‘What’s it got to do with you?’ Challenging the medical profession’s future in the assisted suicide debate

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Bill insisted on leaving the visit until the day he died. As one of my four patients to qualify to use the Northern Territory’s Rights of the Terminally Ill (ROTI) Act [1] back in 1996, Bill knew he had to see a psychiatrist before he died. Indeed, it was necessary to see a psychiatrist in order to die. That was one of the safeguards of the ROTI Act. That was the criteria the politicians had set down to protect the general populace from themselves.

On Bill’s last day alive, and after discharging himself from Darwin Private Hospital, he and I drove to the rooms of Len Marinovich. I remember the day well, not least because the receptionist insisted on up-front payment for the consultation. I remember it most though, at seeing Bill’s relief at finding that he was not, as he had most feared, “depressed” and denied access to the legislation. Despite showing ‘elements of depression’ [2], Dr Marinovich certified that Bill knew what he was doing in wanting to use the ROTI Act. In so doing, the consultation helped open an important chapter in the history of the psychiatric profession in this country.

Legislative history

On 1 July 1995 the Northern Territory of Australia became the first place in the world to legalize voluntary euthanasia. While the Dutch undertook a 20 year trial run at the decriminalization of the same, and the Oregonians became the unwitting targets of then US Attorney General John Ashcroft’s stymieing court actions [3], it was the Northern Territory who legislated first.

The Northern Territory law was ground-breaking on many counts. Technically, the law allowed for both voluntary euthanasia and assisted suicide. That is, it provided for a doctor to give a patient a legal, lethal, voluntary injection (euthanasia). It also allowed a doctor to prescribe to a patient lethal drugs which could be taken home and used at some undefined moment in the future, should the need ever arise (assisted suicide).

From the day the law was first used by prostate cancer sufferer, Bill Dent, on 22 September 1996 to the day the Australian Senate passed the Euthanasia Laws Act (known colloquially as the Kevin Andrews Act) on 23 March 1997 – a move which exploited the constitutional loophole which allows the Commonwealth to make laws for its territories – this law was living on borrowed time.

When then Prime Minister John Howard devoted an unheard of amount of parliamentary debate time to the Private Member’s Bill of the Honourable Member for Menzies, Kevin Andrews, those in favour of voluntary euthanasia knew it was likely the law would be overturned. As history now tells it, the law lasted a few days short of nine months. With a fifth patient waiting to use the law over the Easter break of 1997, the Governor General, Sir William Dean used his Good Friday holiday to give Royal Assent to the Euthanasia Laws Bill, denying retired nurse Esther Wilde legal recourse to end her suffering.

The march of legislative progress

Since March 1997, voluntary euthanasia and/or assisted suicide has been legislated in the US states of Oregon and Washington, and countries such as the Netherlands, Belgium, and Luxembourg. The US state of Montana has cleared the way for a law to be passed, while that
European bastion of social liberalism, Switzerland, has at referendum overwhelmingly voted to continue their unique criminal code – that allows for a person who not ‘for selfish motives, persuades or assists another person to commit suicide’ will commit no crime. A person who acts to the contrary is liable for imprisonment of up to five years [4]. Furthermore, in Switzerland, the person assisting need not be a member of the medical profession.

The UK too is edging its way towards legalization. In September 2009, the Director of Public Prosecutions, Keir Starmer, issued new guidelines about when and where a prosecution for assisting a suicide would be likely. Under these guidelines, a set of public interest factors, for and against, is applied to cases of assisted suicide. Factors against prosecution include if ‘the victim had a clear, settled and informed wish to commit suicide’, ‘the victim had a terminal illness or a severe and incurable physical disability or a severe degenerative physical condition from which there was no possibility of recovery’ and if ‘the suspect was wholly motivated by compassion’ [5]. While this is hardly a solution, it is a step in the right direction. The 14-odd attempts at voluntary euthanasia legislation, which have been made in the various state parliaments of Australia, also show that the issue continues to occupy the attention of our own lawmakers.

**Transparency through legislation**

In each of these places, the legalization of assisted suicide has heralded extensive community debate. Each law has also brought with it a degree of transparency over the circumstances of both voluntary and non-voluntary deaths. The Remmelink Reports of the Netherlands and annual reporting by the Oregon Department of Human Services allow a level of oversight not possible in countries such as Australia where to assist in a suicide brings harsh legal sanction.

In Queensland, Western Australia and the Northern Territory a guilty verdict for assisting a patient to do something that is lawful (suicide is not against the law), brings a penalty of up to life imprisonment. In the more enlightened southern state of Victoria, the penalty is five years for a person who ‘aids and abets any other person in the commission of suicide or in an attempt to commit suicide’ [6]. Given the savagery of the penalties associated with the act of ‘assisting’, should we be surprised that in one study, at least, the rate of intentional ending of life without a patient’s request by doctors was higher in Australia than the Netherlands [7]?

**Safeguards and the role of the psychiatric profession**

In the legislative models of assisted suicide operating around the world there are a number of mandated safeguards. In the Northern Territory these were as follows:

1. To qualify to use the Act, the person had to be over eighteen years of age.
2. In the treating doctor’s opinion, the person had to be ‘suffering from an illness that would, in the normal course and without the application of extraordinary measures, result in the death of the patient.’
3. The patient had to consult three medical professionals in addition to their own doctor.
4. A mandatory 48 hour cooling-off period applied [8].

One of the medical consultations had to be performed by a psychiatrist in order to certify that the person was not ‘suffering from a treatable clinical depression in respect of the illness.’ And this leads us back to Bill and his last minute visit to Dr Marinovich.

Notwithstanding Bill’s fear of being diagnosed as depressed, he was not the only one of my patients to resent this clinical intrusion into his final days. Bob Dent, too, expressed a mixture of resentment and resignation at being mandated to have his mental health certified at the precise moment when he felt most vulnerable. But in many ways the cases of the four individuals who used the Northern Territory’s ROTI Act were the easy ones. Since that time, a new cohort has emerged which present a much greater challenge to the psychiatric profession.

**Rational suicide and the tired of life phenomenon**

Within a legislated, clinical setting a terminally ill patient’s decision to suicide becomes sanctioned. Firstly, the law states the various bases for patient qualification. Secondly, and for our purposes, the law identifies the role of the medical profession. Thirdly, the legislation creates and legitimizes a social milieu in which any decision to hasten death can be seen as the sensible, even desirable, thing to do. Far from being an irrational act that demands professional intervention, the act becomes self-regarding and rational.

Outside of this setting, however, and in the absence of legislation that criminalizes suicide (suicide has not been a crime in most Australian states since at least the 1960s), there is a much less clear framework for understanding,
let alone facilitating, the suicide process. The cohort I refer to here are the well elderly, those 80-somethings who identify as ‘tired of life’. On the basis of the changing demographic make-up of Exit International (the advocacy organization founded by Philip Nitschke after the ROTI Act was overturned, operating in a number of countries throughout the English-speaking world), it is this group which we predict will occupy centre stage of the right to die debate in years to come. Here, the role of the psychiatric profession will be questioned, given the lack of a legal mandate. The moral issue, though, is an entirely different matter.

While critics will likely insist that elderly elective suicide is nothing short of ‘malignant narcissistic preoccupation masquerading as autonomous self-regard’ [9], this view has not stopped this new social movement from emerging. In Australia there have been high profile proponents of the ‘tired of life’ mindset such as retired French academic, Lisette Nigot. In November 2002, the Sydney Morning Herald reported Nigot’s reason for ending her life as ‘she did not want to live to 80’ [10]. A member of Exit International, in the documentary film Mademoiselle and the Doctor, Lisette stated that her intention was to ‘go while the going is good.’

More recently in the Netherlands, the citizens’ action group, Uit Vrije Wil, has reportedly gathered over 100,000 signatures to force a referendum on whether 70-somethings who are not experiencing hopeless or unbearable suffering, people who believe they have lived ‘long enough’ should be able to obtain assistance to die [11]. While some reports state that the Royal Dutch Medical Association has rejected the proposal outright [12], other reports say a middle ground has been proposed by including ‘anyone who is elderly and weary is suffering from some degree of geriatric affliction’ as falling within the current Euthanasia Act guidelines of ‘hopeless and unbearable suffering’ [13].

**Conclusion**

With the exception of Switzerland, the medical profession is pivotal to and controls the modern assisted dying process. While Swiss law does not mandate the involvement of the profession in an assisted suicide, the fact that the sodium pentobarbital can only be prescribed by, and at the sole discretion of, a doctor places the profession at a critical juncture in the suicide process.

Outside of these current legislative models awaits an altogether more challenging environment. This is because it is unlikely that the existential needs of the elderly ‘tired of life’ cohort will ever be addressed by assisted dying legislation. Therefore, given that the chosen actions of such a group will lie outside of such laws, but within current criminal codes, the questions to be asked are how, and indeed should, the medical profession and psychiatry in particular be involved? How, in the face of an increasingly complex dying process, should the wishes of this generational group be addressed, respected or dismissed as the ultimate indulgence of the modern autonomous lifestyle?

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