WRONGFUL DEATHS BY ASSISTED SUICIDE OR EUTHANASIA

BETTER OFF DEAD

Are the disabled at risk of wrongful death from an assisted suicide law?

- In the Netherlands and Belgium disability – both physical and intellectual – is accepted as a reason to euthanase a person.
- In Oregon the **five main reasons** given for requesting assisted suicide **all relate to disability** issues.
- People with disabilities are often seen in our society as "*better off dead*".
- Depression is less likely to be diagnosed and treated in a person with disability.
- The boundary between physical disability and terminal illness is fuzzy, not clear.

Netherlands and Belgium

A 2018 paper examines nine case reports on euthanasia in the Netherlands between 2012 and 2016 of people with an intellectual disability or an autism spectrum disorder.[1]

The case reports make for chilling reading, illustrating how once euthanasia becomes normalised in a society it becomes the go-to, accepted, "*final solution*" for "*difficult*" patients.

A man in his 60s with Asperger's, described as "*an utterly lonely man whose life had been a failure*", was euthanased because he was "horrified at moving into sheltered accommodation". Although he had been diagnosed with "*severe and probably chronic depression with a persistent death wish*" another psychiatrist, after seeing him just once, certified that he was free of depression in order to facilitate his euthanasia.

Another man in his 30s, also with Asperger's, was euthanased based on his distress at "*his continuous yearning for meaningful relationships and his repeated frustrations in this area, because of his inability to deal adequately with closeness and social contacts*".

A third case was of an intellectually disabled woman in her 60s who was euthanased for tinnitus despite a finding that:

the patient had indeed gone through many treatments in the past, but also, that often the wrong treatments had been instigated. It had also become clear to the physician that the patient often wanted to abandon the treatments, and that the treating

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[1] https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-018-0257-6

practitioners had not encouraged her to try and persevere with these treatment(s) a bit longer.

In Case 2016-44 the Netherlands Review Committees approved the action of a doctor who euthanased a man aged between 80 and 90 years of age on the sole ground of having progressive loss of vision due to macular degeneration with his lack of capacity to read being accepted as unbearable and hopeless suffering.[2]

In Belgium, in December 2012 identical twin brothers were euthanased on the grounds of their psychological distress at learning they were both going blind. The brothers were reportedly distressed that they would not be able to see each other.[3]

Commenting on this case, Dr. Marc Maurer, President of the [US] National Federation of the Blind,[4] said:

"*This disturbing news from Belgium is a stark example of the common, and in this case tragic, misunderstanding of disability and its consequences. Adjustment to any disability is difficult, and deaf-blind people face their own particular challenges, but from at least the time of Helen Keller it has been known that these challenges can be met, and the technology and services available today have vastly improved prospects for the deaf-blind and others with disabilities. That these men wanted to die is tragic; that the state sanctioned and aided their suicide is frightening*."[5]

Disability issues accepted as leading reasons for assisted suicide: "You would be better off dead!"

Assisted suicide proposals usually would require two doctors to agree to a person's request for a prescription for a lethal dose to be used to end the person's life. To do so the doctors essentially need to agree that the person would "be better off dead" or at least that it is reasonable for a person in that position to consider that he or she would be better off dead.

The five main reasons given for requesting assisted suicide in Oregon in 2017 are **not primarily to do with pain (only 21%)** but rather with concerns about decreasing ability to participate in activities that made life enjoyable (88.1%), loss of autonomy (87.4%), loss of dignity (67.1%), physical or emotional burden on family, friends, or caregivers (55.2%)

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[2] https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2016/april/12/jaarverslag-2016/RTE_jaarverslag2016.pdf

[3] http://www.telegraph.co.uk/news/worldnews/europe/belgium/9798778/Belgian-identical-twins-in-unique-mercy-killing.html

[4] http://www.facebook.com/NationalFederationoftheBlind

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

and the loss of control of bodily functions, such as incontinence and vomiting (37.1%) .[6] **These are all disability issues.**

Any assisted suicide proposal that includes a subjective notion of suffering as part of the eligibility criteria would allow assisted suicide for a similar set of concerns.

This set of concerns reflects the day to day realities of life for many people living with disabilities of various kinds.

If we legalise assisted suicide for incontinence, a loss of ability to engage in one's favourite hobby, a need to have other's take care of your physical needs, a loss of mobility and so forth what is the take home message for those who live with these challenges every day?

Are we saying they would also be better off dead?

Stella Young

The late Stella Young, comedian, writer and disability activist, wrote on the implications of legalising assisted suicide for people living with disabilities:

As a disabled person, I'm accustomed to conversations about quality of life and dignity. Specifically, I'm accustomed to assuring people that my life is worth living. I'm short statured, a wheelchair user, and I frequently have bone fractures. All the visual cues that make me 'the other' are front and centre.

People make all sorts of assumptions about the quality of my life and my levels of independence. They're almost always wrong.

I've lost count of the number of times I've been told, "I just don't think I could live like you," or "I wouldn't have the courage in your situation," or, ***my favourite one to overhear (and I've overheard it more than once), "You'd just bloody top yourself, wouldn't you?"****. What we as a society think we know about what it means to live as a disabled person comes from cultural representations of disability seen through a nondisabled lens. And we, as people with disability, rarely get to tell our own stories.*

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[6] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf

Also, social attitudes towards disabled people come from a medical profession that takes a deficit view of disability. This is my major concern with legalising assisted death; that it will give doctors more control over our lives. As a disabled person who has had a lot to do with the medical profession, I can tell you that this is the space in which I've experienced some of the very worst disability prejudice and discrimination. Doctors might know about our biology, but it doesn't mean they know about our lives.

Media reports on assisted dying feed these misconceptions. ABC News reported this week on the case of Barbara Harling, a Queensland woman with motor neurone disease who said that she would consider moving to Tasmania if the Voluntary Assisted Dying Bill had passed. Harling is quoted as saying: "Well, let's put it this way. I can use my left hand, my right hand is just about useless. If I can't use my left hand to wipe my bottom, then I can do nothing else for myself. That means someone has to do everything for me. I couldn't bear to live like that."

The thing is, a lot of people do live like that. I know many, many people who depend on personal assistants for all of their daily living tasks, some of them requiring 24 hour care. ***Having to rely on someone else to wipe your bum may not be something anyone aspires to, but I'm quite sure it's never killed anyone.***

Perhaps our discomfort with this kind of thing is why we don't hear the counter view in reports about assisted dying. Often we hear supporters of euthanasia and assisted suicide talk about wanting to avoid the pain and suffering that often comes with imminent death. But more often, we hear stories like Barbara Harling's, which are more about wanting to avoid a loss of autonomy and independence. [7]

Screening for depression or coercion

Proposals for assisted suicide offer require assessing doctors to screen for depression or other mental health conditions that may be affecting the person's decision making capacity. Similarly the assessing doctors are supposed to determine that the request is voluntary and not the result of coercion.

Doctors are less likely to identify depression in people with disability, simply by assuming that it is normal for a person with disability to show signs of depression such as sadness and lack of hope.

Doctors may also easily miss the particular vulnerability of a person living with disability to overt or subtle coercion from family or caregivers who reinforce a feeling that the person is a burden, "*too much trouble*", "*life is too hard*" and so forth.

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[7] http://www.abc.net.au/rampup/articles/2013/10/18/3872088.htm

Terminal condition or disability?

Proposals for assisted suicide may suggest making assisted suicide available to people with a specified length of time to live, such as six or twelve months or use some vaguer term such as where death is reasonably foreseen.

However, such proposals generally indicate that the prognosis should take account of which treatments are "acceptable to the person". On this basis various condition that are not in themselves terminal may be considered as terminal for the purpose of offering assisted suicide if the person decides to forego an effective, available treatment for whatever reason.

This approach poses a severe risk to people following an initial acquisition or diagnosis of a condition that may involve a considerable level of disability.

Marilyn Golden writes :

Research overwhelmingly shows that people with new disabilities frequently go through initial despondency and suicidal feelings, but later adapt well and find great satisfaction in our lives.

However, the adaptation usually takes considerably longer than the mere fifteen-day waiting period [generally] required by assisted suicide proposals. People with new diagnoses of terminal illness appear to go through similar stages. In that early period before one learns the truth about how good one's quality of life can be, it would be all too easy, if assisted suicide is legal, to make the final choice, one that is irrevocable.

Dr. Richard Radtke, a well-known retired academic oceanographer in Hawaii, provides one such example. Dr. Radtke has had a very disabling form of muscular sclerosis for over 25 years. In the period after his diagnosis, doctors often classified him as terminally ill. He experienced severe depression for two years. Had assisted suicide been legal, he acknowledges that he would have chosen it and died long ago. Today, still with an extremely limiting disability, he has retired from a successful academic career, is a happily married father, remains the president of a charitable foundation, and is grateful for the length and varied experiences of his life.

How many such individuals is our society prepared to sacrifice as the collateral damage from the legalization of assisted suicide? [8]

Conclusion

Legalising assisted suicide poses a direct threat to the lives of some people with disabilities who may be assessed as eligible to request it. Doctors are more likely to agree that they are "*better off dead*" and to miss signs of depression or coercion.

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[8] https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/

Legalising assisted suicide for being a burden, incontinence and loss of ability to enjoy activities trivialises issues faced daily by persons living with disability and demeans their courage in facing the challenges of life.