

Committee Secretary
Senate Standing Committee on Legal and Constitutional Affairs
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Sir/ Madam

Re: Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008

Women's Forum Australia (WFA) is pleased to provide a submission to this inquiry. WFA is an independent women's think tank that conducts research, education and public policy development about social, economic, health and cultural issues that affect women.

WFA is opposed to the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* becoming law as it would restore the legitimacy of the *Rights of the Terminally Ill Act 1995* (ROTI) which permitted assisted termination of life in the Northern Territory.

At first glance, it is not obvious why euthanasia and assisted suicide are issues of special significance to women. However, around the world some of the most prominent assisted death cases have involved women, including in Australia, Nancy Crick, Sandy Williamson, Norma Hall and Lisette Nigot. Are these deaths demonstrations of personal autonomy, expressions of the catch cry 'my body, my choice'?

As part of WFA's submission I attach an article written by myself entitled 'A woman's choice? The gendered risks of euthanasia and physician assisted suicide', published in 2007 in the academic journal, the *Medical Law Review* by Oxford University Press.

Based on this research, WFA's submission argues that the reasons some women decide for assisted death challenge the rhetoric of choice. This article investigates evidence of underlying forces that might motivate women's decisions for death. These influences include structural factors such as economic and social disadvantage and cultural stereotypes that idealise feminine self sacrifice, passivity and compliance.

This research identifies a striking correlation between patterns of male violence against women and so called 'mercy killings': both are animated by domination, possessiveness and control by male intimates. In our submission, legalising assisted death under ROTI would legitimise and increase access to methods of suicide that appeal particularly to women, as shown by data from the Netherlands, Oregon and elsewhere.

This research has implications not just for women, but for other groups who might be considered vulnerable to deciding for euthanasia such as the elderly, people with disabilities and people from racial and ethnic minorities. Although currently there is no evidence that such groups disproportionately favour assisted death in places like the Netherlands or Oregon, 'A woman's choice?' argues that even if there is no greater incidence of women and other vulnerable populations deciding for assisted death, the *reasons* for these decisions can point to a lack of autonomy and thus an abuse of the rights that ROTI would seek to uphold.

I have also provided another submission to this Inquiry in my capacity as a Lecturer in Law, University of Western Sydney. That submission addresses wider issues of concern with the Bill.

Yours sincerely

Katrina George
Chair

A WOMAN'S CHOICE? THE GENDERED RISKS OF VOLUNTARY EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

KATRINA GEORGE*

I. INTRODUCTION

The principle of autonomy is a familiar justification for voluntary euthanasia and physician-assisted suicide.¹ Advocates argue that legalising these practices would have a positive impact on patient autonomy, engendering as Magnusson puts it, '... a libertarian effect, by creating a space for personal choice'² in death.

This may have particular resonance with women who historically have struggled to win choice in their lives and control over their bodies.³ Some of the most prominent assisted death cases have involved women: in the United States, Diane Trumbull, Janet Adkins, Marjorie Wantz and Sherry Miller; Dianne Pretty in the United Kingdom; in New Zealand, Victoria Vincent and Lesley Martin who assisted her mother, Joy, to commit suicide; in Canada, Sue Rodriguez, and in Australia, Nancy Crick, Sandy Williamson, Norma Hall and Lisette Nigot.⁴ In this

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¹ Voluntary euthanasia is defined as the intentional killing of a patient at the request of the patient, usually by lethal injection administered by a physician. Physician-assisted suicide is defined as the ending of one's life through the voluntary self-administration of lethal medications prescribed by a physician for that purpose. In this paper, 'assisted death' is a shorthand reference for both voluntary euthanasia and physician-assisted suicide.

² R. Magnusson, *Angels of Death. Exploring the Euthanasia Underground* (Melbourne University Press 2002) at 281.

³ For example, women's efforts to secure justice in marriage and family life, financial independence, freedom to participate in public life and paid employment, respect for bodily integrity and freedom from violence.

⁴ Diane Trumbull, a 45-year-old leukaemia patient, was assisted to die by Dr Quill who later wrote about this experience (see T.E. Quill, 'Death and Dignity—a Case of Individualized Decision Making' (1991) 324 *New England Journal of Medicine* 691). Janet Adkins, a 54-year-old Oregon woman, suffered from Alzheimer's disease and died with the assistance of Dr Kevorkian. Marjorie Wantz, 58 years old and undiagnosed,

paper, I critically analyse the theory that such deaths are demonstrations of personal autonomy, expressions of the catch cry ‘my body, my choice’. I will argue that the experience of women exposes the precariousness of ‘choice’ as the foundation of any policy that sanctions assisted death.

In Part II of this paper, I investigate currently available empirical evidence in order to assess the incidence of assisted death among women. I posit that, if disproportionate numbers of women decide for euthanasia or physician-assisted suicide, this might indicate that women are more susceptible to these practices and call in to question the autonomy of their decisions. Overall, the data are inconclusive on this point. However, the available evidence does indicate that women display a strong preference for the more structured, passive methods of assisted death such as euthanasia. I argue in Part III that this preference could point to women’s unique reasons for deciding for assisted death.

In Part III, I consider why women decide for euthanasia and physician-assisted suicide. I will argue that even if there were no greater incidence of women deciding for assisted death, the reasons for these decisions could suggest a lack of autonomy. I investigate evidence which points to underlying forces which might animate women’s decisions for assisted death. These include structural inequalities and disparities in power—most evident in women’s experience of violence—and social and economic disadvantage and oppressive cultural stereotypes that idealise feminine self-sacrifice and reinforce stereotyped

suffered from pelvic pain and died with Sherry Miller with the assistance of Kevorkian. Dianne Pretty died of Motor Neurone Disease (MND) in 2002 at age 43 after losing right to die court challenges in England and the European Court of Human Rights. In September 2002, former Voluntary Euthanasia Society member Victoria Vincent, 83 years, was found dead with a bag over her head. Lesley Martin, a euthanasia campaigner, gave her mother Joy Martin a morphine injection in May 1999 as she was dying of cancer, later recording this in a book (see L. Martin, *To Die Like a Dog: a Mother, a Daughter, a Promise Kept* (M-Press 2002)). Sue Rodriguez suffered from MND and suicided in 2004 after losing a constitutional challenge in the Canadian Supreme Court. Her story was recorded in the documentary *At the End of the Day: The Sue Rodriguez Story*. Nancy Crick, 69 year old, was not terminally ill when she suicided in 2002 in the presence of 21 family, friends and supporters of voluntary euthanasia with the aim of challenging laws against assisting suicide. She had received advice from voluntary euthanasia campaigner Dr Philip Nitschke as had Sandy Williamson, in her mid-50s, who suffered from MND and suicided in 2002 after significant media interest. Norma Hall, a 72-year-old cancer patient, died in 2001 with advice of Nitschke. Lisette Nigot, healthy and 79 years old, killed herself in 2002 with the advice of Nitschke, her story recorded in the documentary *Mademoiselle and the Doctor*. Numerous other cases of such women could be cited. However, there are exceptions: for example, Bob Dent who died in 1996 with the assistance of Nitschke was the first person to avail himself of the voluntary euthanasia legislation in the Northern Territory, Australia before that legislation was overturned.

gender roles of passivity and compliance. This is not to assert that women are incapable of deciding within such a context, but it does require us to examine the autonomy of women's decisions for death, 'to question how much real value, worth and power these so-called choices have ... Choice can be conformity if women have little ability to determine the conditions of consent'.⁵

Part IV considers what kind of legal regime more effectively safeguards patient autonomy at the end of life, as research shows that euthanasia and physician-assisted suicide are practised even under prohibition.⁶ I will argue that although legalisation of these practices might expand the range of choices for some patients, their wider availability might pose special risks to the autonomy of other patients, particularly women. I demonstrate that when assisted death is legal, there is a disproportionate increase in the number of women who end their lives.

II. THE INCIDENCE OF VOLUNTARY EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE AMONG WOMEN

In this section, I analyse the available studies that disclose firstly the incidence of death by voluntary euthanasia and physician-assisted suicide and, secondly, the gender of patients who make these decisions.⁷ In 1998, Muller *et al.* published their analysis of the empirical research regarding the incidence of assisted death amongst the elderly population.⁸ Their assumption was that if certain groups were more likely to decide for assisted death, this would be indicated by a disproportionate percentage of such groups requesting and receiving assisted death.⁹ I apply the same assumption to women: a significantly higher incidence of voluntary euthanasia and physician-assisted suicide among women than men would suggest that women are susceptible to these practices.

⁵ J.G. Raymond, *Women as Wombs: Reproductive Technologies and the Battle Over Women's Freedom* (Spinifex Press 1994) at 100 and 103. Raymond's quotation here refers to women's decisions to use reproductive technologies such as in vitro fertilisation and surrogacy. I argue that the same questions should be asked about women's 'so-called choices' for assisted death.

⁶ See, for example, R. Magnusson, *supra*, n. 2.

⁷ Analysis of the gender ratios of participants in voluntary euthanasia and physician-assisted suicide was included in a publication by Kaplan *et al.* in 2002. The present paper has the benefit of more recent data from the Netherlands and Oregon. See K.J. Kaplan, M. Harrow and M.E. Schneiderhan, 'Suicide, Physician-assisted suicide and Euthanasia in Men Versus Women Around the World: The Degree of Physician Control' (2002) 18 *Ethics and Medicine* 33.

⁸ M.T. Muller, G.K. Kimsma and G. van der Wal, 'Euthanasia and Assisted Suicide: Facts, Figures and Fancies with Special Regard to Old Age' (1998) 13 *Drugs & Aging* 185.

⁹ The authors found that no such disproportion is evident in the oldest age group and concluded that the elderly are not vulnerable in relation to assisted death (at 187).

A. *The Netherlands*

Under a defence of ‘necessity’, both voluntary euthanasia and physician-assisted suicide have been legally permitted in some circumstances in the Netherlands since 1973 and since 2001 in accordance with a statutory protocol.¹⁰ Quantitative studies of the rates and characteristics of voluntary euthanasia and physician-assisted suicide were conducted in 1990, 1995 and 2001. Random samples were taken of death certificates from the central death registry.

In both 1990 and 2001, more men than women decided for voluntary euthanasia or physician-assisted suicide: 55% of these deaths in both years were men.¹¹ However, 1995 saw the reverse.¹² The incidence of euthanasia and physician-assisted suicide was higher among women: 56% of these deaths were women.¹³ The authors of this study are unable to explain this difference in the 1995 results.¹⁴ When these figures are projected across the sample periods, the incidence of euthanasia and physician-assisted suicide taken together is equally balanced between gender: overall in 1990, 1995 and 2001, 51% of these deaths were men and 49% women.¹⁵

Yet, when the incidence of voluntary euthanasia and the incidence of physician-assisted suicide are considered separately, significant gender differences become evident. Overall in 1990, 1995 and 2001, the rate of voluntary euthanasia was equal between genders: 51% of these deaths were men and 49% were women.¹⁶ But the rate of physician-assisted suicide was higher among men: 57% of physician-assisted suicides across the three years were men and 42% were women.¹⁷

¹⁰ Magnusson, *supra*, n. 2 at 64; J. de Haann, ‘The New Dutch Law on Euthanasia’ (2002) 10 *Medical Law Review* at 58.

¹¹ Percentages calculated from Table 3, B.D. Onwuteaka-Philipsen, A. van der Heide, D. Koper *et al.*, ‘Euthanasia and Other End-of-Life Decisions in the Netherlands in 1990, 1995, and 2001’ (2003) 362 *The Lancet* 395 at 397. See also P.J. van der Maas, J.J.M. van Delden, C.W.N. Looman, ‘Euthanasia and Other Medical Decisions Concerning the End of Life’ (1991) 338 *The Lancet* 669.

¹² Email from B.D. Onwuteaka-Philipsen to K. George on 8 December 2003. According to B.D. Onwuteaka-Philipsen the relevant data are also published in the Dutch report which she translates as: G. van der Wal, A. van der Heide, B.D. Onwuteaka-Philipsen, P.J. van der Maas, ‘Medical Decision Making at the End of Life. Practice and Euthanasia Notification Procedure’ (2003 Utrecht: De Tijdstroom).

¹³ Percentages calculated from Table 3, Onwuteaka-Philipsen *et al.*, *supra*, n. 11. See also P.J. van der Maas, G. van der Wal, I. Haverkate *et al.*, ‘Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990–1995’ (1996) 335 *New England Journal of Medicine* 1699, Table 3.

¹⁴ B.D. Onwuteaka-Philipsen, *supra*, n. 12.

¹⁵ Percentages calculated from Table 3, B.D. Onwuteaka-Philipsen *et al.*, *supra*, n. 11.

¹⁶ Percentages calculated from B.D. Onwuteaka-Philipsen, *supra*, n. 12.

¹⁷ *Ibid.*

While overall only a small proportion of all patients decide for physician-assisted suicide,¹⁸ the data here could suggest that in the Netherlands, physician-assisted suicide appeals less to women than men as the preferred method of assisted death.¹⁹

B. Oregon, USA

The same pattern is present in the 246 physician-assisted suicides that have been performed in Oregon since it was legalised in November 1997. Voluntary euthanasia is not legal in Oregon. Of the physician-assisted suicides between 1998 and 2005, 53% were men and 47% were women.²⁰ The experience of the Netherlands and Oregon suggests that the more proactive method of physician-assisted suicide (where the patient is required to self ingest the fatal prescription of drugs) appeals more to men than to women. Women display a stronger preference for the more passive, structured method of euthanasia where the physician administers the lethal dosage to the patient.

C. National US Survey

In 1996, a national survey of euthanasia and physician-assisted suicide was conducted in the United States at a time when these practices were illegal across the entire country. Completed questionnaires were received from 1902 physicians across a range of medical specialities. Eighty-one deaths by euthanasia and physician-assisted suicide were

¹⁸ B.D. Onwuteaka-Philipsen, *supra*, n. 12.

¹⁹ This conclusion might be underscored by the data about physician-assisted suicide among psychiatric patients. In practice, only physician-assisted suicide (not euthanasia) is offered to psychiatric patients because the patient's self-ingestion of the fatal dose is considered a final guarantee of voluntariness (*Office of Public Prosecutions v. Chabot*, Supreme Court of the Netherlands, Criminal Chamber, 21 June 1994, no.96.972; J. Griffiths, 'Assisted Suicide in the Netherlands: the *Chabot* Case' (1995) 58 *Modern Law Review* at 244). One study estimated that 63% of requests for physician-assisted suicide among psychiatric patients were by women. This might support the observation that when euthanasia is also an option (as it is among the general patient population) women display a stronger preference for euthanasia over physician-assisted suicide than do men. However, this data should be read with caution since the same study estimates that only about two to five physician-assisted suicides occur among psychiatric patients per year, out of approximately 320 requests by men and women: J. H. Groenewoud, P.J. van der Maas, G. van der Wal *et al.*, 'Physician-Assisted Death in Psychiatric Practice in the Netherlands' (1997) 336 *The New England Journal of Medicine* at 1795–1801.

²⁰ Oregon Department of Human Services, *Eighth Annual Report on Oregon's Death with Dignity Act* (2006) <<http://www.oregon.gov/DHS/ph/pas/docs/year8.pdf>> at 20 October 2006.

reported.²¹ Striking gender differences in assisted death preference are evident. Of the 36 patients who died by physician-assisted suicide for whom sex was reported, 97% were men. Of those who died by euthanasia, 57% were men and 43% were women.²² This confirms that the more proactive method of physician-assisted suicide is the preference of men more often than women. Although participants of both genders overall preferred euthanasia, this preference was more pronounced among women.

The results of this 1996 US study are a challenge to the autonomy of decisions for assisted death and decisions for euthanasia in particular. In only 21% of the euthanasia cases was an explicit request for death received, compared with 75% of the physician-assisted suicide cases. The patients themselves made the request for death in 95% of the physician-assisted suicide cases, but in only 29% of the euthanasia cases. The influence of a family member or partner is stronger in the euthanasia cases where a family member or partner made the request for death 54% of the time.²³

For the women in this US study, the rhetoric of choice rings a little hollow. Compared to men, women died in circumstances where their requests were less likely to be explicit, less likely to be at their personal request and more likely to be initiated by family members or partners. The euthanasia cases were also characterised by weaker doctor-patient relationships: in 12% of cases, the physician had known the patient for less than four weeks.²⁴ Thus, the women considering whether to end their lives were also less likely to have the benefit of an established relationship with their physician.

D. Dr Kevorkian

The studies about the suicides assisted by Dr Jack Kevorkian between approximately 1990 and 1997 reveal a significantly higher incidence of assisted death among women than men: depending on the sample size, either 72% or 68% of the Dr Kevorkian deaths were women.²⁵ The authors considered this finding 'remarkable', given that in the

²¹ D.E. Meier, C. Emmons, S. Wallenstein *et al.*, 'A National Survey of Physician-Assisted Suicide and Euthanasia in the United States' (1998) 338 *New England Journal of Medicine* 1193 at 1195.

²² *Ibid.* at 1195, Table 4.

²³ *Ibid.* at 1195.

²⁴ *Ibid.* at 1195.

²⁵ S.S. Canetto and J.D. Hollenshead, 'Gender and Physician-Assisted Suicide: An Analysis of the Kevorkian Cases, 1990–1997' (1999–2000) 40 *OMEGA* 165 at 168 (72% of their sample of 75 assisted suicides were women); K.J. Kaplan, M. Harrow, M.E. Schneiderhan, *supra*, n. 7 at 36 (68% of their sample of 93 assisted suicides were women).

United States it is men who are more likely to kill themselves by a ratio of 1:4.²⁶

Dr Kevorkian employed two methods of death. The first method was the inhalation of carbon monoxide, triggered by the patient, via a tube and mask over the patient's face and mouth. The second method required considerably more physician involvement and was more structured: in this method, the physician established an intravenous line and a saline drip, followed by the patient releasing barbiturates into the line.

The authors of one of the Kevorkian studies point out that:

[s]triking gender differences emerge here: Of the 27 carbon monoxide deaths, 56% were women and only 44% were men. Of the 20 lethal injection deaths (the more passive, structured method) 85% were women and only 15% were men ...²⁷

Like other research analysed here, the Kervokian studies strongly indicate women's preference for a passive death, with a significant degree of physician participation.²⁸

E. A Woman's Choice?

I caution careful consideration of these various studies because of the differences in their methodologies. My analysis of the available data

²⁶ S.S. Canetto and J.D. Hollenshead, *supra*, n. 25 at 182. See also K.J. Kaplan, M. Harrow and M.E. Schneiderhan, *supra*, n. 7 at 37.

²⁷ This comment was about the first 47 cases of the sample for which both psychological and physical post-mortem data were available: K.J. Kaplan, M. Harrow and M.E. Schneiderhan, *supra*, n. 7 at 33.

²⁸ There are other studies that analyse the incidence of assisted death according to gender. However, they do not report the gender characteristics separately for euthanasia and physician-assisted suicide. A 1998 US study of 355 randomly selected oncologists revealed 17 cases of euthanasia and 20 cases of physician-assisted suicide. One case remained ambiguous. Among these 38 patients, 60.5% were women. (E.J. Emanuel, E.R. Daniels, D.L. Fairclough and B.R. Clarridge, 'The Practice of Euthanasia and Physician-Assisted Suicide in the United States: Adherence to Proposed Safeguards and Effects on Physicians' (1998) 280 *Journal of the American Medical Association* 507 at 509). A study was conducted of a randomly selected 1925 deaths that occurred in 1998 in Flanders, Belgium. At the time assisted death was illegal. Twenty-five cases of euthanasia and physician-assisted suicide were disclosed. Of these deaths, 15 were women (L. Deliens, F. Mortier, J. Bilsen *et al.*, 'End-of-Life Decisions in Medical Practice in Flanders, Belgium: a Nationwide Survey' (2000) 356 *The Lancet* 1806 at 1808 Table 2). There is also a study of more than 20,000 deaths that occurred between June 2001 and February 2002 in the Netherlands, Switzerland, Denmark, Sweden, Belgium and Italy. The gender breakdown varied significantly. But broadly the data discloses that in four of these countries, males were more likely to receive assisted death, and in two of these countries, women were more likely (A. van der Heide, L. Deliens, K. Faisset *et al.*, 'End of life Decision-Making in Six European Countries: Descriptive Study' (2003) 362 *The Lancet* 345 at 348 Table 3).

about the incidence of assisted death by gender is inconclusive. However, I argue for closer scrutiny of this issue in empirical research. It is important to point out the empirical studies²⁹ report an extensive range of valuable data, but fail to report vital information about the characteristics of patients deciding for assisted death, including their gender. Moreover, our understanding of the issues would be advanced if empirical studies reported individually the gender breakdown of deaths by euthanasia and deaths by physician-assisted suicide.

In Part III of my paper, I will investigate more closely the evidence that men are more likely than women to prefer physician-assisted suicide, and women demonstrate a stronger preference for the more passive method of euthanasia. I argue that even if more men overall decide for assisted death, the reasons that underlie the decisions of some women are gender distinctive and challenge the rhetoric of choice.

III. THE REASONS WOMEN DECIDE FOR EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

There are no qualitative studies that explore the reasons why women, as distinct from men, decide for, or, given the opportunity, would decide for, either euthanasia or physician-assisted suicide. This is a significant gap in the research.³⁰ I now critically examine some key explanations for women's decisions for assisted death. I consider the extent to which there is empirical evidence to support these explanations. Are the reasons women decide for assisted death indicative of self-determination, choice and autonomy? Although theories of autonomy are diverse, and there is disagreement as to its meaning and limitations, one defining characteristic is considered essential: liberty—the independence from controlling influences.³¹ My analysis leads me to

²⁹ For example, H. Kuhse, P. Singer, P. Baume, M. Clark and M. Rickard, 'End-of-Life Decisions in Australian Medical Practice' (1997) 166 *Medical Journal of Australia* 191.

³⁰ Gail Tulloch has recently noted the importance of monitoring the reasons women decide for assisted death where empirical data permit (although she does not examine the available data herself): G. Tulloch, 'A feminist utilitarian perspective on euthanasia: from Nancy Crick to Terri Schiavo' (2005) 12 *Nursing Inquiry* at 159. In 1999, Diane Raymond concluded that there was not enough data to justify an inference that women are 'worse off' with assisted death. This paper has the benefit of more recent data and draws more widely from a variety of interdisciplinary studies to shed light on women's reasons for deciding for assisted death: D. Raymond, "'Fatal Practices': A Feminist Analysis of Physician-Assisted Suicide and Euthanasia' (1999) 14 *Hypatia* at 6.

³¹ T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics* (5th edn.) (Oxford University Press 2001) at 58.

conclude that for some women, the decision for death may be a 'non-choice', induced by controlling influences that subvert women's autonomy at the end of life.

A. Women are Concerned about Self-Determination

Women's concern about self-determination in death could reflect women's historical struggle for choice and control over their bodies.³² There is some evidence that this concern relates to more than reproduction. An analysis of judicial decisions in US cases about the termination of treatment for incompetent patients revealed gender-patterned reasoning:

... a woman's moral identity is more likely to be discounted as treatment decisions are assigned to family ... women are disadvantaged in having their moral agency taken less seriously than that of men when a controversial medical decision is evaluated ...³³

In this context, 'concern about self-determination in death might be particularly relevant to women'.³⁴

Against the explanation, however, stands research which demonstrates less support for assisted death by women than by men. For example, a 1994 US poll found that 74% of men, compared with 67% of women, supported life ending practices.³⁵ Another study noted opposition to assisted death amongst women as well as marginalised groups, including black people, the elderly, those with less education, low incomes, dementia or intellectual impairment.³⁶ Thus, the explanation that women are particularly concerned about self-determination in death is undermined by the evidence of their more negative attitudes towards assisted death than men.

B. Women Live Longer than Men

Another explanation for women deciding for assisted death is the fact that women tend to live longer than men do, and so are more likely

³² S.S. Canetto and J.D. Hollenshead, *supra*, n. 25 at 184–185.

³³ S.H. Miles and A. August, 'Courts, Gender and "The Right to Die"' (1990) 18 *Law, Medicine and Health Care* 85 at 92. See also J.A. Parks, 'Why Gender Matters to the Euthanasia Debate' (2000) 30 *Hastings Center Report*.

³⁴ S.H. Miles and A. August, *supra*, n. 33.

³⁵ The same study also shows that other marginalised groups similarly demonstrate less support for assisted death: 73% of Anglos, 65% of Hispanics and 53% of Blacks were in favour. E. Morrow, 'Attitudes of Women from Vulnerable Populations Toward Physician-Assisted Death: A Qualitative Approach', (1997) 8 *The Journal of Clinical Ethics* 279 at 279.

³⁶ H.G. Koenig, D. Wildman-Hanlon, K. Schmader, 'Attitudes of Elderly Patients and Their Families Towards Physician-assisted Suicide' (1996) 156 *Archives of Internal Medicine* 2240 at 2240.

to suffer from the diseases and disabilities that motivate the request for assisted death. Numerous studies in the USA and Britain have confirmed that elderly women are significantly more likely to develop disabling conditions than elderly men. For example, in Britain 'above age 80, nearly 20% more women than men are functionally disabled'.³⁷

Countering this explanation, however, is US data about suicide mortality patterns. Between 1968 and 1982 it was the male suicide rate that rose between the ages of 65 and 85, the age of declining health and increase in chronic disease and disability. The authors note:

It is striking that, though white female life expectancy is higher and females report more chronic diseases and health service use at advanced ages than males, there is no comparable late life rise in their suicide rates.³⁸

Data also demonstrate that rates of participation in physician-assisted suicide and euthanasia decrease significantly with age, for both men and women.³⁹

Women's relative longevity also means that they are more likely than men to experience the death of a partner or spouse and be deprived of this support in older age. For example, in the US

[i]n 1988 there were 6.5 million women age 65 and over living alone, in contrast with fewer than 2 million men in that situation. Women age 65 and over are almost half as likely as their male age peers to be married.⁴⁰

It might be expected that this could influence women's decisions for assisted death.⁴¹ The incidence of suicide and suicidal ideation increases significantly in people who are lonely or alone.⁴² However, this does not appear to be the case for elderly women. Although they are more likely

³⁷ S. Arber and J. Ginn, 'Gender and Inequalities in Health in Later Life' (1993) 36 *Social Science and Medicine* 33 at 37; and see studies cited therein.

³⁸ M.A. Woodbury, K.G. Manton and D. Blazer, 'Trends in US Suicide Mortality Rates 1968 to 1982: Race and Sex Differences in Age, Period and Cohort Components' (1988) 17 *International Journal of Epidemiology* 356 at 360.

³⁹ Oregon Department of Human Services, *supra*, n. 20; B.D. Onwuteaka-Philipsen, A. van der Heide, D. Koper *et al.*, *supra*, n. 11.

⁴⁰ S.S. Canetto, 'Elderly Women and Suicidal Behaviour' in S.S. Canetto and D. Lester (eds) *Women and Suicidal Behaviour* (Springer Publishing Company 1995) 215-233 at 221.

⁴¹ See, for example, L.M. Kohm and B.N. Brigner, 'Women and Assisted Suicide: Exposing the Gender Vulnerability To Acquiescent Death' (1998) 4 *Cardozo Women's Law Journal* 241, at 267-268.

⁴² L.A. Roscoe, J.E. Malphurs, L.J. Dragovic and D. Cohen, 'Antecedents of Euthanasia and Suicide Among Older Women' (2003) 58 *Journal of the American Medical Women's Association* 44 at 46.

to live alone, there is no corresponding increase in the suicide rate of women aged 65 and over, as noted above. There is also the evidence of the Kevorkian deaths. Although women who were divorced or never married were significantly more likely to opt for assisted death than those who were married, women who were widowed were less likely to opt for death.⁴³

Overall, the available evidence does not support women's relative longevity as an explanation for their assisted deaths. Elderly women suffer greater disease and disability than men. However, research suggests that this does not influence their requests for assisted death. Although women are likely to outlive their spouse or partner and lose this support in their old age, the available evidence indicates (somewhat counter-intuitively) that this does not impact on their rate of suicide.

C. Assisted Death of Women Reproduces Gendered Patterns of Violence

Another explanation, not hitherto advanced in the literature, is that the assisted death of women reproduces gendered patterns of violence. I argue that we must consider women's decisions for assisted death within the context of male domination and sexist oppression. I go on to identify striking correlations between patterns of male violence against women and the mercy killing of women. The possibility that the same dynamics might sometimes underlie female euthanasia and physician-assisted suicide is a challenge to an unquestioning confidence in the autonomy of these decisions.

1. 'The Ubiquitous Phenomenon of Male Domination and Hierarchy'

While feminist theory is far from homogenous, '[t]he insight that women are subject to pervasive gender domination remains a driving force of all forms of feminism'.⁴⁴ Bender points out that

[m]uch of feminist theory begins by describing, defining and exposing ... the ubiquitous phenomenon of male domination and hierarchy ... men have had the bulk of the power and have used that power to subordinate women ... men have clearly been in control ... men have had social, economic and political power.⁴⁵

⁴³ L.A. Roscoe, J.E. Malphurs, L.J. Dragovic and D. Cohen, 'A Comparison of Characteristics of Kevorkian Euthanasia Cases and Physician-Assisted Suicides in Oregon' (2001) 41 *The Gerontologist* 439 at 443.

⁴⁴ R. Hunter, 'Deconstructing the Subjects of Feminism: The Essentialism Debate in Feminist Theory and Practice' (1996) 6 *The Australian Feminist Law Journal* 135 at 138.

⁴⁵ L. Bender, 'A Lawyer's Primer on Feminist Theory and Tort' (1988) 38 *Journal of Legal Education* 3 at 5-6. This is a perspective most closely associated with radical feminism

Even in liberal, democratic societies that profess a commitment to justice and self-determination, women have less access than men to structures of power.⁴⁶ Correspondingly, women are also disadvantaged in their access to material resources.⁴⁷ However, the phenomenon of male domination and female subjugation is not just manifested in, and reinforced by, structures and systems. Smart refers to feminist psychoanalytic literature which attempts to explain how relations of domination and subjugation form part of the unconscious of both men and women.

... the way we think ... cannot be separated from the cultural meanings attributed to gendered difference. But these meanings are not simply imposed upon us: we continuously reconstruct

which regards the male–female relationship as the model of all power relationships: see, for example, K. Millet, *Sexual Politics* (Doubleday 1970); R. Rowland and R.D. Klein; ‘Radical Feminism: Critique and Construct’, in S. Gunew (ed) *Feminist Knowledge: Critique and Construct* (Routledge 1990) 271–303. From this perspective, women’s oppression is the first and deepest oppression and the most widespread, existing in virtually every society: A.M. Jagger and P.S. Rothenberg, (eds), *Feminist Frameworks* (McGraw-Hill 1984). See also, for example, M. French, *Beyond Power: On Women, Men and Morals* (Summit Books 1985); R. Morgan, *Going Too Far* (Vintage Books 1978) at 9.

⁴⁶ As of September 2005, ‘the global average for women in parliaments stands at 16.0%. Additionally, women have achieved 30% representation or more in national parliaments in 19 countries. However, progress has been uneven and slow, and in some cases, there have been significant setbacks’. United Nations Division for the Advancement of Women (DAW), *Equal Participation of Women and Men in Decision-Making Processes, with Particular Emphasis on Political Participation and Leadership*, Report of the Expert Group Meeting, Addis-Ababa, Ethiopia, 24–27 October 2005. Access to structures of power goes beyond political representation, however. See also, for example, Dorothy Smith who argues: ‘Being excluded, as women have been, from the making of ideology, of knowledge, and of culture means that our experience, our interests, our ways of knowing the world have not been represented in the organisation of our ruling nor in the systematically developed knowledge that has entered into it’. *The Everyday World as Problematic*, (Northeastern University Press 1987) at 17–18.

⁴⁷ For example, in Australia, women’s average weekly earnings are 66% of those of men (factoring in data on all work, including part-time work) and ‘16% of females and 7% of males earned less than \$200 per week in August 2000, whereas 2% of females and 7% of males earned \$1400 or more per week.’ Australian Bureau of Statistics, *Employee Earnings, Benefits and Trade Union Membership*, Cat 6310.0, August 2000, at 3, quoted in R. Graycar and J. Morgan, *The Hidden Gender of Law* (Federation Press 2002) at 146. For details of the US situation see L.M. Kohm and B.N. Brigner, *supra*, n. 41 at 257–259. Worldwide, the ‘feminisation of poverty’ means that the gap between impoverished men and impoverished women has continued to widen. Of the 1.5 billion people living in poverty, the majority are women: United Nations Department of Public Information, *The Feminization of Poverty* (May 2000). <http://www.un.org/womenwatch/daw/followup/session/presskit/fs1.htm> at 15 March 2006.

them to make sense of the world; they explain, validate, and create our experience and subjectivity.⁴⁸

However, critiques of feminist essentialism reject the view that there are essential, defining characteristics of women that unite them as a group distinct from men.⁴⁹ Each woman's experience of oppression will be different, because of the different conditions of their lives, such as race, class and culture. Some theorists also question masculinist essentialism, arguing that not all men are part of the dominant masculinity.⁵⁰ It is not possible here to do justice to the complexity and range of this debate. However, to acknowledge the context of male domination and female oppression is not to subscribe to determinism, to confine women and men to fixed categories, nor to deny the possibility of change:

Existing differences between women and men may have been generated out of the different worlds we inhabit as social groups, including our experience of power and powerlessness. But this is not to say that these differences are immutable.⁵¹

2. Violence Against Women: Domination, Control, Possession

I will now examine criminological studies which expose this gender domination in patterns of violence. There is compelling evidence of correlations between these patterns of violence and women's experience of mercy killing. I contend that women's experience of violence provides striking insight into the influences that might explain their decisions for assisted death, and belie the language of autonomy and choice.

The impact of male violence on women as a group is pervasive: in Australia one in three women report having experienced violence at some time in their lives, frequently at the hands of a current or previous

⁴⁸ C. Smart, 'Law's Power, the Sexed Body, and Feminist Discourse' (1990) 17 *Journal of Law and Society* 194 at 201. However, the relationship between psychoanalysis and the socio-historical concerns of feminism is controversial: see T. Brennan, 'An Impasse in Psychoanalysis and Feminism' in S. Gunew (ed) *A Reader in Feminist Knowledge* (Routledge 1991).

⁴⁹ See, for example, T. Grillo, 'Anti-Essentialism and Intersectionality: Tools to Dismantle the Master's House' (1995) 10 *Berkeley Women's Law Journal* 16.

⁵⁰ See, for example, R.W. Connell, *Gender and Power: Society, the Person and Sexual Politics* (Polity Press 1987); L. Segal, *Slow Motion: Changing Masculinities, Changing Men* (Virago 1990).

⁵¹ R. Rowland and R.D. Klein, *supra*, n. 45 at 298. Indeed, Carol Smart, for example, notes that 'women have resisted and negotiated constructions of gender' and warns that 'we should not slip into a new form of determinism which suggests that, because power constructs, it produces women in some predetermined, calculated, powerless form'. C. Smart, 'The Woman of Legal Discourse', in N. Naffine (ed) *Gender and Justice* (Ashgate 2002) 30 at 40.

sexual intimate.⁵² Although both male and female victims of homicide are most at risk from family members, an analysis of homicides in New South Wales (NSW), Australia, between 1968 and 1981 revealed that '[b]oth as a proportion of their sex, and in absolute numbers, females were far more likely than males to die in domestic homicides'.⁵³

An undercurrent of male domination and sex stereotyping appears to drive patterns of violence against women. For example, in the NSW study an 'overwhelming feature of many such killings, particularly those of wives and lovers, was the widespread use of violence by men to control their wives' activities'.⁵⁴ The same study revealed that 'men were five times more likely than women to kill lovers and/or sexual rivals'.⁵⁵ In an Australia-wide study, nearly 60% of femicides were committed by a sexual partner, and 90% of these killings were precipitated by domestic arguments, desertion, termination of a relationship, jealousy and/or rivalry.⁵⁶ Another study of homicides in Victoria, Australia, between 1985 and 1989 revealed that the common feature of male homicide of sexual intimates was the way in which men viewed women as possessions. Most of these femicides were the man's attempt to exert control over the woman, often as the result of jealousy. There were no cases of a woman killing a partner out of jealousy.⁵⁷

An in-depth analysis of 110 adult sexual intimate homicides in NSW and Victoria disclosed similar themes. Twenty-one cases out of the 87 with male offenders were characterised by a type of 'obsessive possessiveness' and exertion of control or power.⁵⁸

⁵² 'Some 45% of sexual violence and some 55% of physical violence [against women] was committed by a current partner, a previous partner or a boyfriend/girlfriend or date'. Data derived from the Australian Bureau of Statistics, *Women's Safety Australia* (Commonwealth of Australia 1996), quoted in Graycar and Morgan, *supra*, n. 47 at 303.

⁵³ A Wallace, *Homicide: The Social Reality* (NSW Bureau of Crime Statistics and Research 1986), quoted in D. Brown, D. Farrier, S. Egger and L. McNamara, *Criminal Laws* (The Federation Press 2001), at 492.

⁵⁴ *Ibid.* at 494.

⁵⁵ *Ibid.* at 492.

⁵⁶ J. Mouzos, *Homicidal Encounters: A Study of Homicide in Australia 1989–1999*, (Australian Institute of Criminology 2000) quoted in D. Brown *et al.*, *supra*, n. 53 at 496; Similarly in Australia in 1999–2000: 'almost half of all female victims . . . were killed as a result of a domestic altercation, jealousy or termination of a relationship', J. Mouzos, *Homicide in Australia 1999–2000* (Australian Institute of Criminology 2001) at 5.

⁵⁷ K. Polk, *When Men Kill: Scenarios of Masculine Violence*, (Cambridge University Press 1994) quoted in D. Brown *et al.*, *supra*, n. 53, at 497. See also K. Polk and D. Ranson, 'The Role of Gender in Intimate Homicide' (1991) 24 *Australian and New Zealand Journal of Criminology* at 15; J. Stubbs (ed) *Women, Male Violence and the Law* (Institute of Criminology 1994).

⁵⁸ P. Weiser Eastaerl, *Killing the Beloved: Homicide Between Adult Sexual Intimates* (Australian Institute of Criminology 1993) at 84–85.

Thus Bean argues that

control is always the primary warning sign for murder. It is also the number one warning signal for violence. Murder is the final irrevocable step, the ultimate expression of men's control over women. For some men, the need for control is not satisfied until this irrevocable step is taken.⁵⁹

Female euthanasia and assisted suicide need to be considered within this context of pervasive male violence against women, particularly against intimates. Wolf cautions:

Before we license physicians to kill their patients or to assist patients in killing themselves, we had better understand the dynamics at work...We had better understand what distinguishes this from other forms of private violence, and other relationships of asymmetrical power that result in the deaths of women.⁶⁰

I would point out, however, that what is remarkable is not what *distinguishes* female assisted death from forms of violence against women. Rather, research points to some striking similarities between the broader patterns of male violence against women and at least one form of assisted death: mercy killing.

3. Mercy Killing

Mercy killing is typically defined as intentional killing carried out with compassionate motives. Frequently, the mercy killers are family or friends of the person killed. A higher incidence of female death is evident in mercy killings. A study of 102 mercy killings in the US between 1960 and 1993 reveals that 65% of the deaths were women.⁶¹ In accordance with the general homicide patterns,⁶² the majority of those who did the killing were men, that is 70%. They were most often in a spouse/partner relationship with the women they killed.⁶³

⁵⁹ C. Bean, *Women Murdered by the Men They Loved* (Harrington Park Press 1992) at 43, quoted in *ibid* at 91.

⁶⁰ S.M. Wolf, 'Gender, Feminism, and Death: Physician-assisted suicide and Euthanasia' in S.M. Wolf (ed.) *Feminism and Bioethics Beyond Reproduction* (Oxford University Press 1996) 282–317, at 284–285.

⁶¹ S.S. Canetto and J.D. Hollenshead, 'Older Women and Mercy Killing' (2000–2001) 42 *OMEGA* 83 at 86.

⁶² For example, in NSW, Australia between 1968 and 1981, 85% of homicide offenders were men: A. Wallace, *supra*, n. 53 at 492.

⁶³ S.S. Canetto and J.D. Hollenshead, *supra*, n. 61 at 87.

The gender incidence is consistent with that reported by an Australian study on mercy killings.⁶⁴ The same pattern is also evident in homicide-suicides among the elderly, which are commonly regarded as mercy killings, because the victim, and sometimes the perpetrator, is usually sick and/or disabled. One study of four medical examiner districts in Florida uncovered 171 homicide-suicides between 1988 and 1994. Of these, 58 (34%) were committed by people over 55. Without exception, the perpetrators were men who killed women, most often their wives or female partners.⁶⁵

Similarly, a newspaper surveillance study of homicide-suicides across the United States from 1997 to 1999 revealed 152 homicide-suicides by older perpetrators, 95.4% of whom were men who killed women, again usually their wives or partners.⁶⁶ An Australian study of homicide-suicide between sexual intimates discloses a similar incidence pattern among the elderly.⁶⁷

The preponderance of women who die by mercy killing runs contrary to the general homicide patterns where men make up the vast majority of homicide victims.⁶⁸ Thus, while in most homicides, men are more likely to be the killers and more likely to kill males, when it comes to mercy killings, men are significantly more likely to kill a woman than another man.⁶⁹ Put another way, women's experience of mercy killing is overwhelmingly at the hands of men. Striking too is the fact that the women killed are almost without exception the spouse or lover of the mercy killer. The pattern of mercy killing correlates precisely with the broader pattern of women's experience of male violence discussed above: death at the hands of a male intimate.

There are other reasons to support my argument that mercy killing is gendered killing. The same themes of domination, possessiveness and control that underlie violent crime against women are characteristic of mercy killings. Cohen states that about 50% of mercy killings among the elderly occur in relationships with a high degree of mutual

⁶⁴ M. Otlowski, 'Mercy Killing Cases in the Australian Criminal Justice System' (1993) 17 *Criminal Law Journal* at 10.

⁶⁵ D. Cohen, M. Llorente and C. Eisdorfer, 'Homicide-Suicide in Older Persons' (1998) 155 *American Journal of Psychiatry* 390 at 392.

⁶⁶ J.E. Malphurs and D. Cohen, 'A Newspaper Surveillance Study of Homicide-Suicide in the United States' (2002) 23 *The American Journal of Forensic Medicine and Pathology* 142 at 146, 147.

⁶⁷ Weiser Easteal, *supra*, n. 58 at 53.

⁶⁸ For example, in NSW, Australia between 1968 and 1981, 64% of homicide victims were men: A. Wallace, *supra*, n. 53 at 491.

⁶⁹ And '... females were likely as to kill a female as a male ... Females were more likely to be killed by a male than by a female ... while males were equally likely to be killed by a male or female.' S.S. Canetto and J.D. Hollenshead, *supra*, n. 61 at 88.

dependence, where the man is dominant and fears losing control of his ability to care for his ailing wife. In another 20% of cases, there is an extreme interdependency, one or both are very sick and the 'male perpetrator is often the dominant personality and the female victim is often submissive'. The remaining 30% of cases might be characterised as 'classic' domestic violence. They involve a history of conflict and aggression, commonly precipitated not by illness, but by events such as pending or actual separation, or the issuance of a restraining order.⁷⁰

Similarly, the older age perpetrators who killed sick wives or partners in the NSW and Victorian study 'also conformed to a certain extent to the male 'ownership' violence motif'.⁷¹ These men perceived their partner as 'an integral part' of themselves.⁷² Just as the women who separated from their partners were no longer willing to play the same role in the relationship, the sick women were no longer able to assume their expected role.⁷³

It is important to point out that these homicide-suicides do not necessarily occur with mutual knowledge and consent, as is commonly assumed. In one significant study, most of the women were shot in their sleep. These mercy killings were almost without exception involuntary on the part of the woman. They were not suicide pacts.⁷⁴

The research I have presented here defies the very notion of 'mercy killing'. Rather, it points to killings animated by domination, possessiveness and control, redolent of wider cultural themes:

Our culture ... draws a close connection between men, physical coercion and the legitimate exercise of authority, usually in order to exert control over another ... Often, this authority is depicted as perfectly appropriate ... vulnerability to force is nearly always given a female form ... Female vulnerability is often invoked to strengthen both our sense of male power and the need for its considered use ... to protect women ... Indeed, women seem to play a vital role in the demonstration of male potency ...⁷⁵

⁷⁰ D. Cohen, 'Homicide-Suicide in Older People' (2000) 17 *Psychiatric Times* 49 <<http://www.psychiatrictimes.com/p000149.html>> at 8 August 2006.

⁷¹ Weiser Easteal, *supra*, n. 58 at 91.

⁷² *Ibid.* at 108.

⁷³ *Ibid.* at 108.

⁷⁴ D. Cohen, 'An Update on Homicide-Suicide in Older Persons: 1995–2000' (2000) 6 *Journal of Mental Health and Aging* 195 at 197. Suicide pacts do occur in the elderly, but are very rare events, representing less than 0.1% of all dyadic deaths: D. Cohen, 'Homicide-Suicide in Older People' (2000) 17 *Psychiatric Times* 49–52 cited in J.E. Malphurs and D. Cohen, 'A State Wide Case-Control Study of Spousal Homicide-Suicide in Older Persons' (2005) 13 *American Journal of Geriatric Psychiatry* 211 at 212.

⁷⁵ N. Naffine, *Feminism and Criminology* (Allen and Unwin 1997) at 146–147.

The construction of these killings as merciful, the loving deliverance of suffering women—against all evidence to the contrary—serves to legitimate the coercive use of male power against women.

In sum, mercy killing reflects gendered patterns of violence. Firstly, the incidence and demographics of mercy killing match those of masculine violence against women generally. Secondly, mercy killings are characterised by the same themes of domination, possessiveness and control which animate other killings of women by men. Usually, there is no consent from the female victims. There is no research which points to similar correlations with euthanasia and physician-assisted suicide. Nonetheless, these insights must challenge the theory that women who decide for euthanasia and physician-assisted suicide are always exercising autonomy. We need to ask *why* they make that decision.

D. Acquiescence to Gendered Expectations of Feminine Altruism

Women's decisions for assisted death should also be considered in light of cultural influences that idealise femininity in terms of self-effacement and self-sacrifice. Women may decide for assisted death to spare their loved ones—especially men—the burden of care.

1. The Ideal of Feminine Self-Sacrifice

Canetto and Hollenshead as well as Wolf point to the analysis of Carol Gilligan who identified a psychology of self-sacrifice among women.⁷⁶

... while society might affirm publicly the woman's right to choose for herself, the exercise of such choice brings her privately into conflict with the conventions of femininity, particularly the moral equation of goodness with self-sacrifice. Although independent assertion in judgment and action is considered to be the hallmark of adulthood, it is rather in their care and concern for others that women have both judged themselves and been judged.⁷⁷

According to Gilligan, in the process of moral development, women come to learn the legitimacy of their own self-interest and the need to care not only for others, but also for themselves.⁷⁸ Yet, there is still the 'continuing power for women of the judgment of selfishness and the morality of self-abnegation ... the continuation through time of an ethic of responsibility as the center of women's moral concern ...'⁷⁹

⁷⁶ S.S. Canetto and J.D. Hollenshead, *supra*, n. 25 at 187; S.M. Wolf, *supra*, n. 60 at 289.

⁷⁷ C. Gilligan, *In a Different Voice, Psychological Theory and Women's Development* (Harvard University Press 1982) at 70.

⁷⁸ *Ibid.* at 149.

⁷⁹ *Ibid.* at 131–132.

Some critics have claimed that there is little evidence for Gilligan's theory and have questioned her methodology.⁸⁰ Is the 'morality of self-abnegation' distinctively female? Some argue that Gilligan has failed 'to demonstrate a quantitative difference in the proportion of the two sexes who show the characteristics in question'.⁸¹ However, even some of those who question Gilligan's empirical rigour admit that the stereotype of female self-sacrifice resonates strongly:

It is clear that women have a greater *reputation* for altruism and empathy than do men, and that women accept its validity. Whether the reputation is deserved is a more complicated question.⁸²

The qualities of self-effacement and self-sacrifice also characterise the 'good woman' of legal discourse, according to Naffine:

She is loyal and loving, compliant and altruistic ... good women can be distinguished by their abandonment of their own interests and their overriding concern for the interests of family members.⁸³

This ideal of female self-sacrifice finds expression in the Western cultural tradition. An analysis of Greek tragedy demonstrates that suicide is portrayed as a uniquely female solution, an expression of self-sacrificing devotion to loved ones. According to Loraux, wives decide for suicide in these tragedies to join men in death. Very few men die in this way.⁸⁴ Other historical sources confirm this practice in the Greek and

⁸⁰ See, for example, Mary Jeanne Larrabee, 'Gender and Moral Development: a Challenge for Feminist Theory' in Mary Jeanne Larrabee (ed.) *An Ethic of Care, Feminist and Interdisciplinary Perspectives* (Routledge 1993) at 5; Mary Brabek, 'Moral Judgment: Theory and Research on Differences between Males and Females' in Mary Jeanne Larrabee (ed.) *An Ethic of Care, Feminist and Interdisciplinary Perspectives* (Routledge 1993) at 45.

⁸¹ Catherine G. Greeno and Eleanor E. Maccoby, 'How Different Is the "Different Voice?"' in Mary Jeanne Larrabee (ed.) *supra*, n. 80 at 197.

⁸² Catherine G. Greeno and Eleanor E. Maccoby, 'How Different Is the "Different Voice?"' in Mary Jeanne Larrabee (ed.) *ibid* at 196. Similarly, Friedman sees female altruism less as an empirical fact than as a powerful ideological construct: M. Friedman, *What Are Friends For? Feminist Perspectives On Personal Relationships and Moral Theory* (Cornell University Press 1993) in R. Tong, *Feminine and Feminist Ethics* (Wadsworth Publishing Company 1993).

⁸³ N. Naffine, *Law and the Sexes: Explorations In Feminist Jurisprudence* (Allen and Unwin 1990) at 137. Similarly, Carlen and Worrall see the construction of the 'normal woman' as 'coping, caring, nurturing and sacrificing self-interest to the needs of others.' P. Carlen and A. Worrall, *Gender, Crime and Justice* (Open University 1987) at 3.

⁸⁴ N. Loraux, *Tragic Ways of Killing a Woman* (Harvard University Press 1987) at 8. Outside of tragic literature, there are cases of male altruistic suicide in Greek and Roman culture, but rarely motivated by self sacrifice for the sake of loved ones

Roman worlds. Women—inferiors subjected to ‘oppressive social forces’—are the only documented cases of spouses who commit suicide after the death of their loved one.⁸⁵ Alcestis, who gave her life in place of her husband’s to ensure the continuation of his house, became an icon for other women whose epitaphs attest to their self-sacrifice at her inspiration.⁸⁶ The theme of the self-sacrificing, loyal wife was so familiar that it was used in the training of young orators.⁸⁷ Young women who were virgins were also sacrificed, and the person putting them to death had to be male.⁸⁸

The ideal of feminine self-sacrifice also appears in non-Western cultures. Biggs highlights the Inuit and Cheyenne of North America who would abandon elderly or sick women no longer able to perform their assigned caregiver roles.⁸⁹ Lester points to the Indian practice of suttee where a widow was expected to die on her husband’s funeral pyre.⁹⁰ Social and economic pressures meant ‘the life of a widow was so bad... that women perhaps favoured death to humiliation’.⁹¹ Similar practices were recorded in Kaliai, New Britain and New Guinea, where elderly widows of deceased tribal leaders were killed at their own request, often by their son.⁹² Lester comments:

... rather than seeing such an act as having been willingly chosen by an autonomous person, it is possible to interpret this behaviour as

which appears to be more characteristically female. Male altruistic suicides were usually social inferiors such as male servants who loyally followed their masters to death. There are also cases of male (and female) self sacrifice to save another person or a whole community, for example, to stave off a curse: see A. van Hooff, ‘Pactus, It Does Not Hurt: Altruistic Suicide in the Greco-Roman World’ (2004) 8 *Archives of Suicide Research*, 43. A tradition of obligatory male suicide existed in some primitive societies. Durkheim identified cultural norms in societies such as the ancient Goths that expected old or sick men to suicide: see S. Stack, ‘Emile Durkheim and Altruistic Suicide’ (2004) 8 *Archives of Suicide Research* 9 at 12.

⁸⁵ A. van Hooff, *supra*, n. 84 at 49, 50.

⁸⁶ *Ibid.* at 55.

⁸⁷ *Ibid.* at 49.

⁸⁸ N. Loraux, *supra*, n. 84 at 12.

⁸⁹ However, men might also be abandoned if they had broken the law, for example: H. Biggs, ‘I Don’t Want To Be a Burden! A Feminist Reflects on Women’s Experiences of Death and Dying’ in S. Sheldon and M. Thomson (eds.) *Feminist Perspectives On Health Care Law* (Cavendish Publishing Limited 1998), 279–295, at 288–289.

⁹⁰ D. Lester, ‘Assisted Suicide and the Elderly’ in D. Lester (ed.) *Now I Lay Me Down: Suicide in the Elderly* (Charles Press Publications 1993) at 232–233. Committing suttee was believed to guarantee the woman, her husband and seven generations of her family direct access to heaven, thus releasing them from the painful cycle of birth and rebirth: L. Vijayakumar, ‘Altruistic Suicide in India’ (2004) 8 *Archives of Suicide Research* 73 at 76.

⁹¹ *Ibid.* at 77.

⁹² D. Lester, *supra*, n. 90 at 232–233.

the result of extreme conformity to sexist oppression ... While widow-suicide has been a cultural practice, there has been no custom of widower-suicide.⁹³

There are indications that a psychology of self-sacrifice and the fear of being a burden influence some patients in their decisions for assisted death.

In one study, 38.3% of 155 oncology patients approved of physician-assisted suicide, and 36.7% approved of euthanasia if the patient's sickness and death would place a burden on the family.⁹⁴ In a survey of AIDS and cancer patients, 60% said that they would not wish to live for more than 30 days if they were totally dependent on others.⁹⁵ Similarly, 82% of 62 terminally ill cancer patients surveyed believed that most cancer patients become a burden on their families. This perception was matched by their acceptance of assisted death,⁹⁶ a correlation noted in other studies.⁹⁷

These studies do not indicate in what proportion these are the attitudes of men or the attitudes of women. But if self-sacrifice is perceived as a particularly feminine virtue, we might expect a strong female identification with these attitudes. All the more so when it is considered that caregiving responsibilities fall disproportionately on women who may be unwilling to accept the role reversal that comes with their own serious illness.

... those women who feel they have nothing left to offer society once they are no longer required to care for others can experience a desire to withdraw from society in order to avoid becoming a burden when they need to be cared for themselves. This desire may be satisfied if euthanasia were readily available.⁹⁸

⁹³ *Ibid.* at 233.

⁹⁴ E.J. Emanuel, D.L. Fairclough, E.R. Daniels and B.R. Clarridge, 'Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public' (1996) 347 *The Lancet* at 1807.

⁹⁵ L.J. Schneiderman, R. Kronick, R. Kaplan, J.P. Anderson and R.D. Langer, 'Attitudes of Seriously Ill Patients Toward Treatment That Involves High Costs and Burdens on Others' (1994) 5 *Journal of Clinical Ethics* 109.

⁹⁶ M.E. Suarez-Almazor, M. Belzile and E. Bruera, 'Euthanasia and Physician-Assisted Suicide: A Comparative Survey of Physicians, Terminally Ill Cancer Patients, and the General Population' (1997) 15 *Journal of Clinical Oncology* 418.

⁹⁷ E.J. Emanuel, D.L. Fairclough and L.L. Emanuel, 'Attitudes and Desires Related to Euthanasia and Physician-Assisted suicide Among Terminally Ill Patients and Their Caregivers' (2000) 15 *The Journal of the American Medical Association* 2460; E.J. Emanuel, D. Fairclough, J. Slutsman, E. Omandsun and L.L. Emanuel, 'Predictors and Outcomes of Significant Caregiving Needs and Economic Burdens Among Terminally Ill Oncology Patients: Results of the Commonwealth-Cummings Project' (1998) 17 *Journal of Clinical Oncology* 422a.

⁹⁸ H. Biggs, *supra*, n. 89 at 289. See a similar argument in L.M. Kohm and B.N. Brigner, *supra*, n. 41 at 260-261.

The fear of being a burden was a prominent reason for deciding for death amongst Dr Kevorkian's suicides that were dominated by women. Ten patients (or 13%) 'anticipated, did not want to, and/or could not afford to be dependent on others'.⁹⁹ Of these 10 patients, 8 were women.¹⁰⁰ This ethic of self-sacrifice is encapsulated by the comments of a friend of one of the suicides: 'She felt it was a gift to her family, sparing them the burden of taking care of her'.¹⁰¹

2. Male Caregivers and Depression

Women's concerns about the caregiving burden are not unfounded. For some men, caregiving responsibilities are so overwhelming that they precipitate the homicide of female patients, particularly among the elderly. In one study of homicide-suicide among the over 55s, approximately half of the male perpetrators were caregivers. In comparison, only 13% of age-matched married men who committed suicide (and not homicide) fulfilled the caregiving role.¹⁰² Similarly, a newspaper surveillance study of homicide-suicides across the United States from 1997 to 1999 found that 31.6% of older perpetrators were caregivers. However, only 2% of younger perpetrators in this study were caregivers, impending divorce or separation being the key co-factors.¹⁰³ In other studies, physical ill health is also an important associative factor among the elderly.¹⁰⁴

The burden of caregiving is closely linked to another co-factor: depression. At least half of the perpetrators in a Florida study of homicide-suicide had undiagnosed and untreated psychiatric problems.¹⁰⁵ Another Florida study of 20 spousal homicide-suicides among the elderly found that 65% of the perpetrators (all men) were reported to have had depressed mood before their death.¹⁰⁶ The authors point out:

Elevated risks for depression have long been associated with the care giving role, and husbands who care for their wives have

⁹⁹ S.S. Canetto and J.D. Hollenshead, *supra*, n. 25 at 179.

¹⁰⁰ *Ibid.* Table 4 at 178.

¹⁰¹ *Ibid.* at 180.

¹⁰² D. Cohen, *supra*, n. 70.

¹⁰³ J.E. Malphurs and D. Cohen, *supra*, n. 66 at 147. A similar pattern is evident in another study, J.E. Malphurs and D. Cohen, *supra*, n. 74 at 213.

¹⁰⁴ See, for example, C.M. Milroy, M. Dratsas and D.L. Ranson, 'Homicide-Suicide in Victoria, Australia' (1997) 18 *American Journal of Forensic Medicine and Pathology* 369 at 369.

¹⁰⁵ D. Cohen, M. Llorente and C. Eisdorfer, 'An Analysis of Contemporary State Statutes About Assisted Suicide' (1998) 155 *American Journal of Psychiatry* 390 at 393.

¹⁰⁶ J.E. Malphurs and D. Cohen, *supra*, n. 74 at 213.

shown evidence of increased marital stress, reduced psychological well-being, and increased levels of depression.¹⁰⁷

Depression was also a significant factor in the homicide-suicides of older aged sexual intimates in the NSW and Victorian study.

... the final tragic act seemed to be generated out of feelings of depression and the inability to accept an almost complete role reversal in the marriage: the former nurturer wife requiring full-time care and no longer able to take care of the husband.¹⁰⁸

The impact of caregiving responsibilities on men is underscored by the fact that 'there were no homicides committed by older women in similar situations'.¹⁰⁹

With this evidence that the caregiving burden and associated depression (often unrecognised or untreated) can trigger the homicide of women patients, we must consider whether the same forces might influence women's seemingly autonomous decisions for assisted death. For some women, their experience of the male caregiver's stress could reinforce the psychology of self-sacrifice identified above, and at least partly explain their decisions for assisted death. Seriously ill patients themselves suffer high rates of depression, and their carer's depression might well sanction their own suicidal desires. In this context, decisions for assisted death might be less about autonomy than acquiescence to gendered expectations of feminine altruism and the pressures of caregiving.

E. Assisted Death is a 'Feminine' Way to Suicide

1. Social Acceptability of 'Passive, Compliant' Female Suicides

Suicidologists suggest that the incidence of different types of suicidal acts is influenced by their social and cultural acceptability.¹¹⁰ For example, non-fatal suicidal behaviour is most acceptable and most common in young women; fatal suicidal behaviour is most permissible and most frequent in elderly males.¹¹¹

¹⁰⁷ *Ibid.* at 215.

¹⁰⁸ Weiser Easteal, *supra*, n. 58 at 101.

¹⁰⁹ *Ibid.* at 91.

¹¹⁰ See studies cited in S.S. Canetto, *supra*, n. 40 at 225.

¹¹¹ *Ibid.* at 226. There is other evidence that points to the influence of the sociocultural context on methods of suicide. Hendin sees a connection between the sociocultural acceptance of guns in the United States and the frequency of their use as a method of suicide. Similarly, because men's use of firearms has greater social acceptance, they are more likely than women to choose firearms as a method of suicide. Hendin has noted that in New York City the chosen method for 50% of African-American suicides is jumping from buildings. 'So much of the life of Harlem is lived in and on top of these tenements that they occupy the conscious and unconscious life of their

Overall, fatal (self-inflicted) suicidal behaviour in females is socially less acceptable than fatal suicidal behaviour in males, and is less common.¹¹² Canetto points to research indicating that this is because self-inflicted suicide subverts cultural stereotypes of femininity:

... women who take their own lives ... may be perceived negatively because, by taking ownership of their body and control of their destiny, they challenge the assumption of femininity as passive and compliant.¹¹³

This is supported by the observations of some feminist theorists that men are typically identified with active characteristics and behaviours (tenacity, aggression, competitiveness) and women with passive behaviours (obedience, responsiveness to approval, kindness, submission, willingness to be led), reinforcing male power and female submission.¹¹⁴ Thus, one explanation of women's reasons for favouring euthanasia and physician-assisted suicide is that these methods make suicidal death appear 'passive and compliant' and, therefore, compatible with cultural stereotypes of femininity.¹¹⁵

There is some evidence to support this explanation. Firstly, as I discussed earlier, the distinct gender patterns in preferences about assisted death methods revealed by the empirical data. Physician-assisted suicide is more likely to be chosen by men than by women. Women demonstrate a stronger preference for the more passive method of euthanasia. Similarly, in the Kevorkian deaths, women strongly preferred the more passive, structured method of death by lethal injection.

The incidence of female self-inflicted suicide compared with the incidence of female assisted death also supports the explanation. In self-inflicted suicides, the people killing themselves must assume an active role. The vast majority of these suicides are men. Thus in the United States, for example, women are less likely to kill themselves than men by a ratio of 1:4.¹¹⁶ This ratio has remained constant since 1989 and 'is consistent with international patterns, with the exception

inhabitants and come to provide a tragic setting for black suicide': H. Hendin, *Suicide in America* (1982 W.W. Norton & Co) quoted in H.I. Kushner, 'Women and Suicide in Historical Perspective', in J. McCarl Nielsen (ed.) *Feminist Research Methods* (Westview Press 1990) 193-206, at 201.

¹¹² S.S. Canetto, *supra*, n. 40 at 226.

¹¹³ S.S. Canetto, *supra*, n. 40 at 225.

¹¹⁴ See, for example, Hester Eisenstein, *Contemporary Feminist Thought* (G.K. Hall 1983) quoted in R. Putnam Tong, *Feminist Thought: A More Comprehensive Introduction* (Westview Press 1998) at 49; R. Rowland and R.D. Klein *supra*, n. 45 at 278.

¹¹⁵ S.S. Canetto, *supra*, n. 40 at 227.

¹¹⁶ S.S. Canetto and J.D. Hollenshead, *supra*, n. 25 at 182.

of rural China'.¹¹⁷ Yet, as I have outlined in Part II, the incidence of assisted death by women in the Netherlands, Oregon and elsewhere is nearly four times that of female self-inflicted suicide in the United States. It is clear that increasing numbers of women decide to die when offered the more passive options of euthanasia or physician-assisted suicide.

There is also the observation, noted at the beginning of this paper, that the assisted deaths that receive prominent media exposure are predominantly women. Canetto and Hollenshead point to pro-euthanasia literature that most often uses women as models or case studies of assisted death.¹¹⁸ Wolf argues:

... even while we debate physician-assisted suicide and euthanasia rationally, we may be animated by unacknowledged images that give the practices a certain gendered logic and felt correctness.¹¹⁹

The studies analysed here challenge the notion that women's decisions for assisted death are unambiguous expressions of autonomy and choice. The decisions for death of some women could reflect the influence of socio-cultural forces that uphold a perception of femininity as passive and compliant, a stereotype that reinforces gendered power differentials.

2. Assisted Death 'Plays Out' Male Dominance and Female Subjugation

Women's experience of power imbalance and gender domination could be 'played out' in a clinical relationship and explain the decision for assisted death. Wolf points to the paternalism which still pervades the medical profession and has a particular impact on female patients:

When the patient is female and the doctor male, as is true in most medical encounters, the problem is likely to be exacerbated by the background realities and history of male dominance and female subjugation in the broader society.¹²⁰

Thus, a male physician's own cooperation with a woman's request for death might reflect entrenched gender roles. His assessment of the

¹¹⁷ L.H. Chaudron and E.D. Caine, 'Suicide Among Women: A Critical Review' (2004) 59 *Journal of the American Medical Women's Association* 125 at 126.

¹¹⁸ S.S. Canetto and J.D. Hollenshead, *supra*, n. 61 at 95–96.

¹¹⁹ S.M. Wolf, *supra*, n. 60 at 289. Kaplan *et al.* suggest another possible interpretation of the pattern in gender preferences for death. They argue that research indicates women 'tend to receive and utilize social supports more than men ... It would be reasonable, then, that women considering a hastened death may be more sensitive to physician support and control than men.': Kaplan, Harrow, Schneiderhan, *supra*, n. 7 at 40.

¹²⁰ S.M. Wolf, *supra*, n. 60 at 293.

meaninglessness or burden of her life might be influenced by the same sexism that could have influenced her request in the first place.

There is evidence that the attitudes of doctors can and do influence their patients' preferences in end-of-life decisions and even their patients' suicides.

Miles refers to several studies demonstrating that doctors underestimate the quality of a patient's life compared with the patient's perception. Largely on this basis, doctors wrongly infer that such patients would decide to abstain from life prolonging interventions. The complex emotions of a difficult clinical relationship can also cause a doctor to legitimate suicidal ideation that may precipitate suicides. This is confirmed by a more recent Australian study of 252 doctor-patient relationships:

where there is a greater perception of a patient's emotional distress and hopelessness, combined with a doctor's limited psychological training and his or her own difficulty in caring for the patient, the doctor may be more inclined to hasten the death of the patient.¹²¹

Moreover, Miles says that doctors may develop an inflated confidence in their insights regarding suicidal patients and proceed to the 'unacknowledged medical enabling of suicidal choices'.¹²² There was a similar finding in the Australian study: 'an attitude that conveys endorsement of the wish to hasten death on the part of the doctor may facilitate that stance on the part of the patient'.¹²³ Miles concludes that there is support for concerns that:

a patient's suicidal decision can at least partly arise in response to a physician's need for release from a painful clinical relationship, rather than as an independent patient's choice.¹²⁴

Women's preferences for more structured, passive deaths at the hands of their physicians could be evidence of gender dynamics at play. Is there a sense that dying in such a way is more 'feminine' and deferential, more befitting of a woman's gender role, and the gender role

¹²¹ B.J. Kelly, P.C. Burnett, D. Pelusi *et al.*, 'Association Between Clinician Factors and a Patient's Wish to Hasten Death: Terminally Ill Cancer Patients and Their Doctors' (2004) 45 *Psychosomatics* 311-318 at 317.

¹²² S.H. Miles, 'Physicians and Their Patient's Suicides' (1994) 271 *Journal of the American Medical Association* 1786 at 1786.

¹²³ B.J. Kelly, P.C. Burnett, D. Pelusi *et al. supra*, n. 121 at 317.

¹²⁴ S.H. Miles. *Ibid.*

of her (more often than not) male physician? One commentator has observed that:

The fatal attraction for the women who used the Kevorkian techniques . . . is that it offered them a passive way to end their life with the approval of a paternalistic figure.¹²⁵

F. Women have Limited Access to Health Care

Canetto and Hollenshead argue that women's decisions for assisted death are influenced by their entrenched social and economic disadvantage that limits their options for care.

Women enter mid- to late-adulthood, the time when decisions about hastened death are most likely to occur, with vastly different personal, social and economic resources than men . . . older women are more likely than older men to suffer from disabling chronic diseases . . . older women are more likely to be poor, widowed, live alone, and to have limited access to . . . family care . . . As a result, they may be more likely to see themselves, and/or be seen by others, as appropriate candidates for a hastened death.¹²⁶

There is evidence that care assistance is less available to women:

Women provide most of the care that is given to dying patients, although women who need care tend to receive less assistance from family members than men, and are more likely to have to pay for assistance even if married . . . Wives are only one third as likely as husbands to report their spouses as caregivers . . .¹²⁷

There are indications that economic disadvantage does influence decisions at the end of life, with one report stating that in 7.9% of actual cases of euthanasia and physician-assisted suicide in the United States, financial burden was a 'core motive'.¹²⁸ Such economic disadvantage falls disproportionately upon women. The suggestion is that some 'choices' for assisted death may be influenced by lack of choice.

There are also indications that women have less access to healthcare than men. For example, a number of studies show that in the US women receive fewer cardiac treatments and procedures than men and have worse outcomes.¹²⁹ Women are also more likely than men to

¹²⁵ H.M. Bratt, 'Passive Way to End Life Lures Women', *The Detroit Free Press* (Detroit, 25 October 1991), quoted in S.S. Canetto and J.D. Hollenshead, *supra*, n. 64 at 193.

¹²⁶ S.S. Canetto and J.D. Hollenshead, *supra*, n. 25 at 186.

¹²⁷ L.A. Roscoe, J.E. Malphurs, L.J. Dragovic and D. Cohen, *supra*, n. 43 at 444.

¹²⁸ E.J. Emanuel, E.R. Daniels, D.L. Fairclough and B.R. Clarridge, *supra*, n. 28 at 510.

¹²⁹ For example, J.G. Canto, W.J. Rogers, N.C. Chandra *et al.*, 'The Association of Sex and Payer Status on Management and Subsequent Survival in Acute Myocardial

suffer inadequate pain control.¹³⁰ However, studies also suggest the converse:

On average, women visit physicians more frequently, use more preventative and curative drugs, are more likely to have a regular doctor and undergo general medical check-ups than men.¹³¹

Others argue that low class position and low income are more determinative of inequalities in health than is gender. One British study demonstrates that 'structural inequalities in health are equally pronounced for women and men in later life'.¹³²

G. Conclusion: Why do Women Decide for Assisted Death?

I have examined some of the explanations advanced for women's decisions for assisted death. The available evidence for these explanations is complex and often conflicting. The explanation that women are particularly concerned about self-determination in death is undermined by the evidence of their more negative attitudes towards assisted death than men. Nor does the fact that women tend to live longer, suffer more disease, disability and isolation than men seem to explain women's motivation for assisted death.

The other explanations are indicative of a lack of autonomy and point to oppressive dimensions of women's socio-cultural context. Criminological studies identify themes of male domination, possessiveness, control and female subordination in patterns of violence against women. I have suggested a striking correlation with so-called 'mercy killings', which must lead us to question whether the same gender dynamics explain the decisions of some women for assisted death.

Another explanation highlights the ideal of feminine self-sacrifice that is strongly embedded in Western and some non-Western cultures. The high profile given to female assisted death could be a reflection of the same oppressive stereotype. This explanation also finds support in the evidence that a psychology of self-sacrifice and the fear of being a burden do influence some patients in their decisions for assisted death.

Infarction' (2002) 162 *Archives of Internal Medicine* 587; and see studies cited in Roscoe, Malphurs, Dragovic and Cohen, *supra*, n. 43 at 444.

¹³⁰ C.S. Cleeland, R. Gonin, A.K. Hatfield, *et al.*, 'Pain and Its Treatment in Out-Patients with Metastatic Cancer' (1994) 330 *New England Journal of Medicine* 592, quoted in L.A. Roscoe, J.E. Malphurs, L.J. Dragovic and D. Cohen, *supra*, n. 43 at 444. See also Kohm and Brigner, *supra*, n. 41 at 259-260.

¹³¹ J. Bookwala, K.M. Coppola, A. Fagerlin *et al.*, 'Gender Differences in Older Adults' Preferences For Life-Sustaining Medical Treatments and End-of-Life Values' (2001) 25 *Death Studies* 127 at 129.

¹³² S. Arber and J. Ginn, 'Gender and Inequalities in Health in Later Life' (1993) 36 *Social Science and Medicine* 33 at 37; and see studies cited therein at 33.

Evidence that stress and depression in male caregivers precipitates the homicide of female patients suggests that the same influences might motivate some women to decide for assisted death.

The data consistently show that women demonstrate a preference for more structured, passive methods of suicide. This requires explanation. One explanation might be that euthanasia and physician-assisted suicide are consonant with cultural stereotypes of women as passive and compliant, and play out gender expectations of subordination and dominance. And if there is evidence that the gender dynamics between a female patient and a male physician influence women's decisions about methods of assisted death, then they are likely to have some influence over the decision for assisted death in the first place. Finally, there is good evidence that women's relative social and economic disadvantage could influence their decision for death, although some evidence also points to the contrary.

However, in the absence of dedicated studies about male and female motivations for deciding for assisted death, no firmer conclusions can be drawn. There is at least preliminary evidence to challenge the theory that these deaths are simply expressions of free choice. For some women, assisted death might not demonstrate their autonomy, but their acquiescence to controlling influences. Further research is warranted.

IV. THE IMPACT OF LEGALISATION

If women are subject to controlling influences in their decisions for euthanasia and physician-assisted suicide, what is the effect of legalising these practices? Is the autonomy of women better protected under legalisation or under prohibition?

A. Legalise and Control?

On the one hand, the disturbing characteristics of some of the Kevorkian suicides, carried out under prohibition, suggest that assisted death is a practice 'crying out' for regulation. Sixty-nine per cent of Kevorkian's suicides were not at the terminal stage of their illness.¹³³ There was evidence of misdiagnosis by Dr Kevorkian and, in a number of cases, the coroner found no evidence of disease.¹³⁴ Twenty-three per cent of his suicides had current and/or past depression, emotional instability and/or other psychological problems.¹³⁵ There was also Dr Kevorkian's consistent violation of his own guidelines, such as his requirement that patients seeking death be examined

¹³³ S.S. Canetto and J.D. Hollenshead, *supra*, n. 25 at 176.

¹³⁴ *Ibid.* Table 1.

¹³⁵ *Ibid.* at 177.

by a psychiatrist. The over-representation of female suicides was also remarkable.¹³⁶

The authors of one of the Kevorkian studies note that their findings run counter to the trends in the Netherlands where assisted death is legal and regulated by specific guidelines. For example, as noted previously, overall in 1990, 1995 and 2001, 51% of assisted deaths were men and 49% women.¹³⁷ In 1990, 85% of Dutch assisted deaths were at the terminal stage of the patient's illness.¹³⁸ What the Kevorkian authors do not consider, however, is that these discrepancies between Dr Kevorkian's practices in the United States and those of the Netherlands parallel the degree of regulation to be found in those jurisdictions.

For most of the period 1990 to 1997, assisted death was illegal throughout the United States.¹³⁹ Over the same period in the Netherlands, voluntary euthanasia and physician-assisted suicide were decriminalised and permitted provided certain requirements were met.¹⁴⁰

This parallel may be evidence of the effectiveness of legalisation over prohibition in controlling, or at least curtailing, disturbing and potentially abusive practices that undermine patient autonomy. Recent research into the 'euthanasia underground' highlights one of the major criticisms of prohibition: that it creates a 'conspiracy of silence' where 'euthanasia is concealed and protected by an all-pervasive culture of deception', marked by a lack of medical professionalism and hidden decision making.¹⁴¹ The Kevorkian suicides reflect these criticisms. It might be expected that legalisation would have the advantage of making assisted death more visible, doctors more accountable and patients and the autonomy of their decision making thus better protected.

B. Legalisation: Reasons for Caution

However, there are also reasons for caution in considering the option of legalisation.

1. Revisionist Practitioners

The Kevorkian deaths may be interpreted as evidence of the 'revisionist' practitioner: the practitioner who will resist legal interference in

¹³⁶ *Ibid.* at 165.

¹³⁷ Percentages calculated from Table 3, B.D. Onwuteaka-Philipsen, A. van der Heide, D. Koper *et al.*, *supra*, n. 11.

¹³⁸ S.S. Canetto and J.D. Hollenshead, *supra*, n. 25 at 182.

¹³⁹ The legalisation of physician assisted suicide took effect in Oregon on 27 October 1997: see R. Steinbrook, 'Physician-assisted suicide in Oregon—An Uncertain Future' (2002) 346 *New England Journal of Medicine* 460.

¹⁴⁰ R. Magnusson, *supra*, n. 2 at 64.

¹⁴¹ *Ibid.* at 254–255.

any form, whether it is prohibition or guidelines under legalisation. This is evident in the 'euthanasia underground' research. Revisionist practitioners performed euthanasia and physician-assisted suicide, but rejected the idea of legalised guidelines as a bureaucratic intrusion into their clinical discretion.¹⁴² In other words, whether assisted death is prohibited or legalised, the efforts of the law to control these practices will always be challenged by the revisionists who will perform assisted death when and how they judge appropriate.

2. Hidden Practices Remain Hidden

There are also indications that even under legalised guidelines the most problematic cases are likely to remain hidden and hence uncontrolled. Despite improvements, significant numbers of physicians in the Netherlands still fail to fulfil their legal responsibility to report their involvement in euthanasia and physician-assisted suicide. In 2001, doctors reported only 54% of assisted deaths to the authorities.¹⁴³ The number of reported cases fell further in 2003, rising again in 2004, yet 'almost half of all cases of euthanasia and physician-assisted suicide are still not reported'.¹⁴⁴

Onwuteaka-Philipsen *et al.* note that consultation with a second doctor—one of the 'requirements of careful practice'—was less likely to occur in the unreported cases.¹⁴⁵ Cases where there was no written report about the decision were more likely to be unreported,¹⁴⁶ although in 2003 these cases represented just 4% of all euthanasia cases.¹⁴⁷ Thus, important safeguards to ensure accountability and transparency in the decision-making process were less likely to occur

¹⁴² *Ibid.* at 107–108.

¹⁴³ T. Sheldon, 'Only Half of Dutch Doctors Report Euthanasia, Report Says' (2003) 326 *British Medical Journal* 1164 downloaded from <http://bmj.bmjournals.com/cgi/content/full/326/7400/1164> on 25 November 2003.

¹⁴⁴ B.D. Onwuteaka-Philipsen, A. van der Heide, M.T. Muller *et al.*, 'Dutch experience of monitoring euthanasia' (2005) 331 *British Medical Journal* at 692. The reporting rate of termination of life without an explicit request in 2001 was even lower. Less than 1%, of cases were reported, similar to previous years: D. van Tol, 'The Latest Nationwide Research on Dutch MBPSL Practice: a summary and critical note', (October 2003) N 8 *Newsletter MBPSL Regulation of Medical Behaviour That Potentially Shortens Life* at 8.

¹⁴⁵ B.D. Onwuteaka-Philipsen, A. van der Heide, M.T. Muller *et al.*, *supra*, n. 144 at 692.

¹⁴⁶ *Ibid.* The substantive requirements for prudent practice in euthanasia and physician-assisted suicide are: the patient's request must be voluntary and well considered; the patient's condition must be unbearable and hopeless; no acceptable alternatives for treatment are available; the method is medically and technically appropriate. The procedural requirements are that another doctor is consulted before proceeding and the case is reported as an unnatural death. *Ibid.* at 691.

¹⁴⁷ D. van Tol, *supra*, n. 144 at 7.

in unreported cases. Onwuteaka-Philipsen *et al.* argue that there are no significant differences between the reported cases and the unreported cases in terms of patient characteristics and clinical conditions.

After a detailed study of the Dutch data, Griffiths *et al.*'s conclusions are more critical of the low reporting rates. They point out that the cases that fail to comply with the Dutch 'requirements of careful practice' such as 'free and voluntary decision' are more likely to be misreported as 'natural death'. When cases were reported, the facts were stated in such a way that the likelihood of criminal investigation was minimised, by comparison with the less favourable descriptions given to the researchers.¹⁴⁸

The pattern was confirmed by the 1996 research and suggests that practices that may not be properly commensurate with patient autonomy remain invisible to the authorities. Thus, in the reported cases, consultation with the patient occurred 94% of the time, but in the unreported cases only 11% of the time. While there was written record keeping in 97% of reported cases, this occurred in only 57% of the unreported.¹⁴⁹ More recently, Griffiths has stated that in the Netherlands 'it is especially the more problematic cases that tend not to be reported... far too great a number of precisely those cases where more control is needed are escaping the control system altogether'.¹⁵⁰

VI. CONCLUSION

It is axiomatic to state that autonomy is one of the most important values to be respected in patient decision making. In death, the question is not whether it should be respected, but how it is to be respected.

The experience of the Netherlands and Oregon, where assisted death is legal, and the deaths by Dr Kevorkian under prohibition demonstrate that when it is readily available, women decide for assisted death at nearly four times the rate of female self-inflicted suicide. Some might argue that the increase in female suicides is positive, because it indicates an increase in personal choice for women. On this view, the legalisation

¹⁴⁸ For example, the patient's suffering was stated to be worse, the first initiative more often by the patient, the death more in conformity with procedural requirements etc: J. Griffiths, H. Weyers, A. Blood (eds) *Euthanasia and Law in the Netherlands* (Amsterdam University Press 1998) at 205.

¹⁴⁹ *Ibid.* at 238.

¹⁵⁰ However, as he notes, 'the reporting rate everywhere outside the Netherlands (except for the state of Oregon) is 0' J. Griffiths, 'Dutch Data in the International Debate: A statement by John Griffiths at a briefing session at the House of Lords', (October 2003) n 8 *Newsletter MBPSL Regulation of Medical Behaviour That Potentially Shortens Life* at 2.

of assisted death is respectful of women's autonomy, particularly, in light of a history of 'unwanted bodily invasion' of women.¹⁵¹

However, I have presented evidence of a risk that the decisions of some women for assisted death are rooted in oppressive influences inimical to genuine autonomy, such as structural factors, for instance, social and economic disadvantage, and stereotypes that idealise feminine self-sacrifice, passivity and compliance. Socio-cultural themes of male domination and female subjugation—played out in women's experience of violence—find striking correlation in the so-called mercy killings of women.

Legalising assisted death can only increase the social and cultural acceptability of methods of suicide, which are already disproportionately favoured by women patients who seek assistance to end their lives. One study has warned that the structure and passivity of assisted suicide

will create a sense of obligation on the part of a woman, especially one who subscribes to stereotypic sex roles to complete a physician assisted death towards which she may be initially ambivalent.¹⁵²

By legitimising and increasing access to methods of suicide which appeal to women, rather than safeguarding the autonomy of women patients, the risk is that for some women a legalised regime will compound the oppressive influences of their context and facilitate the last of many non-choices.

¹⁵¹ S.M. Wolf, *supra*, n. 60 at 308.

¹⁵² K.J. Kaplan, M. Harrow and M.E. Schneiderhan, *supra*, n. 7 at 42.