



LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT

Ms Bec Cody MLA (Chair), Mrs Vicki Dunne MLA (Deputy Chair), Ms Tara Cheyne MLA,
Mrs Elizabeth Kikkert MLA, Ms Caroline Le Couteur MLA.

Submission Cover Sheet

End of Life Choices in the ACT

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Submission to the Inquiry into End of Life Choices in the ACT Women's Bioethics Alliance

March 2018

To The Secretary

Select Committee on End of Life Choices in the ACT

Legislative Assembly for the ACT

GPO Box 1020

CANBERRA ACT 2601

23rd March 2018

To The Secretary

Thank you for the opportunity to contribute to this important inquiry into end of life choices in the ACT.

We are a group of women who are concerned with the exploitation and abuse of women's bodies through medical practice.

We wish to address the matter arising in the Terms of Reference at point (c), that is **the risks to individuals and the community associated with voluntary assisted dying and whether and how these can be managed.**

We offer an evidence-based argument that substantial gendered risks are involved in euthanasia and assisted suicide that render women more vulnerable.

First, we describe briefly how psychological suffering is frequently a reason for euthanasia or assisted dying in jurisdictions where it is legal. It is our strong view that those suffering in this way should be offered intensive high-quality treatment rather than death.

Second, we show how Australian women experience mental illness differently and at higher rates than men and suggest that the availability of assisted dying combined with inadequate mental health care will make them more vulnerable to 'choose' death.

Third, we point out that most public assisted suicide cases as well as mercy killings involve women, and we ask why this might be.

- 1. Psychological or psychiatric suffering is often an accepted condition for euthanasia or assisted suicide in countries where it is legal. This is a natural part of the "rational suicide" concept that motivates euthanasia lobbying in Australia as well.**

Fundamental to our submission is the observation that in jurisdictions where euthanasia and/or assisted suicide are legal, there are many cases of individuals accessing it for reasons of “unbearable suffering” that is not related to terminal illness, but instead related to psychiatric or psychological distress.

We draw your attention to the tragic case of a 20-year-old woman who was killed by lethal injection in Belgium in 2015 (Mitchell 2016). She had been sexually abused between the ages of 5 and 15. She suffered PTSD, severe anorexia, chronic depression, hallucinations, suicidal mood swings, self-harming tendencies and obsessive compulsive behaviours. Her psychiatrist declared that there was no prospect of recovery, and doctors believed (incredibly) her to be “fully competent with no major depression or mood disorders affecting her thinking.”

Also in Belgium was the case of Nathan Verhelst, born as a girl called Nancy and unwanted by her mother (“If only you had been a boy...”). She was sexually abused by her brothers from the age of twelve. Later in life, Nathan underwent hormone therapy, a mastectomy, and failed surgery to construct a penis. He requested and received euthanasia in 2013. “I did not want to be a monster... I was the girl that nobody wanted,” he said in an interview just before his death (Waterfield 2013).

To add empirical evidence to these cases, we ask you to consider two reports on euthanasia and assisted suicide in Belgium and The Netherlands where euthanasia is legal and widely practiced.

The first study reports on Dutch patients with psychiatric disorders 2011 to 2014. Seventy percent (n=46) of these patients were women (Kim, De Vries & Peteet 2016). Four of these women were cognitively impaired; some had eating disorders, other experienced prolonged grief. Most were lonely and isolated.

Similar data involving Belgian patients who had psychiatric disorders or dementia was analysed from 2002 to 2013 and found that absolute numbers were increasing over that time, with the majority of patients being women and especially an increase in euthanasia of female patients with mood disorders (Dierickx *et al* 2017).

2. Australian women experience psychological and psychiatric distress at higher rates than men.

Australian women and girls are more vulnerable than men to anxiety, depression, PTSD and eating disorders (Beyond Blue 2018). Women experience mental health very differently to men and there are many reasons why: biological, psychological and social factors are intertwined.

There are clear structural factors at work: poverty, gender based violence, intimate partner violence, caregiving and unpaid work, and lower political participation. All these could be discussed at length but we will remain brief and simply point out that *instead of legalising assisted death, Australia should be addressing all these issues urgently.*

Mental disorders represent the leading cause of disability and the highest burden of non-fatal illnesses for women in Australia. Most alarming is the suicide rate of Aboriginal and Torres Strait Islander women, the highest within the 20-24 years old age group (21.8 per

100,000), more than five times higher than their corresponding nonindigenous counterparts (4.0 per 100,000) (Duggan 2016, px).

Australian teen girls are experiencing suicidal ideation and suicide attempts at a higher rate than teenage boys (Mars *et al* 2018; Zubrick *et al* 2016).

It is disturbing that more and more Australians including teens are taking their own lives using Nembutal, the drug promoted by Philip Nitschke and Exit International. Undeterred, Philip Nitschke responded by saying that the fact younger people were accessing the drug should be balanced against "the very large number of people who get immense comfort from knowing they have a safety net in place" (Butt 2015).

Australia's official response to those suffering should be compassion and the best medical care, not death. But we have very broad concerns about the inadequacy of Australia's mental health system, both qualitatively and quantitatively, to effectively treat and prevent mental illness in women. This is best described by an important major review of Australian women's mental health from 2016:

"Whilst there are pockets of good practice in the provision of current services to women with mental health problems, there is little cohesion or collaboration across the various sectors, agencies and practitioners involved with women experiencing mental distress. Women seeking help at key transition points in the life course – when they may have to deal with overwhelming interactions between biological, social, emotional and economic risk factors that require integrated and holistic responses – often experience extremely negative consequences..."

"Mental health services have historically received a lower proportion of federal and state budgets than physical health services and Medicare only covers certain kinds of mental health services. The result is a two-tiered system in which people with financial resources and/or health insurance can access a wider range of service options and for a longer period of time, whilst those who have no coverage must rely on the public health system. This has negative and discriminatory impacts on women. Women's concentration in lower wage sectors and in part-time employment makes them more likely to be ineligible for employee assistance programs and extended healthcare coverage." (Duggan 2016, px)

Further, Australian women later in life are especially vulnerable to psychological distress and dementia:

*"The pattern for much older women appears to be different again, with an increase in psychological distress in late old age (>85 years of age). Older women also have particular mental health needs related to loss, multimorbidity, depression and dementia. The likelihood of dementia increases with age, and women are twice as likely as men to develop dementia, in part because of their greater longevity (Alzheimer's Disease International 2015). Despite this, little research exists on the progress of depression and other mental disorders in older women in Australia and services and interventions are gender-blind and scarce, particularly in rural areas (Alston *et al.* 2006). A recent systematic review (Luppa *et al.* 2012) reported increasing rates of psychological disorders in the oldest age groups (85–89 years and >90 years) yet particularly low utilisation of treatment (Byles *et al.* 2011). National and international data point to high rates of hospital admission for mental health*

needs and high rates of depression in clinical and aged care settings (Rich et al. 2013).” (Duggan 2016, p7).

We urge great caution in allowing euthanasia or assisted suicide when there are so many vulnerable women already thinking about death.

3. The majority of high profile euthanasia cases are women.

Australia has watched carefully as several women have publicly requested death, including Sandy Williamson, Nancy Crick, Lisette Nigot, Esther Wild, Shirley Nolan, Janet Mills. In fact, the stories on Exit International’s website feature twelve women and only seven men (Exit International 2017).

Infamous euthanasia doctor Jack Kevorkian assisted many people to die between 1990 and 1997; 72% were women (Canetto & Hollenshead 1999-2000). The main reasons given by his patients for receiving assisted death were having disabilities, experiencing pain, and being a burden.

In Belgium, requests and prevalence of euthanasia are increasing yearly, and the largest increase in granting requests were among women (Dierickx *et al* 2015).

Another clue to the gendered risks of euthanasia is the phenomenon of “mercy killing”. It is disturbing to observe that the majority of mercy killings involve men killing women, often while the women sleep (Canetto & Hollenshead 2000-2001).

The legalisation of “assisted suicide” presents Australian courts with further arguments from the defense counsel of accused murderers of female partners who already use a range of arguments attributing deaths to victims themselves (e.g., “rough sex”). We envisage an “assisted suicide” defense of woman-killing to become a frequent and useful plea of perpetrators of domestic violence leading to murder.

Yet in Australia and elsewhere, men make up a clear majority of suicide statistics. This is especially true in nursing homes, where victims of suicide are overwhelmingly male (Murphy *et al* 2018).

Why this gender imbalance in euthanasia and assisted suicide? Euthanasia advocates might argue that women do not wish to die violently and alone, that they seek death with dignity surrounded by family and friends. But this data indicates that some women will seek euthanasia or assisted death when they otherwise would not have attempted suicide.

Burdensomeness is a key point here, and much has been written about the strong cultural expectation that women feel deeply, to be useful, independent, and not burden others.

Jane Aronson (1992) described this at length according to her research with older women:

“Living with this lack of alternatives and, thus, having to turn to younger relatives was not an easy process. A commonly-expressed sentiment about accepting the help of younger family members was a wish not to feel indebted or diminished in any way. For example, in explaining how her daughter helped her out in numerous ways for which she was less and less able to reciprocate, one woman was quick to assert that her acceptance of help did not render her a “poor granny.” She and others noted that they paced their requests for help from their children, so as not to seem

"demanding," sometimes deciding that it was simpler to just go without whatever it was they needed, rather than risk appearing burdensome.

"For women who remembered feeling responsible for their own mothers in the past, the importance of concealing their needs and measuring their requests for help was heightened. A "sandwich generation" before the term was coined, they remembered how they felt their primary responsibilities were to their husbands and children. They felt guilty at diluting attention to their families, thus defined, guilty about their mothers, and torn and stretched by the competing claims on their time and energy. These women did not want to visit the same tensions on their daughters."

"In these patterns, we see the working out in old age of the selflessness, low expectations and capacity for self-blame that characterize women's psychological structuring over the life course and that silence complaint or anger."

We observe that standards for "quality of life" in the case of women tend to be set at a very high level, given the expectation that women unable to care for others and perform the usual female roles in society are living lives of terrible deprivation and suffering. High profile assisted suicide cases like Lisette Nigot and Nancy Crick were not about terminal illness. Rather, they were promoted as desiring "rational euthanasia" as Philip Nitschke puts it, that is euthanasia cases that appeal to the public based on how awful their lives were.

Conclusion

We argue that women are more vulnerable to euthanasia or assisted suicide because of gender stereotypes and structural pressures upon women. Women are expected to be useful, productive, attractive, young – certainly not sick, disabled, old or unattractive – and women are more likely to give their lives to avoid burdening others, having served others all their lives.

The gender imbalance also speaks of the age discrimination that women face as they get older, for example the story of Lisette Nigot, who did not want to turn 80. And clearly women favour a more passive death, carried out by a doctor.

We are very concerned that legalising euthanasia or assisted suicide will offer a method of death that appeals more to women but will fail to safeguard vulnerable women from subtle coercive factors that could undermine their autonomy.

Yours sincerely

Dr Caroline Norma

Senior Research Fellow, RMIT University

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Jamison ACT 2614

Mob: ██████████

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