

FINRRAGE (Australia)

Feminist International Network of Resistance to Reproductive and Genetic Engineering

Submission

on Euthanasia Laws Bill 1996

The Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRRAGE (Australia) welcomes the opportunity to make a submission to the Senate Legal and Constitutional Legislation Committee

"Suicide ... [is] a woman's solution." ¹

"[i]t is by men that women meet their death, and it is for men, usually, that they kill themselves." ²

FINRRAGE (Australia) supports the Euthanasia Laws Bill 1996 to overturn the Northern Territory's Rights of the Terminally Ill Act 1995.

We are opposed to the Rights of the Terminally Ill Act because of its potential effects on people on the margins of society especially the chronically ill, people with disabilities, aboriginal people and elderly women whose vulnerability, we believe, has increased with the passage of the Act.

We are not taking this position lightly. As a feminist network FINRRAGE (Australia) strongly supports women's own decisions - as individuals and as members of the social group women. However we believe there is much evidence to support a contention that a pro-euthanasia climate will lead to certain segments of society "requesting" the hastening of their deaths through physician-assisted euthanasia and that women and people of 'lesser merit' in general will be amongst them.

Importantly we believe that the implications for women have not been given adequate scrutiny in the current euthanasia debate nor in the Act itself.

There are many problems faced by women in the provision of health care. These gender correlated disadvantages have been documented. ³

1 Nicole Loraux, *Tragic ways of killing a woman*, Anthony Forster, trans. (Cambridge, MA: Harvard University Press 1996). p.8 cited in *Feminism & Bioethics; Beyond Reproduction*, Susan M. Wolf ed Oxford University Press

2 Ibid, p.23

3 Dorothy H. Broom, *Damned if We Do, Contradictions in Women's Health Care* Allen and Unwin Sydney NSW 1991; Charollette F Muller *Health Care and Gender*, Russell Sage Foundation New York 1990

In her chapter "Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia" in *Feminism and Bioethics*, Susan Wolf observes: "...dimensions of health status and health care that may affect a patient's vulnerability to considering physician-assisted suicide and euthanasia - including depression, poor pain relief, and difficulty obtaining good health care - differentially plague women." ⁴

An American Medical Association report on gender disparities says women receive more care even for the same illness, but the care is generally worse. Women are less likely to receive dialysis, kidney transplants, cardiac catheterisation, and diagnostic testing for lung cancer. The report urges physicians to uproot "social or cultural biases that could affect medical care" and "presumption about the relative worth of certain social roles."⁵

The difficulties of many women in getting good medical care, appropriate pain relief, combined with a higher incidence of depression, and a higher rate of poverty may combine in influencing women to ask for euthanasia. Women are over-represented in the ranks of the poor and often lack the resources to cope with disability and disease.

FINRRAGE (Australia) would suggest that it is likely many women may request euthanasia because their needs remain unmet.

It cannot be denied that there remains widespread devaluation of women who are sick, disabled and elderly. Ageism and sexism force many older women to experience self-derogation and to feel dejected, degraded, devalued, useless, and worthless.⁶ The very fact that women outlive their male partners exacerbates their vulnerability because of loneliness, lack of support and feelings of alienation in couple-preferring society which devalues single women at any point in their lives but particularly in old age.

The Dutch Attorney General, T.M Schalken, stated in 1984 that "elderly people begin to consider themselves a burden to the society, and feel under an obligation to start conversations on euthanasia, or even to request it."⁷

The story of an 84-year-old woman who had lived with her daughter for 20 years gives credence to this. In a letter in the Santa Rosa (California) Press Democrat, Sept 14, 1993, she wrote:

Everything went fine for many years but when I started to lose my hearing about

4 *Feminism & Bioethics; Beyond Reproduction*, Susan M. Wolf ed New York and Oxford University Press p.283

5 Council of Ethical and Judicial Affairs, American Medical Association, 'Gender Disparities in Clinical Decision Making' *Journal of the American Association* 266 (1991): 559-62

6 Nancy J. Osgood, Susan A. Eisenhandler, Gender and Acquiscent Suicide: A suicidologist's perspective *Issues in Law and Medicine*, Vol 9 (4) 1994, 370 The authors discuss the concept of "acquiscent suicide" which, they write "emerges when individuals yeild to the context surrounding them ... institutionalisation may become the social context conducive to acquiscent suicide for older women"

7 Margaret A. Somerville, The Song of Death: The Lyrics of Euthanaisa, *Journal of Contemporary Health, Law and Policy*, Vol 9 (1), 47

three years ago, it irritated my daughter...She began to question me about my financial matters and apparently feels I won't leave much of an estate for her...She became very rude to me... Then suddenly, one evening, my daughter said very cautiously she thought it was ok for older people to commit suicide if they cannot take care of themselves. ...So here I sit, day after day, knowing what I am expected to do when I need a little help

FINRRAGE (Australia) believes women are particularly vulnerable to euthanasia because of what Gilligan has called an "ethic of self-sacrifice among women." Many women remain powerless and have been inculcated from girlhood with the notions that they should "not make a fuss," "not get in the way", "not be a burden" and always put other people first. These characteristics may make women more 'willing' to 'choose' euthanasia."⁸ Submitting oneself to euthanasia could be extolled as the ultimate act of altruism.

The report of the Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death Report stated: "If ... the doctor is confident that the patient's disabilities, coupled with his (sic) genuine distress about the trouble and expense of the care he (sic) needs, make continued life devoid of any enjoyment, the doctor's response [whether or not to provide euthanasia] will depend on the more general question of how he (sic) regards his ethical responsibilities in relation to assisting death."⁹ "She" could also find her "genuine distress" about the "trouble and expense of care she needs" exploited for euthanasive gains as well.

Stephanie Gutman, writing in *The New Republic*, has observed that in Dr Jack Kevorkian's "medicide" of Sherry Miller and Marjorie Wantz, "one woman seems to have been suffering from depression rather than organic disease, and the other from a particularly self-abnegating sense of the trouble her disease caused others."¹⁰

Gutmann points out that in the patients approaching Dr Jack Kevorkian, most of the men were declared terminally ill by their own doctors. The women, however "had more ambiguous complaints". Gutmann cites a chart compiled by Kalman Kaplan, director of the Suicide Research Center at Columbia-Michael Reese Hospital in Chicago.

[w]e see that most of the Kevorkian women were not diagnosed terminal and had not been complaining of severe or constant pain. We see conditions like breast cancer (for which there is now great hope), emphysema, rheumatoid arthritis and Alzheimer's (a condition that usually burdens relatives more than the people who have it). Reading the case histories it is clear that many of these women's lives were

8 Carol Gilligan, *In a Different Voice: Psychological theory* Cambridge, MA: Harvard University Press 132

9 'Assisted Death'. Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death *The Lancet*, Sept 8, 1996, 611

10 Stephanie Gutman, 'Death and the Maiden', *The New Republic* June 24, 1996, 24

messy and unattractive. But in all-too-typical female fashion, the patient often seems to be have been most worried about the disease's impact on others. **Is it possible that a certain type of woman - depressive, self-effacing, near the end of a life largely spent serving others - is particularly vulnerable to the "rational," "heroic" solution so forcefully proposed by Dr. Death?**¹¹

For many women, "choosing" euthanasia could be extolled (by others) as an act of nobility and humble self-sacrifice. There are claims that in the Netherlands "the highest terms of praise have been applied to the request to die: this act is 'brave,' 'wise,' and 'progressive.'¹²

Women may seek such accolades, even in death.

FINRRAGE (Australia) has always questioned the rhetoric of 'choice'. Many women at best make decisions between often equally poor alternatives. Their so-called 'choice' is influenced by innumerable mitigating factors. We therefore believe that 'choice' is not an accurate word to use when describing women's decision making process.

Wolf has identified this:

In circumstances in which women and others who have traditionally lacked resources and experienced oppression are likely to have fewer options and a tougher time getting good care, mechanical application of the rights equation will authorise their deaths even when less drastic alternatives are or should be available. It will wrongly assume that all face serious illness and disability with the resources of the idealised rights bearer - a person of means untroubled by oppression. The realities of women and others whose circumstances are far from that abstraction's will be ignored.¹³

Wolf argues that the request for death is socially constructed : "We construct a story that clothes the patient's terrible despair in the glorious mantle of "rights."¹⁴

It is very possible that many requests for euthanasia are symbolic of a breakdown in relationships and social networks, in essence a cry for help. There are already examples surfacing of women who are not chronically ill, being euthanased. A doctor was charged under the Dutch Penal Code with assisting the suicide of a 50-year-old woman who wanted to die because of her grief at the deaths of her two sons and her marriage breakdown. The doctor has not been punished.

A Harvard psychiatrist has speculated about why those women among Kevorkian's "patients" who were still capable of killing themselves (suicide is decriminalised in the US)

11 Gutman, op cit, 27 emphasis added.

12 Somerville, op cit, 47

13 Wolf, op cit, 299

14 Wolf, op cit, 300

instead sought Kevorkian's help. "The psychiatrist wondered whether turning to Kevorkian was a way to seek a relationship."¹⁵

We believe that the language of euthanasia has been blurred to hide the reality that it is deliberate killing of one person by another. Evidence for this can be seen in the aforementioned Institute of Medical Ethics Working Party report which stated:

... more important is rejection of the word 'killing'. This word is generally used to indicate a violent act in war or crime, rather than to describe a gentle act of merciful clinical care.

de Wachter quotes a Dutch physician as saying that "there are situations in which the best way to heal the patient is to help him (sic) die peacefully and the doctor who in such situation grants the patient's request acts as the healer *par excellence*".¹⁶

FINRRAGE (Australia) is also concerned about the possible ramifications of pro-euthanasia legislation because of the traditional power relations between women and the medical profession. Because medical practitioners have often placed themselves in a superior position of overriding authority and because of the privileged position of many in the medical field, women may put aside their own views and submit themselves to the pre-eminence of a doctor's opinions.

FINRRAGE (Australia) is seriously concerned that under the *Rights of the Terminally Ill Act*, a psychiatrist must certify that the patient is not suffering from "treatable clinical depression in respect of the illness". The psychiatrist does not have to determine whether the patient is suffering from depression unrelated to the illness or whether there is depression which is not considered "treatable". The psychiatrist also does not have to determine if the patient is suffering from any other psychiatric illness or disorder. The Coroner has no power to investigate circumstances of the euthanasia.

We also accept the argument that once euthanasia is legislated in "voluntary" cases, it becomes practice in many non-voluntary situations. This is demonstrated by the Netherlands experience.

John Keown has examined the slide from voluntary to non-voluntary euthanasia in Dutch practice and the shift in Dutch opinion towards condonation of non-voluntary euthanasia. He writes: "...there is ample evidence from the Dutch experience to substantiate the relevance of the 'slippery slope' argument. Within a decade, the so-called strict safeguards against the slide have proved signally ineffectual".¹⁷

The Journal of the Royal Society of Medicine reported the following account which

15 B.D. Colen, 'Gender questions in assisted suicides' *Newsday*, Nov 25, 1992: 17

16 Somerville, op cit, 46

17 John Keown, 'Euthanasia in the Netherlands: Sliding down the slippery slope' In *Euthanasia Examined* *Ethical, Clinical Perspectives*, John Keown ed, Cambridge University Press, 263,269

illustrates the reality of this slippery slope:

A patient with disseminated breast cancer had severe pain. Eventually, she was receiving more than 2g of morphine a day but was still in pain. Several weeks previously, at an outpatient clinic, she had told the doctor that she would never choose euthanasia because of her beliefs. She was admitted one Saturday under the care of the same doctor and treated with intravenous midazolam¹⁸ and morphine. She became unconscious, so the dose of midazolam was decreased. She woke up and said she was free of pain. After a weekend on duty, the doctor went home on Monday morning. The patient died 30 min later. Next day, a nurse told the weekend duty doctor that another doctor had ordered a 20-fold increase in the dose of morphine. Her family had been asked to leave the room, the order was given verbally and the doctor refused to confirm it in writing. When challenged by the weekend duty doctor, the second doctor replied 'It could have taken another week before she died: I just needed this bed.'¹⁹

Another example from the Netherlands, is also illustrative of the potential devaluation of patients once euthanasia becomes established practice:

A general practitioner called to a patient's home, and seeing her for the first time, immediately asked her to choose between hospitalisation and euthanasia. When the stunned patient could not reply, he gave her one hour to think it over.²⁰

In addition to these points we share the concerns of disability rights advocates that the disabled in Australia could become a special target for non-voluntary euthanasia especially in a climate of scarce health care resources and inadequate services for the disabled and chronically ill.²¹

The cover story in *America* in May last year reported the fears of the disabled that their lives may be ended unwillingly. "Responding to the legitimate fears of handicapped people, the Dutch Patients' Association has deemed it necessary to issue wallet-sized "Life Passports" intended to prevent involuntary euthanasia in case of admission of the signer to a hospital."²²

Prenatal screening followed by abortion for genetic and other defects is now widespread.

18 Midazolam is a sedative often combined with morphine intravenously, used in Intensive Care settings often for its amnesiac properties.

19 Robert G. Twycross DM, 'Euthanasia: going Dutch' *Journal of the Royal Society of Medicine* Vol 89 (29) 1990

20 Robert G. Twycross DM, 'Assisted Death: a Reply' *The Lancet*, Vol 336 (8719), 796-798, September 29, 1990

21 Director of the Linacre Centre for Health Care Ethics in London, Mr Luke Gormally, when in Australia last year referred to a study at Harvard University which linked calls to legalise euthanasia to economic depressions.

22 Peter J Bernadi, 'The hidden engines of the suicide rights movement. *America* Vol 172 n16 p14 (4) May 6th 1995

Peter Singer and others advocate infanticide of handicapped newborns.²³ We believe that these practices and beliefs contribute to the creation of a society which will have even less tolerance for those considered imperfect in some way. Many disabled people have testified to attitudes expressed that they would have been "better off dead". Parents of disabled children have also spoken of being asked "Why didn't you have the test"? Those escaping the screening net are already being seen as screening failures. These survivors may be placed under extreme pressure to acquiesce to euthanasia at a later stage. "Putting us out of your misery" is the unfortunately apt title of an article in *Quad Wrangle* last year.²⁴

Australian disability rights advocate Christopher Newell, wrote recently:

Furthermore, we live in a society which has oppressed people with disability via its very structures and norms, and where the dominant knowledge is that it is 'better to be dead than disabled.' Indeed, unless one is presented with a positive social model which suggests that people with disabilities can achieve, and which challenges dominant stereotypes of the quality of life for people with disabilities, then inevitably it is seen as reasonable that people should either be allowed to end their lives, or have their lives ended for them, voluntarily or involuntarily ... Australian society faces a challenge to inject the same effort into allocating resources and effort to support people, as is found in efforts to facilitate their killings.²⁵

FINRRAGE (Australia) upholds the position that the less powerful "cannot be adequately protected in a regime where medical killing is legalised or decriminalised... such measures could actually increase the oppression experienced by people with disabilities."²⁶

We endorse the House of Lords Select Committee on Medical Ethics enquiry which stated in 1993:

We are concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death. We believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life."

23 See, for example, Peter Singer and Helga Kuhse, (1985) *Should the Baby Live? The Problems of Handicapped Infants*. Oxford University Press, Melbourne and Peter Singer: *Rethinking Life & Death: The Collapse of Our Traditional Ethics*, The Text Publishing Company, Melbourne, 1994.

24 Joan Hume, 'Putting us out of your misery', *Quad Wrangle*, Spring 1995. Hume quotes the NSW Humanist Society's position on Euthanasia: A baby 'born with severe mental or physical disabilities, ... should be terminated by legal process before any person becomes emotionally attached to it'.

25 Christopher Newell, 'Critical reflections on euthanasia and people with disability', *AQ*, Vol. 68 No.3 1996, p.49-50, 56.

26 Christopher Newell, 'Medical Killing and People with Disability: A Critique', *Australian Disability Review*, No.2, 1996, p.28

This statement stands in stark contrast to the contemptuous words of former Australian Governor General Bill Hayden who said: "There is a point when the succeeding generations deserve to be disencumbered...of some unproductive burdens."²⁷

FINRRAGE (Australia) sees in the NT legislation the death of human solidarity, communitarian values and the duty of care.

French psychoanalyst De Hennezel believes society is "governed by th(e) myth of a good death." This "good death" is "a discreet and rapid death, unconscious, and, particularly, of no bother to anyone else." Death is "experienced in great solitude and with no guideposts or values ... [a] world of effectivity, efficiency, performance, with priority given to cost-effectiveness [and] consumption...[a] world of objects not of subjects - in short, a world stripped of souls and spirit, a world without love".²⁸

We foresee a situation where the disabled, ill and elderly will be placed in a position where they will be required to justify a preference to live. As Brock has pointed out: "the existence of the option becomes a subtle pressure to request it."²⁹ For all the afore mentioned reasons this will be particularly true for women.

Melbourne bioethicist Nick Tonti-Filippini understands what this could mean to the very sick:

Those of us who are chronically, seriously ill now look at the costs of our care with real fear, knowing that our continued medically dependant existence is not inviolate. How small a step it would be to move from making us feel guilty about continuing to live, as we now are made to feel, to taking away our access to life support or prescribing death when we can no longer protest. These are fearful times in which to be chronically ill, frail and elderly.³⁰

And, we would add - female.

As individuals we have responsibilities to others. The exulting of independence, self-sufficiency and radical individualism has, we would argue, resulted in the breakdown in human solidarity, networks of care, and contempt for dependency. "By exalting autonomy to the degree we do, we systematically slight the very young, the severely ill or disabled, the

27 Bill Hayden, 'A right to live, and die, without intervention', *The Australian*, June 23, 1995

28 M. de Hennezel 'The Myth of the Perfect Death: The New Meaning of Death in the Context of AIDS', Plenary Address, "Caring Together/Entraide: Conference Proceedings", Ottawa, 1991, 33-38, 34.

29 Brock, *supra*, note 25, p.17, referring to Velleman) D.W. Brock, "Voluntary Active Euthanasia", *Hastings Center Report*, 1992; 22(2):10,19 Somerville,

30 Nicholas Tonti-Filippini, 'Human rights must precede State rights', *The Australian*, October 28, 1996, p.9.

frail elderly, as well as those who care for them."³¹

The taking of life can never be a private decision between a patient and his/her doctor. It affects all of us. The House of Lords Select Committee on Medical Ethics observed: "We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole."³²

FINRRAGE (Australia) supports the right to refuse life-sustaining treatment, to be free of treatment considered burdensome and to be free from unwanted bodily invasion.

We strongly support increased funding for palliative care. In our analysis, we believe euthanasia will result in less attention and resources being devoted to palliative care. Palliative care remains underfunded, suffering a 10 percent funding cut in the last budget, with funding after June 1997 in doubt.

The Victorian Association for Hospice and Palliative Care Inc wrote recently: "It would be a sad comment on our society if those vulnerable people facing the end of their lives, sought euthanasia as a release from their suffering, in their ignorance about the enormous developments within the discipline of palliative care over recent years."³³

In conclusion, we commend to the Committee the words of Roy and Rapin, writing in *The European Journal of Palliative Care*:

The challenge of civilisation to our societies at the end of this decade is to transform our care of the suffering and the dying, not to legalise an act that would all too easily substitute for the palliative competence, compassion and community that human beings need during the most difficult moments of their lives...The signs in our society of overt discrimination, latent racism, and utilitarian insensitivity to the vulnerable are too prominent for us to be naive about proposals to decriminalise euthanasia.³⁴

It is the duty of the Commonwealth to protect the most vulnerable.

We urge the Parliament of Australia to carry out this obligation by rejecting the *Rights of the Terminally Ill Act 1996* and upholding the *Euthanasia Laws Bill 1996*.

31 Mary Ann Glendon, *Rights Talk: The Impoverishment of Political Discourse* (New York, NY: Free Press, 1991), p.74

32 House of Lords, Report of the Select Committee on Medical Ethics, HL. Paper 21-1, London: HMSO, 1994

33 Letter, October 1996

34 Regarding euthanasia", David J Roy, Charles-Henri Rapin, *European Journal of Palliative Care*, Vol 1(1) (1). Spring, 1994.