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

Submission

EXECUTIVE SUMMARY

From a legal perspective, one of the critical questions raised by Senator Brown's Bill is whether it is possible to draft legislation that succeeds in confining euthanasia and assisted suicide within agreed boundaries. The *Rights of the Terminally Ill Act* 1995 (ROTI) purports to do just that: assistance to terminate life is conditional upon a decision that is made 'freely, voluntarily and after due consideration' by a terminally ill patient who is experiencing 'severe pain or suffering' but is not suffering from treatable clinical depression. ROTI thus contains a number of safeguards that seek to control the practice of assisted death.

In this submission I critically examine the ROTI safeguards which aim 'to provide procedural protection against the possibility of the abuse of the rights recognised' by the Act, as Senator Brown expressed it in his second reading speech.

Firstly, I explain why the gatekeeping role of doctors created by ROTI is problematic. I then draw on the experience of the Netherlands which has struggled with the challenge of devising effective legal safeguards for more than two decades. The ROTI safeguards are in significant respects similar to the Dutch safeguards. It is thus of serious concern that crucial safeguards such as the voluntariness of the patient's request, consultation with the patient and the reporting requirements which aim to increase scrutiny of decision making are frequently ignored in the Netherlands. We must ask why it would be any different in the Northern Territory, should Senator Brown's Bill be passed.

This submission argues that the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill* 2008 should *not* be made law. It would restore the legitimacy of ROTI which, despite its numerous safeguards, cannot satisfactorily control the risk of abuse to patients. It is acknowledged that euthanasia and assisted suicide are practised even now in Australia when they are prohibited. Prohibition, however, does perform a significant symbolic and educative function in influencing attitudes and practices concerning the taking of life. My submission concludes by examining evidence from the Netherlands that demonstrates how legislation such as ROTI, by sanctioning and legitimising the termination of life in some circumstances, results in a liberalisation of euthanasia practice, including a growing acceptance of non-voluntary euthanasia.

THE DOCTOR AS GATEKEEPER

An in depth study into the ROTI Act during the nine months of its operation provides important insights in to the role of the medical profession in assisting the termination of life under this legislation. The authors of the study – including Dr Philip Nitschke who was the doctor assisting in the deaths – have described the doctor's function under ROTI as 'gatekeeper':

> Medical practitioners working with the ROTI Act had to exercise clinical judgment about the nature and process of an illness, its previous and current management, and any further potentially worthwhile treatment. The decision-making process involved review of the accuracy of diagnosis and the suitability of treatment, with exclusion of confounding factors. This could be described as a gatekeeping function, in which the vulnerable are protected through the wise application of the law (Kissane et al, 1101).

The authors argue that there are 'clear limitations of the gatekeeping roles of the medical specialist and psychiatrist in the ROTI legislation'. (Kissane et al, 1102)

- ***Role of the psychiatrist in assessing depression***

One of the conditions for assisting a patient to end their life under section 7 of ROTI is that a psychiatrist examines the patient and confirms that the patient is not suffering from a treatable clinical depression. Dr Nitschke confirmed that each of the seven patients who sought his help under ROTI perceived that requirement as a hurdle to be overcome. Thus the psychiatrist was viewed as an adversary and the authors question whether this can be an impediment to a genuine assessment of the patient's condition. (Kissane et al, 1101)

For example, in one case the patient withheld significant information during the psychiatric assessment about grief, personal loss and family alienation which might have been suggestive of unrecognised depression. (Kissane et al, 1101)

The authors raise concerns about other cases under ROTI:

> Four of the seven cases had symptoms of depression, including reduced reactivity, lowered mood, hopelessness, and suicidal thoughts. Case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management (Kissane et al, 1101).

Thus the operation of ROTI suggests that not only is the psychiatrist-as-gatekeeper function ineffective in screening inhibit the provision of adequate psychiatric care. This is of particular concern given the number of studies which have found an association between clinical depression and the desire to die. (Kelly et al 2003; Kelly et al, 2004).

- ***Role of the medical practitioner in assessing whether illness is terminal***

One of the conditions for assisted suicide under the ROTI Act is that the patient is suffering from a terminal illness, defined as an illness 'that will, in the normal course and without the application of extraordinary measures, result in the death of the patient.'

This requirement proved problematic during the operation of the Act. The first patient to seek assistance under ROTI suicided before the legislation was passed. Although she described herself as ‘terminally ill’ to the media, she was not and according to Dr Nitschke she understood that surgery could be successful (Kissane et al, 1098). She would not have qualified for assistance.

One patient who did die under ROTI ‘showed the Act's lack of ability to deal with differences of opinion.’ (Kissane et al, 1101). Ultimately, the medical practitioner who certified terminal illness was not a specialist in the relevant field, but there is no requirement under ROTI that the certifying doctor have relevant specialist expertise. The patient was suffering from a relatively rare type of non-Hodgkin's lymphoma which included symptoms of skin trauma, infection and aural discharge.

> one oncologist gave the patient's prognosis as 9 months, but a dermatologist and a local oncologist judged that she was not terminally ill. Other practitioners declined to give opinions. In the end, an orthopaedic surgeon certified that the ROTI provisions for terminal illness had been complied with. (Kissane et al, 1100)

Thus the final certification for the terminality of a dermatological condition was provided by an orthopaedic surgeon when other apparently more qualified specialists had declined to do so.

- ***Doctors’ attitudes can encourage patient suicide***

There is evidence that the attitudes of doctors can and do affect their patients’ preferences in end of life decisions and even their patients’ suicides. This calls in to question the appropriateness of a medical practitioner acting as the gatekeeper of their patient's assisted termination under Part 2 of ROTI. The doctor's own experiences and feelings can influence their decision about whether it is appropriate to assist a patient to terminate their life.

> Doctors may feel impotent, frustrated, disgusted with disease or the dying, and hopeless and helpless by being presented with a situation they cannot control, with their omnipotence shattered in the face of death (Leigh and Kelly, 2001, 195).

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 (Kelly et al, 2004, 317)

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' (Miles, 1994, 1786). 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' (Kelly et al, 2004, 317). 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 (Miles, 1994, 1786).

Such research highlights the difficulties associated with the doctor's gatekeeping function under ROTI. The numerous conditions with which a medical practitioner must comply before assisting a patient cannot safeguard against abuses if the position of gatekeeper itself is so problematic.

VOLUNTARINESS OF PATIENT REQUEST

One of the conditions for assisted termination of life under the ROTI Act is that the 'patient's decision to end his or her life has been made freely, voluntarily and after due consideration' (section 7(1)(h)). However, for a number of reasons this requirement is not an adequate safeguard for patients.

- ***Voluntariness condition does not prevent non-voluntary termination of life***

Like the ROTI Act, the Netherlands legislation requires that the patient's decision for assisted termination be voluntary. Notwithstanding this, research shows that in the Netherlands most cases of assisted termination of life are *without* explicit patient request and that the rate is likely increasing. There is no reason to believe that the situation would be any different under ROTI.

As is well known, in 1990, 1995, 2001 and 2005 researchers conducted replicated studies about the incidence and practice of euthanasia and physician assisted suicide in the Netherlands. The interpretation of these studies is highly contested in the academic literature, as it was in the 1997 Senate Inquiry (Report pages 103-106). Some explanation is required.

Since 1990 the number of deaths without explicit request has remained stable at around 0.8% of all deaths that occur in the Netherlands, most recently in 2005, 0.4% (van der Heide et al, 2007, 1961). At first glance this would seem a small number, but interpretation is controversial. As Dr Kuhse explained in her evidence to the 1997 Inquiry (Report, 106) the disagreement centres on how to classify different methods of intentionally terminating life. The Dutch studies define ‘ending life without explicit request’ with reference to the method of death: administering drugs with the explicit intention of ending the patient’s life without an explicit request from the patient (Onwuteaka-Philipsen et al, 2003, 396).

I argue that there are other methods to terminate a life such as withdrawing or withholding life sustaining treatment, or increasing medication. Ordinarily these would be legitimate and non-controversial medical practices, if, for example, the treatment was clinically futile or death was a foreseen – but not intended – ‘side effect’ of pain medication. However, when these practices are performed with the explicit intention of ending a patient’s life, then I argue they should be factored into the calculations of terminating life without explicit patient request

- ***Most termination of life in the Netherlands is without patient request***

Thus when we consider all methods of death where the primary purpose was to hasten death - lethal injection, pain relief or the omission of life sustaining treatment – the rate of death without explicit patient request increases significantly. Thus, in 1990 there were an estimated 10,558 deaths where the primary purpose was to hasten death. Of these, 5,450 deaths occurred without explicit patient request - 52% of the total. In other words most cases where the primary purpose was to hasten death occurred *without* the patient's explicit request (Keown, 1995, 278; Griffiths, 1998, 26).

- ***Non- voluntary -termination of life is increasing***

Replicated Dutch studies were performed in 1995, 2001 and 2005. They report that death by the administration of drugs without an explicit request has declined slightly since 1990 (van der Maas, 1996). If analysis was limited to that method of death, the conclusion might be that death without explicit request is controlled by the Dutch guidelines, or at least held in check.

But if we consider the broader definition of taking life, a different picture emerges. The rates of omission of treatment with the primary purpose to cause death without explicit request increased, from 2,670 deaths in 1990 to

14,200 deaths in 1995 (Jochemsenand and Keown, 1999, 17).

- ***Even the lives of competent patients are terminated without request***

In 1999 Jochemsen and Keown pointed out that although in the majority of the 1995 deaths the patient was incompetent or partially incompetent, 140 patients were competent, according to their doctors (Jochemsenand and Keown, 1999, 18).

Similarly, not all of the 900 patients whose lives were terminated by drugs without explicit request in the 1995 survey were incompetent. In 15% of cases where consultation with the patient was possible but did not occur, the doctor did not have a discussion because the doctor judged that termination was in the patient's best interests (Jochemsenand and Keown, 1999, 17). In a third of the 900 patients 'there had been a discussion with the patient about the possible termination of life, and some 50% of these patients were fully competent, yet their lives were terminated without an explicit request' (Jochemsenand and Keown, 1999, 18).

Although there is no direct proof of a causal connection between legalisation and the incidence of terminating life without request, I argue that there is evidence of an association between the two. At the very least, the research demonstrates that legalisation in the Netherlands, with its requirement of voluntariness, has failed to control abusive practices such as taking life without explicit request. There is nothing to suggest that ROTI with the same condition of voluntariness would be any more effective.

REPORTING REQUIREMENTS

One argument in favour of legislation such as ROTI says that euthanasia and assisted suicide are practised even where they are legally prohibited. Indeed, well known but controversial Australian studies in 1997 and 2001 confirmed that euthanasia and assisted suicide goes on in this country (Kuhse et al, 1997; Douglas et al, 2001). Other research in Sydney, Melbourne and San Francisco has exposed a euthanasia underground, 'an informal chain of associations facilitating the organisation and provision of euthanasia services' (Magnusson, 2002, 257). It paints a disturbing picture of coercion upon patients, rash or hasty involvement of doctors with minimal, if any, relationship with patients and idiosyncratic decision making (Magnusson, 2002, 254).

With this evidence of hidden euthanasia and lack of medical professionalism under prohibition, some argue that it would be better to legalise euthanasia. In the Netherlands physicians are required to report cases of euthanasia and assisted suicide to regional review committees which assess whether the physician has complied with the 'requirements of careful practice' such as voluntariness and consultation with an independent doctor. The rationale is that the reporting procedure allows greater transparency, scrutiny, communication with physicians and thus the opportunity to influence practice (de Haan, 2002, 61; van Delden, 1999, 24).

Part 3 of the ROTI Act similarly requires assisted terminations to be reported to the Coroner, including records of the patient’s request, their state of mind and the steps taken to assist the patient. However, the experience of the Netherlands suggests that such reporting requirements cannot adequately safeguard patients because the most problematic deaths remain hidden from the authorities.

Since 1990 the proportion of reported cases has increased significantly in the Netherlands, at its highest in 2005 when 80.2% of euthanasia or assisted suicide cases were reported (van der Heide et al, 2007, 1957). This is significantly better than the reporting rate under prohibition: 0%.

- ***When safeguards are ignored, deaths are more likely to be unreported & hidden***

But hidden decision making still occurs in the Netherlands. There are indications that even with legalised safeguards the most problematic cases are likely to remain hidden and hence uncontrolled.

For example, part 2 of ROTI requires a second medical practitioner to confirm the first doctor’s opinion and prognosis. The Netherlands has a similar requirement. However, Dutch researchers have noted that this requirement of consultation with a second doctor is less likely to occur in the unreported cases (Onwuteaka-Philipsen et al, 2003, 692).

ROTI also requires the medical practitioner who assists termination of life to keep specified written medical records, similar to the requirement in the Netherlands. However, in the Netherlands when doctors fail to keep a written record of the decision, the death is more likely to go unreported (Onwuteaka-Philipsen et al, 2003).

Also of concern is that while consultation with the patient occurred 94% of the time in Dutch cases reported to the authorities, it occurred in only 11% of the deaths that went unreported (Griffiths, 1998, 238.)

Thus the Netherlands experience suggests that important safeguards to ensure accountability and transparency in the decision making process – like those in ROTI - are not always observed. When these safeguards are ignored, the deaths are more likely to remain unreported and thus hidden from scrutiny.

Other Dutch research shows that some of the reported deaths are actually misreported. Griffiths et al reveal that the euthanasia cases that fail to comply with Dutch safeguards such as ‘free and voluntary decision’ are more likely to be misreported as ‘natural death’, not euthanasia. When such cases are reported, the facts were stated in such a way to minimise the likelihood of criminal investigation, by comparison with the less favourable descriptions given to the researchers (for example, the patient’s suffering was stated to be worse than it was, the first initiative more often by the patient, the death more in conformity with procedural requirements etc) (Griffiths, 1998, 205).

- ***‘Revisionist’ doctors: a law unto themselves***

Supporters of legalisation argue that along with the increased visibility of reported euthanasia comes increased *accountability* of doctors and health professionals. However, research points to doctors who will resist legal interference in any form, whether it is prohibition or safeguards such as those in ROTI.

In the Netherlands a small sample of physicians who failed to report assisted death was asked the reasons for their nonreporting. In 6.6% of these cases the physician said they did not report as they considered the ending of life as a private matter between doctor and patient (van der Heide et al, 2007, 1961).

Similarly, research in Australia and San Francisco points to so called ‘revisionist’ doctors and health professionals who practice assisted death but oppose legalisation in any form as a threat to their clinical discretion (Magnusson, 2002, 107). If these ‘revisionists’ believe that their experience and judgment are sufficient safeguards for patients under prohibition, under what circumstances would they comply with the safeguards of legislation such as ROTI?

- ***The most problematic deaths remain hidden***

Thus legalised safeguards cannot adequately safeguard patients from abuse. Reporting requirements like those set out in Part 3 of ROTI do not ensure transparency in euthanasia practice. According to Griffiths 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’ (Griffiths, 2003, 2). There is no reason to believe it would be any different in the Northern Territory under ROTI.

THE ADVANTAGE OF PROHIBITION:
ITS SYMBOLIC AND EDUCATIVE FUNCTION

This submission argues that the prohibition of euthanasia has one advantage over its legalisation - a symbolic and educative function that influences attitudes towards human life and controls the liberalisation of taking life.

It is very difficult to enforce criminal prohibition of euthanasia since the risk of discovering violations is very small and the ability to investigate and prosecute a case is limited. Thus criminal enforcement is rarely anything more than a symbolic threat. But symbols matter. When fundamental values are at stake, such as the protection of life and patient autonomy, rightly or wrongly people do tend to look to the criminal law as the only mechanism of control which is ‘good enough’. . There is research to support the influence that legal and medical authority has on end of life practices.

- ***The influence of legal and medical authority***

In one study a team of sociologists and psychologists from the University of California investigated the effect of two widely publicised deaths facilitated by physicians (Phillips et al, 1999). The first death was the suicide of a female leukaemia patient assisted by Dr Timothy Quill which he wrote about in the *New England Journal of Medicine* in 1991. The second death was that of Nancy Cruzan, a comatose accident victim who died after the Missouri Supreme Court ruled that artificial feeding and hydration could be withdrawn.

The study hypothesised that in conditions of ethical uncertainty, people look to authority for guidance: in the case of physician facilitated death, they said, this included both medical and legal authority. The study found that female leukaemia deaths rose by 11.3% above the expected rate just after Quill’s article was published. And following the court’s decision in Cruzan, the death of comatose accident patients rose by 57 per cent.

The authors conclude that the increase in leukaemia deaths was the result of physician assisted suicide publicised by the Quill article. Secondly they concluded that the increase in deaths of comatose accident patients was prompted by the court's decision in the Cruzan case.

I am not making comment on the ethics or legalities of the Quill and Cruzan deaths. The significance of this study is that it demonstrates the symbolic influence of the law. Legal and medical authority influences behaviour and attitudes towards taking life.

This prompts the question: what is the effect on behaviour and attitudes when taking life in certain circumstances is legalised – in effect institutionalised by the state?

In this submission I argue that in the Netherlands the legalisation of euthanasia and physician assisted suicide is associated with a liberalisation of attitudes towards the termination of life in the medical context. This is indicated by more accepting attitudes towards non voluntary euthanasia and secondly by a shift from 'euthanasia as last resort' to 'euthanasia as choice'.

i) Attitudes towards non voluntary euthanasia

John Keown offers an historical sketch which he says demonstrates this shift in ethical sensibility in the Netherlands (Keown, 1995, 285-286). Keown states that in 1984 there was little support for non voluntary euthanasia. The Dutch definition then – as now - incorporated the need for a request by the patient.

In 1985 a State Commission on Euthanasia decided against allowing a third party to request euthanasia for incompetents such as children or the senile elderly (Leenen, 1997). In 1989 its Vice Chairman, Professor Leenen, a supporter of legalisation, affirmed that a request was 'central' to the Dutch definition, saying that '[w]ithout it the termination of a life is murder (Leenen, 1997, 520).

Similarly, writing in the Hastings Center report in 1989 Henk Rigter said that 'In the absence of a patient request the perpetrator renders him or herself guilty of manslaughter or murder (Rigter, 1989,31).

Keown provides other examples of legalisation advocates expressing similar sentiments around this time. One was the Director of the National Hospital Association affirmed the necessity of patient request and said:

> Consequently it is impossible for people who do not want euthanasia to be...forced in to it. The requirement of voluntariness means no one need fear that his or her life is in danger because of age or ill health and that those who cannot express their will...shall never be in danger as long as they live (Keown, 1995, 285).

- ***Increasing acceptance of non-voluntary euthanasia***

However, there seems to have been a shift in these earlier attitudes towards increasing approval of *non*-voluntary euthanasia – death without request. The early sentiments are contrasted with what Keown says has been a move to official condonation of non-voluntary euthanasia. For example, he points to the Remmelink Commission’s response to the 1000 deaths without explicit request uncovered in the 1990 study. Rather than criticise this obvious flouting of patient autonomy, the Commission defended the killing of incompetents as usually ‘inevitable’ because of the patient’s ‘death agony’ (although only 30% of doctors even mentioned pain or suffering as a reason for killing these patients) (Keown, 1995, 277). The Commission recommended, and the Dutch Parliament agreed, that these cases should be reported in the same way as cases of voluntary euthanasia. Instead of ‘non-voluntary euthanasia’ the Commission characterised these deaths as ‘care for the dying’ (Keown, 1995, 283).

Similarly, Keown points out that the 1992 Committee of the Royal Dutch Medical Association condoned the killing in certain circumstances of incompetents like babies and the comatose (Keown, 1995, 276).

This shift towards an increasing approval of non voluntary euthanasia is also evident in 1993 when Dutch researchers wrote that many Dutch doctors feel deaths without explicit request are justified in exceptional circumstances:

> there will always be some situations in which terrible suffering, which can end only when the patient dies, arises when the patient cannot give a clear judgement about the desired course of action (Pijenborg, 1993, 1199).

These researchers do, however, emphasise that terminating life without explicit request is only permissible if safeguards are followed such as optimal palliative care, discussion with relatives, a colleague and nurses, reporting and the absence of economic motives. This is significant: the Dutch researchers believe that safeguards must be followed even though the very fact of a death without explicit request means that the key safeguard of voluntariness has already been breached. This is suggestive of a proposal to re-write the safeguards, to in fact remove one of the most fundamental safeguard of all – voluntariness - in order to accommodate the breach.

In contrast to the earlier attitudes of Dutch legalisation supporters– when death without explicit request was characterised as murder – these researchers conclude that when the safeguards are observed death without explicit request 'is certainly not murder'.

ii) From 'euthanasia as last resort' to 'euthanasia as choice'

A second shift in Dutch euthanasia practice and attitudes is also associated with its legalisation. A Netherlands researcher, Dr van Delden, has pointed out that the official Dutch approach – like that of most proposals to legalise euthanasia including ROTI – has been on the grounds of compassion. Thus when palliative care fails, there is no prospect of improvement and the illness is causing the patient severe pain or suffering, the principle of respect for life is overridden and euthanasia is tolerated as the option of last resort (van Delden, 1999,23).

But van Delden says that in the Netherlands there is an increasing emphasis on patient choice: ‘The reality of the Dutch euthanasia practice, however, seems to be developing in another direction, with increasing emphasis on respect for patient autonomy’ (van Delden, 1999,23).

- ***‘psychiatric euthanasia’***

The infamous case of Dr Chabot is part of this trend. A 50 year old woman who had lost two sons in tragic circumstances and had endured a difficult divorce after a long and unhappy marriage repeatedly asked her psychiatrist Dr Chabot to help her suicide. In 1994 he obliged. She was neither terminally or physically ill. The Supreme Court held that psychiatric suffering could justify euthanasia and although Dr Chabot was convicted on another ground he was not punished. ‘Psychiatric euthanasia’ has now become a legitimate practice (Huxtable and Moller, 2007, 121).

- ***Euthanasia for ‘life fatigue’***

The Dutch definition of suffering contained in the safeguards has further evolved. Edward Brongersma was 86 years old and had neither a physical or psychiatric condition when he suicided in 1998, assisted by Dr Philip Sutorious. Brongersma was motivated by ‘life fatigue’ and according to Dr Sutorious he ‘experienced life as futile, was unhappy and lonely’ (Moller and Huxtable, 2001). Dr Sutorious was prosecuted on the basis that he had failed to comply with the Dutch safeguard that he should be satisfied on reasonable grounds ‘that the suffering is unbearable and that there is no prospect of improvement’. Acquitted by the District Court, Sutorious was convicted by the Court of Appeal in Amsterdam on the ground that he had failed to investigate other options of relieving Brongersma’s suffering. In other words, the Dutch Court failed to rule out ‘life fatigue’ as a legitimate ground for euthanasia (Huxtable and Moller, 2007, 118). Sutorious was not punished. A Committee of the Royal Dutch Medical Association has now advised that ‘life fatigue’ should be brought within the bounds of the euthanasia law (Huxtable and Moller, 2007, 126).

What are we to make of this trend away from ‘euthanasia as the last resort’ to ‘euthanasia as choice’? Dr Van Delden says it indicates an increasing respect for patient autonomy (van Delden, 1999, 24). But this interpretation is problematic given the still significant numbers of deaths that occur in the Netherlands without explicit request – deaths that signify the antithesis of patient autonomy.

What this trend does signify is that over a period of time in the Netherlands there has been a liberalisation of attitudes towards taking life, a widening of the patients considered candidates for an assisted death: the incompetent, patients who are not terminally or physically ill, and psychiatric patients. Finally, with the Brongersma case, euthanasia is now legitimised as a response to the social isolation of old age.

Reflecting on the lessons of the ‘life fatigue’ case for jurisdictions that consider legalising euthanasia, two academics highlight the need for ‘rigorous drafting of any permissive laws. However, the Dutch policy arguably had clear qualifying criteria but they have become rather malleable’ (Huxtable and Moller, 2007, 125).

The Netherlands experience demonstrates that safeguards such as those contained in ROTI fail to restrict the practice of euthanasia within agreed boundaries.

CONCLUSION

The *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill* 2008 should not be made law. I have argued that there is strong evidence that the safeguards within ROTI cannot control the practice of euthanasia and protect patients against the possibility of abuse. The doctor’s gatekeeping role demanded by the safeguards is inherently problematic. Moreover, protecting patients from the risk of abuse requires more than safeguards: it requires compliance with those safeguards. Twenty years of safeguards in the Netherlands demonstrates a disturbing lack of compliance. When the safeguards become incongruent with increasingly permissive attitudes towards euthanasia is control achieved by reworking the safeguards to accommodate the breach? This is the experience of the Chabot case and the euthanasia of psychiatric patients. Is this control, or its caricature?

The risk of ROTI is the negative impact legalisation would have on attitudes and behaviours towards the value of life and the taking of life. Can this be controlled by guidelines and safeguards? The law is a blunt instrument and such an ethical shift may be too gradual and subtle for its strike.

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