in place.

There are two main types of ratchet tie-down – ones with a hook and ones without: the only type that you are interested in is the one without (see illustration). It is possible to place the loop from the ratchet tie-down around the upper part of the neck, tightening with the ratchet until the carotid arteries are compressed sufficiently for the blood supply to the brain to be interrupted (without interrupting the breathing). This results in loss of consciousness followed by death.

It is very important to familiarise yourself with the way the ratchet tie-down works before placing it around your neck.

Illustration showing the type of ratchet tie-down useful in self-deliverance.

The thumb release mechanism generally needs a bit of practice. Read the instructions on the box and experiment with strapping down luggage or using it on your thigh (where you can see what you are doing and remove it easily).

Only practice with the ratchet on your neck if you are extremely confident that you can operate the mechanism easily and release it when required.

Some people will find that, once fitted, the ratchet tie-down is more aesthetically pleasing than many other methods. The webbing material is also comfortable against the neck and generally will not necessitate additional padding.

Other variations on the compression method:

Successful suicides have been recorded in the medical literature with two other methods – continuous looping and suspension.

a) Continuous looping means simply passing a cord around the neck quickly with many turns, using a material that doesn't slip. Nylon

coated cords, for instance, tend to slip, whereas many cords (such as traditional string) create a certain amount of friction. Simple knots with some of the turns may help. Once the cord has been wrapped tightly around the upper part of the neck it tends not to slip and, if there is sufficient pressure to occlude the arteries, death results. This variation is only recommended in an emergency (for instance if no other materials were available). You need to be agile enough to wrap the cord quite quickly for a lot of turns. For comfort, some padding is desirable, especially if using thin cord or string.

b) Suspension is a gentle method that has been recorded frequently in the medical literature. It does not require suspension of the whole body (as in hanging) but simply uses the weight of the upper body to apply pressure via a large loop or strap to the carotid arteries. The loop can be attached to any fixed object such as a door handle, hook, stair rail or kitchen bar. The loop is placed around the neck in such a way that, by slumping forward (facing the floor), pressure is placed on the carotid arteries. The carotid arteries are compressed with as little as seven pounds of pressure (the jugular veins with even less – about four and a half pounds). This varies greatly between individuals, but is quite small, which is why a sitting or semi-reclining position is sufficient. A massive 33 pounds of pressure, in contrast, are needed to compress the airway. Suspension does not require much knowledge and can be accomplished even by invalids

How to find the carotid arteries

This is usually quite easy (but don't worry if you can't find them!) The instructions from St John's Ambulance read: "With the head tilted back, feel for the Adam's apple with two fingers. Slide your fingers back towards you into the gap between the Adam's apple and the strap muscle [the easily identifiable muscle running up the side of the neck from the shoulder blade to the hinge of the jaw] and feel for the carotid pulse." You are feeling under the jaw bone at the front/side of

the neck. Use the pads of the fingers rather than fingertips or thumbs. Some people have a stronger (or more apparent) pulse here than others. In workshops, most, but not all, participants were able to identify the carotid artery successfully. Knowing where it is will make it easier to understand what you are going to accomplish when you compress it with the ligature, but don't worry if you can't feel the pulse.

A word of warning

It has been argued that the *brain stem* (that part that controls automatic functions that continue even into permanent vegetative state when the brain has died) has its own blood supply which, in theory, could mean that a person using the compression method could suffer brain death but with the body continuing to breath. There seem to be no cases of this happening in the medical literature. There are many reported cases of successful suicide with the compression method alone. If however, *you wished to take extra precautions, a small to medium bag placed* over the head and slipped under the tourniquet or tie-down would ensure that breathing would stop.

The compression method is particularly suited for unforeseen circumstances, such as hospitalisation. When in such a desperate 'emergency' situation, detailed fine tuning may seem superfluous.

What you need

For the tourniquet method:

- Only household equipment is needed although any of the following may come in useful:
- Stockings, bowtie, rope, flex, window sash-cord or webbing. The type of material used in a ratchet tie-down is quite adaptable and can be purchased easily (you can use almost anything from which you can make a tourniquet loop – be inventive!) Note that some

neckties tend to be 'stretchy' and are less than suitable; stockings, on the other hand, will only stretch so far.

- Padding. If you can obtain one, a foam cervical collar (buy on the Internet from medical suppliers) is excellent, but almost any padding will do.
- A plastic bag if desired.
- Mixing spoon, large pen, sturdy artist's brush, or similar (anything which you can use as a rod to turn the tourniquet).

Although favourite materials can be obtained in advance (and especially for practice purposes), suitable implements can be found in most situations and environments with a minimum of fuss or trouble. You might even want to make an occasional habit of looking round a new room or environment and thinking, "What would I use?"

For the ratchet tie-down method:

- A ratchet tie down, the sort without hooks

Main features

Compression provides a simple method of ending one's life that is not dependent on having previously acquired equipment to hand. Properly done, there is little or no discomfort and it can be performed without arousing too much unwanted attention. The ease with which it can be done makes it suitable both as a mainstay method or for emergencies if one becomes confined to a nursing home or hospital bed.

General description

Pressure is applied by one of a number of means such that the arteries and veins in the neck that supply blood to and from the brain are compressed though without enough pressure to compress the windpipe (In the classic judo 'choke' for instance, which uses the same

principle, pressure is often achieved by pulling cross-wise on the lapels). Without a fresh supply of oxygenated blood, the brain then dies within a few minutes. (Allow 20 minutes however to ensure you will not be disturbed.) As with other methods of starving the brain of oxygen, interruption early on could lead to brain damage.

What is the evidence for compression?

The evidence for compression comes from three main sources. Firstly, in the medical literature, many cases have been reported. Secondly, in the academic literature concerning sexual deviance, many cases of auto-erotic asphyxiation are known (one partner applying pressure to the other's neck to obtain a 'high' by partial stopping of oxygen to the brain, or self-induced compressions for the same purpose – the fatalities occur when the pressure is continued for too long). Thirdly, the technique used by martial arts experts (and for some time the police) of applying pressure to an opponent is well understood.

Some further stories from the medical literature

1. A woman aged 73 was lying full length on the floor of a bedroom, which she shared with another patient in a nursing home. The bed clothing had been thrown back in a manner consistent with getting out of bed. There were no signs of any struggle. She was dressed in a nightgown and a brown stocking was round her neck; the fellow of a pair was seen suspended over the head of the bed. The stocking was applied with a half-knot at the nape on the first turn and with another half-knot at the front of the neck. The first turn was tight, but the second, although close to the first, was easily released. There were no other signs of violence, but a little bleeding, which produced a small stain 1 in. in its diameter, had occurred from the nose; the stain was directly below her nose. Her face and neck, above the ligature, were congested and of purple colour.

Bleeding had occurred beneath the conjunctivae [eyelids], but petechial haemorrhages [pinpoint haemorrhages often found in asphyxia] were not seen in the skin of the forehead and face. The tongue protruded, but was not bitten; she had dentures, but these were on her bedside table.

2. In one case, however, a 53-year-old man succeeded . . . . He wrapped twine around his neck 35 times, tied a knot and tightened it. He then bent forward on his knees with his head down, which increased his neck circumference, and thus, pressure from the twine; this is the posture in which he was found. Since this is an unusual position, the police were initially suspicious. However, there was no internal damage to the fairly delicate anatomical structures in the neck, a fact consistent with suicide, but not murder.

There are many more case histories, often with ingenious variations. Additionally, the case histories in autoerotic asphyxiation show examples of unintentional death.

How quickly does it work?

Like helium, compression works by starving the brain of oxygen and takes no more than a few minutes.

Are there any unpleasant side effects?

There may be slight discomfort from the pressure on the neck, though this is not enough to interfere with breathing. As the blood supply to the brain is interrupted, there is a sense of dizziness or fainting, followed by unconsciousness and death. Judo practitioners have described their experience of losing consciousness from compression-technique judo holds as 'quite pleasant', like controlled fainting.

Checklist:

- You need two items: something you can make a strong loop with, and something you can use to tighten the tourniquet. Make a list of suitable household items. Even get into the habit of looking around or imagining yourself in other situations such as hotels, nursing homes, or on holiday – what would you be able to use in an emergency? You will find there are types of material that are more comfortable, but stockings are fairly easy to obtain at any hour of the day or night (for instance, from 24-hour petrol stations).
- If using an elasticized material (such as stockings or tights), make the loop the size you want when the material is at its maximum stretch.
- A fraction of the pressure that would compress the windpipe is needed to compress the carotid arteries (these supply oxygenated blood to the brain). Avoid placing pressure on the windpipe though by keeping the loop higher around the neck rather than lower down. Padding may be used for extra comfort – find out by experimenting with different loops and see which ones are comfortable without padding (don't cut into the skin) or which ones need padding.
- Practice making the tourniquet on your thigh first, rather than your neck. This allows you to see what you are doing. Make sure you can do the knot easily.
- When you come to practice the tourniquet around your neck, maybe have a pair of scissors handy to cut the practice stocking (or cord) should you need to.
- A wooden kitchen spoon is excellent for practice. Try turning it until you can feel the pressure (but not causing you to feel dizzy or faint). See how it catches on the collar bone or jaw. Decide if turning it in one direction or the other feels to work better for you.
- The tourniquet 'lever' can be placed at any point, but at the side and towards the front of the neck is perhaps easiest and most comfortable.

- The pressure needed for self-deliverance is the same pressure that is needed to cause you to become dizzy and faint, so exercise due caution during your dress rehearsals.

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Drugs

Introduction – main features – using chloroquine – general description – myths about chloroquine – what is the evidence for chloroquine? – how quickly does it work? – are there any unpleasant side-effects? – obtaining chloroquine – anti-nausea drugs – obtaining sleeping tablets – shelf-life of drugs and buying drugs abroad – buying drugs on the Internet – the best way to take tablets – what you need – preparation and method – other drugs – checklist – references

Introduction

Often when people think about drugs for suicide their attention turns to one of two main groups. Attempted suicides are common with the highly available but highly unsuitable drug paracetamol (known in the US as acetaminophen) Paracetamol is likely to cause very painful yet non-fatal internal organ damage. More educated persons, such as members of right-to-die organisations, sometimes go on a (usually fruitless) quest for what they believe is a perfect drug. They spend much time and energy writing letters to find out if barbiturates are available in Mexico or through the Internet, oblivious both to the dangers of such a quest and to the reality – which is that suitable drugs can usually be obtained very easily at home.

If, because of your medical condition, you happen to have a good supply of barbiturates, these can be ideal on their own (see later this chapter). Otherwise there is one drug on which there is more accumulated evidence for its use in suicide than any other, but it is a drug which must be used with great care and in combination with a specific range of other drugs. That drug is chloroquine.

Main features

In the US a prescription is needed, but in most other countries chloroquine is available without prescription (see later in this chapter for ways of obtaining chloroquine). This makes it attractive as a 'drugs only' method as long as you also have (or can obtain) enough suitable sleeping tablets to ensure a deep sleep. Chloroquine is not a gentle drug however. A person using chloroquine needs to be confident of completing the procedure effectively and not vomiting the large amount of drugs ingested.

Using chloroquine

Although chloroquine ingested in sufficient doses is undoubtedly fatal, a proportion of people (about one in five) experience side-effects, therefore a suitable sedative is needed in conjunction with the chloroquine. A further concern is that a large group of sedatives – benzodiazepines – interact with chloroquine and are even used as the standard hospital treatment for chloroquine overdose, so the choice of sedative is important.

Benzodiazepines – the drugs to *avoid* in combination with chloroquine – include temazepam (one of the drugs of choice for use with plastic bags – see next chapter). Most benzodiazepines end in '-azepam' and so are readily identifiable. These include nitrazepam (Mogadon), diazepam (Valium), flurazepam (Dalmane), loprazolam, lormetazepam, and temazepam (Restoril, Normison). In the preceding list, I have given some of the *brand* names in brackets. These change from time to time and vary from country to country. If in doubt, examine the packaging or literature enclosed with the drug to find out the *generic* ingredient. This is the chemical name of the drug and does not vary. Some of these drugs are also prescribed for anxiety.

So what sedative is suitable for use with chloroquine? The most obvious drug of choice is zolpidem (known in the US as Ambien). If

you obtain zolpidem in the UK, it may be packaged as zolpidem or have the brand name *Stilnoct* added. It is small, making it easy to swallow, and doesn't interfere with chloroquine. It is a prescription drug for sleep disorders, but widely prescribed and so relatively easy to obtain. Other sleeping drugs are also fine in combination with chloroquine *as long as they are not benzodiazepines such as temazepam.*

Methods of suicide using drugs alone, other than the chloroquine method, tend to rely on drugs that are very hard to obtain (such as barbiturates), have a poor success rate, or else have very serious side effects either before death occurs or in the event of failure. Some (such as tricyclics) are not only increasingly hard to obtain but require detailed consideration as to whether they are suitable for a particular individual. As these drugs collectively form a tiny area of suitably dignified means of death, they will be considered towards the end of this chapter.

General description

An anti-nausea drug is taken some time before the main drugs. A large dose of chloroquine is taken (about 50 pills) followed by enough of the appropriate sleeping tablets to ensure deep sleep. (If drugs other than chloroquine are used, an anti-nausea drug is still required.)

Myths about chloroquine

There are a number of myths about chloroquine frequently banded about, so it is necessary to address them directly.

Myths about chloroquine (1): a failed attempt can cause blindness

This is a common objection, often suggested by doctors who have a passing, inadequate knowledge of chloroquine. They have learnt that chloroquine can cause blindness in toxic doses. This is true, but leaves out the essential factors: chloroquine is only known to cause perma-

nent blindness when there is long-term overdose, not a single overdose. Any visual disturbances are reversible with acute (one-off) overdose. This is known from a large number of highly reputable studies, such as those published by the World Health Organisation and Toxicology Management Review (see appendix). What is worth stressing however, is that chloroquine is a very dangerous drug and not suitable for the faint-hearted. Recovery from a failed attempt (compared to a failed attempt with a plastic bag) could potentially be distressing.

Myths about chloroquine (2): any sleeping tablets are suitable

This is also untrue and widely recognised now following the revelations in the book *Departing Drugs* and publication of *The Chloroquine Controversy* (which is reprinted in the appendix). Before that, some organisations, even with medical advisors, had suggested using chloroquine with benzodiazepine -type sleeping drugs. True, if you ingest enough chloroquine there is very little that can be done to prevent death, even with medical treatment; but it makes little sense to take the standard antidote (benzodiazepine) with the drug chloroquine itself. Following publication of *The Chloroquine Controversy,* organisations that had previously recommended the use of benzodiazepines with chloroquine withdrew their publications, in some cases replacing them with *Departing Drugs.* But concern over chloroquine (and lack of understanding) has in many cases not persuaded many right-to-die societies to re-introduce chloroquine among their recommended methods (with appropriate cautionary advice about benzodiazepines). This is regrettable.

Original recommendation for chloroquine (without the precautions over benzodiazepines) came from doctors. Similarly, the concerns over chloroquine and blindness have also come from doctors. In both cases doctors have spoken from inadequate knowledge and their advice was accepted simply because they were doctors. Doctors are expert in the

use of drugs to heal, not in their use for suicide. Similarly, doctors that practice euthanasia are expert in the specific drugs they use, but often wide of the mark elsewhere unless they have done their research. Doctors do, however, tend to be quick to acknowledge flaws in their beliefs, as they have done when we have presented them with peer-examined, scientific data and published proof. Many authors on self-deliverance, like the proverbial doctor, encourage an almost religious acceptance that what they say is gospel. This book takes no such attitude and encourages readers to sceptically examine *every* recommendation, particularly in the absence of supporting data. *Five Last Acts,* whether in the main body or the Appendix, includes many references so you can verify and have scientific confidence in the written assertions.

Remember that drugs like benzodiazepines can remain in the system for a while – for several days after taking them. If you have been taking them for any other reasons, it may be advisable to allow time for them to completely leave the body.

What is the evidence for chloroquine?

Chloroquine has a long history and has been routinely provided to armed forces stationed abroad. Given that suicides among this group of the population are noted rapidly, there is a remarkable amount of data in the medical literature on suicide by means of chloroquine – more so than with any other drug studied. See the *appendix* for some of the many medical sources on death by chloroquine.

How quickly does it work?

The time varies, but several uninterrupted hours should be set aside. As it is normally taken with sleeping tablets, unconsciousness ensues quickly (in cases where sleeping tablets are not taken, unconsciousness often occurs within half an hour, but sleeping tablets are strongly recommended.)

Are there any unpleasant side-effects?

Quite possibly – at least if appropriate sleeping tablets are not taken. Of the various side-effects, the most serious is extreme hyperactivity and convulsions, which affects one in five people taking a chloroquine overdose without sleeping tablets. Therefore, although it is a reliable method of suicide, it should really only be considered in combination with suitable non-benzodiazepine sleeping tablets. In the case of a failed attempt, there may be some persistent side-effects, including disturbances to vision, but not permanent ones.

Obtaining chloroquine

Chloroquine is commonly dispensed as an anti-malarial. This means it is available from any chemist (for instance in the UK) without prescription but at the discretion of the pharmacist. The chemist may ask where you are going. Anti-malarials are used for travel to most parts of Africa, the hot parts of South America, Central America, and South-East Asia. The chemist will probably also enquire as to how long you are going for. Working out the exact number of tablets needed against malaria uses a formula that includes a period before and after travel as well as weekly dose while you are away, so the chemist will expect you to state a time period rather than a number of tablets. Some people will ask for sufficient for their whole family travelling together. People who are stockpiling the drug for use in self-deliverance will often visit several chemists to ensure a sufficient supply. If you really are planning on getting drugs to prevent malaria, you may want to look into it more carefully for that purpose (mosquitoes have developed resistance to chloroquine as many areas). Sometimes a chemist will suggest more modern or area-specific drugs, but I usually say I prefer chloroquine as it doesn't upset my system. The main brand names of chloroquine are Nivaquine and Avloclor. Sometimes they come in foil packs and sometimes loose. The most common size is 200 or 250mg. Fifty of this strength of pill is recommended. Less will probably do, but that is a dosage that no-one has survived, out of many hundreds of suicides.

Anti-nausea drugs

If you are taking a large number of tablets, the stomach's immediate reaction will be to try to vomit them up, therefore you need an anti-nausea drug (sometimes called an anti-emetic or anti-sickness or travel-sickness drug) to control and prevent any nausea and vomiting. There are many adequate ones available over the counter, or you can use a prescription drug such as metaclopramide or prochlorperazine. If you buy them over the Internet, take some reasonable precautions (such as testing the prescribed dosage when you are feeling nauseous). Although the usual precautions apply (see *Buying drugs on the Internet*, below), as most of these drugs are quite cheap there is not the same motivation to sell counterfeits.

One thing to be aware of with anti-nausea drugs is that some of them cause drowsiness. This is particularly true with some of the antihistamine preparations. Unless you are specifically using the drug to cause sleepiness, check the details carefully. There are too many to list, but antihistamines fall into two categories, those that also cause severe drowsiness and those that do not (or cause less drowsiness). Ask the pharmacist (and also check the notes on the packet when you buy them) or your doctor. Try the normal dosage recommended for travel-sickness or other genuine medicinal reason and see if you feel drowsy. Hyocine is an anti-nausea drug that is also available as a patch applied to the skin rather than as a tablet. It may cause some drowsiness though. Not all anti-nausea drugs are used for travel-sickness. Metoclopramide, for instance, is ineffective for tummy upsets caused by travel so won't be offered for that purpose. At the time of writing, a less-sedating, anti-nausea drug is cinnarizine (brand names include Stugeron and Cinazière), which is an over-the-counter (non-prescription) drug available in the UK, used for travel sickness among other things. Although it is an antihistamine, it is less sedating than many other antihistamines.

The exact choice and number of anti-nausea drugs is far less crucial than using common sense. Ideally you would take an initial dose a couple of hours before the self-deliverance drugs and a further dose about twenty minutes before taking lethal drugs. You would increase the normal dose slightly, but not excessively.

Anti-nausea drugs are also routinely prescribed for certain conditions, as part of advanced palliative care, and commonly in patients with advanced cancer.

Obtaining sleeping tablets such as zolpidem (Ambien)

When will a doctor prescribe these sleeping tablets? Not just because you fancy some, that's for sure! Your doctor is responsible for your 'whole being' health so this means that if he or she is convinced that your *sleeping problems are interfering with a normal life* then a prescription can be justified. For instance, if your lack of normal sleep means you cannot perform your job properly or it is interfering with a normal social life. Sleeping tablets are usually prescribed on a short term basis (they can't be taken on a daily basis for a long period as their effect wears off or they become addictive). Sometimes if your doctor trusts you to use drugs sensibly and not too often, a more regular small amount may be prescribed. Prescribing will normally follow the 'least medication needed' option, which goes something along these lines –

1. Serious sleep problem.

2. Doctor suggests lifestyle changes or occasional use of over-the-counter medication.

3. Patient tries this *for a month or so* and reports back that sleeplessness is still a serious problem. (Each stage requires a certain amount of time to give it a proper chance of working, so can rarely be skipped.)

4. Doctor prescribes a mild sleeping tablet such as Zopiclone for occasional use. (Note the similar spelling: Zopiclone is a markedly different drug to Zolpidem.)

5. After maybe a couple of months, the patient reports back that it has some effect but does not really work that well at providing reliable sleep, and/or there are unpleasant side-effects such as upsetting the system in some way. Zopiclone, for instance, can sometimes cause mood changes or daytime clumsiness or daytime restlessness.

6. Doctor prescribes Zolpidem or the (benzodiazepine drug) Temazepam (also called Restoril), possibly in the lowest dose. Although Temazepam tablets tend to be a bit bigger than Zolpidem tablets, they are quite suitable for the plastic bag method.

7. Repeat of stage (5), at which point doctor prescribes different drug (Zolpidem or Temazepam) or a different dosage.

Another reason sleeping tablets are prescribed are for long-haul travel. If I am flying a considerable distance and have to give a lecture shortly afterwards, it is important I get a good sleep on the plane. I generally ask my doctor for a small number of sleeping tablets and indicate any that, from experience, I find ineffective or unpleasant!

Zolpidem usually comes in tablets of 5mg or 10mg. Temazepam tablets and capsules vary. In the UK, Temazepam is available in 10mg and 20mg doses (which are very roughly equivalent to the 5mg and 10mg Zolpidem strengths).

Zolpidem is an excellent drug of choice in combination with the plastic bag. It can also be used with chloroquine. Temazepam is not recom-

mended with chloroquine but is an adequate drug for use with the plastic bag method.

Buying drugs abroad and shelf-life of drugs

Some people get stuck on the idea that they can find the perfect chemist somewhere abroad, maybe Mexico, and get their dream prescription. The logic of spending much time, effort and money on such a quest seems dubious. Firstly, it is usually relatively easy to get the drugs in your home country where you know they are genuine and in good condition and where you are not breaking any laws. We do not recommend you go abroad especially to look for prescription drugs. But if you do buy drugs abroad, some common sense observations will help you determine their worth.

You need to know that they are genuine and secondly that they have been stored in suitable conditions. Many pharmacies in hot climates will keep main drug supplies in a specially air-conditioned room – some will not. Drugs sold in foil packs are less likely to have deteriorated than those that are not, and tablets/pills are more resistant to deterioration than capsules. Tablets are hard, compacted, whereas capsules are soft and more easily affected by external conditions. Generic drugs may be just as good as branded ones or they may (in poorly controlled countries) be weaker. I've seen accompanying small print that said where the actual drug was not available a suitable 'substitute' would have been used in manufacture. Even if it appears branded this is not a cast-iron guarantee of authenticity: there is a large black market in counterfeit drugs, even down to the packaging.

When it comes to sleeping pills, if you believe you have a genuine product, you can test them in the normal way – to see if a normal dose will give you a good night's sleep, and also (as a precaution) find out how many you need to get eight hours sleep in daylight hours. Obvi-

ously most drugs other than sleeping tablets *can not* be tested in this way.

Another common worry about whether drugs have been affected by storage is the shelf-life or 'use by' date. Testing drugs is a very expensive business. Most people who obtain drugs for medicinal reasons will renew them or use them within a relatively short space of time, so there is no need for drug companies to test them for many, many years. This does not mean they suddenly become useless, merely that they have not been tested. In the case of tablets, if they have been kept in dry conditions at a reasonable temperature, it is unlikely that they will deteriorate for a very long time. For chloroquine, just get new ones every few years or so (or if you live in the US, whenever you travel outside). For sleeping tablets, if you have kept them for a long time, test them with the 'estimating dosages' experiment. If you get a good eight hours sleep in the day time with, say, two, then just multiply that number by ten for use with a plastic bag or chloroquine.

There are reliable stories of persons travelling to Mexico and buying barbiturates over the counter by asking for the vetinary brand names and saying it is for 'putting down their pets', then bringing them home and using them without getting caught on the way. Barbiturates are highly controlled substances and possession of them without a legal prescription is a serious offence. If you are caught at customs, the likelihood is that they will be confiscated and you will face a very serious charge. We don't recommend breaking the law. Apart from anything else, if you are caught you may face a situation where it is almost impossible to put any plans for self-deliverance into action.

Buying drugs on the Internet

Similar concerns apply as buying from abroad. Regulations (such as which drugs can be mailed from which countries to which countries) change from time to time, as do web addresses. There are many

reputable firms online and also many involved with counterfeit drugs or simple fraud. While you may find some useful drugs online but we do not recommend it as a primary route.

Gulp or grind? – the best way to take tablets

How do you usually take tablets? Some people gulp them down with barely a sip of water. Some people like a slug of whisky, and some a whole pint of water. Some people can take several at once, and some will struggle over one. Your ability to swallow tablets may also vary according to how you feel or other factors. No-one has yet invented a simple and reliably painless 'one-tablet solution' for self-deliverance. Most tablets are quite bitter tasting. The degree of difficulty swallowing sufficient of the drugs concerned can be factor determining how suitable this method is for you. Remember it may change once you are very ill.

To overcome the worry about swallowing tablets, many people will grind them up and then mix them with something like apple sauce or chocolate pudding. These are two of the more popular foodstuffs to hide the taste, but bear in mind they are unlikely to mask it entirely. Grinding tablets up also has the advantage that they will be absorbed slightly quicker once in the stomach. If you plan to grind them up, a small mortar and pestle from a kitchen accessories shop will make the job easier. A sensible amount of sauce or pudding is enough to mix the tablets but not too much. If it is more than a few spoonfuls you may start to feel sleepy before you have finished swallowing the tablets.

An alcoholic drink to wash them down is quite acceptable. Alcohol increases the effect of many sleeping drugs but can also irritate the stomach. The general rule is to drink alcohol if you feel inclined to do so, but not vastly more than you would usually. Stick to your usual tipple or increase it slightly. Don't go to great excess, especially with a form that you generally avoid. Whisky, for instance, disagrees with my

digestion whereas I can enjoy wine without an upset stomach. Let your body be your guide, as it varies greatly from person to person. Understand also that antacids can slow the rate of absorption of chloroquine and so should be avoided.

What you need

For a drugs-only self-deliverance:

- A lethal quantity of drugs
- A handful of anti-nausea tablets
- A mortar and pestle for grinding up drugs (helpful, not essential). A coffee grinder can also be used.
- Apple sauce or something to mix the drugs with (helpful, not essential). Partly melted ice-cream (about half a cupful) is an option, possibly sweetened with honey. Milk products are generally avoided as they slow absorption, but a *little* milk may help to line the stomach just enough to decrease irritation. A little food should be just as effective – something light, such as toast. Generally you do not want to have too much in your stomach.
- Undisturbed time – at least several hours

For using drugs with a plastic bag for self-deliverance, please see the *plastic bags* chapter)

Preparation and method

Firstly you might want to estimate how high on your preference list this method is, and your next most preferred method. After stockpiling sufficient drugs, get an idea of how easy or difficult it will be for you to swallow them. Sleeping tablets can work quite quickly – will you have the time and ability to swallow all that you need? If you want to know exactly *how* bitter-tasting the drug is, try just one tablet with the apple sauce and taste it as part of a dress rehearsal. If and when the time

comes, you will need to act decisively and quickly, so estimate your own ability to swallow all the drugs effectively.

Next, go over in your mind the exact scenario, several times. Plan your timetable. The order in which the drugs should be taken is anti-nausea drugs, followed by a gap to let them work, then the chloroquine, then the sleeping drugs immediately afterwards or at least within a few minutes.

Make sure everything is arranged, notes written, the place warm and comfortable, *before* you start. You will probably unplug the phone and disconnect the doorbell. If in a hotel, you have left the *Do Not Disturb* sign up.

When taking sleeping tablets, especial care must be taken to ensure the full amount intended is consumed swiftly. There have been cases of failed suicides where the person fell asleep before finishing swallowing the drugs.

Other drugs – barbiturates

If you have access to barbiturates then these are normally sufficient to induce sleep and death quite safely on their own. Anti-nausea medication is still required, as mentioned above, and you need to pay particular attention to making sure you swallow sufficient of the drugs swiftly so that you do not pass out before finishing them. Sleep is normally followed by respiratory depression and death. Beyond that, there are a few considerations as follows:

Although death will normally occur within a few hours, it some cases it may take longer. Cases of persons being alive (in a coma) up to four days before dying have been recorded. Certainly the precautions against being disturbed should allow for this. The use of a plastic bag in addition can securely avoid this drawn out possibility.

There are three broad categories of barbiturate according to their duration of action in therapeutic doses. Long-acting barbiturates include barbital and phenobarbital (Veronal, Luminal, Gardenal). Medium-acting barbiturates include butobarbital/secbutobarbital, mephobarbital, amylobarbital (Soneryl, Butisol, Meberal, Amytal). Short-acting barbiturates include pentobarbital, quinalbarbital/secobarbital (Nembutal, Seconal). Tuinal is a mixture of amylobarbital and secobarbital. While this classification is helpful for therapeutic purposes, shortness of action is not equated with lack of toxicity. Long-acting barbiturates have caused the most fatal poisonings, but some authorities believe the short-acting ones lead to a deeper coma. If given a choice, the short-acting ones seem overall preferable. Pentobarbitone (pentobarbital) is used for euthanasia in the Netherlands. In practice, their availability is so scarce that it is a case of using what you have or, if you are not sure if you have sufficient, using them to cause deep sleep in combination with a plastic bag or chloroquine.

A minimum recommended lethal dose is 60 capsules of 100mg Seconal or Nembutal. The usual three or four anti-nausea pills are taken half an hour to twenty minutes beforehand. It is also best, if possible, to take a beta blocker with the anti-nausea pills, such as three tablets of 80mg Inderal (propranolol hydrochloride). This reduces the blood pressure and makes the system immune to adrenalin. Although the 6 grams recommended above may be optimal, more may be desirable if your stomach can stand them, and death has frequently been recorded with as little a 3 grams of butabarbital. In the Netherlands, 10g (100 x 100mg) of pentobarbital is used, and even then a secondary drug (delivered by injection) is the norm.

In Britain, all barbiturates are classified as Controlled Drugs. Preparations containing secobarbital (quinalbarbitone) are in schedule 2 of the Misuse of Drugs regulations along with cocaine. Receipt and supply must be recorded in the Controlled Drugs Register. Barbiturates are

also controlled as class B drugs under the Misuse of Drugs Act. Doctors can still prescribe them and patients take them, but unauthorised possession or supply is an offence. Maximum penalty is five years imprisonment and a fine for possession, and 14 years imprisonment and a fine for supply. If prepared for injection, barbiturates are regarded as class 'A' drugs with even more severe penalties.

If a suicide attempt with barbiturates fails, there may be some lingering disorientation but no seriously disturbing long-term effects.

Alcohol greatly increases the effect of barbiturates. A reasonably large amount is a good idea – as long as you don't take so much that it makes you vomit. This varies from person to person, so know you usual alcohol intake (or the amount you can drink without vomiting).

Other drugs – Orphenadrine, Propoxyphene, Tricyclics

These have been listed in *Departing Drugs* or *Beyond Final Exit* and are sometimes acceptable drugs. Compared to the main methods described in this book, they are no longer drugs of choice. They will be considered briefly.

Orphenadrine

Orphenadrine is prescribed for a variety of conditions including Parkinsonism and as a muscle relaxant. Three grams (30 times 100mg tablets) is considered reliably lethal. Side-effects are potentially very serious though. It is best avoided unless you feel you do not have other options. If you do use it, be sure to use plain tablets, ground up, *not* orphenadrine compounds.

Propoxyphene (and Dextropropoxyphene)

This painkiller drug is less widely available now. Many forms available were combinations with drugs such as paracetamol or aspirin, which have very serious side-effects in failed overdose. It was considered a

suitable drug for use in combination with the plastic bag (or with other sedatives) but is being withdrawn in most countries.

Tricyclics

Tricyclics are a class of anti-depressants. They are sometimes prescribed less than before, as the newer SSRIs (anti-depressants like Prozac) are considered to have a lower side-effects profile – in other words, side-effects don't include possible death. Prozac (fluoxetine) is considered by some studies to increase the lethal effect of the tricyclics if taken in combination. Alcohol or barbiturates increase the toxicity. Some studies have suggested diazepam increases the toxicity of amitriptyline. Of all the tricyclics, amitriptyline is generally the most useful in self-deliverance.

But tricyclics are a complex area for use in self-deliverance. Some are highly sedating and some less so. Those with *sedative properties* include amitriptyline, clomipramine, dosulepin (dothiepin), mianserin, trazodone amd trimipramine.

The *less sedating* ones include imipramine, lofepramine and nortriptyline.

If you have sedative tricyclics (ones from the first list), especially if you have amitriptyline, they may be considered a suitable sedative if you take precautions. Firstly, if you have been taking them for a therapeutic reason, you need to stay off them for a few weeks to ensure you have not become acclimatised to them. Then, a few weeks before using them for self-deliverance, you need to do the *Estimating Dosages* experiment to see if a small dose knocks you out for several hours daytime sleep. With this amount as a base increase your planned self-deliverance dose by a factor of ten if you are using them with the plastic bag. Individual reaction to tricyclics varies.

Although there are numerous cases of suicide with tricyclics alone, there are so many variables that they cannot be confidently recommended as a stand-alone self-deliverance drug.

Other drugs not mentioned so far

There are many drugs that can kill you, but very few that can do so reliably and painlessly. There are also drugs on which there is insufficient information to make a recommendation one way or the other.

Checklist

- o If you are using chloroquine, do you have suitable (non-benzodiazepine) sleeping tablets to take with it?
- o Do you understand the dangers associated with various drug-orientated methods of self-deliverance?
- o Have you taken into account your ability to swallow the required amounts of drugs, either in tablet form or crushed up? Do you have an alternative method should you one day be in a condition that eating and swallowing is slow and difficult? (Antacids are best avoided with chloroquine as they can slow the rate of absorption.)
- o Have you made suitable arrangements not to be disturbed?
- o If in doubt about the any aspects of your drugs-only plan, have you considered using a plastic bag as an additional safeguard?

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Plastic bags

Story – what you need – main features – general description – what is the evidence for plastic bags? – how quickly does it work? – are there any unpleasant side-effects? – checklist – references & diagrams

Jennie's story

Jennie drew her life to a close using one of the most traditional of methods – sedatives and a plastic bag. The sedatives weren't the cause of her death, but they were sufficient to ensure she was deeply unconscious when the oxygen in the bag was exhausted. Everything was planned carefully and she had practiced the 'dry-run' on many occasions – she would place a couple of rubber bands around her neck then slip the bag over the top of her head and tuck the ends in underneath the bands. It was a large bag to give the drugs time to be fully effective. She had experimented with several variations – two bags inside each other, a large garden garbage bag, one of those 'compression' bags used for storing clothes (she had cut the seal off to make it easier to tuck under the rubber bands) – in fact whenever she was out shopping she was always on the look-out for suitable bags. She used two rubber bands in case one broke. They were the right size, fitting quite snug around her neck without being in the slightest uncomfortable.

The bag she had settled on was a see-through plastic. This was nice. It let the light through as well as looking less unpleasant to whoever would eventually find her. Everything was arranged. She had her anti-sickness pills ready to be taken twenty minutes or so beforehand, then the sedatives that she would take immediately before arranging the bag (putting the bag on quickly before they started to make her feel drowsy). She also had a book of Keats, her favourite poetry, to hand,

and a CD of Beethoven's 2nd symphony which she would listen to while making the preparations and leave playing as she 'went under.'

Jennie's 'kit' that she had put together over the years also included a wide-brimmed hat and a painter's mask. Some of the literature suggested them to keep the plastic of the bag from being sucked against the face; but she found with the bag she had chosen it was not necessary – the plastic material was quite heavy and, when she shook the bag to get lots of air inside prior to putting it over her head, it didn't seem to fall against her face even after several minutes. Practicing with the bag but without the sedatives was quite safe – you never became drowsy and could take the bag off long before the air got hot and difficult to breathe (that would take up to half an hour at least).

Jennie lived with her son. Under English law, no-one could be in the house at the same time that she made her 'exit' so she was careful to make sure he was going to be out for a good few hours. Her son was sympathetic to his Mum's beliefs and understood her tact and why she wanted to make it clear to everyone that this would be her act, without anyone's help or assistance. When he had left, she also unplugged the phone, removed the batteries from the doorbell, and did a last mental check to make sure no visitors were expected.

The amounts of drugs were carefully laid out. She had used the 'estimating dosages' routine (see *Frequently Asked Questions)* and avoided taking any of the drugs for medicinal purposes for some months so her body was not accustomed to them at all (in other words, she didn't have an acquired tolerance that sometimes occurs with frequent dosaging).

Jennie knew she could relax until the last minute and that then she had to act swiftly. Once she started taking the sleeping tablets, all the preparations had to be completed quickly before they started taking

effect. As an extra precaution, she had taken some anti-nausea pills a couple of hours ago. She ground up her sleeping tablets ready to be mixed with some chocolate pudding. She left her farewell note where it would be easily found. She hadn't eaten all day, wanting to keep her stomach fairly empty. Now she treated herself to a small meal – some toast and croissants – and took another dose of anti-nausea tablets, just over twice the therapeutic amount. They were the sort that did not make you overly drowsy, but she could still feel the effect. Fortunately she was well rehearsed.

With an eye on the clock, Jennie waited about twenty five minutes for the anti-nausea pills to be absorbed. She switched her music on. Then she mixed the ground-up tablets with the pudding. She placed the rubber bands around her neck before downing the mixture in a few spoonfuls, washing it down with a glass of champagne she had placed nearby. Without pausing (the sleeping tablets could start to work within half a minute!) she slipped the bag over her head and tucked it securely under the rubber bands, checking all the way round so she knew it was a good seal. She sat back in her comfortable armchair and had time to pick up her Keats. It was a large print volume and she could see the lines clearly through the plastic bag.

But this is human life: the war, the deeds,
The disappointment, the anxiety,
Imagination's struggles, far and nigh,
All human; bearing in themselves this good,
That they are still the air, the subtle food,
To make us feel existence, and to shew
How quiet death is.

How does it work?

Very soon after taking the sleeping tablets and quickly donning a plastic bag, the person falls into a progressively deeper sleep. The air in the bag is gradually 'used up' – the lungs remove oxygen from the air with each inward breath. That oxygen is transferred to the blood which in turn keeps the brain alive. The outward breath contains a higher proportion of carbon dioxide and eventually the air in the bag contains insufficient oxygen to oxygenate the blood and keep the brain alive (anoxia). The process is hastened by the build up of carbon dioxide, which is toxic in higher concentrations. When the entire brain ceases to function, all the automatic processes of the body also stop: death occurs.

Drugs to use with plastic bags

Any sleeping drug of your choice that is effective. This can be from over-the-counter drugs, if they work for you, to the stronger ones obtainable on prescription or sometimes via the Internet. Test them with the *Estimating Dosages* routine. For a fuller description of various options and approaches to obtain them, please review the *Drugs* chapter.

What you need

- A suitable bag. The preferred size is shown in the diagrams, but you may select a smaller one as long as you are aware of the difference this presents.
- A couple of elastic bands.
- Sufficient sleeping tablets to put you in a deep sleep.
- Some anti-nausea tablets.
- Lots of practice putting the bag on!
- Other options include a wide brimmed hat or painter's mask to keep the bag away from your face. Many people will find these unnecessary, but you will be able to tell during your dress-rehearsals if your bag has a tendency to fall against the face.

Main features

The plastic-bag-plus-drugs method is historically the most established method of self-deliverance that is still used today. It is a 'safe' method in the sense that if a person doesn't get it quite right, the worst that is likely to happen (unless they are disturbed) is that they wake up with one hell of a hangover. It requires relatively little in the way of equipment or know-how. Some people find the plastic bag method unaesthetic.

General description

It is important to understand the mechanics of the 'plastic bag method' to avoid errors. It is a good method, but many failures have also been reported. Failures can usually be explained by the wrong size of bag being used, or occasionally the wrong type of plastic.

The use of sedatives is not just to cause sleep, but a sufficiently deep sleep for you to be immobilised. Otherwise it is quite possible that you will tear the bag off in your sleep. You know how most people toss and turn occasionally in bed at night? If something (such as the bed quilt) falls over the face and makes it too hot to breathe comfortably, you will probably move or push it off without waking up – it is an automatic reaction.

As the air in the bag is used (or you get 'hot and stuffy' under the bed covers), what happens is that the percentage of carbon dioxide in the air is increased as a result of exhalation. One of the side-effects of breathing a higher concentration of carbon dioxide is hyperventilation – an increase in the depth and rate of breathing – and you easily become more physical as a result.

Without putting too fine a point on it, it is easy enough to calculate the given amount of air in a bag and roughly how long it will last. Although they vary slightly from one individual to another, we also know the amount of time that sleeping drugs take, firstly to put you to sleep (which is very quick) but also, more importantly, how long it takes before you are immobilised and not going to thrash about a lot.

Early self-deliverance manuals recommended a medium–small sized plastic bag. Although there are many successes with such a bag, we know from the calculations just described that the volume of air in a medium sized bag is insufficient to allow time for the drugs to immobilise you. Which is why there are many cases of people 'waking up' and wondering how the bag got torn off.

Off course, if this happens to you, you will probably not have anything more serious to deal with physically as a result of the failed attempt than a bad hangover, but psychologically the experience can be traumatic and frustrating. To avoid this, find a larger bag – no need to measure it, but the picture is a good guide. When you are sitting with the bag on, then if it comes down to your knees (in sitting position) then that is a good size. Give it a good shake before you put it on (to fill it with air) and you will have about an hour of comfortable breathing before the oxygen runs out – which is plenty of time for the drugs to work fully.

When the oxygen runs quite low, insufficient oxygen will go into the blood, which means not enough oxygen gets to the brain. Deprived of oxygen for a few minutes, the brain shuts down and then death occurs.

Using a larger bag represents the safest course, but some people will choose a medium sized one because it is more comfortable or easier to use or they just prefer it in some way. If it is quite sturdy there should

be no problem, but armed with the full facts you can now make your own choice.

In some cases where people have been suffering intensely, a small bag has successfully been used. This is not the pleasantest way to go, but there is a trade off between how desperate the circumstances are and any further discomfort that can be tolerated. Using a small bag is straightforward death by suffocation. Some tranquillisers might be taken to ease the unpleasant sensations in such a case.

Try out as many different bags as you can in a dress rehearsal. Not when you are sick, but when you are well, so you can make your mind up which one to use well in advance should the need ever arise. Those with very thick plastic require a bit more manual dexterity to position. If the bag is quite thin, you might want to use two bags, one inside the other. You could even make or obtain a customised bag with a velcro strip for fastening it around the neck. You want to know how to get it on with ease (when you are adding rubber bands to keep it in place, a bit of practice comes in handy.) Remember the sleeping tablets may work very quickly, so there is no time for fumbling.

If you are unable to get anything else, over-the-counter sleeping drugs (available in most countries) can be used, but a safer option is modern prescription-only sleeping tablets such as zolpidem (Also called Stilnoct. In the US it is often called Ambien). Over the counter sleeping medications often contain the antihistamine diphenhydramine – their effectiveness is lower than prescription drugs and may also vary over time.

Zolpidem is fast-acting and also has the advantage of usually being supplied in a very small tablet, which makes it easier if you are swallowing quite a quantity. (n.b.: zolpidem is rarely lethal in itself: it is taken as

a drug to put you in a deep sleep so that you will not experience any gasping for breath when the oxygen in the bag is used up.)

It has sometimes been possible to buy zolpidem on the Internet without a prescription. If you do so, beware that there is a bourgeoning market in counterfeit or substandard drugs on the Web and you should be careful about sources and also test a small quantity properly before relying on them for self-deliverance. Does one or two put you to sleep properly in the daytime (in other words, when you wouldn't normally just drift off)?

Most people will obtain zolpidem from their doctor and simply stockpile it. For more advice on obtaining zolpidem, see the 'obtaining sleeping tablets' section in the previous chapter.

What is the evidence for plastic bags?
Use of plastic bags for suicide is long-established and attested to by police reports, newspaper reports, medical journal reports, eye-witness accounts and so on. The science involved is fairly straightforward.

What is the evidence against plastic bags?
The reason for failures with plastic bags are now fairly well established. The evidence comes largely from reports of right-to-die societies by people who have failed. Exit received a number of such reports and the Dutch right-to-die society told the authors of *Departing Drugs* of many failed attempts. This lead to further research. Scientific calculations (as well as descriptions of failures) showed that some failures were due to too small a bag. In these cases, a person's oxygen supply ran low while they were asleep but before the drug had put them in a sufficiently deep sleep. A small number of failures could not be attributed to this cause. Collaboration with the physics department of a major university brought to light that some plastics are oxygen-porous.

These plastics are not generally employed in the type of bags used in suicide, but are hard for the user to identify.

How quickly does it work?

With the type of bag in the illustrations, a little over one hour. A smaller bag will mean less time, but increase the (small but harmless) risk of failure. Once the oxygen supply has been fully depleted, the brain shuts down in a matter of minutes and death occurs.

Are there any unpleasant side-effects?

Not really. A good-sized bag will overcome any worries about hotness, or stuffiness.

Myths about plastic bags (1): the plastic bag method is foolproof

Actually there are many failures with plastic bags. I once spoke to a man who had failed six times before getting our literature and understanding how to do it in a way that minimizes failure. Exit similarly has many reports of failures from other countries. The slightly reassuring factor is that failure with the plastic bag does not generally lead to any serious complications (other than the trauma of having failed after such a momentous decision). You can try again. But it is helpful to understand how things can go wrong and so minimize the chance of failure.

Myths about plastic bags (2): any reasonable plastic bag will do

The most common culprit of failure is too small a bag – a 'medium' sized bag. This can result in lack of oxygen and hyperventilation (a reflex action involving an increase in the depth, rate, and duration of breathing which, in this case, is triggered by carbon dioxide build-ups). This can happen even when the person is asleep. If it happens too early, and the person is not so deeply asleep as to be incapable of reflex action such as struggling, they will often tear the bag off in their sleep, eventually waking up hours later and wondering how on earth it

happened. This is not to say there have not been many successful suicides with a medium sized bag; but if you want to avoid this particular danger a larger bag means the carbon dioxide poisoning (which causes the hyperventilation) does not occur until later on. By this time the sleeping tablets have put the person in a *deep* sleep so no movement is possible.

Another culprit, though quite rare, is 'the wrong type of plastic'. Some plastics are oxygen-permeable, which means that, over a period of time, oxygen particles can seep through the bag, possibly in sufficient quantities to maintain life. This accounts for those cases where a person wakes up hours later, head still inside the bag, and the bag intact and in place.

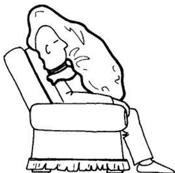
To a non-physicist, this sounds so surreal that it was a long time before cross-disciplinary investigations revealed this fact about certain plastics. Permeability can now be understood by anyone with access to books on physics such as those listed in the appendix (see the end of the references list in the section *Finding the Truth about Plastic Bags).*

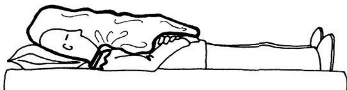
Checklist

- o Have you practiced thoroughly?
- o Have you got everything in place so that you have the minimum to do once the sleeping tablets have been consumed?
- o Have you made sure you won't be disturbed?

Diagrams showing two alternative relaxed and comfortable postures for using the plastic bag. In the first one, the person is in an ideal armchair, leaning back, and the chair is such that falling out of it is unlikely. The size of the bag in the diagram is a good indication of the ideal size when using a 'larger' bag.

A lying down position is the next best option.





References:

- Please see the articles in the *Appendix* for a list of references.

Starvation and other means

Overview of methods so far – starvation – main requirements – best approach – detox practices – how long does it take – are there any unpleasant side-effects? – main features – firearms – jumping – charcoal tents, carbon monoxide and exhausts – hypothermia – methods not recommended – checklist – references

Of all last acts, there is probably no better example of how individual the choice of method is than starvation. Starvation is not simply a matter of choice. It will be possible for some individuals and not others. It may be physically unsuitable for you.

In the last four chapters I've explored the main methods of self-deliverance. For enduring peace of mind, I recommend that you are thoroughly familiar with at least two or three of them. There are many other methods, but most of them rely on drugs that are difficult to obtain, or are unreliable, or carry a high danger of increased suffering in the event of a failed attempt. Importantly, you can rarely predict with certainty your situation near the end of life, so you may have to make your choices according to circumstances.

Under *Helium,* we looked at a method that is entirely free of discomfort and suitable in most situations where you have the freedom to put the equipment together in advance, store it securely, and have access to it when the time comes.

Under *Compression,* we looked at a set of simple methods that have minor discomfort at the most and can be used in a wide variety of

situations when you maybe don't have the freedom to get hold of drugs or equipment.

Under *Drugs,* we dispelled myths about chloroquine and sleeping tablets, as well as looking at the main other drugs of interest, as stand-alone drugs or for use with a plastic bag.

Under *Plastic Bags,* we cast an intense spotlight on the variations, showing the different reliability and comfort factors.

In this chapter we look at methods that are significant enough to be of interest to a proportion of readers and that, correctly used, can also result in a good death. They give you another string to your bow in addition to the methods of the preceding chapters. As with all the methods, our aim is to separate fact from fiction, and remove the myths that can obscure a proper, safe understanding of the methods. In many cases, a doctor offering an opinion based on insufficient information, has proclaimed a method safe or foolproof, when it needed more attention to detail and overcoming of loopholes.

Starvation

This method is emphatically not for everyone. But some people have successfully used it for a peaceful and dignified end and it deserves mention. One American neurologist created much publicity with claims that it was the best method. Careful review of the literature shows this is evidently not the case.

Death through starvation can be very dignified or very undignified, depending to a great extent on factors that may be beyond your control, so you may want to research it as a back-up method rather than as a primary one. A study in the State of Oregon USA (where physician assisted suicide is legal), found that of those terminally ill patients who decide to precipitate their deaths, twice as many die by

cessation of eating and drinking than by physician-assisted suicide. Stopping eating and drinking when terminally ill may come fairly naturally as the body starts shutting down. Self-starvation when suffering from an unbearable, unrelievable, but non-terminal disease may be very different indeed.

In India, up to a hundred Jains are believed to die by willed fasting every year. The method has been handed down by tradition but there is little data on whether the results are always as peaceful and pain-free as is believed. A study of the deaths by starvation by the Northern Ireland hunger strikers in the Maze Prison reveals quite harrowing ordeals, but these were not the willed deaths of right-to-die enthusiasts and may also be misleading.

Main requirements

A careful review of the literature (see *Appendix)* indicates that these are three:

- A physical check-up by a qualified medical practitioner to make sure you do not have either a body type or existing prognosis that is likely to lead to complications;
- Nursing care, both for providing comfort care and to initiate emergency action if unbearable complications occur;
- A considerable amount of will-power.

What is the best way to approach self-deliverance through starvation and dehydration?

First of all, get a good idea of what is involved, especially the dangers. You can do this by careful reading of the appendix on starvation in this book. Next you might consider the variety of circumstances that could trigger such a decision. In some terminal illnesses (including many cancers), the body will naturally start to shut down and the desire for

food and water will become less. Drastic reduction of food and water in such circumstances may speed up an inevitable process. Next, ask yourself how strong your will-power is. When you first stop eating, your desire for food will probably be very strong. After three days it will probably be very small. Following a 'detox' practice (see below) will give you a better understanding of how your body reacts to foods and liquids. It will enable you to better plan a healthy diet beforehand, and a sensible reduction that maintains essential nutrients and avoids strong foods (such as red meat) that place a greater strain on the body.

A 'detox' practice

You might like to experiment with this by doing a controlled health-fast – the sort of thing yoga practitioners recommend – the sort of 'detox' that is also encouraged at many health retreats. Many people will approach a detox fast by consuming only fruit and vegetable foods, while eliminating caffeine, tobacco, alcohol and sugar. Work up to a full day when you drink only fruit juice. The hunger pangs are strongest at first, especially if you are used to a diet of three meals a day with lots of red meat. After 36 hours (a full day plus the night-time each side) you may feel more in control of your hunger. The full details of controlled fasting-for-health are beyond the scope of this book and you may wish to look into it further before attempting more than a one-day fast. There is no direct correlation between 'detox' fasts and fasts-to-the-death, but it will give you an idea of some of the territory.

Fasting to death – how long does it take?

On the basis of reports by nurses, patients in hospice care who voluntarily choose to refuse food and fluids usually die a 'good' death within two weeks after stopping food and fluids. A Jain woman reported in the media after fasting to death in India also fasted for two weeks.

Are there any unpleasant side-effects?

Yes – but not in all cases. The precautions listed under *Main Requirements* (above) are to minimise the risk of unpleasant side effects – either by alerting the person to their likelihood in his or her particular case or having the facilities on hand to cope. Weakness, blindness and internal organ failure are all possibilities. Many people may consider the first two bearable, especially with a carer on hand, but internal organ failure can be extremely painful. Again, a carer with at least basic medical knowledge can, in such circumstances, arrange emergency medical treatment if required. In cases where there is no internal organ failure, a carer can play a major part in reducing serious discomfort. Ice chips to moisten the lips, being moved to avoid bed sores (when too weak to move oneself), and other comfort-care measures are necessary for any Westerner contemplating death through refusing food and water.

Main features

Fasting to death has a certain lifestyle attraction. It is perhaps the only 'passive' method of intentionally ending one's life and has an appeal, whether aesthetic or to accord with a person's beliefs, over the more active methods. In certain instances it has not been regarded as 'suicide' and avoids the stigma that some people attach to that word. Legally, it probably allows both a person to be present (in jurisdictions such as England, presence at a suicide could normally be construed as criminally aiding and abetting) or palliative care to be administered during the process. An advantage is that it cannot be done impulsively and is seen not to be done impulsively. It requires a great deal of will-power and is not suitable for all personalities or body types.

Use of firearms

Most right-to-die activists and researchers, largely because of the inherent violence and the disagreeable nature of others later finding a body with gunshot wounds to the head, have shunned the idea of using firearms for suicide. Suicide by means of a firearm is not without

other problems, but as it is a not uncommon method it should perhaps be considered in passing.

Suicide by using a gun is more prevalent in countries where guns are easily available or else where the person has ready access to a gun because of profession (as is the case, for instance, with farmers or military personnel). Across the US, firearms are used in approximately 60% of all suicide deaths. Failure (which is not uncommon) results in devastating injury. Many intended suicides by gunshot leave the person alive but brain-damaged. Placing it to the temple risks the skull changing the bullet's trajectory. The gun must be powerful enough for the attempt to succeed. Placing the barrel in the mouth pointing upwards towards the brain would seem to be the most reliable. Care must be taken not to lean forward – failures have been attributed to leaning forward at the last minute or to jerking the gun as it fires (and so altering the path of the bullet).

The main consideration in using a firearm successfully is to have some knowledge, experience and training with firearms. Other considerations include minimising the upset to others by appropriate choice of location (cleaning body tissue off walls and ceilings is a particularly gruesome task.)

Jumping

The question of consideration to others mentioned above applies doubly. Cleaning up the mess will be an unpleasant task. Persons witnessing the death may be traumatised. If jumping from a building, there is the danger that someone might be killed when you fall on them. People also underestimate the height of buildings needed for a successful suicide. There are cases of people surviving (although totally paralysed) after jumping from as many as six stories. Jumping from ten stories or more is 100% successful. High cliffs stand a better chance of success if there is no chance of the fall being broken on the way.

Jumping from bridges is often unsuccessful. If you are washed up only 'half' drowned you risk long-term brain damage. Jumping in front of trains is not only inconsiderate (to the driver), but has a high failure rate, with people being pushed underneath and sustaining terrible injuries.

Charcoal tents, carbon monoxide and exhausts

Before catalytic converters (which reduce the emission of carbon monoxide) were fitted to cars, this was a popular form of suicide. A hosepipe was run from the exhaust into a semi-closed window and the car kept running, usually in a locked garage. Carbon monoxide (not to be confused with carbon dioxide – a gas which we exhale when breathing) is tasteless and odourless. Its toxicity stems from the fact that it drives oxygen out of the red cells of the blood and thus deprives the body and brain of its normal supply of oxygen. A concentration of even one per cent in the air can lead to death. The greater the concentration, the faster death occurs (it can be anything from a minute to two hours). Failed attempts result in varying degrees of brain damage. One woman I spoke to still has recurrent memory loss a result of a failed attempt many years ago. One study suggests that a person's lifespan can also be reduced due to damage to the heart muscle.

If you have the mechanical knowledge to remove the catalytic converter from your car, and you have a reliable enough engine that won't cut out, it is still a possible method. Just be aware of the serious dangers if it goes wrong (the motor cutting out or you being discovered and 'rescued'). Bear in mind you are probably breaking the law by removing the converter. In the UK, if your car was registered after 1st August 1992 you must have the converter present and working for the MoT. Previously registered cars can have the converter permanently removed.

Another method has gained popularity in Japan after 1998. Charcoal briquettes (the sort used in barbeque grills or stoves) burnt within an enclosed area, such as a small sealed room, tent, or car, produce large amounts of carbon monoxide. In a typical scenario, the windows of a rented van are sealed with vinyl tape from the inside, and four charcoal stoves placed on the floor. Charcoal burner heaters can be purchased online or from garden and patio accessory shops.

Hypothermia

Death from exposure to cold has only a moderate success rate. It requires *reliably* cold temperatures over a sufficient period for death to occur. Failure can produce severe injury. Some drugs, such as barbiturates, chlorpromazine and even paracetamol (acetaminophen/Tylenol) accentuate symptoms of hypothermia. Immersion in cold water causes loss of body heat at a much faster rate than air at the same temperature. Hypothermia is relatively painless but has potentially dire consequences if interrupted (for instance if someone spots and rescues you). In can be as quick as half an hour in freezing cold water or a couple of hours on land. Wearing little clothing helps, and fat people will take longer to die than thin people. Some sedatives are desirable.

Methods not recommended

Slitting one's wrists is not as reliable method as it is sometimes portrayed in the movies. A *Guardian* newspaper interview with the paramedics who attended the alleged suicide of David Kelly says, "Over the years they have raced to the scenes of dozens of attempted suicides in which somebody has cut their wrists. In only one case has the victim been successful." Finding a suitable artery requires greater knowledge of anatomy than most people possess. Usual attempts tend to sever the surface veins. These veins are neither particularly large nor carry as much pressure as the arteries, and so such cuts are not usually life-threatening. They can clot before a fatal quantity of blood is lost. If you were intent on trying this method, one of the easier arteries to

sever is the radial artery, which is fairly near the surface and where the wrist and thumb come together (feel for the pulse there). Failure may result in simply severing the flexor tendons. Wrist cutting has a very low success rate.

Poisonous plants – although there are a number of plants that are reliably poisonous, they are not reliably lethal or free of very unpleasant side-effects. Hemlock is undoubtedly poisonous, but its side-effects differ markedly from the tale of the supposedly peaceful death enjoyed by Plato.

Checklist

- The methods in this chapter all carry a certain risk. Have you fully understood the risks and how to cope with them?
- Have you acquainted yourself thoroughly with several of the main methods from previous chapters?
- If you are reasonably healthy at the moment, have you looked ahead and considered the various situations you may find yourself in?
- Have you prioritised your preferred methods but know enough methods to be adaptable to changing or unexpected circumstances?

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n.b.: For the extensive list of references about starvation please see the relevant chapter in the *Appendix*.

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Appendix

My aim in the body of this book has been to make the text readable enough to convey the necessary knowledge to anyone. Some of the research behind the conclusions however, is more technical, and needs to be included for reference, or to cast aside worries about whether the information is reliable. We would urge every reader to investigate methods for themselves. Do not believe something just because a doctor or campaigner said it was so or a famous speaker on euthanasia proclaimed it successful. The methods in *Five Last Acts* and our conclusions about them are well-researched but, on the above advice, it makes good sense to verify that for yourself!

The chapters in this appendix will provide a starting point for just that, as well as presenting the ideas from a slightly different angle. You can take our references and follow them up in any good medical library, such as that attached to larger universities. You can search toxicology manuals, such as Martindale's, to find out more about specific drugs. Bear in mind, at this point, that drug companies test drugs for their *therapeutic* purposes only. If the manufacturers (or toxicology manuals, or doctors – who are also trained in therapeutic use of drugs but rarely in their use in suicide) say such-and-such a dose can be fatal, that is exactly what they mean – not that it necessarily *will* be fatal! The information they provide may offer clues but their aim is at odds somewhat with ours. A further (and in many ways better) approach is to look at statistics on successful and unsuccessful suicides. If you investigate chloroquine, for instance, you will find a wealth of data available. (Anecdotal evidence also has a place, but mostly suggestive – especially when it contains reports of failures: several drugs and certain ways of using plastic bags have been discovered to be flawed by following up the leads from failed attempts.) Eventually there comes a reasonable cut-off point where, with a given method or drug, no-one survives. Anyone can research this – you do not need a medical degree,

but you need the patience to understand the terminology so you clearly follow what is being said. If you are doing serious research, after you follow your conclusions to a logical result, it is worth having them reviewed by an expert in that field who is qualified to assess the hypotheses in case you have missed something.

Information on new methods has been published in the *Exit Newsletter* (formerly *Voluntary Euthanasia Society of Scotland Newsletter*) or in *Beyond Final Exit*, the companion book to our 1993 manual *Departing Drugs*. Ordering back copies is not only time-consuming and expensive but for ease of reference the articles need to be gathered together in one place. In addition to background material based on the workshops, this appendix also includes reprints of key articles, updated where appropriate.

I am sometimes asked why have I not updated *Departing Drugs*. If you are interested, I recommend you obtain the original. There is no need for an update: some of the drug names have changed (but that can easily be ascertained by looking at the box and referring to the generic, or chemical, name of a drug); more importantly, knowledge of viable methods has grown and, rather than overload the reader with an encyclopaedic account of every possibility, I have distilled the essential methods in this volume to take this into account.

What is asphyxia?

Understanding asphyxia helps us with several of the five 'Last Acts'.

It maybe helps to consider asphyxia in some of these terms:

- A process rather than an event
- Cutting off oxygen from brain
- Interference with breathing (e.g. suffocation with a pillow, drowning, hanging, or pressure on the chest or larynx)
- Removal of oxygen from the air (e.g. by inert gas such as helium or 'plastic bag method')
- Preventing oxygenated blood from reaching the brain (e.g. pressure on the carotid arteries)
  or
- Preventing oxygenated blood from entering the brain (e.g. pressure on jugular veins prevents exit of used (de-oxygenated) blood)

It explains how, in different ways, the plastic bag, compression and helium all cause death. Many other methods of death can be attributed to asphyxia – such as drowning or car exhausts, but the ones listed in the main part of the book are the ones with least risk and least discomfort.

Research into asphyxia

Helium, carbon monoxide generators, 'de-breathers', the 'COgen' self-deliverance device and self-asphyxiation in various forms have all hit the news repeatedly in recent years. This chapter examines some of the methods hitting the headlines and asks if they are trends or simply 'trendy' and media-grabbing?

In 1995 *Exit* Research Associate Cheryl Smith published a ground-breaking article Carbon Monoxide for Self-Deliverance in *Beyond Final Exit*[1]. The volume also included a chapter on Nitrogen and other Inert Gases and mentioned helium. Since then, hardly a year has gone by without proclamations about new 'suicide machines', most of which rely on some device to ensure that the person committing suicide dies (within minutes) of asphyxiation[2] by inhaling increased volumes of carbon monoxide or helium. When one of the most popular books on self-deliverance, *Final Exit*[3] by Derek Humphry, went into a third edition, a noticeable addition was a chapter on helium.

Carbon monoxide

Carbon monoxide[4,5] is a highly poisonous gas and has long been used for causing death. In Greek and Roman times it was used for executions. In high concentrations it causes death within minutes. Before natural gas, it was the component that allowed people to die by putting their head in an unlit gas oven. Until catalytic converters arrived, it was the component of car exhaust that enabled suicide by car fumes. More recently, Dr Kevorkian used cylinders of carbon monoxide attached to a gas mask (available at military surplus or medical supply stores) and a hose. A gas mask is not essential – any relatively enclosed space will do (such as a tent, or a tube tent as sold quite cheaply at outdoor adventure shops for emergency use). Even cylinders are not essential – quite fortunately as they are not that easy to buy. A popular method in the East is the use of hibachi or charcoal burners (or any other carbon

based fuel). Which brings us to some of the drawbacks: If you fill an area with carbon monoxide, that may also be poisonous to anyone finding you. If you leave something burning, it might end up causing damage by fire – even damaging the means of deliverance if you use a tube tent. The main danger of this (and all) asphyxia methods however is the possibility of brain damage if the process is interrupted due to intervention, running out of gas, or tearing or removing the gas mask, plastic bag or tent while unconscious. This can be minimised by using a high concentration of the gas, which causes most rapid loss of consciousness but, as with any method of self-deliverance, the dangers are to be taken seriously – injuries include dementia, psychosis, paralysis, cortical blindness, memory deficits and parkinsonism; the latter two are the most common.

Carbon monoxide has limited uses in medicine and in metallurgy and I found six UK suppliers on the Internet (using a 'Google' search), but given the concerns about carbon monoxide poisoning it is likely that any would-be purchaser would need to convince the supplier that they had a bona fide trade use in mind.

Notwithstanding these problems, there is plenty of room for experimentation. A standard laboratory method for producing carbon monoxide for instance is by using concentrated sulphuric acid to dehydrate formic acid.[6] Philip Nitschke is an Australian campaigner who, like *Exit* here in the UK, has run self-deliverance workshops. He has put much time into trying to develop a carbon monoxide generator or 'COgen' as he terms it. Nitschke's prototype device replaces the rather unaesthetic gas mask with nasal prongs such as are often used to deliver oxygen in hospitals.

Helium

Helium is a colourless odourless gas which is not combustible. As helium is less dense than nitrogen, breathing of a mixture of 80 per

cent helium and 20 per cent oxygen requires less effort than breathing air. Such mixtures have been used in patients with acute obstructions of the respiratory tract. Mixtures of helium and oxygen are used by divers or other workers working under high pressure to prevent the development of caisson disease (decompression sickness, or 'the bends'). Breathing helium speeds up the vocal pattern and increases vocal pitch. Death by breathing helium is caused by displacing the oxygen that the brain needs to stay alive. Unlike carbon dioxide, it does not cause hyperventilation (rapid breathing) and the associated discomfort.

One of the great advantages of helium over carbon monoxide as a means of self-deliverance is that it is easily available. Party balloon kits, available by mail order, include canisters of helium.[7] An increasing number of successful suicides are being reported using this method. The helium tank is connected to a hose, the other end of which is firmly attached by tape to the inside of a medium sized plastic bag. Tranquillisers or sleeping tablets (and anti-emetics) may be taken beforehand for added comfort.

As with other forms of asphyxia, interruption may result in permanent brain damage so, although the method is relatively straightforward, care would obviously be needed.

Footnotes

1.Beyond Final Exit is no longer in print, but key articles have been re-published in Exit Newsletters.

2.Asphyxiation is commonly associated with suffocation or choking - but it simply means a loss of oxygen to the brain and so covers a wide range of methods, not all of them necessarily uncomfortable.

3.See subsection on helium. The helium bag technique is also explained in a chapter of Final Exit 3rd edition, by Derek Humphry, which is obtainable through any good bookstore.

4.See also separate article this volume.

5.Not to be confused with carbon dioxide, which is the gas we exhale and which has very different properties.

6. HCOOH > CO + H2O

7. At the time of writing, UK suppliers of helium balloon kits that can be found on the Internet include: Imagination Creative Balloons, 3, Dunkerly Street, Oldham, OL4 2AX, England (Tel/Fax: +44 (0)161 626 8734 Internet: www.flowermill.co.uk/balloons Email: balloons@flowermill.co.uk) who offer a helium tank ("Each helium tank will fill approximately 40-50 9" latex balloons") for £42 plus £9.95 for postage and packing; or Icarus Limited, Broadgate House, Church Street, Deeping St. James, Peterborough, PE6 8HD England,
tel: +44 [0]1778 347609 or www.connected.org.uk/icarus/index.html or email them at enquiries@icarusballoons.co.uk They offer three different sizes of helium canister.

Finding the truth about plastic bags

Numerous press reports, both before and after the first 'self-deliverance' manuals appeared in 1980[1], have ensured that plastic bags have long been known as a method sometimes used in suicide. The exact practicalities have been debated at greater length in various books since[2], but there remains concern over some details, especially in the light of reported failures with the method.

The aim of this article is to assemble some of the pertinent issues and scientific theory and act as a focus for developing thought on this method of self-deliverance. Feedback is encouraged.[3]

Popularity

Plastic bags, combined with drugs, are often seen as the method of choice,[4] yet the pitfalls are considerable. On the other hand, some people view bags as unaesthetic or undignified – these factors come down to personal preference or other methods being ruled out for one reason or another. Except in extreme circumstances, plastic bags are usually seen as a back-up device for suicide by ingestion of drugs.[5] Less reliably, they have been used as a suicide device with non-lethal drugs.

> On paper it seems easy: a terminally ill person secures a plastic bag over her head, nods off with the help of an appropriate dosage of prescription barbiturates, and dies in her sleep from asphyxiation due to lack of oxygen. To a desperately suffering individual, this will often seem like a comfort and a realistic option. In fact it is much more complicated.[6]

General methodology and reactions in use

The recommended method with step-by-step instructions is detailed in *Departing Drugs*,[7] as well as this book, but an overview of the process follows for the purpose of this article. To live, we need oxygen. When

we lose the availability of oxygen we asphyxiate ('suffocate'). Common methods of asphyxia include drowning, strangulation and obstructed airways. Asphyxia can also be caused by the absence of oxygen in an environment where we are free to breathe, such as inside a plastic bag (while technically suffocation, this does not necessarily mean that there will be the reactions commonly associated with suffocation, such as struggling – the large amount of nitrogen remaining in the plastic bag allows breathing to continue). We produce carbon dioxide (CO_2) as a waste product. It is a colourless and odourless gas, acidic in taste in concentrations above ten per cent). The body is very sensitive to high levels of CO_2 and when they are present involuntary reactions will normally include an increased rate of breathing and may include panic. You can try this with a plastic bag over your head. In a minute or two you will become very conscious that you need to breathe fresh air. Even though you have yet to experience oxygen deprivation, your body has become aware of high levels of CO_2 and is automatically alerting you to seek fresher air. As the effect increases, you will hyper-ventilate (breathe more quickly with increasing depth and duration).

The most important physiological effect of carbon dioxide is to stimulate the respiratory centre.[8] The stimulation is pronounced at levels of five per cent and above.[9] As much as 30 percent may be tolerated for some time provided the oxygen supply is adequate.[10] Oxygen deprivation begins when oxygen levels have fallen to twelve percent and the symptoms of headache and rapid breathing become severe when it falls to eight per cent. Unconsciousness and death do not occur until the oxygen is down to five percent, "unless the patient makes strenuous exercise, in which case death may come when there is still eight per cent oxygen."[11]

One correspondent, after a failed suicide, wrote, "After everything was done I felt like removing the bags again because I couldn't stand the hot plastic sticking at my nose each time I took a breath."[12] Sugges-

tions for overcoming this minor problem have included a wide-brimmed hat or a spray-painter's mask.

Failures

The Scottish euthanasia society (*Exit,* formerly Voluntary Euthanasia Society of Scotland or Scottish Exit) has received many letters over the years detailing failure in the use of plastic bags for suicide, though far fewer since we issued detailed instructions in *Departing Drugs.* One man said he had attempted, and failed seven times. A typical letter read: "I put the bags on again, because I wanted to succeed, and then I don't remember anything any more. Subconsciously I must have removed them again, because the following morning I woke up dizzily." Anecdotal evidence conveyed by the Dutch euthanasia society also indicated an alarmingly high failure rate with plastic bags. Some documented cases of failure with plastic bags are additionally recorded in the literature.[13]

The type of plastic used, the size of the bag, the type of drugs, drug dosages, varying metabolisms and medical conditions, and the failure of an assistant to realise that the patient was not in fact dead[14], have all been cited as possible causes. Oversensitivity to carbon dioxide levels in the body's breathing control system can cause sleep apnea (a temporary inability to breathe) in some people with heart failure. Enhanced sensitivity could destabilise breathing during sleep. Normally, carbon dioxide levels rise during sleep, causing breathing to increase slightly to eliminate the excess carbon dioxide. Even among many normal people, if carbon dioxide levels fall too low (as they can during hyperventilation), breathing stops until the levels return to normal. In patients with an oversensitivity to changes in carbon dioxide levels, however, rising levels during sleep stimulate an exaggerated response in the form of hyperventilation. Hyperventilation then drives carbon dioxide levels below the threshold where breathing

ceases, causing sleep apnea. The result is periodic breathing with recurring cycles of apnea and hyperventilation.[15]

Types of plastic

Plastic bags, even those that seem 'airtight', have both myriads of tiny holes[16] and a degree of permeability to oxygen.[17] The 'permeability coefficient' is the constant relating the rate of transfer of a diffusing substance (such as oxygen) through a unit area of a film or sheet of a given thickness to the concentrations of the substance on either side of the sheet.[18] While the permeability of bags used in attempted suicide is probably small, it cannot be ruled out as negligible. The chemical structure of the plastic is the main factor affecting permeability, although physical factors, such as density, thickness and elements in the manufacture may all influence the degree to which oxygen can permeate the bag and so extend the dying process. Low-density polythene may allow more than seven times as many oxygen molecules through its surface than high-density polythene. PVC allows substantially less.[19]

Sizes of bags, drug dosages and types of drugs

The recommendations as to size of bag in *Departing Drugs*[20] and this book are based on logical arguments relating to the time taken for drugs to immobilise the patient as opposed to merely put the patient to sleep. It is not difficult to calculate, from a given volume of air in a bag of a certain size, and the average amount of air breathed in a minute, how long the oxygen portion of the air in the bag will last. The calculations can be checked by experimentation (non-harmful) where an observer looks for first signs of cyanosis (a bluish-purple discolouration of the skin resulting from a deficiency of oxygen in the blood, which may first manifest itself in the fingertips).[21] The speed of action of drugs can also be estimated – not with precision, but with sufficient accuracy to make a broad judgement. The stages of drug action can include a) deep sleep, b) immobility and c) death. If asphyxiation

begins before stage (b) has been reached, then the patient may struggle violently, even though asleep. In some cases the patient tears through the bag(s) or effects removal. If the drugs used prove insufficient to cause death then the patient in most cases eventually awakes, with or without additional severe damage depending largely on the drugs taken. In earlier self-deliverance manuals it was only thought necessary to use drugs to put one into a sleep so the plastic bag could have its effect – nowadays we know that additional precautions are desirable: namely, that the bag should be large enough to allow the drugs ample time both to put the patient to sleep and to produce a degree of immobility, and that the drugs in themselves (if possible, though not essential) should be of a lethal variety.

An exception to the usual recommendations about the size and use of plastic bags has been pointed out in the case of people who are very desperate and so wanting something very quick even at the expense of a short period of discomfort. In this situation it has been suggested that a very small bag can be used so as to minimize the amount of time before oxygen runs out. This method, while having its advantages, does not have the dignity of the more elaborate methods recommended in various manuals.[22]

Advantages of plastic bags

Whether to disguise the cause of death by having an assistant remove the bag afterwards, or for other reasons, the fact that plastic bag suicide in itself leaves little trace of the cause of death sometimes makes it attractive.

> Analysis of the autopsy findings showed no specific features for this method of suicide. In particular, petechiae,[23] which are often considered a marker of asphyxia, were present in only a small minority of cases (3%). Furthermore, the scene investigation rarely revealed specific features, other than the plastic

bag in place. Thus, if the plastic bag were removed after death, the cause and manner of death would be obscure.[24]

Drugs of most sorts are prone to a certain percentage of failures and the plastic bag provides a back-up mechanism to help guarantee success in self-deliverance. Of the drugs where lethality is better documented, many are almost impossible to obtain by most people or else require very careful use to avoid mishap.[25]

Unlike drugs and firearms, plastic bags are, however, easily available.

Disadvantages of plastic bags

Over-reliance on plastic bags as a principle mechanism for achieving death, failure to obtain a suitable bag[26] and possible premature removal of the are all disadvantages. The successful deployment of a plastic bag in suicide needs either luck or careful planning. Development of physician-assisted suicide with appropriate safeguards[27] will, hopefully, in the longer term, make such deliberations and dilemmas redundant.

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2. Principal, detailed descriptions are found in:

i) Docker C, Smith C, (North American title:) "Departing Drugs: An international guidebook to self-deliverance for the terminally ill." UK title: "Supplement to How to Die With Dignity – Departing Drugs". 1993, Voluntary Euthanasia Society of Scotland. North American edition published by The Right to Die Society of Canada.

ii) Humphry D, "Self-deliverance from an end-stage terminal illness by use of a plastic bag" 1993 ERGO! pamphlet.

iii) Humphry D, "Final Exit" 2nd edition, revised and updated, Dell Paperbacks 1996.

3. Feedback should be sent to the author, not necessarily for publication. Personal experiences as well as scientific data and published accounts are all welcomed.

4. See for instance, Colin Brewer's article "Darkness at Midnight", VESS Newsletter Sept 1987.

5. Or occasionally to facilitate death by lethal gases. A Northern Californian man, attempting to follow the deaths of the "Heaven's Gate" cult suicide victims, placed a bag over his head and inserted a propane hose under the bag and turned on the gas. (Nando.net, Assoc. Press 1997).
6. John Pridonoff, former Director of Hemlock USA, "Meyer Case Exposes Problems With Use of Plastic Bag", Hemlock Timelines Nov-Dec 1994:5.
7. Supra. A not-for-profit booklet available from Exit. Applications can be made by members of right to die societies of at least three months' standing together with acceptable documentary proof and appropriate payment in Sterling currency or by credit card.
8. Hamilton and Hardy's Industrial Toxicology 4th edition Asher J Finkel 1983, pp.154-155.
9. The composition of air at sea level is 78.08 per cent nitrogen, 20.95 per cent oxygen, 0.93 per cent argon and 0.03 per cent carbon dioxide.
10. Supra, Hamilton and Hardy.
11. Ibid.
12. Letter from abroad received at the Office of the Voluntary Euthanasia Society of Scotland
13. Ogden, R, "Euthanasia, Assisted Suicide and AIDS", 1994 Peroglyphics Publishing p.83. See also: Jamison S, "When Drugs Fail: Assisted Death and Not-So-Lethal Drugs" in: Battin M, Lipman A, (eds) "Drug Use in Assisted Suicide and Euthanasia" 1996 Hawarth Press.
14. This is not as uncommon as it might sound. One particularly dramatic account can be found in Holtby M, "Assisted Suicide – Gone Wrong" Colorado's AIDS Newsletter, Resolute! April 1995.
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16. Correspondence from Glasgow University, December 1995.
17. Pauly S, "Permeability and Diffusion Data", in: Brandrup J, Immergut E, Grulke E, Bloch D, "Polymer Handbook" 3rd edition, John Wiley & Sons 1989. I am indebted to Professor Whitehead of the Science Faculty at Glasgow University for bringing this to my attention.
18. Ibid, Pauly, p.435-436. The permeability coefficient equals P in the equation $F=P(C1-C2)/L$ where F is the rate of transfer, L is the thickness of the sheet and C is the concentration(s) of the substance. The values of P can vary widely depending on the particular gas/polymer being considered. This for oxygen, values vary from 1.3 x 10-18 for polyvinylidene chloride (a barrier polymer) to 205 000 x 10-18 for silicone rubber. Most plastic bags are made of low-density polyethylene (polythene).
19. Ibid, pp.435-449.
20. Supra pp.20-21.

21. Experiments of the International Drugs Consensus Working Party, 10th November 1993, Edinburgh.
22. Humphry D, "Self-deliverance from an end-stage terminal illness by use of a plastic bag" ERGO!, 1993. Humphry himself puts forward this method as an alternative for extreme cases.
23. Petechiae are minute discoloured spots on the surface of the skin caused by underlying ruptured blood vessels.
24. Haddix T, Harruff R, Reay D, Haglund W, "Asphyxial suicides using plastic bags" American Journal of Forensic Med Pathol 1996 Dec;17(4):308-11.
25. Barbiturates are very difficult to obtain for most people in most countries. Certain over-the-counter anti-malarials, documented in *Departing Drugs*, are difficult to obtain in the USA, and in any case require careful combination with suitable sedatives.
26. This article is not recommending any particular type of bag. It tries to set out the criteria and facts on which readers can make intelligent decisions. Some readers have written to us about the customised "Exit" bag mentioned in an addendum to Beyond Final Exit, which, in spite of the name, has no connection with Exit. Although Exit welcomes ongoing research and developments, no recommendations concerning this bag manufactured by a third party are made at the present time.
27. See the model approach in VESS Newsletter Vol.19 No.4 by Prof. S.A.M. McLean for a considered approach to legal reform.

Information on permeability and diffusion in plastics can be found in Polymer Handbook, by Brandrup, E.H. Immergut, E.A. Grulke (Eds.); Wiley, New York, 1999. the relevant chapter is: by Pauly, S, Permeability and Diffusion Data (pp VI 435-449)

The chloroquine controversy

CG Docker & CK Smith

This is a reprint of the ground-breaking article from the April 1993 VESS Newsletter *and from* Beyond Final Exit *and is reprinted here for reference. Readers please note that chloroquine is not readily available in the United States, but otherwise the article contains all the necessary scientific information regarding the use of this drug, which requires considerable care and deliberation.*

No universally accepted authority on self-deliverance euthanatics currently exists. Doctors are not trained on this aspect of drugs and the drug companies' interest, like that of medical schools and medical practice, relates only to therapeutic effects. While toxicologists may be able to determine the minimal lethal dose of a drug, they cannot necessarily indicate possible side-effects that might make the drug unsuitable, in some or most cases, as a euthanatic. The drugs involved in physician aid-in-dying, a procedure used in the Netherlands, may not be applicable in cases of self-deliverance. In addition, findings of doctors who have prescribed lethal drugs have not been published, due to restrictive public opposition or illegality.

At least two right-to die societies have advocated the use of chloroquine as a euthanatic,[6,10,26] one of these especially in combination with other drugs.[6] The German society, DGHS, has advocated the use of chloroquine for self-deliverance since 1983.[6] Members of the World Federation of Right-to-Die Societies generally have been sceptical of this use of chloroquine. Widely differing opinions and conclusions have been reached, yet no supportive documentation, to our knowledge, has been put forth to justify them. In an attempt to encourage further dialogue in a logical manner, we first considered three areas:

i) physiological effects of chloroquine overdose and speed of onset, from published data (theoretical),
ii) observed evidence from case studies (clinical), and
ii) patterns or popularity of use in suicide (sociological).

We obtained data on theoretical aspects by examining some forty published papers from 1964 to 1991, as well as established reference works. Some of these contained no relevant data – e.g., certain papers looked exclusively at long-term therapeutic use. We avoided extrapolation and paraphrased as little as possible. We approached clinical aspects by review of papers that included detailed case studies and we also sought unpublished information on case studies of intentional suicide from the German right-to-die society (DGHS). Our research indicated that chloroquine has been, and still is, a popular suicide agent in several parts of the world – e.g. Africa,[14] Papua New Guinea[28] and Germany.[27] This sociological factor seemed to warrant serious attention, although other considerations, such as distressing side-effects, are of more importance. We visited the staff at DGHS, the German right-to-die society, to learn from their extensive practical experience with the use of chloroquine. Our findings are not final or absolute, and we invite input from any interested parties who have other relevant data that will further discussion on this issue.

What evidence is there to suggest that chloroquine can be lethal?
Eleven of the twenty-seven sources reviewed specifically state that chloroquine can be lethal[2,3,5,7,11,14,15,16,19,24,26] and, one of these, *Toxicology Management Review* (TMR), reports that, according to published studies, the mortality rate is among the highest in clinical toxicology.[14] Some rare cases of survival following ingestion of large amounts have been reported when prompt, aggressive treatment had been undertaken,[2,5,26] although according to TMR the higher the dose the greater the likelihood of death.[14] While "1.5g (20mg/kg

body weight)"[24] is the generally accepted minimal toxic dose, a recent (1991) report in *Intensive Care Medicine* pointed out that "ingestion of more than 5g chloroquine is usually reported to be fatal without effective treatment".[11]

Chloroquine is described as a potent myocardial poison[7] that is rapidly absorbed from the gastrointestinal tract.[26] Although the drug is slowly excreted,[28] toxic effects rarely last more than 24 hours.[26] The drug depresses the heart and lowers the blood pressure by dilating blood vessels distant from the heart.[7] Death is caused by failure of the heart to contract, complicated by a slow and abnormal heartbeat,[7] with eventual cardiorespiratory arrest.[5] At least one study on the effects of chloroquine poisoning on the heart indicated that a person's weight is more relevant than age to the toxicity of the drug.[7]

One problem with some of the papers that we studied was the inconsistent use of the term chloroquine. As a letter to the *New England Journal of Medicine* points out, failure to differentiate between the base equivalent of chloroquine and the entire salt would hinder calculations of the projected amount needed to produce death.[20] Chloroquine base 100mg approximately equals chloroquine sulphate 136mg or chloroquine phosphate 161mg.[19] Tablets commonly prescribed in Britain contain 250mg of the phosphate (approx 155 base), or 200mg of the sulphate (approx 150 base). In the United States they generally contain 250mg of the phosphate (approx 155 base), or 500mg of phosphate (approx 310 base).

How quickly does chloroquine take effect?

Case studies vary, with death occurring in less than an hour[16] to up to twelve hours[5] after ingestion. The studies indicated that a greater number of deaths occurred in two to three hours[14,5] or less.[16] One author stated that "the absence of cardiac effects 4 – 6 hours after

ingestion makes survival likely."[22] DGHS literature suggests that death from chloroquine overdose occurs in 12-24 hours.[6]

What evidence suggests unpleasant side-effects with chloroquine?

Possible side-effects include both unpleasant symptoms that might be experienced before death (or coma leading to death) and serious long-term symptoms that might occur in the case of a failed suicide.

The published reports discuss a wide variety of side-effects that may be caused by chloroquine. The most common of these are respiratory difficulty, drowsiness, and cardiovascular symptoms including low blood pressure, low potassium in the blood and abnormal heartbeat.[14] Other common symptoms include gastrointestinal problems,[3,5,16,19,28] hyperexcitability,[16,22,28] convulsions,[3,7,14,16,22,26] difficulty in breathing,[5,16,22,24] headache,[3,19] slurred speech,[5,16,22] coma,[3,22] and visual difficulties.[1,4,14,19,21,26] Interestingly, some individuals may have no symptoms until suffering cardiac arrest.[24] Gastrointestinal problems, including nausea and vomiting, can interfere with ingestion. Chloroquine has a bitter taste[4] which can exacerbate the problem. According to DGHS, these symptoms, which could weaken the effect of the lethal dosages, may be alleviated by taking a few tablets of an anti-emetic an hour in advance.[6] In one case of hyperexcitability, the patient became wild and struggling and four persons were required to restrain him.[16]

Regarding long-term effects, opponents of the use of chloroquine as a euthanasic drug have raised concerns about the potential for blindness resulting from a failed chloroquine suicide attempt. This concern may have come about as a result of knowing that quinine may, in fact, cause blindness when taken in toxic doses.[1,14] TMR, however, cites a number of authorities, including the *Bulletin of the World Health Organisation*, in asserting that "Blindness in acute

chloroquine intoxication is always transient and recovers without sequelae, in contrast to the retinopathy following long-term chloroquine therapy".[14] One study of long-term use of chloroquine indicated that withdrawal of treatment caused a reversal of side-effects.[9] The possibility of brain damage after a failed suicide attempt is also of concern. We found only one case in the literature of a survivor exhibiting evidence of brain damage.[17] Unfortunately, there was no indication as to whether the damage was long-term or permanent. Conversely, one documented case discussed a patient who took a very high overdose of chloroquine with no related medical problems one year later.[2]

What evidence suggests interactions between chloroquine and other substances?

Evidence suggests that the cardiotoxicity of chloroquine might be decreased by the concomitant administration of diazepam.[14,19] In fact, diazepam is considered to be a treatment for chloroquine overdose, and may significantly decrease the mortality rate.[24] Several authors noted that patients who had taken diazepam along with as much as 5g chloroquine showed no clinical symptoms of chloroquine poisoning.[14,24] Milk products, antacids, and kaolin decrease the absorption of drugs, including chloroquine.[6,12,19] On the other hand, cimetidine may increase the effects of chloroquine,[18] and although chloroquine is not soluble in alcohol,[19] alcohol may nevertheless have a synergistic effect.[16] Cardiotoxicity is also influenced by the degree of pre-existing heart disease.[3]

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Fasting to death

The arguments on terminal fasting are fairly complex, as this chapter demonstrates. They have been summarised in the Starvation chapter earlier for general reading, but anyone seriously contemplating doing without food and water in order to end their life is strongly advised to investigate the facts in considerable detail. This chapter, which is a slightly amended version of the article which first appeared in *Beyond Final Exit.* can provide that necessary starting point.

Sitting quietly one day, a month before his 100th birthday, Scott Nearing (the American conservationist, peace activist, educator and writer) said: "I think I won't eat any more." It was 1983. The house, which he had had a hand in building himself, overlooked a quiet bay in Maine. Scott wanted the tranquillity of his life to be mirrored in his dying. For a month he drank fruit juice, then he decided he wanted only water. Lucid, and with no pain, pills, or professional nursing, he was in good spirits. Gradually, his breathing became fainter, as if he were detaching himself. He spoke his last words and died so gracefully that his death inspired a book as a testament of his passing from one who was with him. (Readers of the earlier chapter may wish to note that Nearing was a vegetarian.)

Compare this passing with a very different one . . .

> Another filling came loose. The choking sputter as the prisoner spat it out hurt his ulcerated throat. The conditions first experienced after a fortnight of fasting were much worse. Six weeks into his hunger strike, the IRA prisoner couldn't move his gaze properly without turning his head. He was light-headed and kept vomiting. Later his speech became slurred and his vision failed, Eventually he was going to die - like nine others who starved themselves to death in 1981 in the Maze Prison of Northern Ireland.

Finally we have yet a another real life scenario . . .

> The crowds gathered. Some took photographs. Jinendra Varni, the Jain scholar, sat cross-legged as the throngs gazed in awe. He has taken a vow of terminal fast and had gradually cut back on solids, then on liquids. There seemed little evidence of any pain or even hunger pangs. Varni abstained from water on alternate days until May 23, 1983 when he gave it up altogether. Reclining onto his side and exuding a tremendous peace and calm, he died the following day.

Different deaths. Different contexts. Different experiences. Why do some people die a horrible death without food and water and others experience an almost idyllic departure? Reports show little consensus. Before considering it as a method of self-deliverance, this article seeks to establish the known facts about starvation (or fasting) and dehydration.

The right-to-die debate, as it affects patients and physicians, has taken a new turn recently in terms of rights, duties and cooperation. Abstinence from food and drink, as a means to willed, voluntary death, has been put forward as a solution to a particular legal and moral stalemate that has persisted between patients and doctors, right-to-die proponents and 'pro-lifers'. For we see that:

> . . . educating chronically ill and terminally ill patients about the feasibility of patient refusal of hydration and nutrition (PRHN) can empower them to control their own destiny without requiring physicians to reject the taboos on PAS [physician-assisted suicide] and VAE [voluntary active euthanasia] that have existed for millennia.[1]

This proposal, which seems to many an attractive one, is beleaguered with apparently conflicting evidence about the painlessness of such a course of action. One of the aims of here is to summarise and hopefully bring some cohesion out of widely disparate claims.

In 1993, the International Drugs Consensus Working Party's[2] comment on fasting as a means of self-deliverance was:

> This method is extremely slow, taking two weeks or more.[3] ... As a traditional method, it was practiced by the American Indians. Unpleasant medical complications may set in before death occurs. A little liquid should be taken to moisten the mouth and prevent painful dehydration.[4]

The recommendation seems to discourage fasting as a method of self-deliverance while nevertheless admitting that it has sometimes been successfully employed. Let us expand on and explore the known facts about fasting and dehydration. My tentative conclusion is that it may be a viable method for suitable individuals, but the evidence suggests that, without medical examination of the person undergoing the fast to ascertain suitability, and the provision of palliative care for alleviation of troubling symptoms, it may be an uncertain course for an individual to embark on, especially when suitable drugs for self-deliverance can be obtained without too much difficulty in most countries and so provide an alternative route to dying in dignity.[5]

A principal feature of fasting however, is that it potentially allows the active cooperation of the health care team. Except in limited parts of Continental Europe, or potentially in Oregon USA under Measure 16, medical assistance in accelerating dying is outlawed, but fasting and dehydration, almost through a legal technicality, allow active participation without active medication. Patients have the right to refuse life-support systems, such as forced feeding by gastric tubes and intrave-

nous drips of expensive nutrient solutions. They also have the right to palliative care.[6]

The moral agendas and societal attitudes which underlie such shaky legal divides are nowhere more evident than in the dilemma facing doctors who feel vocationally devoted to curing or comfort care but not to being an active assistant in the death of a patient. Thus:

> . . . there is no disagreement that physicians are morally and legally prohibited from overruling the rational refusal of therapy by a
> competent patient even when they know that death will result. There is also no disagreement that physicians are allowed to provide appropriate treatment for the pain and suffering that may accompany such refusals.[7]

It is hardly surprising, however, that even in Britain or the United States where medical law is widely disseminated, confusion should arise in the minds of health care workers. Although a competent patient can refuse nutrition and hydration, the incompetent patient may not be afforded the same option. Lord Musthill, for instance, noted that: . . . in 20 out of 39 American states which have legislated in favour of 'living wills' the legislation specifically excludes termination of life by the withdrawal of nourishment and hydration.[8]

In one study:

> 75 percent of physicians surveyed objected to the idea of withdrawing intravenous fluids. This is understandable given the widespread emphasis in medical education on acting, on doing something, however futile, even if no real good is brought about for the patient.[9]

This reluctance to permit death to occur by withdrawing fluids is reinforced by popular images of what 'good doctors' do: paradoxically, ignorance of the law may involve breaking it in the false belief that one is staying on the right side of it:

> The symbolic power of 'giving a cup of water to a thirsty person' is almost overwhelming. How much greater is the symbolic power of food and water intervention when nothing else we can do will actually help the dying patient? . . . It must be frankly acknowledged that one reason physicians might use for ordering nutrition for the dying is to avoid a lawsuit . . . . Nevertheless, using the dying patient to protect oneself is a violation of the principle of beneficence upon which medicine rests. It is also a violation of the implied or explicit contract with patients through which the physician must act to care for their best interests.[10]

For a doctor trained in medicine, rather than ethics and the law, the number of situations requiring virtuosity of approach is almost overwhelming:

> Ethical dilemmas in the field of hydration and nutrition cover a wide spectrum, from dehydration due to dysphagia of various aetiologies, through terminal cancer with intestinal obstruction, to the persistent vegetative, state, terminal Alzheimer's disease patients who are unable to eat, and patients with anorexia nervosa or elderly depressives who deliberately refuse nourishment to the point of self-annihilation.[11]

. . . not to mention the rational self-deliverance of someone who has decided to end their own interminable and unrelievable suffering.

Full awareness of the law is necessary before physicians will be persuaded to embrace such an idea.

> When death results from lack of hydration and nutrition, it is less plausible to say that the death was caused by the disease process - thus someone must be assigned responsibility for the patient's death and physicians wish to avoid this responsibility. Physicians who recognize that patients have the authority to refuse any treatment, including hydration and nutrition, are more likely to avoid unjustified feelings of responsibility for their deaths.[12]

The issue has been further complicated by ignorance as to the therapeutic value, if any, of nutrition or hydration in terminal care, and reliance on possibly erroneous assumptions.[13] A more scientific rationale has been forwarded by Thomasma et al, who concluded:

> Our policy rests on an argument that there is a morally relevant difference about chronic illness, debilitation, and terminal illness that permits us to treat the patients suffering from these assaults on bodily integrity differently than we would other patients. This morally significant difference lies in the ratio between contemplated intervention and possible benefit. The only medically secure treatment for a dying patient is comfort. That is the only way medicine can benefit such persons. We have argued that nutrition and fluids are optional treatments on this basis.[14]

The goal, or good of the patient, has often been obscured by the immediate medical contingency. Medicine has become enraptured of itself, and dilemmas are solved by what is medically correct rather than what is correct for the patient. Most of the problems connected with voluntary euthanasia, living wills and self-deliverance arise because of

this excessively medicalized introversion that has the effect of marginalising the patient. Beneficent paternalism often occurs when the patient is enervated, incapacitated or confused as a result of disease, leaving opportunity for the practitioner to combine medical evaluation and expertise with a sensitivity to the wishes, values and needs of the patient; dogmatic paternalism occurs with increasing frequency when the problem is seen only in the (increasingly complex) language of medical science, and with an ear to medical science for the answer. The lure of professional challenge calls for the best answer - but with little regard to what the patient might reasonably conceive to be best. Even objective standards are easily ignored when there has been a failure to ask the right questions. As Pearlman discovered:

> Questionnaires of clinician beliefs and chart reviews of patients receiving tube feedings indicate that 'medical indications' without major regard for patient comfort or a patient-centered evaluation of benefits to burdens are a major factor in these decisions.[15]

To examine the underlying issues, which include not only medical and physiological problems but ethical and cultural challenges that are themselves surrounded by controversy, it is first necessary, as Justice Butler-Sloss said, to rid ourselves of the emotional overtones and emotive language which do not assist in elucidating the profound questions which require to be answered.[16] The paucity of reliable material and the inadequacy of rigorous research in this area, together with an overdose of popular but possibly erroneous sentiment, has been highlighted by Printz:

> In the literature, the issue of medical hydration and nutrition in the dying patient remains one of the underexplored areas of medicine.
> Articles objectively dealing with this issue are scarce, and

> documented research on comfort in dying patients is even more scarce. Opinions about this emotionally laden subject, however, abound.[17]

Source material available is in widely differing contexts - differing academic theories and total fasting studies,[18] hydration and nutrition studies in terminal patients,[19] deaths connected with anorexia,[20] hunger strikers,[21] isolated case studies of voluntary and willed death through fasting,[22] famine victims,[23] and deaths through malnutrition during persecution and war.[24] All these areas are emotionally laden in differing ways, and the bias thus implied must be stripped away before any scientific examination of the facts can take place. Even provision of artificial nutrition and hydration to dying patients remains controversial, with opposite practices sometimes being implemented in hospices and hospitals;[25] the mechanisms of anorexia are poorly understood, often arousing irrational responses in the public who unsuccessfully try to differentiate between a mental illness and a physical need; case studies of mystics or unusual individuals who manage to fast to death in a peaceful, serene manner are viewed by right-to-die enthusiasts as definitive rather than as the anecdotal descriptions which they tend to be; pictures of famine victims, with bloated bellies, give a graphic and horrifying picture of starvation and an emotional bias that links the supply of nutrition to a caring attitude - reinforced (rightly in this instance) by relief agencies such as Oxfam; macabre descriptions of the day-to-day deterioration of prisoners-of-war dying of malnutrition reinforce the idea that lack of food and water results in a very unpleasant death. It may perhaps be very easy, though somewhat disingenuous, to choose out-of-context, colourful, and ultimately specious examples to either support or oppose the notion of peaceful death through willed, voluntary fasting;[26] but such arguments should be viewed as dangerous, and the more responsible approach is to set out the benefits, burdens and precautions that seem advisable should any

person decide against the more obvious methods of ending one's life and seriously contemplate fasting to achieve such an end.

To fast implies a willed action concerning one's own abstaining from food; starving, on the other hand may imply external circumstances forcing themselves on the individual, or, at least, the connotations of a painful condition or lingering death.[27]

Although much of the physiology may be connected, there are great ethical and possibly other differences between fasting and starvation. Additionally, the differing emotive import of the two words makes it very necessary to avoid using the wrong terms. As Ahronheim (et al) said: "The cruelty and abandonment implied in the word 'starvation' are not relevant to the dying patient."[28] Physicians frequently regard fluids and food to be minimum standards of care for the dying.[29] Siegler said that, "For physicians, provision of ordinary means of comfort and care like food and water demonstrates our personal, professional, and social commitment to the dying patient."[30]

Dehydration is also a state which, for the purposes under discussion, requires definitional analysis. On the first level, it is frequently confused with thirst - a state which it may not, as this article will show, necessarily even parallel. Secondly, there are differing types of dehydration from a physiological viewpoint and, depending on the antecedent cause, the resulting symptomatology may be different.[31]

There is an important difference between being thirsty and being dehydrated. Thirst is an uncomfortable sensation experienced when the mouth is dry. Discomfort from dehydration may be entirely absent as long as the mouth is kept moist.

Various authors agree that there may be very different clinical syndromes for sodium depletion as opposed to pure water loss.[32]

Normonotraemic dehydration, characterised by normal sodium concentration, is a common disturbance of fluid balance and is usually not severe. It is caused when fluid loss and sodium loss occur in equal proportions, such as in mild vomiting and diarrhoea.

Hyponotraemic dehydration, characterised by low sodium concentration, results from depletion of both water and sodium but with salt loss predominating, or when salt and water are lost together but only water is replaced. Losses like this arise from the gut (for example, vomiting and diarrhoea) or from the kidneys (for example, overuse of loop diuretics, diuresis caused by glucose osmosis or severe uraemia, or adrenal insufficiency).

Hypertraemic dehydration, with high sodium concentration, develops when water loss is greater than the loss of sodium and may occur when fluid intake is insufficient (for example, in unconscious patients with no fluid intake) and, rarely, with loss of normal thirst. It also results from increased fluid loss, such as that associated with vomiting and diarrhoea, from the skin and lungs in febrile patients, or the fluid loss caused by burns.[33]

Sutcliffe notes that:

> Dehydration in the terminally ill patient may present as a mixed disorder of salt and water loss and may be caused by normal water losses from the lungs, skin and kidneys, with failure to replace those losses, or there might be abnormal gastrointestinal or renal losses. Normonatraemic dehydration may also occur.[34]

Early rapid weight loss, for instance, is primarily due to negative sodium balance.[35] It is perhaps desirable that, as with any other method of willed death, the subject becomes conversant with the process to

understand probable effects, their causes, and how to manage them. It is also important to note these differences because some of the evidence presented here and elsewhere for fasting to death is based, in part, on observing terminal patients. We should be aware that different factors come into play and that terminally ill patients who stop taking food and water are in a rather different category to comparatively healthy people who decide on a terminal fast.[36]

What evidence is there of unpleasant effects when intake of food and water ceases?

Many effects have been listed and observed. Kerndt et al include gout and urate nephrolithiasis, postural hypotension and cardiac arrhythmias,[37] and point out that, "The sense of well-being that may occur during short-term fasting is in contradistinction to that seen during prolonged periods of semi-starvation when mental lethargy, apathy and irritability are common."[38] Miller, in his observations on hunger-strikers notes:

> The net result of these metabolic changes is that the person who
> consumes insufficient protein and calories will experience progressive loss of both muscle and fat. No body organ is spared. The skeletal muscles atrophy more rapidly than cardiac muscle or kidney, but as protein energy starvation continues, the heart and kidney lose mass progressively.[39]

And goes on to explain:

> Lymphatic tissues atrophy, causing impaired cell-mediated immunity and reduced bactericidal activity of polymorphonuclear leukocytes. There is an increased morbidity and mortality during common infections. Pneumonia is a common cause of death . . . metabolic rate is reduced, and hypothermia is com-

> mon . . . . On physical examination, there is a drawn appearance of the face, the temporal areas of the head are wasted. The intercostal spaces are fleshless, the skin hangs in folds on the wasted limbs. The skin flakes and loses pigmentation, as does the hair. The patient appears pale. He may be edematous. Skin and decubitus ulcers are common.[40]

Sutcliffe lists the potential disadvantages of dehydration as including extreme electrolyte imbalance (eg acidosis), hypernatraemia, hypercalcaemia leading to apathy and depressive states ranging from lethargy to coma and confusion, and also neuromuscular irritability and twitching, hypovolaemia leading to falls, postural hypotension leading to increased risk of pressure sores, reduced skin perfusion leading to increased risk of pulmonary embolism and deep vein thrombosis, water deprivation leading to headaches, nausea and vomiting and muscle cramps, reduced urine output leading to dysuria and increased risk of urinary tract infection, reduced fluid leading to constipation and gastrointestinal tract pain and discomfort. He adds that clinical manifestations often associated with volume depletion include signs of circulatory insufficiency (such as reduced blood pressure, postural hypotension, cold peripheries, decreased cerebral perfusion), uraemia, hyponatraemia and haemoconcentration. Patients may experience dryness of the mouth and mucous membranes, diminished sweat, decreased skin turgor and neurological complications such as weakness, restlessness, confusion, coma and seizures. He tells us that nausea, vomiting, anorexia and taste loss have been noted in experimental subjects with hyponatraemic dehydration; but notes that these may be contributing causes rather than a result of that condition.[41]

Collaud affirms that symptoms rarely mentioned in the literature include nausea, muscular cramps and hunger.[42] Keys et al. note that gastrointestinal disorders are prominent, such as diarrhoea, nonspecific dysentery, colic, flatulence, and a protruding abdomen, which, they say,

are universally recognized symptoms of calorific undernutrition and have been observed wherever man's natural food supply has been seriously curtailed.[43] They also say that there is an increased sensitivity to cold,[44] and that numerous physiological changes ensue with malnutrition which become progressively far reaching as the condition continues;[45] slow heart rate,[46] mild cyanosis, cold skin, increased circulatory time,[47] increased water consumption, salt hunger (subjects will consume several times normal quota of salt if available), edema,[48] depressed libido,[49] looking and feeling older,[50] greater accident proneness, diminishing of tendon reflexes, a sharpening of the senses with vision unlikely to deteriorate and hearing may becoming more acute - but with subjects tending to act dull and insensitive as though unaware of or incapable of feeling many of the ordinary stimuli of sound, sight or touch - are all further possible symptoms.[51] Fainting, is common,[52] and there is general weakness and reduced capacity for work.[53]

Winick, in his book of observations in a Warsaw Ghetto, tells us that the skin becomes pale, dry and scaley,[54] and that initial complaints (on 800 calories a day, comprising 3g fat, 20-30g vegetable protein, and the rest carbohydrate; protein was of low quality and very deficient in certain vitamins and minerals, particularly A, D, K and E, calcium & iron) included thirst, polyuria and nocturia, dryness of the mouth. rapid weight loss, and constant craving for food.[55] The skin is easily traumatized,[56] and there is a sensitivity to the sun, readily resulting in redness, swelling, local hyperthermia and fever blisters; temperature response to diseases which usually produce a high fever, such as typhus, is blunted.[57]

What evidence is there of beneficent symptoms (or lack of unpleasant symptoms) when intake of food and water ceases?
Keys et al. tell us that

> . . . academic portraits of so-called classical deficiency diseases are idealizations or even rather unreal abstractions with regard to the actual finding where real malnutrition is endemic or epidemic. Moreover, there is material for argument against the idea of a progression from positive, nutritional health through sub-clinical deficiency to the full-blown disorder, in which the subclinical state is supposed to be characterised by vague malaise, fatigue, and so on. Some of the cases of amblyopia and ataxia developed with little or no premonitory change in the sense of well-being.."[58]

There is also a considerable amount of well-documented but apparently contradictory evidence, and possible reasons for such discrepancies will be examined presently. Firstly, however, let us examine some evidence of peaceful and dignified deaths by the method under consideration. While there are individual, anecdotal reports that seem to offer much hope, two principle sets of data I propose to draw attention to cover a) voluntary fasting by a particular religious sect and b) voluntary fasting in a hospital (or more usually hospice) setting; with this second category will also be grouped withdrawal of nutrition and hydration in competent patients. These groups, however, may be considered to some extent atypical. The former covers an ascetic and well controlled graduated fast by relatively healthy subjects; the second relates primarily to subjects who are mostly elderly, terminally ill and, most importantly, have access to adequate palliative care.

Voluntary fasting to death within a religious sub-group appears to be confined to the Terapantha order within the Jaina Digambara community,[59] where it is said that several well known cases occur every year.

The fast is described thus:

> In early 1983 a prominent Jaina scholar and writer by the name of Jinendra Varni, then in his early eighties, although in reasonable health, decided that he wanted to fulfil his life's journey through a dignified yogic death (samadhimarana). On 12 April 1983 Varni formally withdrew from his worldly commitments and upon request received from the head preceptor of his order, with due acclamation for his courage, initiation into the vow of terminal fast (sellekhana). He had already reduced his food intake; now as each day went past he cut back on certain vegetables, milk, clarified butter, yoghurt, dried fruits, giving up something every day, but retaining small portions of boiled vegetables and sultanas for one meal of the day. Occasionally he would fast all day long, and break the fast with broth from a boiled vegetable. By the end of the month his fluid intake was reduced as well and gradually given up, with plain water remaining as his only intake, which too was set aside on alternate fast days. On 23 May water was given up altogether. Varni reclined with his body to one side during the last days but there was apparently no evidence of hunger pangs, pain of any other kind (particularly from by-now deteriorating internal organs), barring some coughs and discomfort while sitting upright owing to his frail frame; nor did he show any significant loss of attention and consciousness. On 24th May, exuding a tremendous peace and calm in his general demeanor, Vami closed over his eye-lids and breathed his last.[60]

This reassuringly peaceful death is a far cry from the horrors of starvation recounted elsewhere. Glimmerings that death from starvation and/or dehydration may not be as horrific as often contemplated have filtered through in mainstream medical literature for some time, probably starting with early fasting studies, through to observations in palliative care when hospice workers realized that artificial nutrition

and hydration were not necessarily beneficial to terminally ill cancer patients, and finally in recent years amidst the right to die debate, advocacy of willed fasting as a means to legal self-deliverance combined with the palliative assistance of hospice care.

In the classic work by Keys et al. on starvation in 1950, it was pointed out that in total fasting studies the hunger sensation almost disappeared after a few days; that ketosis was a typical result of fasting but did not develop in semi-starvation; and that famine edema had never been reported in total starvation.[61] In looking at comfort measures for the terminally ill, Billings went a stage further in noting: " . . . fluid depletion in dying patients should be regarded as a disorder with relatively benign symptoms. Successful treatment of the discomfort of thirst and a dry mouth generally does not require rehydration.[62] By 1988, Printz had publicized the little known situation where:

> . . . a hospice nurse in 1983 noted a correlation between comfort and lack of medical hydration. It appeared to her that terminally ill patients in end-stage dehydration experienced less discomfort than patients receiving medical hydration. The dehydration, resulting from lack of nasogastric or IV fluid, seemed to produce a natural anaesthetic effect, often allowing for a reduction in pain medications.[63]

A study by Andrews and Levine published in 1989 showed widespread support among hospice workers for dehydration in some terminal patients:

> Of the hospice nurses surveyed, 71 percent agreed that dehydration reduces the incidence of vomiting, 73 percent agreed that dehydrated patients rarely complain of thirst, 51 percent reported that there is relief from choking and drowning sensations when fluids are discontinued, and 53 percent agreed that

> dehydration can be beneficial for the dying patient. Also, 85 percent of nurses surveyed disagreed with the need for hydration by IV and/or tube feeding when dehydrated patients have a dry mouth. Finally, 82 percent of the nurses disagreed with the statement that dehydration is painful.[64]

They concluded that, in contrast to the assumption of most health professionals, dehydration was not painful, and that it was therefore a viable alternative to facilitate a comfortable death.[65] Concerning the medical symptoms, they observed that: "With dehydration there is decreased urine output and less need for the bedpan, urinal, commode, or catheterization and fewer bed-wetting episodes. There is a decrease in gastrointestinal fluid with fewer bouts of vomiting. A reduction in pulmonary secretions is also seen with less coughing and congestion and a decrease in choking and drowning sensations. A reduction in the edematous layer around the tumor resulting in less pain may also occur."[66]

In 1990, Ahronheim and Gqsner concurred: "Withholding or withdrawing artificial feeding and hydration from debilitated patients does not result in gruesome, cruel or violent death.[67] Interestingly, . . . deprivation of fluid rapidly results in further depression of consciousness and then coma and the experience does not appear to be painful. There is also some evidence that impaired thirst may occur naturally with advanced age or neurological impairment, and that there may be endogenous production of substances producing natural analgesia.[68]

Sutcliffe and Holmes listed some benefits of dehydration to the dying patient as: reduced urine output leading to reduced incontinence and a reduced need for catheterization; reduced gastro-intestinal fluids leading to reduced vomiting; reduced pulmonary secretions leading to reduced coughing and choking, reduced drowning sensation, and reduced use of tracheal suction; extreme electrolyte imbalance (eg

acidosis, hypernatraemia, hypercalcaemia) and hypovolaemia, leading to analgesia due to states ranging from lethargy to coma; anaesthetic effect of ketone production in calorie deprivation leading to anaesthesia; increased production of opioid peptides in malnutrition and dehydration leading to analgesia.[69]

Bernat et al also concluded that, "Scientific studies and anecdotal reports both suggest that dehydration and starvation in the seriously ill do not cause significant suffering" and that " . . . the overwhelming majority of hospice deaths resulting from lack of hydration and nutrition can be managed such that the patients remain comfortable." The consensus of experienced physicians and nurses was that terminally ill patients dying of dehydration or lack of nutrition do not suffer if treated, properly.[70]

Miller and Albright also reported that death associated with dehydration or malnutrition was not perceived as painful.[71]

By 1993, a founding member of the Nutrition Society of Canada and former senior toxicologist at the Bureau of Human Prescription Drugs, Health,and Welfare in Canada was quoted as saying that self-deliverance by starvation was reasonably fast and that it could be painless, or that therapeutic, non-toxic doses of analgesics could be used if required for any reason to alleviate pain and discomfort.[72]

Further studies showed specific differences with men and women, old and young, or thin and obese.

> In an experiment with healthy active elderly men (67 to 75 years old) and seven healthy young men (20 to 31 years old) it was found that the older men were less thirsty and drank less after water deprivation.[73]

Why there should be such striking differences in comparisons with, say, prisoners of war, is largely a matter of speculation, but one can hypothesize that other, concurrent factors could play a very large part. For instance, Phillips et al. suggest that if water intake in the elderly is deficient in the face of physiological need, for example in diarrhoea or fever, it could lead to clinical dehydration requiring hospital treatment in addition to aggravating other conditions (eg, constipation or renal stone disease).[74]

Keys et al. even note some possible geographical differences. Retrobulbar neuritis, spinal ataxia, burning feet ('acrodynia') with corneal changes, deafness, a myasthenic bulbar syndrome ('kubigassari') - these conditions, though not uncommon in the Orient, are exceedingly rare in modern Europe. The prevalence of nutritional neuropathies and of disorders of the mucocutaneous tissues is far greater in tropical and semitropical regions than in the temperate and subarctic zones, and any influence from racial factors may be ruled out on the basis of the experience with Europeans in the tropics and subtropics.[75]

Other variations observed are: (Sutcliffe:) Thirst is often absent in hyponatraemic dehydration, as this symptom is primarily provoked by a raised sodium concentration.[76] (Kerndt et al:) Lean persons become ketotic earlier than obese persons, and women become ketotic more rapidly than men;[77] . . . fasting ketosis develops more rapidly in women than in men . . . This sex difference, however, disappears with increasing body weight; and . . . little or no rise in hormone growth is seen after prolonged fasting in obese subjects.[78] (Symptoms of ketosis include drowsiness, headache and deep respiration.)

It is clear that some individuals have experienced a peaceful death as a result of stopping food and water. It is also clear that probably a greater number of these have been assisted with expert palliative care.[79]

Bernat et al. go so far as to suggest:

> A pact should be made with the patient that the physician will do his or her best to minimize suffering during the dying process and will remain available to comfort the patient by physical presence as well as skillful treatment of symptoms, including dyspnea, and dryness of the mouth.[80]

As death from lack of nutrition alone is a potentially very lengthy process, a combination of ceasing nutrition and hydration by some method is likely to be a preferred course. This area undoubtedly needs much more research. While a peaceful death by this method seems feasible in some instances, without particularized medical advice and medical back-up, and/or until more is known about the process of self-deliverance through fasting, an isolated individual acting alone would appear to have greater assurance of success by means of drugs. Abstinence from food and drink as a means of accelerating death does however have the distinction of being the only method at the present time in which all sides in the "right to die" debate may reach common agreement under the law.

Having tried to separate myth, misinformation and scare stories from well-documented evidence, it is still difficult to say that refraining from food and drink will guarantee a peaceful death. Someone wanting a 100 per cent foolproof method might consider it foolhardy to emulate Jinendra Varni. A young, obese woman who has never followed a healthy diet might be ill-advised to attempt total fasting even in the face of unrelievable distress or a lingering, terminal illness.

But this is an area where a personal medical advisor may be able to narrow the odds and, if things go wrong, keep you comfortable in your dying without violating any laws and thus being branded a criminal.

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3. Saudek C, Felig P, The Metabolic Events of Starvation, American Journal of Medicine 1976; 60:117-126, pl 17: Considering the total calories available to the normally fed man . . . there is enough to last more than 80 days, even assuming utilization of 2,000 calories/day. See also: Miller W, "The Hunger-Striking Prisoner," Journal of Prison & Jail Health 1987; 6(1):40-61, p.45: Total absence of food and water intake results in death from dehydration within a few days. The normal person with an average supply of fat and muscle may survive total starvation for several months, if adequate water is ingested. During the first week of total starvation, the average adult loses 4 to 5 kg. of body weight. After the first two weeks, the overwhelming desire for food disappears. Stomach cramps end. The skin becomes parched and dry. Fillings drop out of teeth. The throat becomes ulcerated. In the case of the Republican prisoners in the Maze prison in Northern Ireland in 1981, after almost exactly 42 days of fasting, each person experienced a severe exacerbation of his condition. Muscle control of the eyes was lost, with rapid involuntary horizontal and vertical nystagmus. Continuous light-headedness and vomiting occurred. These symptoms persisted for four to five days, after which they ended, leaving the patient in a state of relative euphoria. Then speech became slurred, hearing diminished, vision failed, smell ceased. Death ensued. See also: Craig G, "On Withholding nutrition and hydration to the terminally ill: has palliative medicine gone too far?" Journal of Medical Ethics 1994; 20:139143, p.140: Even a Bedu tribesman riding in the desert in cool weather can only survive for seven days without food or water. Also: Sherwood L, Parris E, "Starvation in Man" New England Journal of Medicine 1979; 282(12):668-675, p.671: . . . a fasting man need drink very little water, the water produced by metabolism approximating that lost in urine and that lost by evaporation from skin and lungs. Therefore, as long as he is in atemperate and humid environment, his water needs are minimal when he is starving . . . . Also: Keys A, Brozek J, Henschel A, Mickelsen O, Taylor H, The Biology of Human Starvation I & II, Minneapolis: University of Minnesota Press 1950, 1:14-15: With edema, the actual water content of the body may not rise, but it does not decrease in proportion to loss of tissue, so there is a relative increase in hydration, recognizable as a puffiness of the ankles and face (it may disappear in the final stages of starvation, and death occur in a dehydrated state.)
4. Docker C, Smith C, Departing Drugs, Edinburgh: VESS 1993, p.25.
5. Ibid.

6. Frederick G, "An Easy Alternative to Assisted Suicide" Globe and Mail 23 Sep 1993 p.A19.
7. Bernat J, Gert B, Mogielnicki R, "Patient Refusal of Hydration and Nutrition" Archives of Internal Medicine 1993; 153:2723-2728; p.2724.
8. Airedale NHS Trust v Bland [1993] 1 All E.R. 820, 888.
9. Thomasma D, Micetich K, Steinecker P, "Continuance. of Nutritional Care in the Terminally I11 Patient" Critical Care Clinics 1986; 2(1):61-7 1, p.63.
10. Ibid p.61-62.
11. Craig G, "On Withholding nutrition and hydration to the terminally ill: has palliative medicine gone too far?" Journal of Medical Ethics 1994; 20:139-143,. p.139.
12. Cook M, "The End of Life and the Goals of Medicine" Archives of Internal-Medicine 1993; 153:2718-2719; p.2718. Also: McCann R et al; "Comfort Care for Terminally Ill Patients" Journal of the American Medical Association 1994, 272('16):1263-1266, p:1263: ...it has been established that legal rationale and precedent exist for respecting a patient's explicit wishes regarding nutrition and hydration. Moreover, there has been wide-spread, although not unanimous support from major religious groups that nutrition and hydration may at times be considered unnecessary form of therapy."
13. "It is argued that the reason dying patients should be given medical nutrition and hydration is that humans have a moral urge to feed the hungry and give drink to the thirsty . . . .the assumption in the argument, that the dying must be hungry and thirsty, has not been proved. Indeed, as has been noted, the opposite is suspected by many who have worked closely with the dying." Printz L, "Terminal Dehydration, a Compassionate Treatment" Archives of Internal Medicine 1992; 152:697-700, 698. Also: Ahronheim J, Gasner M, "The Sloganism of Starvation" Lancet 1990; 335:278-279, 279: "Since the beginning of time, until very recently, people who grew too old, too disabled, too weak, or too sick to eat and drink died without a feeding tube in place. Although superimposed medical illness in such people can now be cured, it is logical to assume that rejection of food is a physiological component of the illness and the dying process."
14. Thomasma D, Micetich K, Steinecker P, "Continuance of Nutritional Care in the Terminally Ill Patient" Critical Care Clinics 1986; 2(1):61-71, p.69-70.
15. Pearlman R, "Forgoing Medical Nutrition and Hydration: An Area for Fine-tuning Clinical Skills" Journal of General Internal Medicine (Editorial) 1993; 8:225-227, p.225.
16. Butler-Sloss LJ, in: Airedale NHS Trust v Bland [1993] 1 All E.R. 821,842.
17. Printz L, "Terminal Dehydration, a Compassionate Treatment" Archives of Internal Medicine 1992; 152:697-700, 698.
18. Keys A, Brozek J, Henschel A, Mickelsen O, Taylor H, The Biology of Human .Starvation I & 11, Minneapolis: University of Minnesota Press 1950, 1:29.

19. eg Miller R, Albright P, "What is the Role of Nutritional Support and Hydration in Terminal Cancer Patients?" American Journal of Hospice Care Nov/Dec 1989; 33-38. Burge F, "Dehydration Symptoms of Palliative Care Cancer Patients" Journal of Pain and Symptom Management 1993; 8(7):454-464. Lichter I, Hunt E, "The Last 48 Hours of Life" Journal of Palliative Care 1990; 6(4):7-15.
20. Keys A, Brozek J, Henschel A, Mickelsen O, Taylor H, The Biology of Human Starvation I & II. Minneapolis: University of Minnesota Press 1950, II:971: Mortality directly attributable to anorexia nervosa is only something like 8 per cent.)
21. Miller W, "The Hunger-Striking Prisoner" Journal of Prison & Jail Health 1987; 6(1):40-61.
22. Albury N, The Natural Death Handbook. 1993 London: Virgin Books. Scott Nearing Maine Times June 28 1991. Eddy D, "A Conversation With My Mother" Journal of the American Medical Association 1994; 272(3):179-181. Bilimoria P, "A Report from India: The Jaina Ethic of Voluntary Death" Bioethics 1992; 6(4):331-355:
23. Keys A, Brozek J, Henschel A, Mickelsen O, Taylor H, The Biology of Human Starvation I & II, Minneapolis: University of Minnesota Press 1950, 1:758-759.
24. Winick M, Hunger Disease - Studies by the Jewish Physician in the Warsaw Ghetto 1979, New York: John Wiley and Son, documents starvation until death. Hunger is divided by Winick (p.38) into three degrees: 1) depletion of fat reserves, 2) aging and withering of patient, 3)terminal cachexia.
25. Sutcliffe J, Holmes S, "Dehydration: Benefit or Burden to the Dying Patient?" Journal of Advanced Nursing 1994; 19:71-76, p.71: It appears that those dying from malignant disease in general hospitals are more likely to receive hydration therapies than those dying at home or in hospices. Haas F, "In the Patient's Best Interests? Dehydration in Dying Patients" Professional Nurse 1994; 10(2):82-87, p.82: In hospital settings, intravenous infusions are often given to dehydrated patients who are terminally ill, without any consideration of whether this is in their best interests. Cf. Andrews M, Levine A, "Dehydration in the Terminal Patient: Perception of Hospice Nurses" American Journal of Hospice Care Jan/Feb 1989, 31-34, p.31: "This study suggests that those hospice nurses who have observed terminal dehydration have a more positive perception of this state than those who have not."
26. Ahronheim J, Gasner M, "The Sloganism of Starvation" Lancet 1990; 335:278-279; 278: In Brophy v New England Sinai Hosp, Inc, a dissenting judge relied on discredited trial testimony and described the painful and gruesome death that would result from removing a feeding tube, telling of the desiccation of each organ in turn; in the event, the feeding tube was removed and the man (who was in PVS) died peacefully, yet the discredited description has been repeated in several other cases and even, almost word for word, on the influential TV program (LA Law).

27. The former is an intransitive verb, emphasising the voluntariness of the action since it implies only the actions of the person fasting; etymologically and by common usage, it often implies a higher purpose, whether for strict religious observance or as a deep expression of grief. The latter can not only be a transitive verb, but its etymology and connotations suggest dying horribly and contemptibly. Oxford English Dictionary; Skeats W, A Concise Etymological Dictionary of the English Language; Oxford: Clarendon Press 1951; pp. 180 & 516. For a fuller comparison of fasting and starvation see: Encyclopaedia Britannica, 11th edition, Cambridge: University Press 1910; 10:193-198. Note also: Bilimoria P, "A Report from India: The Jaina Ethic of Voluntary Death" Bioethics 1992; 6(4):331-355, p.334: The determination made and the ethical prescription adopted to terminate one's life is known as "voluntarily-embraced death" (prayopravesana and more commonly as santhara). The practice more usually . . . involves undertaking an extended fast, ie a graduated withdrawal from the urges of life and desisting from intake of solids, fibrous substances and fluids up to the moment of death . . . . Sallekhana or terminal fast is intended to result in a peaceful passing away of the encumbent (santi-marana) or, in more ascetic terms, in a yogic or `enlightened' death (samadhi-marana).
28. Ahronheim J, Gasner M; "The Sloganism of Starvation" Lancet 1990; 335:278-279, 279: See also: Derr P, "Why Food and Fluids Can Never Be Denied" Hastings Center Report 1986; 16(1):28-30.
29. Thomasma D, Micetich K, Steinecker P, "Continuance of Nutritional Care in the Terminally I11 Patient" Critical Care Clinics 1986; 2(1):61-71, p.61.
30. Siegler M, Schiedermayer D, "Should Fluid and Nutritional Support Be Withheld from Terminally Ill Patients? - Tube Feeding in Hospice Settings" American Journal of Hospice Care March/April 1987, 32-35, p.35.
31. Billings J, "Comfort Measures for the Terminally Ill: Is Dehydration Painful?" Journal of the American Geriatrics Society 1985; 33(11):808-810, p.808: Dehydration, defined here as a loss of normal body water, is a term that is often used imprecisely to describe conditions with differing causes, symptoms, and management.
32. Ibid p.808 Nadal et al., however, suggested the important notion that quite different clinical syndromes could be associated with two prototypical forms of dehydration: sodium depletion and pure water loss.
33. Sutclife J, "Terminal Dehydration" Nursing Times 1994; 90(6):60-63, 60-61; for all these definitions and descriptions.
34. Ibid p.61. Also note: Sodium depletion is . . . sometimes called volume depletion, a term that also is imprecise but that points to the prominence in this condition of signs of circulatory insufficiency. Billings J, "Comfort Measures for the Terminally Ill: Is Dehydration Painful?" Journal of the American Geriatrics Society 1985; 33(11):808-810, p.808.

35. Kerndt P, Naughton J, Driscoll C, Loxterkamp D, "Fasting: The History, Pathophysiology and Complications" Western Journal of Medicine 1982; 137:379-399,p.379. See also: Derr, P "Why Food and Fluids Can Never Be Denied" Hastings Center Report 1986; 16(1):28-30, p.29: A social decision to permit physicians or health care facilities to deny food and fluids to patients who are capable of receiving and utilizing them, directly attacks the very foundation of medicine as an ethical profession. For Derr, the patient's wish is no justification; and he goes on (p.30) to draw an analogy with a patient who desires a botched hernia repair with massive postoperative morbidity . . . Another commentator draws a differing view: "No matter how simple, inexpensive, readily available, noninvasive and common the procedure, if it does not offer substantial hope of benefit to the patient, he has no moral obligation to undergo it, nor the physician to provide it, nor the judge to order it." Paris J, "When Burdens of Feeding Outweigh Benefits" Hastings Center Report 1986; 16(1):30-32; p.32.
36. Printz L, "Is Withholding Hydration a Valid Comfort measure in the Terminally Ill?" Geriatrics 1988, 43(1 1):84-88, p.86: "The symptoms of dying patients who are not undergoing medical hydration and nutrition are more difficult to evaluate than the laboratory data. The range of sensations, other than those of the primary disease, which have been reported vary from no distress and possible analgesia to lethargy, weakness, dry mouth, thirst, restlessness and nausea."
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42. Collaud T, Rapin H, "Dehydration in Dying Patients: Study with Physicians in French-Speaking Switzerland" Journal of Pain and Symptom Management 1991; 6(4):230-240, p.235.
43. Keys A, Brozek J, Henschel A, Mickelsen O, Taylor H, The Biology of Human Starvation I & II, Minneapolis: University of Minnesota Press 1950, 1:587.
44. Ibid 1:45.
45. Ibid 1:575.
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49. Ibid 1:578.
50. Ibid 1:579.

51. Ibid I:581.
52. Ibid 1:635.
53. Ibid at I, Chapter 34.
54. Winick M (ed), Hunger Disease: Studies by the Jewish Physicians in the Warsaw Ghetto, New York: John Wiley & Son 1979, p.38.
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56. Ibid p.38. .
57. Ibid p.39.
58. Keys A, Brozek J, Henschel A, Mickelsen O, Taylor H, The Biology of Human Starvation I & 11, Minneapolis: University of Minnesota Press 1950, 1:583.
59. Bilimoria P, "A Report from India: The Jaina Ethic of Voluntary Death" Bioethics 1992; 6(4):331-355, p.338.
60. Ibid p.335.
61. Keys A, Brozek J, Henschel A, Mickelsen O, Taylor H, The Biology of Human Starvation I & 11, Minneapolis: University of Minnesota Press 1950, 1:29.
62. Billings J; "Comfort Measures for the Terminally Ill: Is Dehydration Painful?" Journal of the American, Geriatrics Society 1985; 33(11):808-810, p.809.
63. Printz L, "Is Withholding Hydration a Valid Comfort measure in the Terminally Ill?" Geriatrics 1988, 43(11):84-88, p.84.
64. Andrews M, Levine A, "Dehydration in the Terminal Patient: Perception of Hospice Nurses" American Journal of Hospice Care Jan/Feb 1989, 31-34, p.32. (This study sent questionnaires to a total of 127 hospice programs - 41 in New Jersey and .86 in Pennsylvania.)
65. Ibid p.34.
66. Ibid p.31.
67. Ahronheim J, Gasner M, "The Sloganism of Starvation" Lancet 1990; 335:278-279,279.
68. Ibid p.278.
69. Sutcliffe J, Holmes S, "Dehydration: Benefit or Burden to the Dying Patient?" Journal of Advanced Nursing 1994; 19:71-76, p.72.
70. Bernat J, Gert B, Mogielnicki R,"Patient Refusal of Hydration and Nutrition" Archives of Internal Medicine 1993; 153:2723-2728,, p.2725-6.
71. Miller R, Albright P, "What is the Role of Nutritional Support and Hydration in Terminal Cancer Patients?" American Journal of Hospice Care Nov/Dec 1989; 33-38, p.35.
72. Frederick G, "An Easy Alternative to Assisted Suicide" Globe and Mail 23 Sep 1993 p.A 19.
73. Phillips P, Rolls B, Ledingham J, Forsling M, Morton J, Crowe M, Wollner L, "Reduced Thirst after Water Deprivation in Healthy Elderly Men" New England Journal of Medicine 1984; 311(12):753-759, p.757: A thirst deficit in the elderly

subjects, as compared with the young controls, was indicated by their remarkable lack of thirst and discomfort after 24 hours of water deprivation.

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76. Sutcliffe J, "Terminal Dehydration" Nursing Times 1994; 90(6):60-63,p.60-61.

77. Kerndt P, Naughton J, Driscoll C, Loxterkamp D, "Fasting: The History, Pathophysiology and Complications" Western Journal of Medicine 1982; 137:379-399, p.396.

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79. Printz L, "Terminal Dehydration, a Compassionate Treatment" Archives, of Internal Medicine 1992; 152:697-700, 700(Table 2): Dry mouth can be palliated by offering frequent sips of cold water: no treatment is required for other symptoms of analgesia, lethargy and weakness. Also: Printz L, "Is Withholding Hydration a Valid Comfort Measure in the Terminally Ill?" Geriatrics 1988, 43(11):84-88, p.85: Thirst and dry mouth can be readily relieved with crushed ice or sips of fluids. Nausea can be treated with antiemetics. Also: Lichter 1, Hunt E, "The Last 48 Hours of Life" Journal of Palliative Care 1990; 6(4):7-15, p.12: Thirst is rarely a problem, and careful mouth hygiene prevents dryness of the mouth which may otherwise be a source of discomfort. Small quantities of fluids can usually be administered by dropper, and ice may be given to suck. In this way the patient can be kept comfortable. Also: Bernat J, Gert B, Mogielnicki R, "Patient Refusal, of Hydration and Nutrition" Archives of Internal Medicine 1993; 153:27232728, p.2726: Clinical experience with severely ill patients suggests that the major symptom of dry mouth can be relieved by ice chips, methyl cellulose, artificial saliva, or small sips of water insufficient to reverse progressive dehydration. While these are relatively simple palliative measures, the availability of adequate pain-relief or more aggressive palliation will be an important safeguard, especially in the final days.

80. Bernat J, Gert B, Mogielnicki R, "Patient Refusal of Hydration and Nutrition" Archives of Internal Medicine 1993; 153:2723-2728, p.2727.

A guide to suicide guides

This is an expanded version of an article previously published in Exit Newsletter *and* Beyond Final Exit. *Its purpose it so explain the history of self-deliverance guides.*

Why the need for guides?

Ironically, some of the strongest supporters of voluntary euthanasia are survivors of the Nazi holocaust – while some of the most vociferous opponents, with no experience of life in concentration camps, use such incidents as the Holocaust and the twisting of the word *euthanasia* to suggest that 'right-to-die' legislation will lead to Nazi-type abuses. Perhaps I can begin this chapter by quoting no less an authority than Lord Kagan, who, having survived a concentration camp in Lithuania during World War II, spoke up in the English Parliament in favour of being allowed to end one's own life:

"I witnessed the fears. The greatest fear was not of being killed, it was not of being dead, but the manner of one's death, the timing of one's death, the power of decision leading to one's death and not having the ability to prepare for one's death. It was not dying, it was not death, but that. There was the fear of torture without escape, without limit as to its extent and without a limit on its time.

"The most fervent prayer in the camp was to acquire the means to end one's life, to achieve the death of one's own choosing at the time of one's own choosing and in the manner of one 's own choosing. This became the ultimate liberation and the greatest prize. To achieve this in the camp one was prepared for any sacrifice and to submit to any deprivation. Having it proved to be a great comfort. It did not encourage one to use it, and this is what I should like to bring to your Lordships' attention. Having the means of the decision to end one's own life in one's own way did not encourage people to use it. It gave one strength to carry on fighting because one felt one had the means, ultimately, not to buy or extend survival at any price. It prevented the

collapse of courage... It prevented the collapse of principle if one got caught and, under torture, feared one would betray one's friends.

"These are extraordinary circumstances I have witnessed, but cruelty and despair can be suffered not only at the hand of man but at the hand of nature in circumstances of illness, particularly terminal illness. Doctors and priests know more about that. But if the reaction in despair is similar to the one which I have seen and lived with, then is it not time not only to stop making the end of one's life a crime, but to establish it as a right?"[1]

Difficult beginnings

In July 1979, a few years before Lord Kagan's speech, EXIT – The Voluntary Euthanasia Society (Great Britain) decided that a booklet on how to end one's own life would be a good idea, passing a resolution to that effect at their Annual General Meeting in October. After publicly announcing their plans, membership rose, from an initial 2000 members, at a rate of 1000 a month over the next six months while the booklet, to be called *A Guide to Self-Deliverance,* was being drafted. In June 1980 two top legal opinions gave contradictory views on the likelihood of prosecution for such a booklet, and in July the VES committee decided not to publish.[2]

The Scottish Region Branch of EXIT was appalled and voted on August 16th to publish such a booklet themselves. The next day, Larry Hill, the acting Chairman in England, telephoned George Mair, the Scottish Organizer, forbidding such an action. At an emergency meeting the following day, the Scottish Branch declared independence from England in order to go ahead and publish a self-deliverance booklet, in spite of the fact that their kitty was empty.[3] The booklet was called *How to Die With Dignity,* written by Dr George Mair, and published in September 1980 in Scotland. It was the first booklet of its kind anywhere in the world. Based on the knowledge of a single

doctor, the information, by today's standards, was rather primitive, and statements about the law were hazy to say the least. But it survived in its original form for 13 years, with minor additions in the form of short supplements. The Scottish Society has struggled on to this day, often with minimal funds, and managed to keep going largely by way of periodic gifts and legacies.

The English Society membership, in expectation of such a book from their own Committee, had risen to 10,000. At their October Annual General Meeting, incensed, the members sacked 11 of the 12 members of the Committee and appointed new people, all pledged to publishing *A Guide to Self Deliverance* as originally promised. But four days later, a testy member of the English society took out a private injunction to halt publication. In March 1981, the injunction was withdrawn, but with EXIT being forced to pay most of the legal costs.[4] In June, 1981, EXIT finally published *A Guide To Self-Deliverance.* Like the Scottish *How to Die With Dignity,* the Guide listed various drugs that were probably lethal. (The two books were unconnected, excepting that they arose from the same initial idea. Authorship and texts were entirely different, though similar in spirit to each other.) Litigation, or the threat of litigation continued, however, and EXIT soon withdrew its *Guide to Self-Deliverance.*

The big disadvantage facing anyone writing such a book at this time was that very little was known about the dosage of any drug that could be relied upon 100% to cause death. The Guide freely admitted that, "lethal doses given are not based on the sort of careful experimentation which now guides most treatment".[5] Most of the information that we have now was not available at that time.[6] Interestingly, it made some mention of tricyclic antidepressants[7] – drugs that were bypassed by the Scottish booklet and most other guides until the advent of *Departing Drugs.*[8] Similarly chloroquine was not mentioned, or the modern physical methods that use as compression or helium.

Manuals published in other countries

Several booklets appeared from continental right-to-die societies – in France, Germany, Belgium, Switzerland – all with a similar format to that of the short-lived English book, or rather the Scottish counterpart. English-speaking people from abroad joined the Scottish Society to obtain Dr Mair's book, but lack of funds and fear of prosecution had precluded the publicity necessary to inform a wider audience.

Then, in 1982, a French book, *Suicide – Mode d'Emploi* appeared on the bookshelves and caused a furor.[9] The French Society's own, more conservative book, *Autodeliverance,* was published the same year. Unlike the European right-to-die societies who stipulated a three-month waiting period before members could purchase a manual, *Suicide - Mode d'Emploi* was on open sale. Its approach was anarchistic, including details of how to forge doctors' prescriptions for lethal drugs as well as some 50 'recipes' for lethal cocktails. The publishers gave interviews expressing optimism about the massive profits they anticipated and the book quickly found a firm place on the French best-seller lists by that April.[10]

Around the same time, a rather more responsible approach was seen in America, where, constitutionally, there seemed less question of being unable to publish such manuals. Derek Humphry, a journalist who had helped his terminally-ill first wife to die at her own repeated request,[11] had by this time spent years researching dying, especially through case-studies which people had brought to him. Incorporating drug information into the text of a general book might be a way of introducing such information to the bookshelves without the tables and 'recipes' of the other manuals that might so easily be abused by the suicidally depressed, and Humphry achieved this to some considerable degree in *Let Me Die Before I Wake.*[12] Initially sold only to members of the Hemlock Society, the book was eventually extended and made available to the public.[13] Later editions also included an index, making it

possible to look up drug references without reading the whole book. Tricyclic drugs are mentioned in passing in *Let Me Die,* though omitted from Humphry's later book, *Final Exit.*[14] Political infighting[15] broke out in America over the publication of *Let Me Die* but sales grew and paved the way for a bestseller, *Final Exit,* in 1991.

In both books Humphry attempted to make use of the best knowledge available in standard medical manuals and further supplemented his extensive anecdotal knowledge by consulting the work of Dutch euthanasists.[16] *Final Exit* quickly became an international bestseller and helped to establish the name of Derek Humphry internationally.

Scientific and multidisciplinary cooperation

At the International Conference in 1992[17] I tried to find out if anyone had scientifically collated evidence on self-deliverance drugs. We were distributing *Final Exit* to our members, as well as *How to Die With Dignity,* yet there seemed to be little or no agreement within the scientific community about what drugs and what dosages could be relied on to cause death. As a young delegate with little authority it was extremely difficult to challenge the status quo, but I found there were indeed several quiet voices who were concerned about the lack of any really scientific research. As an initial project, I invited Cheryl Smith, then staff attorney for Hemlock, if she would like to investigate a drug called chloroquine with me that was mentioned in the German society's booklets but not in any other manuals. There were many strong opinions being bandied around about this drug, for and against, but nobody seemed to have any reliable evidence. In the months following the conference, we collected folder upon folder of published research from medical journals on chloroquine. By using good medical libraries and computerised search facilities we were able to uncover a wealth of information – why had nobody looked before now? Debates over chloroquine caused much concern, but could be pursued with considerable intellectual rigour thanks to the vast amount of published

information. The project culminated in a scientific paper,[19] which, after professional pre-review for accuracy,[20] was published by both VESS and Hemlock and reprinted in the Canadian magazine, *Last Rights.* (April-May, 1993)

The success of the chloroquine paper was offset by the fact that it not only challenged but disproved conventional ideas about its use for rational suicide. Research also showed that the drugs to be combined with chloroquine to achieve sedation before death needed to be chosen carefully, and the German society, who had initially alerted us to the drug's potential, withdrew their booklet which at that time had only limited information.

Departing Drugs — the first scientific manual on rational suicide
The methods used to research chloroquine could obviously be applied to other drugs. Cheryl Smith left Hemlock after completing the project on chloroquine and I invited her to cooperate on a new drugs book. She had contributed substantially to Humphry's work on *Final Exit,* was well versed in the subject and also aware of the limitations of methodology employed to date. We applied the same techniques of computerised search, repeating our efforts in various leading libraries and using different computer databases, acquiring vast amounts of material that then needed to be sifted through and collated. But published medical information alone was not enough.

What of the cases where people had followed the advice of 'experts' in trying to take their own lives but not been successful? Interviews followed, the most striking being from eye-witness accounts of failed suicides. Weaknesses in earlier manuals were eventually identified with some certainty, and medical hypotheses re-examined with greater scrutiny. Many errors in self-deliverance information result from following doctors' advice. This is a very flawed approach. Doctors are trained and qualified in how to keep people alive, not in what quantity

of a drug will reliably cause death. They generally offer little more than educated guesses, and we had to provide meticulously documented evidence to overthrow the opinions of many doctors. Similarly, pharmacists and pharmaceutical manuals give an idea of what quantity of a drug *may* be dangerous or lethal, but not how much is reliably so. This is largely due to two factors: the drugs testing by pharmaceutical companies (aimed, in this respect, mostly to establish the limits of safe doses) and the data provided on this basis. 'A lethal dose', in pharmaceutical terms, simply means someone has died or might die from such a dose, which is very different from saying that no-one taking such a dose will survive. This is why *failures* have always played such a big part in our research, as they allow us to go back to the drawing board and question original assumptions.

A similar reservation applies to knowledge obtained by first-hand observation – either by assisting someone to die or being present. Just because a method has worked well for several people is no proof in itself that it will work in all or even most cases. Our knowledge of failures came from several sources, including letters and phone calls from our own members, but also from the Dutch society NVVE and a counsellor in California, Stephen Jamison, and others. With this data, we were able to refine the advice in the booklet to minimise the chance of failure or make the instructions sufficiently foolproof to be relied on with confidence. Our final drafts were however checked by medically qualified experts to ensure we had not overlooked anything. The process was largely one of negation, to rule out inaccuracies or unsuitable methods or flaws by a process of subtracting them or re-submitting them until no flaws could be found by any of the scrutinizing processes.

I sent the early draft to over 40 individuals around the world who might have some expertise to add. Their comments were carefully examined. Finally, evidence was forthcoming from the Netherlands[21]

which showed that some patients self-administering euthanasia, in a hospital and under clinical conditions, had taken 10g of barbiturate and yet survived in a coma for up to several days. A doctor in the Netherlands in this situation can administer a further drug to speed death, and tests in such circumstances on dextropropoxyphene and orphenadrine (considered lethal by previous self-deliverance manuals) also threw doubt on the efficacy of these drugs. Knowledge of drugs, particularly barbiturates, has evolved considerably, and the properties of different classes of barbiturate are now better understood. The long coma of a person taking barbiturates in the Netherlands is not a problem there, but to isolated individuals in other parts of the world it poses the worry of discovery and resuscitation.

Arguments over the best way to use the 'plastic bag', and what drugs were effective with this method were resolved, but only finalised at the Working Party's meeting in July 1993. Physical calculations were made, based on published data, concerning air volume (and hence bag size); evidence of failed suicides and medical data combined to ascertain drug suitabilities (especially regarding speed of action and depth of sedation), and practical experiments made to confirm comfort in a suitably-sized bag for the given period. The draft was revised and checked several times. Smith repeatedly worked into the early hours of the morning with me after the Working Party Meeting while we checked and double-checked that data was presented accurately. Then the final draft was circulated to the rest of the Working Party for approval with its copious reference lists and glossaries. It contained clear descriptions of methods and drugs, in simple easy-to-understand language, but not omitting precise technical details and references.

An extensive glossary covered hundreds of brand-name drugs and explanations about the most common drugs queries was added. Dozens of drugs were mentioned for the first time in a self-deliverance publication. A country-by-country appendix gave specific brand names

for particular countries. There were sections dealing with obtaining drugs abroad, storage of drugs, buying drugs and obtaining prescription drugs. There were step-by-step sections on different methods as well as an 'essentials checklist' and sections covering legal and financial concerns relating to self-deliverance. An extensive bibliography was included to encourage further research into specific areas. Myths on many drugs were exploded. No longer need self-deliverance books be a collection of doctors' opinions or anecdotal evidence.

Distribution and safeguards

Departing Drugs is available to members of right-to-die societies who have been members for at least three months. The Working Party agreed certain conditions to be strictly imposed: i) a 3 months' wait, ii) *Departing Drugs* to be a non-profit venture, iii) absolutely no alteration or addition to the agreed text. These conditions were drawn up into the form of a legal contract by Smith (who fortuitously combined a law degree with a medical background, a rare occurrence).

To enforce the non-profit condition more stringently and to enable it to reach more readers at minimal cost, the Working Party authorised it to be published and distributed by myself (for VESS) in Sterling, by Smith in US dollars and by John Hofsess[22] (for RTDSC) in Canadian dollars. Legal contracts were signed by these distributors but giving no authority to the parent societies: signatories are held individually responsible. Each had the task of distributing the new book with only minimal funds. None of the people on the Working Party received any payment – neither are they allowed to make profit, either personally or on behalf of a society. It was with this attitude of self-sacrifice and beneficence that we hoped to continue to evince the services of top experts that had been invaluable so far and could probably never be bought.

German, French and Spanish translations would also be subject to similar safeguards. Why so much fuss? Why not just publish and pass the profits to the right-to-die societies? For one answer, we look at articles such as *Increase in Suicide by Asphyxiation in New York after the Publication of Final Exit* (published in the *New England Journal of Medicine*).[23] A demand for self-deliverance books and their availability in the bookshops may increase public awareness and help to reach those who need them, but it also evokes the criticism of making information available irresponsibly to suicidally depressed individuals who might use it irrationally instead of solving their temporary emotional or psychological problems. We have to take such criticisms seriously if we are to maintain serious respect as a movement. *Departing Drugs* also went much further than manuals such as *Final Exit,* since it contained information about over-the-counter drugs and easy-to-obtain prescription drugs. So it became even more pressing to have strict safeguards to try to ensure it was properly used. Ironically, although the cooperation from Europe, Australia and New Zealand was warm, and helpful in ensuring that their members could get the book, political problems from several societies in North America have hindered sales, and, although *Departing Drugs* is probably the single most important development in self-deliverance (or auto-euthanasia), several world federation right-to-die societies avoided mentioning it.

From 1993 to the present

In Britain, the legality of publishing information that can be used for suicide has never been tested in court. The Canadian publication, *Last Rights*, in its *Beyond Final Exit*[24] series, was at the time probably the only regular source of information on new developments in this field that you can read. Most 'good ideas' about methods of suicide are not such good ideas in practice, and the series has fortunately been able to expose the shortcomings of such hopes as street drugs or toxic plants. As the available space in *Departing Drugs* was limited for detailed scientific information useful to the lay reader, some of the more

technical analysis of the findings encountered in researching that book were still to be published. *Last Rights* eventually ceased publication. Exit's dwindling resources meant reassessing priorities, but Exit's governing body saw that self-deliverance was not only the original reason for the formation of the Society but the one area where Exit could still make a vital difference. Self-deliverance updates were therefore published in the Newsletter. There have been two main advances in suicide methods since that time: the use of helium and the application of compression techniques.

Although helium was mentioned in *Last Rights*, its practical use, particularly in the USA, led to the technique becoming more widely accepted. It was dealt with in some detail in the third edition of Humphry's book *Final Exit*[25] and in the article 'Before the Lights Go Out – Revisiting Asphyxia' in *Exit Newsletter*[26]. A great asset to the development of knowledge both of helium and of compression techniques (where the oxygen supply to the brain is cut off) was a ground breaking book from outside the right to die movement in 1999 called *Suicide and Attempted Suicide*[27] and written by a pharmacologist. Exit has largely pioneered the use of the compression technique[28] through its UK-wide workshops. Exit, like the Swiss organisation *Dignitas,* receives no recognition or assistance from the large World Federation of Right to Die Societies[30] and works on a tiny shoe-string, developing the key practices and methods that the larger, wealthier organisations and their members rely on.[31] In 2006, Philip Nitschke co-authored *The Peaceful Pill Handbook*[32], which included mention of the helium method (the title was derived from the theoretical desirability of a pill for suicide).

Since 1993, we have had a number of requests to 'update' *Departing Drugs* but the advice contained in it has not really changed. The extensive list of local names of various drugs around the world could be updated, but as generic names are provided with any drugs literature

this is easy for individuals to check rather than for us to expend the exorbitant time, money and effort obtaining the dispensing information from countries around the world and reprint. The main update needed was not on drugs but on physical methods.

Five Last Acts

Although *Exit Newsletter* has provided necessary updates on self-deliverance methods, ordering back-copies is not an ideal way of collecting all the information in one place. Self-deliverance workshops across the UK over several years have demonstrated that people want to know the *best practical methods.* Additionally some people want to know how to *check the information* by reference to more academic articles. When there are several good, reliable methods available, with relatively easy-to-obtain drugs and equipment, it makes little sense to embark on a holy grail for (difficult-to-obtain) barbiturates or knowledge of wild and wacky methods. The aim of *Five Last Acts* is to condense everything you need to know in one slim volume, presenting the best, properly validated methods, but with sufficient background material to do your own research if you desire.

There are a number of other books available on self-deliverance. You may want to browse them for background reading and ideas – it will help you think your ideas through – but apart from *Departing Drugs* and *Beyond Final Exit* we cannot vouch for the accuracy of the information and advice. Many of them contain well-meaning and reassuring recommendations that do not stand up to critical examination – just because the author 'knows someone' who used a specific method or is a medical doctor is, in itself, no guarantee.

What next?

Developing the frontiers in self-deliverance relies on a very small band of dedicated people, often living and working with little or no pay. Your purchase – of this book, membership of Exit, your donations

and legacies – all are helping that work to happen. Not only is your money going to an excellent, near-unique cause, but as a member you are among the first people to have access to the best expert advice and get the information that can give such peace of mind at the end of life.

References

1. The passage is taken from his speech in support of Lord Jenkins' attempt to modify the laws on assisted suicide and reprinted in The Euthanasia Review Vol. 1(2) Summer 1986:120-126.
2. Exit. A Guide to Self-Deliverance (1981):32 A Chronology.
3. Minutes of the Executive Committee Meetings 16/17 August 1980.
4. Exit, supra.
5. Ibid.p.19.
6. Chloroquine is a notable exception - hundreds of case studies had already been published in medical journals, but largely overlooked until examined in The Chloroquine Controversy. Correct use of chloroquine was first explained in Departing Drugs, qv infra.
7. For an analysis of the literature on tricyclic antidepressants, see: Smith C, Tricyclic Antidepressants and Suicide (1993) Last Rights No.l0:43-45.)
8. Docker C, Smith C (eds) and The International Drugs Consensus Working Party (Docker C, Smith C, Brewer C, Schobert K, and another). Departing Drugs - the International Supplement to How to Die With Dignity. (1993) Edinburgh: VESS. Reprinted in Victoria BC: RTDSC. (The fifth member of the Working Party, from Netherlands, agreed to give evidence on condition of anonymity).
9. Guillon C, Le Bonniec Y. Suicide - Mode d'Emploi - histoire, technique, actualite. Paris: Alain Moreau 1982. The rather gruesome nonchalance of Mode d'Emploi is repeated even more fully in a new Japanese bestseller called The Complete Manual of Suicide by Wataru Tsurumi, that includes such 'gems' as the location of suitably high buildings or how to lock oneself in the refrigerator.
10. Going Gentle into That Good Night in: Time, March 21, 1983; France's "How-To" Suicide Text Object of Outrage, Brisk Sales by Carolyn Lesh, Associated Press. Both news items were reproduced in Compassionate Crimes, Broken Taboos (1986) Los Angeles: The Hemlock Society, ed. D Humphry.
11. Humphry D. Jean's Way. London/New York: Quartet 1978.
12. Humphry D. Let Me Die Before I Wake - Hemlock's book of self-deliverance for the dying. Los Angeles: Hemlock; Member's draft 1981, First edition 1982.
13. Ibid, from a statement on origins and purposes at the front of the 1987 edition.
14. Humphry D. Final Exit - The Practicalities of Self-Deliverance and Assisted Suicide for the Dying. Oregon: The Hemlock Society 1991.

15. Humphry D, Wickett A, The Right to Die - Understanding Euthanasia. London: Bodley Head 1986: ppll3-114.
16. Such as: Admiraal P. Justifiable Euthanasia - A Manual for the Medical Profession. Amsterdam: NVVE 1983 (English translation: 1984). 11pp. Early drugs-manual issued to doctors in the Netherlands to guide them if they decided to assist dying. Its information is now considered out of date but no update has yet been printed in English.
17. World Federation of Right to Die Societies 9th Biennial International Conference, Kyoto.
18. Deutsche Gesellschaft fur Humanes Sterben, Medicaments List. Booklet of the German right-to-die society. No longer issued.
19. Docker C, Smith C. The Chloroquine Controversy. VESS Newsletter April 1993.
20. Pre-publication review by Dr Colin Brewer MB.MRCS.DPM.MRCPsych, Medical Director of The Stapleford Centre, London.
21. Unpublished research presented at the first meeting of the International Drugs Consensus Working Party, Edinburgh, 10-11 July 1993.
21. Euthanasia Research and Guidance Organization. A newly formed society. Headed by Derek Humphry. A pamphlet by Derek Humphry has recently been published under its auspices called: Self-deliverance from an end-stage terminal illness by use of a plastic bag. This is not connected in any way with the work of the International Drugs Consensus Working Party.
22. Hofsess had supplied me gratis with extensive medical material from Canada, pharmaceutical manuals, and had even promptly researched specifics by phone and fax for me to ascertain availability of Canadian brand-names. His magazine Last Rights demonstrated considerable publishing capabilities and the Working Party had no hesitation in deciding to make him the Canadian outlet for the book.
23. New England Journal of Medicine, 11 November 1993. Observing these criticisms does not minimize the ground-breaking work of Final Exit in bringing the dilemmas of self-deliverance to the attention of the world.
24. Beyond Final Exit was both the name of the series of articles in Last Rights and the name of the Departing Drugs companion work that gathered the articles together in a single volume. Both are now out of print, but all the key articles have been reprinted or updated in Exit Newsletter. The title 'Beyond Final Exit' was connected with Derek Humphry's book Final Exit inasmuch the editor of Last Rights wanted to extend and refine the Humphry's work by way of the Last Rights series of articles.
25. Humphry D, Final Exit #3 - The Practicalities of Self Deliverance and Assisted Suicide for the Dying, New York: Dell Publishing 2002.
26. Docker C, Before the Lights Go Out (revisiting asphyxia) in: Exit Newsletter Vol 23(1) Edinburgh: April 2003.
27. Stone G, Suicide and Attempted Suicide, New York: Carroll & Graf 1999.

28. Covered in some detail in Exit Newsletters Vol 21(3) (Letters) Autumn 2001 and 24(1) July 2004 (whole edition).
29. Dignitas is the small German organisation that has afforded many people from the UK the chance of assisted suicide at their clinic.
30. The World Federation of Right to Die Societies (WFRDS) is a would-be 'umbrella' group for societies worldwide. It claims to provide "an international link for organisations working to secure or protect the rights of individuals to self-determination at the end of their lives." Exit seceded due to the high WFRDS membership fees and the perception that the WFDS "was not demonstrating it was pursuing efficient means to further the cause of voluntary euthanasia". Exit's motions for improving the basis of the WFRDS by a basic code of ethics, although passed, was not implemented, and Exit noted that at the last Board meeting - admission to which being one of the few benefits of WF membership - the time was spent chiefly on discussion of the internal constitution, and at considerable expense, and that discussion of matters relating to v.e. was shelved. (Comments taken from Exit's official statements in July 1997 Newsletter.)
31. Departing Drugs is provided on a non-profit basis to members of other societies and is distributed under licence in several languages by foreign right to die societies. Exit Newsletter is sent on a complimentary basis to most right to die societies worldwide.
32. Nitschke P, Stewart F, The Peaceful Pill Handbook, Exit International US Ltd 2006. (Exit International US and other organisations using the name Exit in various forms are not connected with Exit, which is an international organisation based in Edinburgh, Scotland).

Recommended further reading

- Departing Drugs. Docker C, Smith C, and the International Drugs Consensus
  Working Party, Voluntary Euthanasia Society of Scotland (EXIT) 1993
  This is a cornerstone book on methods of suicide. Readers should bear in mind it was published many years ago, but it is still useful and recommended reading. There are various restrictions on its purchase: buyers must be established members of Exit or show a minimum of three months membership of another recognised right-to-die society on the official application form.
- Suicide and Attempted Suicide. Stone G, Carroll & Graf 1999
- How We Die. Nuland S, Chatto & Windus 1994
- British National Formulary. Pharmaceutical Press, PO Box 151, Wallingford, Oxford, OX10 8QU, https://www.pharmpress.com. (You may find an equivalent drugs manual more suited to the country you are living in if outside the UK, but failing that the BNF carries much useful generic information.)
- Martindale – The Complete Drug Reference. Pharmaceutical Press, London.
  Martindale provides professional and comprehensive information on drugs and medicines used throughout the world. It is an expensive volume, so you may wish to consult it by going to a good library.

About EXIT workshops

Exit[1] workshops are one-day intensive, interactive sessions covering the main methods of self-deliverance. They cover the information in this volume in a 'hands-on' way. Participants are limited to about 25 people to allow for plenty of time to convey techniques in ways that each person understands. There are demonstrations, and at different points in the workshop, the participants will work in teams or individually to make sure they have mastered the material (although no-one is forced to join in more than they want to.)

Exit subsidises these workshops so that people are not prevented from attending due to cost. They are held in different parts of the UK based on perceived demand and may be taken abroad in the near future.

Here are some of the comments we have received in letters from people who have attended:

From Warminster, Wiltshire:
I just wanted to thank you for all the care and detail you put into the Workshop that took place on Saturday 17th December in London. I was very sorry that I was unable to stay until the end and so missed two of the subjects - but I find the other two very helpful and the whole day was extremely interesting and thought provoking.

Sheila M Jones

From Wimbledon, London:
It is hard to say how great an impact the Workshop I attended in December last has had on me. I've been a member of EXIT on and off since 1975 but never before had practical hands-on information. The workshop was conducted in a friendly manner and at the right level, assuming little or no previous knowledge or expertise. I enjoyed

[1] Exit refers to the Scottish based organisation of that name. There are other societies in different countries that use the same name that are not connected with Exit in any way.

very much the presence of others of like knowledge. The practical experience of actually using materials "hands on" is invaluable and should always be emphasised. As you say, we think, 'OK, I've got my "stuff" - I'll just go when I'm ready - but the details could be difficult to overcome when push comes to shove.

Hazel Sherrington

From Edinburgh:
At the workshop in Glasgow in November, you asked for feedback. I'd like to break down my comments into sections:

a) Organisation: I thought the choice of venue was good – I'm not familiar with Glasgow but, knowing that it would be near the stations made me happier about booking. I also appreciated the fact that reasonably priced food was available on the premises – it made it easy for us to get into conversation at lunchtime in a way that wouldn't have been possible if we'd been wandering the street looking for a café. I also felt the size of the group was good: small enough not to be intimidating but, I would think, large enough for those who didn't want to speak to feel comfortable.

b) Content: I expected to find it informative (since I knew nothing to start with!) but I particularly appreciated the practical details you included: where to buy things, what to ask for, etc.

c) Presentation: I was impressed with the way you handled questions and comments, and with the way in which you varied your 'teaching' techniques in the course of the day. (I have the attention span of a gerbil but was kept interested throughout!)

If the above sounds like I am easily pleased, I want to assure you that the reverse is true! I've just retired from 30 years of teaching, and

specialised in work with 'difficult' teenagers, so I know that keeping an audience – even one of willing adults – engaged all day is quite a challenge. Also, through my job, I've had a lifetime of sitting through conferences and courses where I felt my time was being wasted due to poor presentation or preparation on the part of the speaker. I've filled countless evaluation sheets with negative comments, so I'm actually a very demanding participant!

So, overall, I'd like to thank you for a very productive day.

Jane Colkett

From Aberystwyth, Wales:
Here is my endorsement of your workshop project, as invited. Attending the Birmingham workshop was a revelation. It made me realise how much this is hands-on work which requires hands-on training. It's too important to rely on the more fallible method of just reading it up. Moreover, working with an experienced trainer gave me much greater confidence and assurance in the methods. And the fellowship of the other workshop participants was heartwarming and supportive. I couldn't have wished for more sane and good humoured companions.

Ken Jones

From Glos:
I wish to thank you for coming down to London last week to conduct a self-deliverance workshop. Although I have been, and still am, a member of various voluntary euthanasia societies in different countries, I have never had the opportunity to attend a workshop. In fact, very few societies offer such a practical workshop.

It was interesting and helpful to me, and I am sure also to other participants, to receive an explanation and assessment of different

methods of self-deliverance and their 'pros' and 'cons'. The group discussion helped individuals decide which method(s) were most suitable for their individual needs and preferences. It was helpful to be able to discuss matters freely among a group of like-minded individuals without fear or apprehension. The whole atmosphere was supportive. I congratulate you on the running of the workshop. (Contribution enclosed.)

Christopher John Aeschlimann

From Bedford:
For some time I had been looking forward to learning how to apply the techniques that I'd read about in the Exit Newsletter, having missed several previous workshops. The resulting day exceeded my expectations in every way, and proved to be a most valuable experience. Many small details were covered that could not be included in written articles, and these might make all the difference when using self-deliverance methods. The following list summarises some of the benefits I found attending.

Having the opportunity to actually try out and handle equipment such as bags, helium cylinder and the ratchet tie-down brought out practical differences in their ease of use that couldn't possibly be had from reading about them.

Trying the methods for myself gave me more confidence that I would be able to use them in practice. It became clear why completely different sized plastic bags were needed when used with helium, compared to without, and the reasons were understood.

I found where my own carotid arteries are for the first time, having looked for them in vain at home before the demonstration. Being shown how to connect a helium cylinder made it much more likely that

I wouldn't make mistakes. I found that some methods needed physical strength that might be demanding if I was frail or ill. However, the variety of methods demonstrated would allow one to be chosen that was suitable for most circumstances.

Interaction between workshop members helped to bring out some aspects that I wouldn't have thought of on my own.

Chris concentrated on methods that were accessible to most people, avoiding, for example, those drugs that are hard to obtain.

It was valuable to meet other members and have the opportunity to talk freely about topics that are taboo among my usual friends.

Like some other attendees, before the workshop I had some apprehension that it might be overly delicate, or rather morbid. In fact, it was a thoroughly pleasant experience, with free and natural discussion in a friendly, relaxed atmosphere. Chris dispelled any artificial formality and led the workshop in a light-hearted, humorous way, while always recognising that we were discussing one of the most important decisions that any of us will have to face. He allowed us to participate fully and interrupt with questions as necessary. At one point he even left us on our own to fathom out the helium connections, since we were more likely to remember what we'd learnt if we had to do it unaided. In spite of the freedom to question and discuss, Chris kept to his timetable and managed to cover all the topics fully. In a lunchtime discussion with several other members, we agreed that this was one of the best-led workshops of many we had attended, including those of our professional lives.

C.C. of Bedford (full name withheld by request)

From Tonbridge:
This is to thank you for a great value-for-money workshop yesterday. A sordid way of putting it. 'Value for time' would have been better. Or perhaps, for the more physically handicapped, Michelin's 'vaut la visite' Would be the most appropriate.

I have been to many meetings/workshops of Exit over the last fifteen years since I joined. My late wife and I were both members, but she was the breadwinner and I had time to take part. I can summarise by saying that a day's workshop has always been worth a month's reading the literature. The literature is fine. Keep it coming. It is there to fall back on. But the workshops provide a hands-on experience which most of us need.

For example, you provided a splendid presentation of the helium method of asphyxiation with a clear series of OHP images. The session which followed reinforced the simplicity of all this but also brought out the small but important difficulty for some of us in opening the rather stiff taps on the cyclinder - and suggested ways of coping with it.

The level of presentations was just right. Neither talking down to children nor up to the techies. There was enough time for pertinent questions, but not for anecdotal stuff which, though interesting, would not have moved us forward much.

Exit members really should make every effort to come to the workshops. Those who do not come have no idea how much they are missing. I know it is difficult for some disabled members to get to a workshop even if it is within possible distance. I myself am held together with all sorts of external tubing and leg bags and live in perpetual apprehension of the plumbing coming apart somewhere where on-the-spot repairs would be difficult, but I don't regret having taken the risk yesterday at all.

A suggestion. With the endless appearance of new proprietary drugs it is often hard to know what sort of an animal a Zolpidem or a Temazepam might be. Having worked in the third world most of my life, where drugs appeared from many sources in the pharmacies, I thought it worthwhile to buy once a year a copy of 'BNF' the British National Formulary. You can get it 'over the counter' at many bookshops or supplied by the publisher, Pharmaceutical Press, PO Box 151, Wallingford, Oxford, OX10 8QU, https://www.pharmpress.com. The ISBN changes with each edition, but usually begins with 9 85369. It gives the generic names of most of the proprietary drugs and lists them all by category (e.g. hypnotics / anxiolytics / antidepressants . . .) But you must have known this already. My suggestion is that readers of the Newsletter should be made aware of it.

Michael Dobbyn

From London:
I would like to thank Chris Docker and Exit for an excellent workshop on Saturday. It was practical, informed, well-paced, thorough, sympathetic and pertinent. Chris Docker was reassuring and amusing and very much in control of his material. The venue was comfortable and the whole day relaxed and easy.

Kim Lewis-Lavender

From London:
I have been a member of Exit for almost 20 years. I joined because I feel very strongly that it is a basic human right to be in control over when and how your life should end. Back then, I focussed on the principles and I wasn't too concerned about the practicalities. Recently I have attended one of Exit's workshops, and found it excellent. It gives such comfort to know how to end your life in a painless and dignified way, if and when the need to do so arises.

Per-Olof Larsson

From Gloucestershire:
We would like to take this opportunity to thank you for the brilliant workshop you ran last Saturday. Both Tom and I gained a great deal of information and came away feeling enlightened and so much happier. We feel that we can now enjoy the rest of our lives secure in the knowledge that we have the necessary information we need to end those lives in dignity as and when we decide to do so - thank you so very much. We did not really know what to expect - there was some apprehension and trepidation - but you put us all at our ease and the whole experience was good. You managed to look at and tackle a very difficult and serious subject with rationality, compassion and even humour at times - not an easy task - well done!

A very pleasant and informative day! If anyone out there would like to go on a similar workshop but is feeling what we initially felt, ie doubt and hesitation, we urge them to attend - they will find it invaluable and very, very comforting.

None of us knows what fate has in store for us and in a perfect world we should have no fear of death, but it is the manner of that dying that is of the greatest concern. To be able to control your own leaving of life is a great source of solace and peace. We are so grateful for receiving this knowledge.

Jan & Tom Edwards

From Somerset:
I would like to take this opportunity to say how very helpful the information gained in the Self-deliverance workshop was, both at the meeting but probably even more so in the time spent thinking things over since. The content and the way in which you conducted the

meeting filled me with the conviction that should I ever need to use this information I would not have fears of not being able to end my life the way I wish to and when I wish to. The opportunity to meet like-minded people who were not afraid to talk openly with great feeling and, thank goodness, humour, was especially uplifting. Having nursed many people at the end of their lives, both family and friends and professionally, I know for sure that if only many had had forethought, knowledge and support they would have been spared so much suffering. Without doubt the ability to communicate one's fears and practical doubts and to receive straight unemotional and solid information must be the best help of all.

Thank you so very much again. I have to say that I really enjoyed myself.

Pauline Macmillan

From Edinburgh:
The day was extremely valuable for many reasons. The technical content was enormously helpful and it was a tremendous relief to know that the various methods of self-deliverance had been so thoroughly researched.

The workshop also made me face up to the actual mechanics of self deliverance and the need for meticulous and early preparation, rather than postponing the planning to some indefinite date in the future.

It was extremely comforting to be sitting in a room with twenty seemingly rational people discussing self-deliverance with seriousness but with such good humour. It made me feel much less isolated and neurotic!

Ruth Malcolm-Smith

Some frequently asked questions

Exit has so few resources that letters are often not answered very quickly. Other things (like producing this book) have to take priority. It seems unfair that people have to wait a long time to get an answer to common questions that sadly have a fairly standard response, so we include some of the common ones here.

Estimating dosages – how do I know how many sleeping tablets I should take?

This varies from person to person. Usually the sleeping tablets are not the cause of death but taken in combination with the plastic bag or chloroquine to ensure a good sleep until the end. (For exceptions to this, see the chapter on Drugs.) The general rule is to see how many tablets you need for eight hours daytime sleep and multiply by ten. This will ensure you are in a sufficiently deep sleep not to wake up. The 'daytime' consideration is so that it is at a time when you wouldn't just fall asleep anyway.

I'd like to visit you in the Office to discuss a few matters . . . .

The Exit office is not generally open to the public. Usually when people say 'discuss a few matters' they mean ask advice about methods of suicide. This one-to-one advice is prohibited in the current legal environment. We can answer questions in the book or workshops for general information on self-deliverance and suicide, but more personal advice leaves us open to charges of assisting. So we don't discuss it, and a visit to the Office would not yield the result sought. (If there's further questions after reading this book, do sign up for one of the workshops – these are held around the UK and may be taken abroad in the future.)

But can you meet me or come to see me for a confidential chat – no-one need know about it?

I'm afraid the answer is the same. We work within the letter of the law, officially and unofficially. Many years ago, an official in one right-to-die group went further and advised and helped people in person. To make matters even more serious, in some of the cases it transpired that the people were not as seriously ill as had been supposed. Such situations would lead to Exit being shut down and no longer being able to help anyone. Exit is very clear about what it does and doesn't do.

Did you know that you can commit suicide by . . .

Exit receives on average one letter a month detailing a new or weird and wonderful way to die. Occasionally they lead to further research and reliable new methods (such as happened with compression, which we first started investigating after an anonymous letter from a judo practitioner). But mostly they fall into one of a number of categories. There are methods that work but frequently produce unacceptable consequences to others, such as jumping from very high buildings. There are methods that have an unacceptably high risk-factor of unpleasant consequences with failure. There are methods that can cause death but not reliably cause death (there are very, very many that fall into this bracket). Then there are methods that we simply don't know enough about (in any scientific sense of being able to assemble sufficient data to recommend them). Research is time-consuming and costly. Saying to you, "I know someone who committed suicide by such-and-such method," doesn't mean it would work for you. This 'anecdotal' evidence is related in many right-to-die books as if it were reliable, but it is a long way from scientifically connected discourse, meta-analysis and peer review that forms the basis of the books published by Exit. If you have confidence in a particular method then by all means use it if you wish – it is your life and your death.

The last category is methods that are only available to a few people, such as doctors or people who can obtain drugs or equipment not commonly available. You could read a whole book on barbiturates, but to little avail if you cannot get hold of them. Concentrating on such methods draws most readers away from practical methods.

I'm very ill. Can you process my Exit application more quickly please?

Exit cannot offer an 'emergency' or 'fast-track' service. This is partly to do with resources, as explained above. Secondly, it is not up to Exit to be a judge and jury to screen people for urgency and need – and doing so could present legal problems of the sort already mentioned. We supply information for future reference, not for use now. But there are also more practical reasons. Preparing for self-deliverance generally requires ample forethought, possibly a stockpiling of drugs, and generally putting things carefully in place while you still have physical and mental health. It is hard to do once you are very ill. With a very short amount of time available and no previous preparation and knowledge, putting one's efforts into getting good palliative care is often more sensible.

Can you tell me where I can go abroad to get euthanasia or assisted suicide from a sympathetic doctor?

Yes and no. Forget about the Netherlands, Belgium and Oregon – they can only offer help to their own people. Switzerland is more sympathetic but the process is far from simple. Only one organisation (at the time of writing) will help foreigners, and that is Dignitas. Their website is http://www.dignitas.ch and includes some information in English. You can also email Dignitas at dignitas@dignitas.ch or write to them at Postfach 9 - CH 8127 Forch. There are certain costs involved, detailed in the *Delegation of the Select Committee on Assisted Dying for the Terminally Ill Bill to Dignitas,2005,* available on the website, and which also explains much of the procedure. There is a registration fee (100CHF - in Swiss

Francs), an annual minimal fee (50CHF) and, if you receive assisted suicide with their help, the associated costs of travel to Zurich, a fee for preparing an assisted suicide (1000CHF) and a fee for Dignitas managing everything with the authorities in relation to burial and matters after the suicide (1000CHF). At the time of writing, 1000CHF is equivalent to about £409 or US$1,024. Dignitas will require a personal letter and also a copy of the person's medical records.

Where can I get drugs on the Internet

Although we don't recommend this as a primary means (see chapter on drugs) it is possible to get some drugs on the Internet. As Internet addresses change from time to time and as we do not have the resources to vet them or test the drugs supplied by various Internet pharmacies, we do not recommend specific Internet sources.

What about living wills?

Living wills (advance medical directives) are a formal way of *refusing* treatment and recognised in law in many countries including the UK. In terms of a willed death, they can benefit only those people who will die when treatment is withheld.

I don't live in the UK – is there any chance you will be doing some workshops where I live?

Yes, but obviously it needs to be coordinated. The best way is to ask the right-to-die society in the country where you live to request one. They are in a position to advertise it and gauge the demand.

Now I have the book, do I need to join Exit?

As you find yourself wanting to understand more and more about the process of self-deliverance, you may find it will come naturally to you to join the organisation and be the among the first to hear of any new developments.

Your notes

Lay down

your sweet and weary head

Night is falling

You have come to journey's end

Sleep now, and dream

of the ones who came before

They are calling

from across the distant shore . . .

From Into the West *by Annie Lennox*

Chris Docker is an established author in the field of Law and Ethics in Medicine, producing key works for the professions and academics on topics such as living wills, death & dying, and human transplants. For 15 years he has been one of the world's leading researchers into the reality of 'self-deliverance' – or the means for a person to accomplish their own easy, peaceful and dignified death when all other measures to relieve suffering and indignity have failed.

Even with modern technology, not all ends are good ones. Although palliative care continues to make great strides, the final hours or days of some people are so difficult that they elect to take matters into their own hands and end things sooner rather than later. Once that decision is taken, lack of knowledge, planning or preparation can result in even greater suffering.

Five Last Acts collects the wisdom of multi-disciplinary research, workshops and developments worldwide in a major new volume. The body of the work is written in easy-to-understand language to offer a practical guide for every reader. Technical explanations are reserved for the appendix. *Five Last Acts* provides the reliable options for the last act in your own play.