Submission

on the

Exposure draft of the Medical Services (Dying with Dignity) Bill 2014

by

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TABLE OF CONTENTS

1. Introduction

On 24 June 2014 Senator Richard Di Natale tabled an exposure draft of the *Medical Services (Dying with Dignity) Bill 2014* in the senate. The Senate referred the exposure draft to the Senate Legal and Constitutional Affairs Legislation Committee for inquiry and report. Submissions are due by 21 August 2014. The Committee is due to report by 27 October 2014.

This submission considers the specific provisions of the proposed Bill in the light of broader considerations about legalising euthanasia and physician assisted suicide based on experience in other jurisdictions that have done so.

2. Legalising murder and aiding suicide

At the heart of the bill is the legalisation of murder and aiding suicide under certain circumstances.

Clause 24 of the Bill would provide a complete immunity from criminal action against a person in relation to acts done in good faith for the purposes of the act and in accordance with the Act.

Clause 25 of the Bill would override the criminal law of the Commonwealth and each of the States and Territories by providing that an act done in good faith for the purposes of the act and in accordance with the Act "*does not constitute an offence*".

The acts that would be authorised by the Bill include acts that currently constitute the criminal offences of murder or aiding suicide in the criminal law of the Commonwealth as well as each State and Territory.

2.1 Legalising murder

The Bill would authorise a medical practitioner, under certain circumstances, to administer a substance to a person in order to end his or her life. (Clause 5(2)(e) with Clause 11(2)(b))

Such an act has all the elements, including the intent, of the criminal offence of murder.

For example, under section 279 of the Criminal Code (Western Australia) "*If a person unlawfully kills another person and the person intends to cause the death of the person killed … the person is guilty of murder*."

Note that Section 261 of the Code provides that: "*Consent by a person to the causing of his own death does not affect the criminal responsibility of any person by whom such death is caused*."

2.2 Legalising assisted suicide

The Bill would authorise a medical practitioner, under certain circumstances, to give information to, prescribe a substance to, prepare a substance for or give a substance to a person "*to enable a person to end his or her life*". (Clause 5(2)(a)-(d) with Clause 11(2) (b).

Such acts have all the elements of aiding a person to kill himself or herself.

For example, section 288 (3) of the Criminal Code (Western Australia) provides that "*Any person who aids another in killing himself is guilty of a crime and is liable to imprisonment for life*."

It is a very serious matter to change the law on murder and assisted suicide.

3. Would the Bill be constitutionally valid?

The Bill seeks to use the device of a Commonwealth law to override the laws of each State and Territory on murder and assisted suicide.

This approach raises issues of constitutionality as well of federalism.

There is a good case for doubting that the Commonwealth Parliament has the constitutional head of power to make a law permitting murder and assisted suicide.

The Bill cites four possible heads of power as the constitutional basis for the Bill.

- the Commonwealth's legislative powers under paragraph 51(xxiiiA) of the Constitution (Clause 6(a));
- any implied legislative powers of the Commonwealth (Clause 6(b));
- the Commonwealth's legislative powers under paragraph 51(xx) of the Constitution (Clause 7(2) and (4));
- the Commonwealth's legislative powers with respect to Territories under section 122 of the Constitution (Clause 7(3)).

Each of these proposed heads of power is discussed below.

3.1 Paragraph 51(xxiiiA) of the Constitution (Clause 6(a))

Clause 6 (a) of the Bill would provide as follows:

6 Constitutional basis for this Act

This Act relies on:

(a) the Commonwealth's legislative powers under paragraph 51(xxiiiA) of the Constitution; and

(b) any implied legislative powers of the Commonwealth.

Paragraph 51 (xxiiiA) of the *Constitution of Australia* provides as follows:

The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:

…

> *(xxiiiA) the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances;*

This paragraph was introduced into the Constitution in 1946 by referendum in order to support an expansion of Commonwealth involvement in social security provision.

The High Court of Australia has considered the meaning and scope of this provision in several cases including:

- *British Medical Association v Commonwealth [1949] HCA 44; (1949) 79 CLR 201 (7 October 1949)*; [BMA]
- *Wong v Commonwealth of Australia; Selim v Lele, Tan and Rivett constituting the Professional Services Review Committee No 309 [2009] HCA 3 (2 February 2009);* [Wong] and
- *Williams v Commonwealth of Australia [2014] HCA 23 (19 June 2014)* [Williams 2014].

Firstly, it should be noted (following Latham CJ in BMA)[1], "*The power is not a power to make laws with respect to, e.g. pharmaceutical benefits and medical services. It is a power to make laws with respect to the provision of such benefits and services.*"

Furthermore, "*the introduction of the words 'The provision of' at the beginning of par. (xxiiiA.) produces the result that the new power given to the Commonwealth Parliament by this constitutional amendment is a power to make laws with respect to the providing by the Commonwealth of the benefits mentioned in the paragraph*".

The Commonwealth may, under this paragraph, legislate with respect to the provision of medical services by legislating for the payment of all or part of a fee for a medical service provided by a medical practitioner to an eligible person. (This is the constitutional basis, for example, of the Medicare scheme as governed by the *Health Insurance Act 1973*.)

The drafters of the Bill have attempted to take this into account by structuring the Bill around the provision of what it calls "*dying with dignity medical services*" to be paid for entirely by the Commonwealth. (cf. Clauses 11 and 18).

Clause 5 of the Bill would define a "*dying with dignity medical service*" as follows:

> *(1) A dying with dignity medical service means a medical service provided by a medical practitioner to a person to enable the person to end his or her life in a humane manner.*
>
> *(2) Without limiting subsection (1), such services include:*
>
> *(a) the giving of information to the person; and*
>
> *(b) the prescribing of a substance to the person; and*
>
> *(c) the preparation of a substance for the person; and*

[1] Latham CJ, *British Medical Association v Commonwealth [1949] HCA 44; (1949) 79 CLR 201 (7 October 1949)* at 59, http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/HCA/1949/44.html

(d) the giving of a substance to the person for self-administration; and

(e) the administration of a substance to the person at the person's request.

This definition would cover such things as:

- instruction in any method of suicide considered "humane", such as the nitrogen inhalation method currently favoured by Philip Nitschke;
- prescribing a lethal substance;
- preparing a lethal substance [NOTE: this is really a pharmaceutical service rather than a medical service];
- giving a lethal substance to a person for self-administration; and
- administering a lethal substance to a person.

Each of these acts would be considered grossly unprofessional under both international and Australian codes of ethics for the medical profession.

The Bill acknowledges this by providing in Clause 24 immunity from all disciplinary action for acts done in accordance with the Act, thus seeking to prevent the medical profession from disciplining those medical practitioners who would breach its codes of behaviour by acts of euthanasia and assisted suicide.

Every provision of a "*dying with dignity medical service*" as defined in the Bill would violate the clear policy position of the Australian Medical Association (AMA) on good medical practice.

> *The AMA believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life* .[2]

In April 2013 the World Medical Assembly, noting that "*the practice of active euthanasia with physician assistance has been adopted into law in some countries*" reaffirmed "*its strong belief that euthanasia is in conflict with basic ethical principles of medical practice*" and strongly encouraged "*physicians to refrain from participating in euthanasia even if national law allows it or decriminalizes it under certain conditions*".[3]

It is clear then that the Bill would authorise and, indeed provide for the entire cost of, acts of "*active euthanasia with physician assistance*" that are considered to be unethical and contrary to good medical practice and the ordinary standards generally observed by the medical profession not just in Australia but internationally.

In doing so the Bill may be going beyond the legislative power of the Commonwealth to make laws "*with respect to the provision of … medical and dental services*".

In Wong, Kirby J observed that there were limits on the kinds of laws dealing with the provision of medical and dental services that could be considered within the legislative power of the Commonwealth. He gave as an example of a law that would be beyond power a law in relation to which:

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[2] Australian Medical Association "The role of the medical practitioner in end of life care", 20 August 2007, 10.5, ,https://ama.com.au/position-statement/role-medical-practitioner-end-life-care-2007

[3] World Medical Association, WMA Resolution on Euthanasia, April 2013, http://www.wma.net/en/30publications/10policies/e13b/

> *a conclusion was reached that the true purpose of the law was not the regulation of the legality and financial integrity of such benefits but an unjustifiable intrusion into the conduct of medical and dental practice, inconsistent with, or travelling significantly beyond, the ordinary standards generally observed by such professions in Australia.*[4]

The Commonwealth has no power to invent by legislative fiat new "*medical services*" in order to then legislate for the provision of these services by the Commonwealth.

It would certainly seem to have no power to do so in relation to acts which are considered by the medical profession in Australia to be acts "*that medical practitioners should not be involved in*"[5] and, by the medical profession internationally, to be "*in conflict with basic ethical principles of medical practice*"[6].

The Bill's claim that its provisions are supported by paragraph 51 (xxiiiA) of the Constitution is insupportable and to the extent that this is the only basis for its provision the Bill would be invalid and it provisions incapable of operating.

3.2 Any implied legislative powers (Clause 6 (b))

The notion that the Commonwealth has any implied legislative powers has never been explicitly endorsed by a High Court majority. Let alone has the Court endorsed the view that such powers would be so broad as to encompass matters such as the subject matter of the Bill.

As Hayne and Keifel JJ explain in *Pape v Commissioner of Taxation*:

> *it may be accepted that there is some implied legislative power in the Parliament that follows from the existence of the national polity. That power extends to laws putting down subversive activities and endeavours. But that implied legislative power does not extend so far as to encompass the general subject of the "national economy*".
>
> *Not only is the content of such a power too uncertain to permit its implication, but, even if the power could be given sufficiently certain content, its implication is not necessary.*[7]

Heydon J points out in the same case that there is only one binding decision on the implied legislative power, namely, *Commonwealth v Tasmania* in which the majority found that if there is any implied legislative power it certainly wouldn't extend, as Dawson J put it, to matters such as "*education, health, the prevention and punishment of crime which are not the subject of Commonwealth legislative power and are consequently within the residual powers of the States.*"[8]

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[4] Kirby J, *Wong v Commonwealth of Australia; Selim v Lele, Tan and Rivett constituting the Professional Services Review Committee No 309 [2009] HCA 3 (2 February 2009)*, at 152

[5] Australian Medical Association "The role of the medical practitioner in end of life care", 20 August 2007, 10.5, ,https://ama.com.au/position-statement/role-medical-practitioner-end-life-care-2007

[6] World Medical Association, WMA Resolution on Euthanasia, April 2013, http://www.wma.net/en/30publications/10policies/e13b/

[7] Hayne and Keifle JJ, *Pape v Commissioner of Taxation [2009] HCA 23 (7 July 2009)*, at 364-365, http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/HCA/2009/23.html

[8] Heydon J, *Pape v Commissioner of Taxation [2009] HCA 23 (7 July 2009)*, at 503 (citing Dawson J, *Commonwealth v Tasmania ("Tasmanian Dam case") [1983] HCA 21; (1983) 158 CLR 1 (1 July 1983)* at 75,

There can be no reasonable expectation that the High Court would suddenly discover an implied legislative power extensive enough to found legislation of the kind proposed in the Bill in the absence of any other head of power. Of course, if there are any other heads of power to found the Bill then the provision in regard to any implied legislative power is redundant.

3.3 Paragraph 51 (xx) of the Constitution - Corporations power (Clause 7 (2))

Paragraph 51 (xx) of the constitution gives the Commonwealth Parliament the power to make laws "*with respect to … foreign corporations, and trading or financial corporations formed within the limits of the Commonwealth*".

Subclause 7(2) of the Bill would provide that:

> *This Act has, by force of this subsection, the effect it would have if its operation were, by express provision, confined to a medical practitioner employed by a constitutional corporation.*

Subclause 7(4) would provide that:

> *In this section:*
>
> ***constitutional corporation*** *means a corporation to which paragraph 51(xx) of the Constitution applies.*

In Williams 2014, the High Court of Australia dismissed the claim that merely because a law authorised a payment by the Commonwealth to a constitutional corporation that law could be characterised as a law "*with respect to trading or financial corporations*".

> *The impugned provisions seek to provide authority for the Commonwealth to make agreements and payments. For the purposes of considering the argument, it may be assumed that the opposite party to an agreement made for the purposes of the National School Chaplaincy and Student Welfare Program and the recipient of payments made under that program can be, even must be, a trading or financial corporation.*
>
> *A law which gives the Commonwealth the authority to make an agreement or payment of that kind is not a law with respect to trading or financial corporations.*[9]

Assuming that the claim in Clause 6 (that the Bill is based on "*the Commonwealth's legislative powers under paragraph 51(xxiiiA) of the Constitution*") is invalid, then the effect of Subclause 7(2) would be to attempt to found the payments, to be made under Clauses 16-18 of the Bill, by the Commonwealth to "*a medical practitioner employed by the a constitutional corporation*" on the corporations power.

In the light of its decision in Williams 2014 this attempt is unlikely to find favour in the High Court.

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http://www.austlii.edu.au/au/cases/cth/HCA/1983/21.html); http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/HCA/2009/23.html

[9] French CJ, Hayne, Kiefel, Bell And Keane JJ, *Williams v Commonwealth of Australia [2014] HCA 23 (19 June 2014)* at 49-50, http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/HCA/2014/23.html

3.4 Section 122 of the Constitution - the territories power (Clause 7(3))

Paragraph 51 (xxiiiA) of the Constitution contains one of the "*comparatively few express, protective guarantees"* in the text of the Constitution, namely the prohibition on the Commonwealth making any law with respect to the provision of medical and dental services that would "*authorize any form of civil conscription*".

This prohibition, like other explicit prohibitions in the Constitution, applies to laws made under any other Commonwealth law making power in the Constitution, not just those made under the power bestowed on the Commonwealth Parliament in paragraph 51 (xxiiiA).

> *In* Bourke *itself, it was held that the phrase in s 51(xiii) "other than State banking" imposes a restriction upon federal legislative power generally, rather than a restriction only upon the ambit of s 51(xiii). Other examples of positive prohibitions or restrictions are found in the paragraphs of s 51 dealing with taxation (s 51(ii)) - "but so as not to discriminate between States or parts of States"; bounties (s 51(iii)) - "but so that such bounties shall be uniform throughout the Commonwealth"; insurance (s 51(xiv)) - "other than State insurance"; and medical and dental services (s 51(xxiiiA)) - "but not so as to authorize any form of civil conscription".*[10]

In Wurridjal[11] the majority effectively overturned a 1969 decision which had treated s122 of the Constitution, the territories power, as immune from the requirement in paragraph 51 (xxxi) that property may only be acquired by the commonwealth on "*just terms*". After Wurridjal it is now clear that other explicit limitations on Commonwealth legislative power would apply to laws made under s122 in respect to territories.

3.5 "Not so as to authorise any form of civil conscription"

Regardless then of which heads of power (including the corporations or territories powers) are relied on as the constitutional basis of the Bill, the constitutionality of the Bill must be tested against the prohibition on "any form of civil conscription" in relation to "medical and dental services", set out in paragraph 51 (xxiiiA) of the Constitution.

At the core of the Bill are the provisions it would introduce by Clauses 10 and 11.

Clause 10 would empower a person, in specified circumstances, to lawfully request "*a medical practitioner*" to "*provide dying with dignity medical services to the person for the purpose of ending his or her life*".

Clause 11 explicitly imposes on a medical practitioner to whom a request under section 10 is made a strict legal obligation to do either of two things:

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[10] Gleeson CJ, Gummow, Kirby, Hayne, Callinan, Heydon and Crennan JJ, *New South Wales v Commonwealth [2006] HCA 52; 81 ALJR 34; 231 ALR 1 (14 November 2006)*, at 220, http://www.austlii.edu.au/au/cases/cth/HCA/2006/52.html

[11] *Wurridjal v The Commonwealth of Australia [2009] HCA 2 (2 February 2009)*, http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/HCA/2009/2.html See in particular, French J at 86; Gummow and HayneJJ at 189 and Kirby J at 287.

- refuse to provide dying with dignity medical services to the person; or (subject to certain conditions)
- to provide dying with dignity medical services to the person.

These provisions should "*properly … be characterised as … intruding into the individual relationship between providers of medical and dental services*" and their patients.[12]

If these core clauses of the Bill are unconstitutional because of the explicit prohibition on any form of civil conscription then the Bill as a whole would be inoperable and must be considered invalid.

Recommendation 1:

As there are serious doubts about the constitutionality of the Bill it should not be formally introduced to the Senate and if it were to be introduced it should be rejected as most probably outside the legislative powers of the Commonwealth Parliament.

4. Federalism

The Bill would explicitly seek to override State laws on a matter central to the maintenance of the peace, order and good government of each State, namely the criminal law of murder and assisted suicide.

There is no evidence that this matter has been the subject of the kind of discussions between the Commonwealth and the States that would normally, in a functioning federal system, take place before even considering a Commonwealth law that would seek to override State laws.

If there was agreement on this matter between the States and the Commonwealth for the need for a law permitting murder and aiding suicide in the specified circumstances, and for that law to be uniform throughout Australia, then mechanisms such as a referral of powers under Paragraph 51(xxxvii) of the Constitution or the enactment of uniform laws by each State could be used to achieve this outcome.

However, several State parliaments have recently considered Bills which would legalise euthanasia or assisted suicide in some form. In each case these Bills have been defeated:

- On 22 September 2010 the *Voluntary Euthanasia Bill 2010* was defeated in the Western Australian Legislative Council by 24 votes to 11.[13]

- On 14 June 2012 the *Voluntary Euthanasia Bill* was defeated in the South Australian House of Assembly by 22 votes to 20.[14]

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[12] Kirby J, *Wong v Commonwealth of Australia; Selim v Lele, Tan and Rivett constituting the Professional Services Review Committee No 309 [2009] HCA 3 (2 February 2009)*, at 150, http://www.austlii.edu.au/au/cases/cth/HCA/2009/3.html

[13] Legislative Council, Hansard, p. 7092, http://www.parliament.wa.gov.au/Hansard/hansard.nsf/0/F4D0DAF694383D55482577AC002FC52B/$File/C38%20S1%2020100922%20All.pdf

[14] House of Assembly, *Hansard*, Thursday 14 June 2012, p. 2152, file:///C:/Users/eganr/Downloads/HANSARD-11-11458.pdf

- On 23 May 2013, the New South Wales Legislative Council defeated the Rights of the Terminally Ill Bill, which would have legalised euthanasia, by 23 votes to 13.[15]

- On 17 October 2013 the Tasmanian House of Assembly rejected the *Voluntary Assisted Dying Bill 2013* by 13 votes to 11.[16]

In the light of this consistent rejection of bills that would permit euthanasia and assisted suicide by the States it would be inappropriate for the Commonwealth Parliament to entertain a Bill to impose these very practices on the States.

5. Specific problems with the *Medical Services (Dying with Dignity) Bill 2014*

5.1 Who can request euthanasia or assisted sucide? – any adult with a condition that "*will … [ultimately] result in the death of the person*"

Any adult who has "*an illness which, in reasonable medical judgement will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the person, result in the death of the person*" would be eligible to request a medical practitioner to end his or her life by euthanasia or assisted suicide.(Clauses 4, 5 and10).

The qualifier "*will result in the death of the person*" makes no reference to the imminence of death. Indeed Schedule 1 uses the phrase "*ultimately result in my death*" making it very clear that the Bill is not intended to be limited in its application to those whose death is imminent but to apply to persons who may have many years of life ahead of them.

It means that this part of the test could be met as soon as a person is diagnosed with an eventually fatal illness, even if they have years to live and even if the illness is not in any advanced stage.

The qualifier "*without the application … of treatment unacceptable to the person*" means that illnesses that can be effectively treated could nonetheless qualify a person because the person refuses to undergo the treatment. There is no requirement that the treatment refused be burdensome or risky just that it be "unacceptable" to the person.

"*Illness*" is defined to include "*disease, injury and degeneration of mental or physical faculties*".

Taken to gather these elements result in very broad eligibility for euthanasia and assisted suicide.

For example, as soon as a person was diagnosed with an illness such as Type 2 diabetes or any form of dementia he or she could qualify. General frailty from old age may also meet the definition of "*a degeneration of mental or physical faculties*" that will "*ultimately result in … death*."

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[15] Legislative Council, *Hansard*, 23 May 2013, p. 20784-20785, http://parliament.nsw.gov.au/prod/parlment/hanstrans.nsf/V3ByKey/LC20130523/$File/LC20130523.pdf

[16] House of Assembly, *Hansard*, 17 October 2013, p. 114, http://www.parliament.tas.gov.au/ParliamentSearch/isysquery/aeb2e586-ecf4-4865-82e3-13dfc45f6781/7/doc/h17october2.pdf

Psychological conditions such as anorexia may also be included, as without treatment anorexia can result in death.

5.2 Who can request euthanasia? – a person experiencing "*severe pain, suffering, distress or indignity*"

The words "*suffering, distress or indignity*" in Clause 10 of the Bill go well beyond the notion of unrelievable physical pain. Suffering may be physical, psychological, social or existential. There is no objective standard involved but merely the subjective assertion by the person requesting euthanasia or assisted suicide that he or she is experiencing suffering, distress or indignity. It could, for example, include incontinence, general loss of energy, a psychological sense of being a burden on others and so forth. This requirement is so subjective it is virtually meaningless and amounts to no more than the person saying that they want euthanasia or assisted suicide.

5.3 Coercing hospitals to employ euthanasia performing medical practitioners and the medical profession to abandon its ethics

Clause 21(2) of the Bill would make it an offence, subject to a penalty of 5 years imprisonment, if a person "*causes or threatens to cause, any disadvantage to a medical practitioner*" with the intention of influencing the medical practitioner to not provide euthanasia or assisted suicide.

This provision would violate the right to freedom of association and the right to freedom of religion and conscience.

A hospital which was established in accordance with the tenets of a religious body which holds euthanasia to be murder ought not to be forced to continue to employ to care for its patients a medical practitioner, who, according to the views of that religious body, has committed murder.

Professional associations such as the Australian Medical Association could be at risk simply by reiterating the view that euthanasia and assisted suicide are contrary to good medical practice.

5.4 Undermining suicide prevention

The Bill would authorise medical practitioners to respond to a request for assisted suicide by providing active assistance to the person to end his or her own life.

This would be completely at odds with, and undermine, the National Suicide Prevention Strategy which is built around the theme that "Living is for Everyone" and reflects a concern for "the risk of suicidal behaviours … across the whole-of-life span".[17]

The National Suicide Prevention Program is directed in part to "*Universal interventions which aim to engage the whole of a population to reduce access to means, reduce inappropriate media coverage of suicide and to foster stronger and more supportive communities and schools*."[18]

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[17] *National suicide prevention strategy*, http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-nsps

[18] Ibid.

The Bill would provide for the use of Commonwealth resources to directly fund access to the means suicide for a significant part of the population.

Recommendation 2:

The Bill would undermine the National Suicide Prevention Strategy by providing Commonwealth benefits for access to the means to commit suicide for a significant part of the population. It should be rejected as contrary to good public policy.

6. Euthanasia and physician assisted suicide laws in other jurisdictions: What they tell us

Several other jurisdictions have changed their laws to allow for either euthanasia or physician assisted suicide.

There is substantial and persuasive evidence of problems in these jurisdictions sufficient to indicate that neither euthanasia nor physician assisted suicide can be safely legalised.

6.1 Oregon

Oregon's *Dying With Dignity Act* allows for medical practitioners to prescribe drugs for self-administration by a person to allow the person to end his or her life as would be permitted under the *Voluntary Assisted Dying Bill 2013.*

Oregon publishes annual reports on the operation of the *Dying With Dignity Act*. A careful analysis of this data reveals significant issues with the practice of physician assisted suicide in Oregon.

6.1.1 Physical suffering not a major issue – "being a burden" is

The Oregon annual reports indicate that physical suffering is not a major issue for those requesting physician assisted suicide.

Of the 752 people who had died from ingesting a lethal dose of medication as of 17 January, 2014 only 23.7% mentioned "*inadequate pain control or concern about it"* as a consideration.[19]

Earlier annual reports noted that "*Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain."*[20]

However, in 2013 nearly half (49.3%) of those who died after taking prescribed lethal medication cited concerns about being a "*Burden on family, friends/caregivers*" as a reason for the request.[21]

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[19] Oregon Public Health Division, *Oregon's Death With Dignity Act -2013 Table 1, Characteristics and end-of-life care of 752 DWDA patients who died after ingesting a lethal dose of medication as of January 17, 2014, Oregon, 1998-2013*, p. 6, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf

[20] Oregon Health Authority, *Sixth Annual report on Oregon's Death With Dignity Act*, 2004, p. 24 http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year6.pdf

Physician assisted suicide has more to do with relieving other people of a "*burden*" than relieving unbearable, unrelievable pain.

For the Commonwealth to facilitate and fund euthanasia and assisted suicide of persons simply because feel they are a burden on family, friends or caregivers sends a cruel message to the disabled or chronically ill who may need the care and support of others in order to function in daily life. It implies that only the strong and fully independent have the right to live.

6.1.2 Mental health: No adequate screening

Research by Linda Ganzini has established that one in six people who died under Oregon's law had clinical depression.[22]

Depression is supposed to be screened for under the Act. However, in 2013 only two out of 71 people who died under the Oregon law were referred by the prescribing doctor for a psychiatric evaluation before writing a script for a lethal substance.[23]

In 2011 Dr. Charles J. Bentz of the Division of General Medicine and Geriatrics at Oregon Health & Sciences University explained that Oregon's physician-assisted suicide law is not working well. He cited the example of a 76-year-old patient he referred to a cancer specialist for evaluation and therapy. The patient was a keen hiker and as he underwent therapy, he became depressed partly because he was less able to engage in hiking.

He expressed a wish for assisted suicide to the cancer specialist, who rather than making any effort to deal with the patient's depression, proceeded to act on this request by asking Dr Bentz to be the second concurring physician to the patient's request.

When Dr Bentz declined and proposed that instead the patient's depression should be addressed the cancer specialist simply found a more compliant doctor for a second opinion.

Two weeks later the patient was dead from a lethal overdose prescribed under the Act.

Dr Bentz concludes "*In most jurisdictions, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient got was a lethal prescription intended to kill him.*" He urges other jurisdictions "*Don't make Oregon's mistake*."[24]

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[21] Oregon Public Health Division, *Oregon's Death With Dignity Act -2013 Table 1, Characteristics and end-of-life care of 752 DWDA patients who died after ingesting a lethal dose of medication as of January 17, 2014, Oregon, 1998-2013*, p. 6, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf

[22] Linda Ganzini et al., "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey", *BMJ* 2008;337:a1682, http://www.bmj.com/highwire/filestream/384131/field_highwire_article_pdf/0.pdf

[23] *Oregon's Death With Dignity Act -2013* p. 3, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf

[24] Charles Bentz, "Oregon's assisted suicide law isn't working", *The Province*, December 5 2011, http://blogs.theprovince.com/2011/12/05/province-letters-icbc-egypt-assisted-suicide-oregon-christmas-pre-marital-sex/

6.1.3 Financial considerations

In 2013 some 5.6% of those who have died under the law cited concerns about the financial implications of treatment as a reason for requesting death.[25]

In two notorious cases, those of Barbara Wagner and Randy Stroup, the Oregon Health Plan informed a patient by letter that the particular cancer treatment recommended by their physicians was not covered by the Plan but that the cost of a lethal prescription to end their life would be covered.[26]

6.1.4 The misleading notion of a peaceful death

Euthanasia and assisted suicide proponents hold out the promise of a peaceful death by fast acting lethal substances. The lethal drugs most likely to be preferred by medical practitioners are secobarbital and pentobarbital. In 2013 in Oregon pentobarbital was used in 90.1% of cases and secobarbital in the remaining 9.9% of cases.[27]

These drugs do not always result in a swift and peaceful death.

The thirteenth annual report on the operation of the Oregon Act gives a complication rate of 4.5% for regurgitation for acts of physician assisted suicide between 1998 and 2009.[28]

The interval from ingestion of lethal drugs to unconsciousness has been as much as 38 minutes while the interval from ingestion to death has ranged from 1 minute to as long as 104 hours (4 days and 8 hours). In 2005, one patient regained consciousness 65 hours after ingesting the medications, subsequently dying from their illness 14 days after awakening.[29]

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[25] Oregon Public Health Division, *Oregon's Death With Dignity Act -2013 Table 1, Characteristics and end-of-life care of 752 DWDA patients who died after ingesting a lethal dose of medication as of January 17, 2014, Oregon, 1998-2013*, p. 6, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf

[26] Susan Donaldson James, "Death drugs cause uproar in Oregon:, ABC News, August 6, 2008, http://abcnews.go.com/Health/story?id=5517492#.Ty9-VsXy8sI ; Dan Springer, "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care", July 28, 2008, http://www.foxnews.com/story/0,2933,392962,00.html

[27] Oregon Public Health Division, *Oregon's Death With Dignity Act -2013 Table 1, Characteristics and end-of-life care of 752 DWDA patients who died after ingesting a lethal dose of medication as of January 17, 2014, Oregon, 1998-2013*, p. 6, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf

[28] Oregon Health Authority, *Death With Dignity Act, Year 13 - Table 1, Characteristics and end-of-life care of 525 DWDA patients who died after ingesting a lethal dose of medication as of January 7, 2011, by year, Oregon, 1998-2010*, p. 3, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/yr13-tbl-1.pdf

Note that from 2010 reports of complications were only recorded if a physician was present at the time of administration so percentages for complications artificially decline as complications are listed as "unknown" for the majority of cases in which no physician was present.

[29] Oregon's *Death With Dignity Act -2012 Table 1, Characteristics and end-of-life care of 673 DWDA patients who died after ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012*, p. 6,

Lumberjack David Prueitt who, after ingesting the prescribed barbiturates spent three days in a deep coma, then suddenly woke up, asking his wife *"Honey, what the hell happened? Why am I not dead?*'

David survived for another 13 days before dying naturally from his cancer.[30]

Since 2005 five other people have regained consciousness after ingesting the lethal medication, one of them some 88 hours (nearly 4 days) after taking it.[31]

In 2012 "*one patient ingested the medication but regained consciousness before dying of underlying illness and is therefore not counted as a DWDA death. The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion*".[32]

6.1.5 Cruel and unusual punishment

Since 2011 sodium pentobarbital has been used by several States in the United States in the execution of prisoners.

David Waisel, MD, an anaesthesiologist, has testified about the use of this drug in executions.

> *… as the lethal injection commenced Mr. Blankenship jerked his head toward his left arm and made a startled face while blinking rapidly. He had a "tight" grimacing expression on his face and leaned backward.*
>
> *Shortly thereafter, Mr. Blankenship grimaced, gasped and lurched twice toward his right arm.*
>
> *During the next minute, Mr. Blankenship lifted his head, shuddered and mouthed words.*
>
> *Three (3) minutes after the injection, Mr. Blankenship had his eyes open and made swallowing motions.*
>
> *Four (4) minutes after injection, Mr. Blankenship became motionless.*
>
> *About thirteen (13) minutes after the injection, Mr. Blankenship was declared dead. Again, his eyes were open throughout.*
>
> *Based on his lurching toward his arms and the lifting of his head and the mouthing of words, I can say with certainty that Mr. Blankenship was inadequately anesthetized and was conscious for approximately the first three minutes of the execution and that he suffered greatly. Mr.*

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http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf

[30] "Oregon man wakes up after assisted-suicide attempt", *Seattle Times*, 4 March 2005, http://seattletimes.nwsource.com/html/health/2002197134_webwake04.html

[31] Oregon Health Authority, *Death With Dignity Act, Year 14 - Table 1, Characteristics and end-of-life care of 596 DWDA patients who died after ingesting a lethal dose of medication as of February 29, 2012, by year, Oregon, 1998-2011*, p. 3, **Error! Hyperlink reference not valid.**http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14-tbl-1.pdf

[32] Oregon's *Death With Dignity Act -2012 Table 1, Characteristics and end-of-life care of 673 DWDA patients who died after ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012*, p. 2, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf

Blankenship should not have been conscious or exhibiting these movements, nor should his eyes have been open, after the injection of pentobarbital.

Given prior executions of Brandon Rhode and Emanuel Hammond in September 2010 and January 2011, respectively, during which these inmates reportedly exhibited similar movements and opened their eyes (Rhode's eyes were open throughout the execution process), Mr. Blankenship's execution further evidences that during judicial lethal injections in Georgia there is a substantial risk of serious harm such that condemned inmates are significantly likely to face extreme, torturous and needless pain and suffering.[33]

6.1.6 Increase in number of deaths

The number of deaths from ingesting lethal substances prescribed under Oregon's *Death With Dignity Act* reached 85 in 2012 continuing a steady rise since 1998, the first year of the Act's operation when 16 people died under its provisions. (Preliminary data for 2013 reports 71 deaths but data is not yet finalised).[34]

6.1.7 Faulty prognosis

The *Death With Dignity Act* provides that before prescribing a lethal substance a doctor must first determine whether a person has a "terminal disease". This is defined by section 127.800 (12) of the Oregon Revised Statute to mean "*an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months*".

In 2012 one person ingested lethal medication 388 days after the initial request for the lethal prescription was made. The longest duration between initial request and ingestion recorded is 1009 days (that is 2 years and 9 months).[35] Evidently in these cases the prognosis was wildly inaccurate.

Dr Kenneth Stevens has written about his experience of how the prognosis of six months to live works in practice under Oregon's law:

Oregon's assisted-suicide law applies to patients predicted to have less than six months to live. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live. This was based on her not being treated for cancer.

At our first meeting, Jeanette told me that she did not want to be treated, and that she wanted to opt for what our law allowed – to kill herself with a lethal dose of barbiturates.

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[33] State of Massachussetts, County of Suffolk., *Affidavit of David B. Waisel, MD,* p. 2-3, http://www.reprieve.org.uk/media/downloads/2011_06_28_PUB_Waisel_Affidavit_FINAL_DRAFT.pdf?utm_source=Press+mailing+list&utm_campaign=26dcb1127c-2011_06_30_Waisel_pentobarbital&utm_medium=email

[34] *Oregon's Death With Dignity Act -2013 Figure 1, Oregon DWDA Prescription Recipients and Deaths*, 1998-2013*, p. 1, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf

[35] Oregon's *Death With Dignity Act -2012 Table 1, Characteristics and end-of-life care of 673 DWDA patients who died after ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012,* p. 6, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf

I did not and do not believe in assisted suicide. I informed her that her cancer was treatable and that her prospects were good. But she wanted "the pills." She had made up her mind, but she continued to see me.

On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated, and her cancer was cured.

Five years later she saw me in a restaurant and said, "Dr. Stevens, you saved my life!"

For her, the mere presence of legal assisted suicide had steered her to suicide.[36]

6.1.8 Short relationship with attending physicians

The Oregon statute specifies that lethal prescriptions only be written by a person's "*attending physician*" who is defined as "*the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease*."[37]

The data indicates that in some cases doctors have had a relationship with the patient of less than one week's duration and that in 50% of cases the doctor-patient relationship was 12 weeks or less.[38]

Sixty-two (62) physicians wrote the 122 prescriptions provided during 2013 (range 1-10 prescriptions per physician).[39]

Taken together this data suggests that there are some doctors very willing to write prescriptions for lethal substances for patients they barely know.

6.2 Washington State

Washington State's *Death With Dignity Act*, based on Oregon's, came into operation on 9 March 2009.

In the first full calendar year of operation, 2010, some 87 prescriptions for lethal drugs were provided under the Act. By 2013 this had virtually doubled (198.8%) to 173.[40]

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[36] Kenneth Stevens "Doctor helped patient with cancer choose life over assisted suicide", *Missoulian*, 27 November 2012, http://missoulian.com/news/opinion/mailbag/doctor-helped-patient-with-cancer-choose-life-over-assisted-suicide/article_63e092dc-37e5-11e2-ae61-001a4bcf887a.html

[37] Oregon Revised Statute, Section 127.800 (2)

[38] Oregon's *Death With Dignity Act -2012 Table 1, Characteristics and end-of-life care of 673 DWDA patients who died after ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012*, p. 6, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf

[39] *Oregon's Death With Dignity Act -2013* p. 3, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf

[40] Washington State Department of Health *2013 Death with Dignity Act Report*, p. 4, http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2013.pdf

Some 64% of those for whom a prescription for lethal drugs was provided did not cite concerns about pain control as a reason for asking for the prescription.

However, 91% cited concerns about loss of autonomy and 61% cited concerns about being a burden on family, friends or caregivers.

Significantly, 13% cited concerns about the financial implications of treatment.[41]

Only 4% of those given a lethal prescription were referred to a psychiatrist or psychological for evaluation. In some cases the prescribing doctor knew the patient for less than a week before writing the prescription, and in more than half the cases (51%) the doctor knew the patient for less than 25 weeks.[42]

6.3 Vermont

On 20 May 2013 the Governor of Vermont signed into law the *Patient Choice and Control at End of Life Act*. The Act permits Vermont physicians to prescribe lethal medication to terminally ill patients.

On 20 May 2014 a community organisation, True Dignity Vermont, reported that since the law was enacted two clinical psychologists had cases of patients believing suicide was now a more acceptable option. Additionally, an 85 year old Korean war veteran from New Jersey suffering depression was seeking information on getting a lethal prescription in Vermont.[43]

These reports confirm the obvious: assisted suicide laws tend to normalise suicide for everyone not just those who formally qualify under the law.

6.4 The Netherlands

Euthanasia was formally legalised in the Netherlands in 2003 after several years in which it was practised openly after court decisions allowing it in certain circumstances.

6.4.1 Complications

Technical problems, complications and problems with completion in the administration of lethal drugs for euthanasia have been reported from the Netherlands.

Technical problems occurred in 5% of cases. The most common technical problems were difficulty finding a vein in which to inject the drug and difficulty administering an oral medication.

Complications occurred in 3% of cases of euthanasia, including spasm or myoclonus (muscular twitching), cyanosis (blue colouring of the skin), nausea or vomiting, tachycardia (rapid heart beat), excessive production of mucus, hiccups, perspiration, and extreme gasping. In one case the patient's eyes remained open, and in another case, the patient sat up.

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[41] Ibid., Table 2 on p. 7

[42] Ibid., Table 3 on p.8

[43] True Dignity Vermont, *Assisted Suicide Law: One year later*, 20 May 2014, http://www.truedignityvt.org/assisted-suicide-law-one-year-later/

In 10% of cases the person took longer than expected to die (median 3 hours) with one person taking up to 7 days.[44]

6.4.2 Increasing number of deaths

The number of reported deaths from euthanasia and physician assisted suicide have risen sharply from 1815 in 2003, the first year under the new law, to 4188 deaths reported in 2012.[45]

This represents an increase of 130% in raw number of reported deaths from euthanasia between 2003 and 2012. In other words the number of euthanasia deaths has more than doubled in the first 10 years of legalisation. In 2003 some 1.28% of all deaths were brought about by reported acts of euthanasia or physician assisted suicide. In 2012 this had risen to 2.97% of all deaths.[46]

6.4.3 Failure to report cases of euthanasia

According to a 2012 paper only 77% of deaths by euthanasia or physician assisted suicide were reported in 2010, that is there were 914 unreported acts of euthanasia as well as the 3136 reported acts of euthanasia making a total of 4050 or 2.8% of all deaths resulting from euthanasia or physician assisted suicide in 2010.[47]

The authors of this study speculate that the temporary decrease of euthanasia deaths following the enactment of the law may have been a result of doctors being uncertain about how the law would be applied. It is clear now that the codification of the law has not led to any lasting decrease in the rate of euthanasia and the trend has increased steadily for the past 10 years.

6.4.4 Grounds for euthanasia

As is usually the case when legalised euthanasia is first proposed supporters in the Netherlands initially focussed solely on unbearable and unrelievable physical suffering associated with a terminal illness.

Even before formal legalisation the grounds for euthanasia were expanded by the courts well beyond physical suffering allowing psychiatric conditions such as depression, anorexia, and anxiety associated with asymptomatic HIV to be are sufficient grounds to justify a physician granting a request by a person for the administration of lethal drugs.[48]

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[44] Groenewoud J, et al. (2000) "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands", *New England Journal of Medicine*, Vol 342, p. 551-556, http://content.nejm.org/cgi/reprint/342/8/551.pdf

[45] Regional Euthanasia Review Committees, *Annual report 2012*, p. 5 http://www.euthanasiecommissie.nl/Images/JV.RTE2012.engelsDEF2_tcm52-39100.pdf

[46] Denominator for calculations for percentage of all deaths (141,936 in 2003; 140.813 in 2012) from Centraal Bureau voor der Statistiek; http://statline.cbs.nl/StatWeb/publication/?DM=SLEN&PA=37943eng&D1=1,21-46,438-439,442-443&D2=(l-16)-l&LA=EN&VW=T

[47] Bregje D Onwuteaka-Philipsen et al., "Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey", *The Lancet*, Published online July 11, 2012, http://press.thelancet.com/netherlands_euthanasia.pdf

[48] "Choosing Death," *The Healthcare Quarterly*, WGBH-Boston, aired March 23, 1993.

One of the requirements of careful practice, under which physicians performing euthanasia and assisting with suicide were assured freedom from prosecution, required that the patient be suffering. Doctors with patients who were suffering physically were not subject to prosecution, but it was not yet clear whether they would be treated the same in cases involving patients with non-somatic suffering. The psychiatrist and general practitioner of a woman suffering from depression decided to assist the woman with suicide. Although they were acquitted, the Rotterdam District Court noted that in cases of non-somatic suffering the consultation of another independent physician is preferable.

In another case, the Almelo District Court held that although the suffering of a 25 year-old anorexia nervosa patient was not primarily physical, it was unbearable and therefore sufficient to dismiss the indictment against the pediatrician who had assisted in the patient's suicide.

The Supreme Court addressed the issue of non-somatic suffering in the landmark 1994 case of Chabot.

Dr. Boudewijn Chabot was a psychiatrist who supplied lethal drugs to a patient who had recently experienced a series of traumatic events that had left her with no desire to live. Although offered treatment for her condition, the patient refused. The Court began by affirming its earlier holdings that euthanasia and assisted suicide can be justified if:

> *the defendant acted in a situation of necessity, that is to say … that confronted with a choice between mutually conflicting duties, he chose to perform the one of greater weight. In particular, a doctor may be in a situation of necessity if he has to choose between the duty to preserve life and the duty as a doctor to do everything possible to relieve the unbearable and hopeless suffering of a patient committed to his care.*

The prosecution argued that the defense of justification should not be available to doctors who assist with suicides in cases where the suffering is non-somatic and the patient is not in the "terminal phase."

The Supreme Court rejected this contention, and held that in such cases the justification can be rooted in the autonomy of the patient herself. The Court noted that,"the wish to die of a person whose suffering is psychic can be based on an autonomous judgment."[49]

Euthanasia is now legally permitted in the Netherlands for dementia patients and for persons with depression or other mental health issues in the complete absence of any physical illness or suffering.[50]

In 2012 there were 14 notifications of euthanasia or assisted suicide involving patients with psychiatric disorders and 42 notifications involving dementia. These were in the absence of any other condition justifying euthanasia.[51]

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[49] Smies. Jonathan T. "The legalization of euthanasia in the Netherlands", *Gonzaga Journal of International Law*, (2003-4) 7, p. 19-20, http://www.gonzagajil.org/pdf/volume7/Smies/Smies.pdf

[50] Regional Euthanasia Review Committees, *Annual report 2010*, p. 10, 13, 22-23, http://www.euthanasiecommissie.nl/Images/JV%20RTE%202010%20ENGELS%20(EU12.01)_tcm52-30364.pdf

[51] Regional Euthanasia Review Committees, *Annual report 2012*, p. 6 http://www.euthanasiecommissie.nl/Images/JV.RTE2012.engelsDEF2_tcm52-39100.pdf

In its June 2011 publication *The role of the physician in the voluntary termination of life* the Royal Dutch Medical Association (KNMG) states that as the elderly experience "*various other ailments and complications such as disorders affecting vision, hearing and mobility, falls, confinement to bed, fatigue, exhaustion and loss of fitness take hold … The patient perceives the suffering as interminable, his existence as meaningless and – though not directly in danger of dying from these complaints neither wishes to experience them nor, insofar as his history and own values permit, to derive meaning from them*." The KNMG considers that "*such cases are sufficiently linked to the medical domain to permit a physician to act within the confines of the Euthanasia Law*."[52]

6.4.5 Euthanasia on wheels

In March 2012 the Dutch Right to Die organisation launched six mobile teams of doctors to "*end their lives free of charge in their own homes*".[53] This approach bypasses any need for the person's regular physician to be involved in the decision making about euthanasia.

6.4.6 Review is too late for the dead patient

The review committees in the Netherlands are required to consider whether all the conditions of the euthanasia law have been met in each case. In case 15 of the 2011 annual report the Regional Euthanasia Review Committees conclude that the attending physician failed to achieve an accurate diagnosis of the woman's back pain and only prescribed limited pain relief medication. Consequently it could not be said that the woman's pain was definitively unrelievable. Of course the woman can get no relief from this finding of error on the part of the doctor who failed her and then euthanased her and she is already dead by euthanasia.[54]

The same lack of remedy applies to the two cases of people with dementia who were euthanased in 2012 in relation to which the Review Committees found "*not to have been handled with due care*".[55]

6.4.7 Euthanasia without request

In the Netherlands between 500 and 1000 adults each year are given lethal injections without making an explicit request.[56]

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[52] KNMG [Royal Dutch Medical Association], *The role of the physician in the voluntary termination of life*, June 2011, p. 23, Available at: http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/Position-paper-The-role-of-the-physician-in-the-voluntary-termination-of-life-2011.htm

[53] Tony Paterson "Euthanasia squads offer death by delivery", *The Independent*, 5 March 2012, http://www.independent.ie/health/health-news/euthanasia-squads-offer-death-by-delivery-3039420.html

[54] Regional Euthanasia Review Committees, *Annual report 2011*, p. 17 http://www.euthanasiecommissie.nl/Images/RTE.JV2011.ENGELS.DEF_tcm52-33587.PDF

[55] Regional Euthanasia Review Committees, *Annual report 2012*, p. 13 http://www.euthanasiecommissie.nl/Images/JV.RTE2012.engelsDEF2_tcm52-39100.pdf

[56] Allen, Mason L, (2006) "Crossing The Rubicon: The Netherlands' Steady March Towards Involuntary Euthanasia", *Brook Journal of International Law*, 31:2, pp 535-575; www.brooklaw.edu/students/journals/bjil/bjil31ii_allen.pdf ; van der Heide, A *et al.* (2007) "End-of-Life Practices in the Netherlands under the Euthanasia Act", *New England Journal of Medicine*, Vol 356:1957-1965, http://content.nejm.org/cgi/content/full/356/19/1957

6.5 Belgium

Belgium legalised euthanasia in 2002.

6.5.1 Increase in number of deaths

In Belgium deaths by legal euthanasia have increased nearly eightfold (773%) from 235 in 2003 – the first full year of legalisation – to 1,816 in 2013. Deaths by legal euthanasia increased by 26.81% from 2012 to 2013. Euthanasia now accounts for about 1.75% of all deaths in Belgium.[57]

6.5.2 Requirements routinely flouted

A study of euthanasia cases from Flanders in 2007 found that 66 (31.73%) out of 208 deaths by euthanasia or assisted suicide were brought about by a doctor without any explicit request from the patient despite the legal requirement for a written request.[58]

Another study found that, contrary to the law which authorises only doctors to perform euthanasia, nurses administered the lethal drugs in 12% of cases involving an explicit request and in 45% of cases without an explicit request.[59]

It is clear that in Belgium the legal requirements for euthanasia are routinely flouted.

6.5.3 Organ donation following euthanasia

Belgium allows organ donation after euthanasia.

The first four cases of organ donation (2005-2007) following euthanasia involved persons who were not in the terminal phase of a terminal illness but who had a "*debilitating neurologic disease, either after severe cerebrovascular accident or primary progressive multiple sclerosis*".[60]

In 2011 a report was published on a partially overlapping set of four cases lung transplants taken from persons who were euthanased between 2007 and 2009. The cases each involved "*an unbearable non-malignant disorder*", including two cases of multiple sclerosis. One case involved a 52 year old woman with a mental disorder manifested with the symptom of automutilation – cutting to cause self-

[57] European Institute of Bioethics, *Euthanasia in Belgium : 10 years on*, October 2012, p. 3 http://www.ieb-eib.org/en/pdf/20121208-dossier-euthanasia-in-belgium-10-years.pdf ;"1.816 personnes euthanasiées en 2013", *Le Soir*, 28 May 2014, http://www.lesoir.be/556765/article/actualite/belgique/2014-05-28/1816-personnes-euthanasiees-en-2013

[58] K Chanbaere et al., "Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey", Canadian Medical Association Journal, 2010, 182:895-90, http://www.cmaj.ca/content/182/9/895.full.pdf

[59] Els, Ingehlbrecht et al., "The role of nurses in physician-assisted deaths in Belgium, *Canadian Medical Association Journal*, 2010, 182:905-910, http://www.cmaj.ca/content/182/9/905.full.pdf ,

[60] D Ysebaert et al. "Organ Procurement After Euthanasia: Belgian Experience", *Transplantation Proceedings*, 2009, 41: 585–586, http://www.coma.ulg.ac.be/papers/death/organ_euthanasia09.pdf

harm. Her consent to euthanasia and organ donation was accepted despite this particular mental illness.[61]

In a paper delivered to the 21st European Conference on General Thoracic Surgery held in Birmingham in May 2013, Dirk Van Raemdonck and his colleagues reported on a total of six lung transplants following death by cardiac arrest brought on by the administration of euthanasia carried out in Belgium between January 2007 and December 2012. Of the six cases, three of them had neuromuscular disorders and three had neuropsychiatric disorders. The authors conclude "*More euthanasia donors are to be expected with more public awareness.*"[62]

There seems to be no awareness of the exploitation involved in accepting consent to euthanasia followed by organ donation from patients with mental illness.

6.5.4 No notification of family

In April 2012 Tom Mortier's mother was euthanased on the grounds of chronic depression. Tom writes:

> *I was not involved in the decision-making process and the doctor who gave her the injection never contacted me.*
>
> *Since then, my life has changed considerably. Up until now, I am still trying to understand how it is possible for euthanasia to be performed on physically healthy people without even contacting their children. The spokesman of the university hospital told me that everything happened according to my mother's "free choice". After my mother's death, I talked to the doctor who gave her the injection and he told me that he was "absolutely certain" my mother didn't want to live anymore.*
>
> *The death of my mother has triggered a lot of questions. How is it possible that people can be euthanased in Belgium without close family or friends being contacted? Why does my country give medical doctors the exclusive power to decide over life and death? How do we judge what "unbearable suffering" is? What are the criteria to decide what "unbearable suffering" is? Can we rely on such a judgment for a mentally ill person?*
>
> *After all, can a mentally ill person make a "free choice"? Why didn't the doctors try to arrange a meeting between our mother and her children? How can a medical doctor be "absolutely certain" that his/her patient doesn't want to live anymore?* [63]

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[61] D Van Raemdonck et al., "Initial experience with transplantation of lungs recovered from donors after euthanasia", *Applied Cardiopulmonary Pathophysiology* , 2011, 15: 38-48, http://www.applied-cardiopulmonary-pathophysiology.com/fileadmin/downloads/acp-2011-1_20110329/05_vanraemdonck.pdf

[62] D Van Raemdonck et al., "Lung transplantation with grafts recovered from euthanasia donors", Abstracts, 21st European Conference on General Thoracic Surgery, Birmingham, 26-29 May, 2013, Abstract O-099, p, 137, http://www.estsmeetings.org/2013/images/documents/ests-abstracts-2013.pdf

[63] Tom Mortier, "How my mother died", *MercatorNet*, 4 February 2013, http://www.mercatornet.com/articles/view/how_my_mother_died

6.5.5 Euthanasia for disability such as blindness

In December 2012 identical twin brothers were euthanased on the grounds of their psychological distress at learning they were both going blind. The brothers were reportedly distressed that they would not be able to see each other. [64]

Commenting on this case, Dr. Marc Maurer, President of the [US] National Federation of the Blind, said: "*This disturbing news from Belgium is a stark example of the common, and in this case tragic, misunderstanding of disability and its consequences. Adjustment to any disability is difficult, and deaf-blind people face their own particular challenges, but from at least the time of Helen Keller it has been known that these challenges can be met, and the technology and services available today have vastly improved prospects for the deaf-blind and others with disabilities. That these men wanted to die is tragic; that the state sanctioned and aided their suicide is frightening.*" [65]

6.5.6 Euthanasia for victims of sexual abuse

In late 2012 a 44 year old woman known as Ann G was euthanased by her psychiatrist on the grounds of unbearable psychological suffering. She had been treated for anorexia since her teenage years by psychiatrist Walter Vandereycken. In 2008 she publicly accused Vandereycken of sexual abusing her under the guise of therapy. In October 2012 he admitted to years of sexual abuse of several of his patients. Following this admission Ann G spoke of some temporary relief from "*the cancer in her head*" but subsequently persisted in her request for euthanasia. [66]

Ann G will not be available to testify against her abuser if charges are laid.

6.5.7 Euthanasia for gender dysphoria

On 30 September 2013 Nathan Verhelst was euthanased on the grounds of unhappiness following a sex change operation. Nathan (previously known as Nancy) had been rejected by a family who hated girls. Commenting on the euthanasia Nathan's mother said:

> "*When I saw 'Nancy' for the first time, my dream was shattered. She was so ugly. I had a phantom birth. Her death does not bother me.*"[67]

The doctors who approved and carried out euthanasia on Nathan Verhelst effectively affirmed the rejection Nathan had experienced since childhood.

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[64] Bruno Waterfield, "Belgian identical twins in unique mercy killing", *The Telegraph*, 13 January 2013, http://www.telegraph.co.uk/news/worldnews/europe/belgium/9798778/Belgian-identical-twins-in-unique-mercy-killing.html

[65] https://nfb.org/national-federation-blind-comments-belgian-euthanasia-deaf-men-losing-sight

[66] "Patiënte van psychiater Vandereycken krijgt euthanasia" *De standard*, 28 January 2013,

http://www.standaard.be/artikel/detail.aspx?artikelid=DMF20130127_00448215

[67] Bruno Waterfield, "Mother of sex change Belgian: 'I don't care about his euthanasia death'", The *Telegraph*, http://www.telegraph.co.uk/news/worldnews/europe/belgium/10349159/Mother-of-sex-change-Belgian-I-dont-care-about-his-euthanasia-death.html

6.5.8 Euthanasia for children

On 12 December 2013 the Belgian Senate voted 50-17 in favour of a bill to amend the euthanasia law to allow "emancipated minors" to request euthanasia on the same terms as adults; and to allow "unemancipated minors" with the capacity for discernment to request euthanasia for a hopeless medical situation resulting in death shortly and who have reported a constant and unbearable physical suffering that cannot be appeased and that results from a serious and incurable disease or an accident.[68] For unemancipated minors at least one parent must consent to the act of euthanasia.

The proposed law was transmitted to the Chamber of Representatives on 13 December 2013[69] where it passed by 88 votes to 46 on 13 February 2014[70]. It was signed into law by the King on 3 March 2014 and is now in effect.

6.5.9 A nurse's view

Claire-Marie Le Huu-Etchecopar is a French nurse who has worked in Belgium since 2008. She has written about her experience with euthanasia in Belgium. These are two of the disturbing cases she has recounted:

> ***Monsieur R. never asked for euthanasia: he was released from life out of 'compassion'***
>
> *This was the view of an oncologist just after the euthanasia of Mr R. Some days before, the doctor informed his wife that her husband was in the terminal phase of lung cancer. The doctor added that the patient 'will suffer enormously, even though he was showing no signs of pain or distress at the moment'. His wife asked the specialist not to say a word to her husband 'so he doesn't suffer further' and at the same moment seeks euthanasia to spare him the 'horror of the end of life'. Mr R died by euthanasia without ever knowing of his illness and without deciding or even once expressing the wish to have recourse to euthanasia.*
>
> ***A sixty year old woman with dementia: The worrying influence of her entourage.***
>
> *The entourage, consisting of friends and some family due to conflict, seemed totally unprepared. They kept harassing caregivers demanding euthanasia for this lady. The Care team felt uncomfortable because they understood that despite the request of the patient there is another reality: that of feeling abandoned because of a lack of solidarity. Her companions were undoubtedly sincere, seeking [her] well-being. But their kindness was devoid of empathy, the perspective necessary for real solidarity. The whole time she was in hospital, she asked for a toothbrush. Instead of a toothbrush, they bring her what they believe to be good according to them: wine, cakes, but never meeting the lady's request.*
>
> *Also, the majority of the care team feel frustrated because lots of measures have been put in place to improve her comfort and her desire to be more surrounded. Initially, she agreed to appropriate structures for her needs, and then under the influence of her environment, she rejected them. Those close to her are locked in the emotion of seeing their friend disabled. They cannot bear to see her different. Any other solution than euthanasia seems unimaginable to them. In a small notebook where they leave her messages while she's sleeping, the question of euthanasia is on every page. You can read words such as:*

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[68] http://www.senate.be/www/?MIval=/index_senate&MENUID=21320&LANG=fr

[69] http://www.lachambre.be/FLWB/pdf/53/3245/53K3245001.pdf

[70] http://www.dekamer.be/doc/PCRI/html/53/ip186x.html

Do not forget your euthanasia, it is your right, you have to ask the doctors or they'll never do it for you…[71]

6.6 Switzerland

Euthanasia is illegal in Switzerland. However the phrasing of the article in the Swiss Penal Code prohibiting assisting suicide has allowed organisations such as Dignitas to offer assisted suicide.

Article 115 reads "*Any person who for selfish motives incites or assists another to commit or attempt to commit suicide shall, if that other person thereafter commits or attempts to commit suicide, be liable to a custodial sentence not exceeding five years or to a monetary penalty*" [72]

6.6.1 Increasing number of deaths

The qualifier, "*from selfish motives*" effectively allows Dignitas to offer assisted suicide to all comers on a "*cost recovery*" basis. Dignitas has assisted in 1701 suicides from 1998-2013.[73] It charges about $7500 (Australian) to help people die.[74]

The number of assisted suicides carried out by Dignitas in 2013 was 205, up 130% from 2009.[75] Only 10% of assisted suicides are of Swiss residents. The remaining 90% involve suicide tourism, including 18 Australians.[76]

Another Swiss organisation, Exit, limits its assistance in suicide to Swiss residents. Assisted suicides of Swiss residents rose dramatically from just 48 in 1998 to 297 in 2009.[77]

The number of suicides assisted by Exit rose to 416 in 2011, up 20% from 2010.[78]

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[71] Claire-Marie Le Huu-Etchecopar, *Lifting the veil on euthanasia: what really happens in Belgium's healthcare system - a nurse's story*, 28 May 2014, http://alexschadenberg.blogspot.com.au/2014/05/lifting-veil-on-euthanasia-what-really.html ; Originally published in French under the title " *Euthanasie: le model Belgie a la derive*, http://plusdignelavie.com/?p=2773

[72]Swiss Criminal Code of 21 December 1937 (Status as of 1 January 2012), Article 115, p. 50, http://www.admin.ch/ch/e/rs/3/311.0.en.pdf

[73] DIGNITAS - Menschenwürdig leben - Menschenwürdig sterben - Forch-Zürich, http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2013.pdf

[74] "Record numbers of Britons ended their lives at Dignitas last year", *The Telegraph*, 22 February 2010, http://www.telegraph.co.uk/news/uknews/crime/7271008/Record-numbers-of-Britons-ended-their-lives-at-Dignitas-last-year.html

[75] DIGNITAS - Menschenwürdig leben - Menschenwürdig sterben - Forch-Zürich, http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2013.pdf

[76] Ibid.

[77] "Almost 300 assisted suicides in Switzerland per year", *The Telegraph*, 27 March 2012, http://www.telegraph.co.uk/news/worldnews/europe/switzerland/9170059/Almost-300-assisted-suicides-in-Switzerland-per-year.html

[78] Sophie Douez "Assisted suicide numbers up in 2011", *SwissInfo*, 20 February 2012, *http://www.swissinfo.ch/eng/swiss_news/Assisted_suicide_numbers_up_in_2011.html?cid=32154940*

6.6.2 Limited screening for depression

Swiss psychiatrist Thomas Schlaepfer, a specialist in depression, is disturbed by the way Dignitas operates. "If somebody flies into Zurich Airport, is brought into an interview for an hour and prescribed medication, that's totally wrong," he says. "That's ethically wrong. Legally, it might be OK in Swiss law, but ethically it's wrong."

Schlaepfer says it is "totally impossible" to find out in a brief visit or two whether someone is of sound mind. Dignitas chief Minelli, however, claims to have no doubts about what he is doing: "Ah, it is not knowing," he says. "It is feeling, and that is much better than knowing."

Dignitas has also helped people with mental illnesses such as schizophrenia to die. Minelli argues that mentally ill people have the same right to take their own lives as others: "You can't say and you shouldn't say that mentally ill people should not have human rights."

But Schlaepfer says suicidal tendencies are often a symptom of mental illness and can be treated. "In this office," he says, "many people said, 'I'm totally depressed; I want to end my life' and weeks later this opinion was changed."

Public prosecutor Andreas Brunner believes the law is dangerously unregulated, giving him little room to act. "These days, everyone - even you or me, we - can make assisted suicides," says Brunner, noting that nothing - not even a medical degree - is required to start an organization that helps people kill themselves." [79]

6.6.3 Non terminal illnesses and disabilities

Dignitas has assisted the suicides of people with nonterminal diseases such as Crohn's disease and rheumatoid arthritis as well as quadraplegics.[80] Research published in the *Journal of Medical Ethics* showed that 21.2% of all those of various nationalities ending their lives at Dignitas had a non-fatal illness.[81]

Between 1998 and 2009 Exit assisted 71 people to die on the grounds of depression and 24 people to die because they were blind.[82]

A 2014 study of assisted suicides in Switzerland found that there was a "*higher rate among people living alone and the divorced*". Study leader, Professor Matthias Egger, commented that "*Social isolation and loneliness are well known risk factors for non-assisted suicides and our results suggest that they may also play a role in assisted suicide.*" 16% of death certificates did not register an

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[79] Mary-Jayne McKay "Switzerland's suicide tourists", CBS News, February 11, 2009, http://www.cbsnews.com/stories/2003/02/12/60II/main540332.shtml

[80]"Suicide clinic challenged over patients who could have lived 'for decades'", *The Guardian*, 21 June 2009, http://www.guardian.co.uk/society/2009/jun/21/dignitas-suicide-clinic-britons

[81]S Fischer et al., "Suicide assisted by two Swiss right-to-die organisations", *Journal of Medical Ethics* 2008;34:810-814,http://jme.bmj.com/content/34/11/810

[82] "Almost 300 assisted suicides in Switzerland per year", *The Telegraph*, 27 March 2012, http://www.telegraph.co.uk/news/worldnews/europe/switzerland/9170059/Almost-300-assisted-suicides-in-Switzerland-per-year.html

underlying cause. A previous study of suicides by two right-to-die organizations showed that 25% of those assisted had no fatal illness, instead citing "*weariness of life*" as a factor.[83]

In 2014 the General Assembly of Exit voted to extend the provision of assisted suicide to the elderly who had no terminal illness. The statutes now refer to "*the right to the freely responsible death of a very old person wishing to die*".[84]

6.6.4 Effect on families

Like any suicide assisted suicide can profoundly affect surviving family members and friends. A recent study found that about 20% of family members or friends who witnessed an assisted suicide in Switzerland subsequently suffered from full (13%) post-traumatic stress disorder or subthreshold (6.5%) post-traumatic stress disorder. [85]

7. Jurisdictions that have rejected euthanasia proposals: Why?

It is also instructive to consider why apart from a handful of jurisdictions proposals to legalise euthanasia or physician assisted suicide have been rejected by most jurisdictions which have considered them.

7.1 United States

Since 1994, over 140 legislative proposals in 27 states of the United States that would have legalised assisted suicide or euthanasia have failed to be accepted.[86]

On 6 November 2012 a proposition to allow physician assisted suicide in Massachusetts was defeated by 51%-49% in a popular ballot.

The concerns of disability rights activists were prominent in the public debate over this measure. Ben Mattlin has congenital spinal muscular atrophy. He has never walked or stood or had much use of his hands. Mattlin wrote in the *New York Times*:

> "*To be sure, there are noble intentions behind the "assisted death" proposals, but I can't help wondering why we're in such a hurry to ensure the right to die before we've done all we can to ensure that those of us with severe, untreatable, life-threatening conditions are given the same*

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[83] "More educated people from wealthier areas, women, more likely to die from assisted suicide", *Medical Press*, 18 February 2014, http://medicalxpress.com/news/2014-02-people-wealthier-areas-women-die.html

[84] "Exit members vote to broaden assisted suicide services", *SwissInfo*, 24 May 2014, http://www.swissinfo.ch/eng/swiss_news/Exit_members_vote_to_broaden_assisted_suicide_services.html?cid=38653642

[85] B. Wagner et al. "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide", *European Psychiatry*, 2012; 27:5422-6

[86] http://www.patientsrightscouncil.org/site/failed-attempts-usa/

open-hearted welcome, the same open-minded respect and the same open-ended opportunities due everyone else." [87]

The only proposals in the United States to succeed to date have been in Oregon where the *Death With Dignity Act* has been in operation since 1997; in Washington where a physician assisted suicide initiative passed in November 2008 and in Vermont where an assisted sucide bill passed in 2013.

7.1.1 New York

The New York Task Force on Life and the Law in a 1997 supplement[88] to its 1994 report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*,[89] affirmed and helpfully summarised its views on the primary risks associated with the legalisation of assisted suicide or euthanasia as follows:

- *Undiagnosed or untreated mental illness.*

Many individuals who contemplate suicide — including those who are terminally ill — suffer from treatable mental disorders, most commonly clinical depression. Yet, physicians routinely fail to diagnose and treat these disorders, particularly among patients at the end of life. As such, if assisted suicide is legalised, many requests based on mental illness are likely to be granted, even though they do not reflect a competent, settled decision to die.

- *Improperly managed physical symptoms.*

Requests for assisted suicide are also highly correlated with unrelieved pain and other discomfort associated with physical illness. Despite significant advances in palliative care, the pain and discomfort that accompanies many physical illnesses are often grossly under-treated in current clinical practice. If assisted suicide is legalised, physicians are likely to grant requests for assisted suicide from patients in pain before all available options to relieve the patient's pain have been thoroughly explored.

- *Insufficient attention to the suffering and fears of dying patients.*

For some individuals with terminal or incurable diseases, suicide may appear to be the only solution to profound existential suffering, feelings of abandonment, or fears about the process of dying. While the provision of psychological, spiritual, and social supports — particularly, comprehensive hospice services — can often address these concerns, many individuals do not receive these interventions. If physician-assisted suicide is legalised, many individuals are likely to seek the option because their suffering and fears have not adequately been addressed.

- *Vulnerability of socially marginalized groups.*

No matter how carefully any guidelines for physician-assisted suicide are framed, the practice will be implemented through the prism of social inequality and bias that characterises the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those

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[87] Ben Mattlin, "Suicide by choice? Not so fast", *New York Times*, 31 October 2012, http://www.nytimes.com/2012/11/01/opinion/suicide-by-choice-not-so-fast.html

[88] www.health.state.ny.us/nysdoh/taskfce/sought.pdf , pp 4-5.

[89] www.health.state.ny.us/nysdoh/provider/death.htm

who are poor, elderly, isolated, members of a minority group, or who lack access to good medical care.

- *Devaluation of the lives of the disabled.*

A physician's reaction to a patient's request for suicide assistance is likely to depend heavily on the physician's perception of the patient's quality of life. Physicians, like the rest of society, may often devalue the quality of life of individuals with disabilities, and may therefore be particularly inclined to grant requests for suicide assistance from disabled patients.

- *Sense of obligation.*

The legalisation of assisted suicide would itself send a message that suicide is a socially acceptable response to terminal or incurable disease. Some patients are likely to feel pressured to take this option, particularly those who feel obligated to relieve their loved ones of the burden of care. Those patients who do not want to commit suicide may feel obligated to justify their decision to continue living.

- *Patient deference to physician recommendations.*

Physicians typically make recommendations about treatment options, and patients generally do what physicians recommend. Once a physician states or implies that assisted suicide would be "medically appropriate," some patients will feel that they have few, if any, alternatives but to accept the recommendation.

- *Increasing financial incentives to limit care.*

Physician-assisted suicide is far less expensive than palliative and supportive care at the end of life. As medical care shifts to a system of capitation, financial incentives to limit treatment may influence the way that the option of physician-assisted suicide is presented to patients, as well as the range of alternatives patients are able to obtain.

- *Arbitrariness of proposed limits.*

Once society authorises physician-assisted suicide for competent, terminally ill patients experiencing unrelievable suffering, it will be difficult, if not impossible, to contain the option to such a limited group. Individuals who are not competent, who are not terminally ill, or who cannot self-administer lethal drugs will also seek the option of physician-assisted death, and no principled basis will exist to deny them this right.

- *Impossibility of developing effective regulation.*

The clinical safeguards that have been proposed to prevent abuse and errors are unlikely to be realised in everyday medical practice. Moreover, the private nature of these decisions would undermine efforts to monitor physicians' behaviour to prevent mistake and abuse. We continue to believe that these profound dangers associated with legalising physician-assisted suicide outweigh any benefits which such a change in law might achieve in isolated cases.

7.2 United Kingdom

On 12 May 2006 the House of Lords voted 148-100 against the *Assisted Dying for the Terminally Ill Bill*. On 7 July 2009 the House of Lords voted 194-141 against a proposed amendment to the *Coroners and Justice Bill*, which would have protected from prosecution those who help a person to seek assisted suicide abroad.

These votes indicate that the House of Lords still considered as valid the conclusions of the House of Lords Select Committee of Medical Ethics 1994 report that society's prohibition of intentional killing should not be weakened.[90] The select committee stated: "*That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia*."[91]

The House of Lords select committee also concluded that it is not possible to set secure limits on voluntary euthanasia and that if a law permitting euthanasia were passed, then vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined, to request early death.[92]

The House of Lords considered the Assisted Dying Bill 2014 on 18 July 2014 and the Bill proceeded through the second reading stage without a vote.

As Lord Mackay of Clashfern remarked, this does not mean the Bill will pass the House of Lords:

> My Lords, I am deeply opposed to the Bill but strongly in favour of it being afforded a Second Reading so that we may have the opportunity to discuss the many vitally important issues that it raises. After such discussion, there will then be an opportunity to take a vote on whether it should pass this House.[93]

On 1 December 2010 the *End of Life Assistance (Scotland) Bill* was defeated in the Scottish Parliament by a decisive 85 votes to 16.[94]

7.3 Canada

In 1995 a Special Senate Committee on Euthanasia and Assisted Suicide made its report, with a majority recommending that assisted suicide and voluntary euthanasia remain criminal offences.

> *In their view, legalization could result in abuses, especially with respect to the most vulnerable members of society. The ill and the frail are particularly dependent on those around them and on the health care system. Inevitably, and often without realizing it, these individuals cede control over their lives to the system and to those on whom they are dependent. For this reason, it would be difficult for others to assess whether an informed choice was made without coercion. If assisted suicide were legalized and accepted by the community, how could the expectations of the people surrounding the patient not influence his or her decision, particularly if the patient feels she or he is a burden on the family.*

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[90] House of Lords, *Report of the Select Committee on Medical Ethics*, Volume 1 - Report, 1994, HMSO.

[91] Ibid., p.48

[92] Ibid., p. 49

[93] House of Lords , *Hansard,* Friday, 18 July 2014, column 778, http://www.publications.parliament.uk/pa/ld201415/ldhansrd/text/140718-0001.htm#14071854000545

[94]The Scottish Parliament, *Minutes of Chamber Proceedings*, 1 December 2010, Vol. 4, No 37 Session 3, http://www.scottish.parliament.uk/parliamentarybusiness/23495.aspx

> *They think that some would feel pressured to resort to assisted suicide where financial and institutional resources are scarce. Financial restraints that affect the health care infrastructure could also result in attempts, perhaps unconsciously, to influence patients to die more quickly and conveniently. All of the above factors could make it difficult to establish whether a request for assisted suicide is voluntary.*[95]

On 21 April 2010 the Canadian House of Commons defeated *Bill C-384 An Act to amend the Criminal Code (right to die with dignity)* by 228-59.[96]

The Quebec National Assembly passed an "An Act respecting end-of-life care" by a vote of 94-22. It is due to come into effect on 10 December 2015. However, the constitutionality of the act is being challenged before the Quebec Superior Court.[97]

8. The Northern Territory experiment (1995-1996)

An examination of the Northern Territory's experience with legalised euthanasia was undertaken by the Senate Legal and Constitutional Affairs Committee in 2008. A majority (5-3) of the Committee recommended against the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008*, which sought to give the Northern Territory, the Australian Capital Territory and Norfolk Island the power to make a law permitting euthanasia and to bring back into operation the Northern Territory's *Rights of the Terminally Ill Act.*

The experiment with legalised euthanasia carried out in the Northern Territory is of particular relevance because it is the only Australian jurisdiction to have any experience with legalised euthanasia.

8.1 Clinical depression or demoralisation

The *Rights of the Terminally Ill Act 1995* (the ROTI Act) was in operation in the Northern Territory from 1 July 1996 until it was suppressed by the Commonwealth's *Euthanasia Laws Act 1997* on 27 March 1997.

During the nine month period in which the ROTI Act was in effect and under its provisions, four people were assisted to terminate their lives by Dr Philip Nitschke.

Case studies on these four deaths have been published.[98] The principal author of this paper is Professor David Kissane, who is a consultant psychiatrist and professor of palliative medicine. Philip Nitschke is a co-author of the paper.

The case studies examine how the conditions required by the ROTI Act were met. Cases numbered 3, 4, 5 and 6 in this paper refer to those cases which ended with the person's life being terminated with the assistance of Dr Philip Nitschke.

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[95] Canadian Special Senate Select Committee on Euthanasia and Assisted Suicide, *Of Life and Death*, June 1995; www.parl.gc.ca/35/1/parlbus/commbus/senate/com-e/euth-e/rep-e/lad-e.htm

[96] http://openparliament.ca/bills/votes/912/

[97] *Medical aid in dying: Court challenge*, 17 July 2014, ***http://totalrefusal.blogspot.ca/***

[98] Kissane, D W, Street, A, Nitchske, P, "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia", *The Lancet*, Vol 352, 3 October 1998, p 1097-1102.

Kissane noted that "*fatigue, frailty, depression and other symptoms*" – not pain – were the prominent concerns of those who received euthanasia. He observed that "*palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care… There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care*."

From the case histories, it is apparent that cases 3 and 4 each had depressive symptoms.

In case 3, the patient had received "*counselling and anti-depressant medication for several years*". He spoke of feeling sometimes so suicidal that "*if he had a gun he would have used it*". He had outbursts in which he would "*yell and scream, as intolerant as hell*" and he "*wept frequently*".

Neither the patient's adult sons nor the members of the community palliative care team who were caring for him were told he was being assessed for euthanasia. "*A psychiatrist from another state certified that no treatable clinical depression was present.*"

In case 4, "*the psychiatrist noted that the patient showed reduced reactivity to her surroundings, lowered mood, hopelessness, resignation about her future, and a desire to die. He judged her depression consistent with her medical condition, adding that side-effects of her antidepressant medication, dozepin, may limit further increase in dose*."

Kissane comments that "*case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management.*" While Dr Nitschke "*judged this patient as unlikely to respond to further treatment*", Kissane, comments that "*nonetheless, continued psychiatric care seemed warranted – a psychiatrist can have an active therapeutic role in ameliorating suffering rather than being used only as a gatekeeper to euthanasia*".

Further concerns are raised by the report on case 5. Dr Nitschke reported that "*on this occasion the psychiatrist phoned within 20 min, saying that this case was straightforward*". This assessment took place on the day on which euthanasia was planned. This case involved an elderly, unmarried man who had migrated from England and had no relatives in Australia. Dr Nitschke recalled "*his sadness over the man's loneliness and isolation as he administered euthanasia*". Dr Nitschke has since revealed in testimony to a Senate committee, that he personally paid for this psychiatric consultation and that it in fact took less than 20 minutes.[99]

Dr David Kissane, comments on the issue of demoralisation:

> *Review of these patients' stories highlighted for me the importance of demoralization as a significant mental state influencing the choices these patients made. They described the pointlessness of their lives, a loss of any worthwhile hope and meaning.*
>
> *Their thoughts followed a typical pattern of thinking that appeared to be based on pessimism, sometimes exaggeration of their circumstances, all-or-nothing thinking in which only extremes could be thought about, negative self-labelling and they perceived themselves to be trapped in this predicament. Often socially isolated, their hopelessness led to a desire to die, sometimes as a harbinger of depression, but not always with development of a clinical depressive disorder. It is likely that the mental state of demoralization influenced their judgement, narrowing their perspective of available options and choices. Furthermore, demoralized patients may not make a truly informed decision in giving medical consent.*

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[99] Nitschke, P., *Hansard,* Senate Standing Committee on Legal and Constitutional Affairs, Reference: *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008,* Monday, 14 April 2008, Darwin, p 42; http://www.aph.gov.au/hansard/senate/commttee/S10740.pdf

Demoralization syndrome … is an important diagnosis to be made and actively treated during advanced cancer. It is recognised by the core phenomenology of hopelessness or meaninglessness about life. The prognostic language within oncology that designates 'there is no cure' is one potential cause of demoralization in these patients, a cause that can be avoided by more sensitive medical communication with the seriously ill. While truth telling is needed, hope must also be sustained so that life may be lived out as fully as possible. Patients with advanced cancer can be guided to focus on 'being' rather than 'doing', savouring the experiential moment of the present, so that purpose and meaning are preserved through inherent regard for the dignity of the person. Active treatment of a demoralized state by hospice services would involve counselling and a range of complementary therapies, use of community volunteers and family supports, all designed to counter isolation and restore meaning.[100]

8.1.1 Terminal illness

The ROTI Act provided (Section 4) that: "*A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life*."

The ROTI Act (Section 3) defined that: "'*terminal illness', in relation to a patient, means an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient*."

The ROTI Act further provided that a "*medical practitioner who receives a request*" may, if certain conditions are met, "*assist the patient to terminate the patient's life*".

The conditions to be met included that:

- "*the medical practitioner is satisfied, on reasonable grounds, that – (i) the patient is suffering from an illness that will, in the normal course and without the application of extraordinary measures, result in the death of the patient; (ii) in reasonable medical judgment, there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure; and (iii) any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress with the object of allowing the patient to die a comfortable death*;" (Section 7(1)(b));

- a second "*medical practitioner who holds prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering*" has examined the patient and has confirmed "*(A) the first medical practitioner's opinion as to the existence and seriousness of the illness; (B) that the patient is likely to die as a result of the illness; and (C) the first medical practitioner's prognosis*" (Section 7(1)(c)(i) and (iii));

- "*a qualified psychiatrist*" has "*confirmed that the patient is not suffering from a treatable clinical depression in respect of the illness*" (Section 7(1)(c)(ii) and (iv)); and

- the illness is causing the patient severe pain or suffering (Section 7(1)(d))

In case 4, there was no consensus that the person was terminally ill. The person was diagnosed with mycosis fungoides. "*One oncologist gave the patient's prognosis as 9 months, but a dermatologist and a local oncologist judged that she was not terminally ill. Other practitioners declined to give an*

[100] Kissane DW., "Deadly days in Darwin" in *The Case Against Assisted Suicide*, K. Foley & H. Hendin (ed), Johns Hopkins University Press, 2002, p.192-209 Available at: http://www.aph.gov.au/senate/committee/legcon_ctte/terminally_ill/submissions/sub589.pdf

opinion. In the end an orthopaedic surgeon certified that the ROTI provisions for terminal illness had been complied with."[101]

In case 3 the patient may have benefited from radiotherapy or strontium but neither of these was available in the Northern Territory.[102]

In case 5, the patient had an obstruction and was clinically jaundiced.[103] The ROTI Act required Dr Nitschke as a "*medical practitioner who receives a request*" to have "*informed the patient of the nature of the illness and its likely course, and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available to the patient*."[104] However, Kissane reports that "*when questioned about options like stenting for obstructive jaundice or the management of bowel obstruction*" Dr Nitschke "*acknowledged limited experience, not having been involved in the care for the dying before becoming involved with the ROTI Act*."[105]

This raises doubts as to whether the patient in this case – who was reported by Dr Nitschke to exhibit "*indecisiveness*" over a two month period about whether or not to request euthanasia – would still have done so if he had been given better symptomatic relief for the jaundice and obstruction.[106]

8.1.2 "Severe Pain or Suffering"

Section 4 of the ROTI Act provided that: "*A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life*."

Section 7(1)(d) provided that "*a medical practitioner may assist a patient to end his or her life*" only if, among other conditions, "*the illness is causing the patient severe pain or suffering*".

Section 8 of the ROTI Act provided that a "*medical practitioner shall not assist a patient under this Act if, in his or her opinion, and after considering the advice of the medical practitioner*" who has the "*prescribed qualifications, or has prescribed experience, in the treatment of the terminal illness from which the patient is suffering*" (cf Section 7(1)(c)(i)), "*there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient*."

Kissane reports that pain "*was not a prominent clinical issue in our study*"[107]. In case 3, "*the patient took morphine for generalised bone pain*."[108] For case 4, "*pain was well controlled*".[109] In case 5 the

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[101] Kissane, D W, Street, A, Nitchske, P, op. cit., p 1101.

[102] Ibid., p 1099.

[103] Ibid., p 1100.

[104] *Rights of the Terminally Ill Act 1995*, Section 7(1)(e).

[105] Kissane, D W, Street, A, Nitchske, P, op. cit., p 1101

[106] Ibid., p 1100.

[107] Ibid., p 1102.

[108] Ibid., p 1099.

[109] Ibid., p 1099.

patient "*complained of mild background pain incompletely relieved by medication*".[110] In case 6, "*regular analgesia was needed for abdominal pain*".[111]

In none of these four cases is there any evidence of severe pain that was not being adequately controlled.

Other kinds of suffering or distress are reported. In case 3, these included "*intermittent nausea, constipation, and diarrhoea*" and "*catheterisation*"[112]. In case 4 the dominant problem was "*pruritus*".[113] In case 5 there were symptoms associated with the obstructive jaundice, which seems to have been inadequately treated. In case 6 a key factor seemed to be patient's distress at "*having witnessed*" the death of her sister who also had breast cancer, "*particularly the indignity of double incontinence*".[114] She "*feared she would die in a similar manner*". She "*was also concerned about being a burden to her children, although her daughters were trained nurses*".

Kissane noted that "*fatigue, frailty, depression and other symptoms*" – not pain – were the prominent concerns of those who received euthanasia. He observed that "*palliative care facilities were underdeveloped in the Northern Territory, and patients in our study needed palliative care… There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care*."

9. Conclusion and recommendation

The *Medical Services (Dying with Dignity) Bill 2014 would*, if enacted, fundamentally change the law in every State and Territory of Australia to permit acts which are currently considered to be acts of murder or aiding a suicide.

The Bill is drafted so broadly that a person who had many years to live and who, on any objective test was not experiencing unrelievable pain could be put to death.

The evidence from all those jurisdictions where euthanasia or assisted suicide is or has been legal is that it does not remain contained to a few hard cases. On the contrary the number of deaths by euthanasia or assisted suicide continues to rise and the conditions for which it is resorted to expand well beyond those first considered.

Euthanasia and assisted suicide are actively promoted and provided by a small group of medical practitioners who are enthusiastic proponents for euthanasia and who are not inclined to be restrained by any formal requirements for legality.

Recommendation 3:

Euthanasia or physician assisted suicide cannot be safely legalised. The Medical Services (Dying with Dignity) Bill 2014 should not be supported.

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[110] Ibid., p 1100.

[111] Ibid.

[112] Ibid., p. 1099.

[113] Ibid.

[114] Ibid. p 1100.