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To die with dignity

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Legislative Council of Victoria, Australia
Legal and Social Issues Committee
Inquiry into End of Life Choices

Are Victorian laws adequately meeting people's expectations regarding medical options available at the end of their life ?

Submission by DIGNITAS - To live with dignity - To die with dignity, Forch, Switzerland

as requested, submitted in electronic format,
by email to lsic@parliament.vic.gov.au

DIGNITAS is happy to give oral evidence if the Committee would wish so

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1) Introduction

"The best thing which eternal law ever ordained was that it allowed us one entrance into life, but many exits. Must I await the cruelty either of disease or of man, when I can depart through the midst of torture, and shake off my troubles? . . . Are you content? Then live! Not content? You may return to where you came from"[1]. These are not the words by a protagonist of the many organisations around the world representing the interests of people who wish for freedom of choice in ending one's suffering and life self-determinedly today, but the words of Roman philosopher LUCIUS ANNAEUS SENECA who lived 2000 years ago, in his letters dealing with moral issues to Lucilius.

In recent years, questions dealing with the subject of end of life choices, including assisted suicide and voluntary euthanasia, have arisen again and are now discussed in the public, in parliaments and courts.

Of the many reasons for this development, one is the progress in medical science which leads to a significant prolonging of life expectancy. During the congress of the Swiss General Practitioners in 2011[2] it was emphasised that a sudden death, for example due to a 'simple' heart attack or a stroke is nearly unthinkable today, due to possibilities of modern intensive care.

Obviously, this progress is a blessing for the majority of people. Who would not want to live as long as possible if one's quality of life, which includes health, is good by one's personal point of view? However, medical advances have led to a vastly increased capacity to keep people alive without, in many cases, providing any real benefit to their health[3] – prolonging life to a point much further in the future than some patients would want to bear an illness. But, more and more people wish to add life to their years – not years to their life. Consequently, people who have decided not to carry on living but rather to self-determinedly put an end to their suffering started looking for ways to do so. This development has gone hand in hand with tighter controls on the supply of barbiturates and progress in the composition of pharmaceuticals which led to the situation that those wishing to put an end to their life could not use this particular option anymore for their purpose and started to choose more violent methods. A further, parallel, development was the rise of associations focusing on patient's rights, the right to a self-determined end of life and the prevention of the negative effects resulting from the narrowing of options.

In Switzerland, over 30 years ago, EXIT (German part of Switzerland) was founded, in the same year as EXIT-A.D.M.D. (French part of Switzerland), and shortly afterwards the first association to offer the option of an accompanied suicide to its members. Further not-for-profit member's societies like EX INTERNATIONAL, DIGNITAS, and LIFECIRCLE followed, the only difference between

1 In: Epistulae morales LXX ad Lucilium
2 Congress of Swiss General Practitioners in Arosa, March 31st - April 2nd, 2011, http://www.arosakongress.ch
3 British Medical Journal 2012, http://www.bmj.com/content/bmj/345/bmj.e4637 full.pdf

these organisations being mainly the acceptance or not of members residing in countries other than Switzerland. As a result of the above-indicated aspects and other developments in modern society, the focus of all associations has widened to include working on suicide preventive issues directly or indirectly, especially suicide attempt prevention, palliative care and the implementation of advance directives (living will).

Today, EXIT has 92,000 members and EXIT-A.D.M.D. 21,000. DIGNITAS, together with its independent German partner association DIGNITAS-Germany in Hannover, counts over 7,000 members worldwide of whom 11 reside in the State of Victoria, with a total of 87 members for Australia altogether.[4]

In the over 17 years of DIGNITAS' existence, 20 Australian – of whom one of the State of Victoria – have made use of the option of a self-determined self-enacted ending of suffering and life with DIGNITAS in Switzerland[5]. For all DIGNITAS-members, being assisted and accompanied through the final stage of their life towards their self-determined end was and is an issue of major importance. DIGNITAS always encourages members to have their next-of-kin and/or friends at their side during the entire process, including the final days.

Whilst it has to be acknowledged that the legal system in Australia permits for palliative care, in some cases if need be applied in the ultimate form of terminal sedation, which provides an essential option for the dying, the option of choosing a safe and dignified self-enacted death, which is ending one's suffering in the frame of assisted/accompanied suicide, is not possible.

This leads to residents of the State of Victoria in Australian having to travel 16,333 kilometres (which is the air-line distance Melbourne to Zürich) when all that he or she wishes is to have a self-determined and self-enacted end of suffering. Furthermore, the present legal situation in Australia has the additional appalling effect that the very important support towards the end of life by next-of-kin and/or friends must take place shadowed by the fear of prosecution. Sometimes, this even leads patients to decide to travel to DIGNITAS only with very few loved ones or even alone.

This is approached differently under Swiss law: whilst in Switzerland, like in Australia, palliative care is established and suicide as such is not a crime, article 115 of the Swiss Criminal Code states:

> "Whoever, from selfish motives, induces another person to commit suicide or aids him in it, shall be imprisoned for up to five years or pay a fine, provided that the suicide has either been completed or attempted."

The obvious difference is the 'selfish motives': whilst in Australia the law basically threatens to punish assistance in suicide whatever the motive, Swiss law

[4] http://www.dignitas.ch/images/stories/pdf/statistik-mitglieder-wohnsitzstaat-31122014.pdf
[5] http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2014.pdf

makes a clear distinction of motives, permitting assistance in self-enacted ending of life out of non-selfish motives, and thus gives a basis for assisted/accompanied suicide for competent patients – made possible by associations like DIGNITAS, EXIT and others.

DIGNITAS very much welcomes the 'Inquiry into End of Life Choices' of the Legislative Council Committee on Legal and Social Issues: it brings the issue of end-of-life-questions to the level where it should be addressed, the legislation. Australia once made an important step forward in legislation when it introduced The Northern Territory Rights of the Terminally Ill Bill in 1996. Unfortunately, the Bill was overturned only a few months later. Still, the introduction of the Bill shows that legislators in Australia are well aware of the need for implementing additional end-of-life-options and the request of Australians to have a choice and say in how their suffering and life should end, that is, to have personal control over time and manner of their death.

2) Who is DIGNITAS and why does DIGNITAS write this submission?

DIGNITAS is a Swiss not-for-profit member's society, a help-to-life and right-to-die, dignity advocacy group, founded in 1998 by Swiss human rights attorney Ludwig A. Minelli. Many years earlier, in 1977, he had already founded SGEMKO, the Swiss Society for the European Convention on Human Rights, a not-for-profit member's society spreading information about the European Convention for the Protection of Human Rights and Fundamental Freedom (ECHR). At an early stage, Mr. Minelli and his colleagues have been convinced that where there is the individual's right to life as enshrined in article 2 of the ECHR, there also must be the individual's right to die – the right to end his or her own life. Many years later, in 2011, the European Court of Human Rights confirmed this opinion in the case of HAAS v. Switzerland, application no. 31322/07 (see further in this submission).

DIGNITAS being a human rights orientated organisation posed the question: if in Switzerland, why not in other countries? Isn't it discriminatory, if access to a dignified end of life depends on domicile/residence and citizenship? The ECHR condemns such discrimination in article 14[6]. Therefore, the logic consequence for DIGNITAS was 1) to allow non-Swiss residents and non-Swiss citizens to access the possibility of an assisted suicide in Switzerland, and 2) to advocate for implementation of 'the last human right', the practice of Switzerland, in other countries too. In its over 17 years of operation, DIGNITAS has been involved in several leading legal cases dealing with the 'right to die' at the European Court of Human Rights, DIGNITAS has been consulted by representatives of the Parliament of England and Scotland with an aim of implementing laws to introduce assisted/accompanied suicide as an additional end-of-life-choice, and has under-

[6] http://www.echr.coe.int/Documents/Convention_ENG.pdf page 13

taken many more activities to implement this 'last human right' around the world.

For DIGNITAS, when it comes to making use of freedom at life's end, it is understood that the discrimination of an Australian or any other citizen against a Swiss citizen is inacceptable and such discrimination should be abolished.

Clearly, the public is in favour of freedom of choice in these 'last issues'[7]. Advocacy for assisted dying law reform is very high across all Australians states, and especially high in Victoria.[8]

No Victorian should be forced to travel to Switzerland in order to have a self-determined, self-enacted, safe and accompanied ending of his or her suffering. Everyone should have access to such option at his or her home, as an additional choice besides palliative care. In consequence, DIGNITAS writes this submission in the name of its Victorian members and for all other Australians who would like to have such freedom of choice, so they won't need DIGNITAS anymore.

3) The freedom to choose time and manner of one's own end from an European Human Rights perspective

All European states (with the exception of Belarus and the Vatican) have adhered to the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR)[9]. In specific cases, set legal situations may be questioned whether they would be in line with the basic human rights enshrined in the ECHR. The European Court of Human Rights[10] has developed a valuable jurisdiction on basic human rights, including the issue of the right to choose a voluntary death. According to its preamble, this international treaty is not only a fixed instrument, "securing the universal and effective recognition and observance of the rights therein declared" but also aiming at "the achievement of greater unity between its members and that one of the methods by which that aim is to be pursued is the maintenance and further realisation of human rights and fundamental freedoms"[11]. The ECHR' text and case law may serve as an example and could be taken into consideration in legislation in the State of Victoria, which is why DIGNITAS herewith outlines some of its most important rulings in relation to a self-determined and self-enacted end of suffering and life.

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7 See for example the national Australian research conducted in late 2012 by Newspoll http://gallery.mailchimp.com/d2331cf87fedd353f6dada8de/files/A21_The_Right_to_Choose.pdf , the First Report of the UK Select Committee on Assisted Dying for the Terminally Ill Bill: http://www.parliament.the-stationery-office.co.uk/pa/ld200405/ldselect/ldasdy/86/8609.htm , the ISOPUBLIC/GALLUP Poll http://www.medizinalrecht.org/wp-content/uploads/2013/03/Results_opinion_poll_self-determination_at_the_end_of_life.pdf and others more.

8 https://www.dwdnsw.org.au/documents/2013/POLL%20WHITE%20PAPER%202012.pdf

9 The Convention: http://www.echr.coe.int/Documents/Convention_ENG.pdf
Member States: http://www.conventions.coe.int/Treaty/Commun/ChercheSig.asp?NT=005&CM=8&DF=25/07/2014&CL=ENG

10 http://www.echr.coe.int/Pages/home.aspx?p=home

11 http://www.echr.coe.int/Documents/Convention_ENG.pdf page 5

In the judgment of the European Court of Human Rights in the case of DIANE PRETTY v. the United Kingdom dated April 29th, 2002[12], at the end of paragraph 61, the Court expressed the following:

> "Although no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees."

Furthermore, in paragraph 65 of the mentioned judgment DIANE PRETTY, the Court expressed:

> "The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity."

On November 3rd, 2006, the Swiss Federal Supreme Court recognized that someone's decision to determine the way of ending his/her life is part of the right to self-determination protected by article 8 § 1 of the Convention stating:

> "The right of self-determination in the sense of article 8 § 1 ECHR includes the right to decide on the way and the point in time of ending one's own life; providing the affected person is able to form his/her will freely and act thereafter."[13]

In that decision, the Swiss Federal Supreme Court had to deal with the case of a man suffering not from a physical but a mental ailment. It further recognized:

> "It cannot be denied that an incurable, long-lasting, severe mental impairment similar to a somatic one, can create a suffering out of which a patient would find his/her life in the long run not worth living anymore. Based on more recent ethical, juridical and medical statements, a possible prescription of Sodium Pentobarbital is not necessarily contra-indicated and thus no longer generally a violation of medical duty of care . . . However, utmost restraint needs to be exercised: it has to be distinguished between the wish to die that is expression of a curable psychic distortion and which calls for treatment, and the wish to die that bases on a self-determined, carefully con-

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[12] Application no. 2346/02; Judgment of a Chamber of the Fourth Section: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-60448

[13] BGE 133 I 58, page 67, consideration 6.1: http://relevancy.bger.ch/php/clir/http/index.php?lang=de&type=show_document&page=1&from_date=&to_date=&from_year=1954&to_year=2014&sort=relevance&insertion_date=&from_date_push=&top_subcollection_clir=bge&query_words=&part=all&de_fr=&de_it=&fr_de=&fr_it=&it_de=&it_fr=&orig=&translation=&rank=0&highlight_docid=atf%3A%2F%2F133-I-58%3Ade&number_of_ranks=0&azaclir=clir#page240

> sidered and lasting decision of a lucid person ('balance suicide') which possibly needs to be respected. If the wish to die bases on an autonomous, the general situation comprising decision, under certain circumstances even mentally ill may be prescribed Sodium Pentobarbital and thus be granted help to commit suicide."

And furthermore:

> "Whether the prerequisites for this are given, cannot be judged on separated from medical – especially psychiatric – special knowledge and proves to be difficult in practice; therefore, the appropriate assessment requires the presentation of a special in-depth psychiatric opinion…"

Based on this decision, the applicant made efforts to obtain an appropriate assessment, writing to 170 psychiatrists – yet he failed to succeed. Seeing that the Swiss Federal Supreme Court had obviously set up a condition which in practice could not be fulfilled, he took the issue to the European Court of Human Rights.

On January 20th, 2011, the European Court of Human Rights rendered the judgement[14] HAAS v. Switzerland and stated in paragraph 51:

> "In the light of this jurisdiction, the Court finds that the right of an individual to decide how and when to end his life, provided that said individual was in a position to make up his own mind in that respect and to take the appropriate action, was one aspect of the right to respect for private life under Article 8 of the Convention"

In this, the Court adhered to the Swiss Federal Supreme Court and acknowledged that the freedom to choose time and manner of one's own end is indeed a basic human right protected by the European Convention of Human Rights.

In a further case, ULRICH KOCH against Germany, the applicant's wife, suffering from total quadriplegia after falling in front of her doorstep, demanded that she should have been granted authorisation to obtain 15 grams of pentobarbital of sodium, a lethal dose of medication that would have enabled her to end her ordeal by committing suicide at her home. In its decision of July 19th, 2012, the European Court of Human Rights declared the applicant's complaint about a violation of his wife's Convention rights inadmissible, however, the Court held that there had been a violation of Article 8 of the Convention in that the [German] domestic courts had refused to examine the merits of the applicant's motion[15]. The case is now pending at the Administration Court of Cologne, and depending on their decision, the case might well continue on to the German Federal Constitutional Court and then again to the European Court of Human Rights.

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[14] Application no. 31322/07; Judgment of a Chamber of the First Section (in French): http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-102939

[15] Application no. 479/09, Judgment of the Former Fifth Section: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-112282

In the case of GROSS v. Switzerland, the European Court of Human Rights further developed its jurisdiction. The case concerned a Swiss woman born in 1931, who, for many years, had expressed the wish to end her life, as she felt that she was becoming more and more frail and was unwilling to continue suffering the decline of her physical and mental faculties. After a failed suicide attempt followed by inpatient treatment for six months in a psychiatric hospital which did not alter her wish to die, she tried to obtain a prescription for sodium pentobarbital by Swiss medical practitioners. However, they all rejected her wish, one felt prevented by the code of professional medical conduct being that the woman was not suffering from any life-threatening illness, another was afraid of being drawn into lengthy judicial proceedings. Attempts by the applicant to obtain the medication to end her life from the Health Board were also to no avail.

In its judgment[16] of May 14th, 2013, the European Court of Human Rights held in paragraph 66:

> "The Court considers that the uncertainty as to the outcome of her request in a situation concerning a particularly important aspect of her life must have caused the applicant a considerable degree of anguish. The Court concludes that the applicant must have found herself in a state of anguish and uncertainty regarding the extent of her right to end her life which would not have occurred if there had been clear, State-approved guidelines defining the circumstances under which medical practitioners are authorised to issue the requested prescription in cases where an individual has come to a serious decision, in the exercise of his or her free will, to end his or her life, but where death is not imminent as a result of a specific medical condition. The Court acknowledges that there may be difficulties in finding the necessary political consensus on such controversial questions with a profound ethical and moral impact. However, these difficulties are inherent in any democratic process and cannot absolve the authorities from fulfilling their task therein."

In conclusion, the Court held that Swiss law, while providing the possibility of obtaining a lethal dose of sodium pentobarbital on medical prescription, did not provide sufficient guidelines ensuring clarity as to the extent of this right and that there had been a violation of Article 8 of the Convention. However, unfortunately, the case was referred to the Grand Chamber and shortly prior to a public hearing on the case, it became known that the applicant had passed away in the meantime, which led to the case not being pursued.

In light of these judgments and because of respect for human personal autonomy, which the Court acknowledges as an important principle in order to interpret the guarantees of the Convention, further legal developments are to be expected.

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[16] Application no. 67810/10; Judgment of a Chamber of the Second Section: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-119703

We would like to emphasize that in this context, since the case of ARTICO v. Italy (judgment of May 13th, 1980, series A no. 37, no. 6694/74[17]), the developed practice (so-called ARTICO-jurisdiction) is of major importance. In paragraph 33 of said judgment the Court explained:

> "The Court recalls that the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective; . . ."

Dignity and freedom of humans mainly consists of acknowledging the right of someone with full capacity of discernment to decide even on existential questions for him- or herself, without outside interference. Everything else would be paternalism compromising said dignity and freedom. In the judgment DIANE PRETTY v. the United Kingdom, the Court correctly recognized that this issue will present itself increasingly – not only within the Convention's jurisdiction, but internationally – due to demographic developments and progress of medical science.

Authorities' restrictions and prohibitions in connection with assisted dying also raise the question of violation of the prohibition of torture, such as enshrined in article 3 of the European Convention of Human Rights, which states that no one shall be subjected to torture or to inhuman or degrading treatment or punishment.[18] A violation could occur for example if a palliative treatment is made with insufficient effect; if physical and emotional suffering and pain of a certain minimum level are given, such approach could possibly fulfill the notion of an inhumane treatment.

As the Convention, in the frame of the guarantee of article 8 § 1, comprises the right or the freedom to suicide, then everyone who wishes to make use of this right or freedom has a claim that he or she shall be enabled to do this in a dignified and humane way. Such individuals should not be left to rely on methods which are painful, which comprise a considerable risk of failure and/or endanger third parties. The available method has to enable the individual to pass away in a risk-free, painless manner and within a relatively short time. Such a method must also consider aesthetic aspects in order to enable relatives and friends to attend the process without being traumatized.

4) The protection of life and the general problem of suicide

In the judgment DIANE PRETTY v. the United Kingdom mentioned earlier, the European Court of Human Rights rightly paid great attention to the question of the influence of the right to life, especially the aspects of protection for the weak and vulnerable. In the meantime, the 17 years of experience of the US-American state of Oregon derived from its 'Death With Dignity Act' shows that the question of the weak and vulnerable does not pose a problem in reality: neither the

[17] http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-57424
[18] http://www.echr.coe.int/Documents/Convention_ENG.pdf

weak nor the vulnerable nor those with insufficient (or even without) health insurance would choose the option of physician assisted suicide, but in fact the self-confident, the above-average educated, the strong ones.[19]

Yet, the principle of protection of life cannot be seen only in the light of the individual life of a single person who wishes a self-determined end to his or her suffering and life; it must also be applied in questions regarding public health, the well-being, the quality of life of the entire society.

Until now, national and international debates on assisted suicide and/or euthanasia hardly realized that, apart from the small number of individuals who wish to end their life due to severe suffering with one of the few available methods (palliative care, assisted suicide, etc.), there is a problem on a much larger scale which questions the sanctity of life: the general problem of suicide and suicide attempts.

In the year 2013, there were in Australia 2,522 registered suicides (underlying cause of death determined as intentional self-harm)[20]

On average, almost seven individuals die every day in Australia as a result of a suicide attempt; 74,7% of them male, with the highest age-specific suicide rates in the group of 85 years and over and the second highest in the age group 40 to 44[21]. Many other states, like Switzerland, show a high number of suicides and even higher counts of failed suicide attempts. In response to the request regarding information on suicide and suicide attempts in Switzerland from Andreas Gross, a member of the Swiss National Council, the Swiss government rendered its comments to the parliament on January 9th 2002[22]: it explained that, based on scientific research (National Institute of Mental Health in Washington), Switzerland might have up to 67,000 suicide attempts annually – that is 50 times the number of 1,350 of fulfilled (and registered) suicides of that year. Thus, the risk of failure of an individual suicide attempt is up to 49:1!

Given the results of the scientific research mentioned before, suicide attempts in Australia must be estimated to be up to 126,100 per year. Even if a lower ratio of an estimated 30 attempts for every completed suicide applied as stated by the Australian suicide prevention charity Lifeline[23], or, even lower, if the ratio of failed suicide attempts to officially registered suicides was 'only' 9:1 as some psychiatrist, therapists and coroners assume (according to the afore mentioned comments of the Swiss government), there would still be 25,220 annual suicide

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[19] See the Death with Dignity Act annual reports of the Department of Human Services of the US State of Oregon: http://public health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

[20] http://www.abs.gov.au/ausstats/abs@ nsf/Lookup/by%20Subject/3303.0~2013~Main%20Features~Key%20Characteristics~10009

[21] http://www.abs.gov.au/ausstats/abs@ nsf/Lookup/by%20Subject/3303.0~2013~Main%20Features~Suicide%20by%20Age~10010

[22] Online (in German): http://www.parlament.ch/d/suche/seiten/geschaefte.aspx?gesch_id=20011105

[23] https://www.lifeline.org.au/About-Lifeline/Media-Centre/Suicide-Statistics-in-Australia/Suicide-Statistics

attempts in Australia – that is almost 3 people every hour. In any case, as the WHO states, for every suicide there are many more people who attempt suicide every year[24]

Quite a number of commonly heard phrases – like "a suicide attempt is normally just a cry for help", "80 % of people who have survived a suicide attempt would not like to repeat it", "someone who talks about suicide will not do it" – are simply 'thought savers'[25]. 'Thought savers' are a way to stop thinking about a particular problem without solving it. It is quite significant that such 'thought savers' are very common in relation to the suicide problem. With a 'thought saver', one may get rid of the problem, belittling it so that it appears no longer worth thinking about. Hardly anyone asks, for instance, when speaking of a 'cry for help': why does this person feel the need to undertake the risk of a suicide attempt in order to find help, instead of talking to other people and saying that they need help? In the special case of a suicidal situation, the reason for the 'cry for help' without words is the risk of losing one's liberty (due to being put in a psychiatric clinic) or the risk of not being taken seriously or being rejected (deprived of affection) if one talks to someone else about suicidal ideas.

Referring to the previously mentioned ARTICO-jurisdiction of the ECHR: no matter whether the risk is 49:1 or 'only' 9:1, it indicates that an individual can only make use of the right to end his or her life self-determinedly by accepting such a high risk of failure and therefore an unbearable (further) deterioration of his or her state of health. This signifies however, that the right to end ones life self-determinedly and self-enacted under the conditions currently found in the State of Victoria is neither practical nor efficient.

The negative and tragic result of 'clandestine' suicides is diverse:

- enormous costs for the public health care system, especially costs arising from caring for the invalid, costs for the public sector (rescue teams, police, coroner, etc.)and costs for a country's economy[26];
- high risk of severe physical and mental injuries for the person who attempts suicide;
- psychological problems for those unintentionally but directly getting involved in the suicide attempt such as train conductors;
- psychological problems for next-of-kin and friends of a suicidal person after their attempt and their death;

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[24] http://www.who.int/mediacentre/factsheets/fs398/en

[25] An expression created by the American journalist Lincoln Steffens, a friend of President Theodore Roosevelt, see: The Autobiography of Lincoln Steffens.

[26] See the study of PETER HOLENSTEIN: http://www.dignitas.ch/images/stories/pdf/studie-ph-der-preis-der-verzweiflung.pdf . In Switzerland, in the year 1999, there were 1'269 registered suicides leading to estimated costs of 65,2 Million Swiss Francs; given that the estimated number of suicide attempts is considerably higher (based on information provided by forensic psychiatrists, coroners, etc., the study calculates with a suicide attempt rate that is 10 to 50 times higher than the registered suicides), these costs could well be around 2'431,2 Million Swiss Francs. In Australia, the report 'The Hidden Toll: Suicide in Australia' refers to a submission by Lifeline which estimates the costs to be AUS$ 12 billion http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2008-10/suicide/report/c02#anc4

- personal risks and psychological problems for rescue teams, the police, etc., who have to attend to the scene at or after a suicide attempt;

In the light of the enormous number of committed/fulfilled and failed suicide attempts and their negative effects, governmental measures towards an improved suicide and suicide attempt prevention are now taking momentum. Some programs seem to focus very much on narrowing access to the means of suicide and a lot of money is spent on constructing fences and nets on bridges and along railway lines. However, the starting point of effective suicide attempt prevention is looking at the root of the problem: the taboo surrounding the issue, the stigmatization, the wall of fear of embarrassment, rejection and losing one's independence.

5) Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual[27]. Palliative care is widely accepted and practiced. It is one of the means of choice if the suffering of the individual is intolerable (in the personal view of the patient, of course) and the life expectancy is only a matter of a few days or weeks. It is certainly humanitarian and good practice in the sense of 'the Good Samaritan' to give a suffering, dying patient all the end of life care necessary and requested by the patient in order to soothe his or her ordeal.

However, voices claiming that palliative care "can solve anything" and "soothes any suffering" are not in touch with reality and try to mislead the public. Based on experience drawn from over 17 years of operating, DIGNITAS very much adheres to Dr. Rodney Syme and palliative care consultant Fiona Randall that 'one of the outstanding developments in medical care in the past 40 years has been palliative care', yet that 'the goal [of impeccable relief of pain and other symptoms] is unachievable and the expectations generated by the philosophy of palliative care are unrealistic'[28]. There are sufferings for which medical science has still no cure, yet, for which palliative treatment is not an option or possibly only applicable in a very advanced late stage of that illness, given that these illnesses are not terminal as such, at least not in the short run. Patients suffering from neurological illnesses such as Amyotrophic Lateral Sclerosis (Motor Neurone Disease), Multiple Sclerosis, etc., or even more so quadriplegics[29] or patients suffering from a multitude of ailments related to old age[30] are generally not *per*

[27] Definition by the World Health Organisation: http://www.who.int/cancer/palliative/definition/en
[28] http://www.theage.com.au/comment/at-lifes-end-we-should-respect-peoples-choices-20140815-104cob.html
[29] Such as for example the British rugby-player Daniel James who was left paralysed with no function of his limbs, pain in his fingers, spasms, incontinence and needing 24 hour care after a sports accident.
[30] Such as for example the well-known British conductor Sir Edward Downes

se eligible for palliative care and terminal sedation because they are not suffering from a life-threatening illness as such. Long-time degenerative neurological disease are, alongside cancer, the 'typical diagnosis' why patient would seek (and in Switzerland usually obtain access to) the option of an assisted/accompanied suicide. Certainly, these patients also receive medical treatment for pain relief, but that cannot be compared with the dosages applied in end-of-life palliative care. Without doubt, such patients are experiencing severe suffering which can lead them to wish to end their suffering and life self-determinedly. In such cases, the wish for an assisted/accompanied suicide and/or voluntary euthanasia is a personal choice which must be respected.

Palliative care and self-enacted ending of suffering and life are not two practices in conflict but in fact they have a complementary relationship even though sometimes the opposite is claimed, usually by opponents of freedom of choice in assisted dying options. Almost every day DIGNITAS receives calls for help from patients stricken by the final stage of terminal cancer as well as their relatives and friends. As the administrative proceedings involved with the preparation of an assisted/accompanied suicide take quite some time, usually several weeks if not months, terminally ill patients are always recommended to also pursue palliative treatment possibly leading to continuous deep sedation (sometimes also called terminal sedation). Thus, DIGNITAS has directed uncountable patients towards palliative care, has given advice how to access the support of specialist doctors, how to implement Advance Directives / Patient's Living Wills in a way that it would give safety to the patient and also to the doctors practising palliative care, etc.

In the judgment DIANE PRETTY v. the United Kingdom mentioned before, the European Court of Human Rights avoided to look into the aspect of the states' positive duty to protect individuals from inhumane treatment in cases of assisted dying, but there is room to look into this aspect more closely in future cases[31].

6) Suicide attempt prevention – experience of DIGNITAS

Everyone should be able to discuss the issue of suicide openly with their general practitioner, psychiatrist, carers, teacher, priest, etc. The taboo which surrounds the topic must be lifted. The possibility of – anonymously as well as openly – using a help-line is a very important service provided by some institutions[32]. However, for many people 'talking about it' does not suffice: they seek the concrete option of a painless, risk-free, dignified and self-determined death, to put an end to their suffering.

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[31] See: STEPHAN BREITENMOSER, The right to assisted dying in the light of the ECHR (Das Recht auf Sterbehilfe im Lichte der EMRK), in: Frank Th. Petermann, Assisted Dying – Basic and practical questions (Sterbehilfe – Grundsätzliche und praktische Fragen), p. 184 ff, St. Gallen, 2006.

[32] In Australia provided for example by Lifeline https://www.lifeline.org.au or the Samaritans http://www.thesamaritans.org.au

DIGNITAS' experience with all people – no matter whether they suffer from a severe physical ailment or other impairment, or wish to end their life due to a personal crisis – shows that giving them the possibility to talk to someone openly and without fear of being put in a psychiatric clinic, has a very positive effect: they are – and feel that they are – being taken seriously (often for the first time in their life); through this, they are offered the possibility of discussing solutions to the problem(s) which led them to feeling suicidal in the first place[33]. They are not left to themselves and rejected like many suicidal individuals who such cannot discuss their suicidal ideas with others through fear of being ostracized or deprived of their freedom in a mental institution for some time.

Furthermore, through their contact with DIGNITAS, not only are their suicidal ideas taken seriously but they also know that they are talking to an institution which could in fact, under certain conditions, arrange for a 'real way out'. This aspect of authenticity cannot be underestimated.

This 'talking openly' unlocks the door to looking at all thinkable options. These include advising the individuals in a personal crisis to visit a crisis intervention centre, referring severely suffering terminally ill to the palliative ward of a appropriately equipped clinic, suggesting alternative treatments, directing patients who feel ill treated by their general practitioner to other clinicians, and so on; always depending on the individual's needs. Over one third of DIGNITAS' daily 'telephone-work' is counselling individuals who are not even members of the association who thus receive an 'open ear' and initial advice free of charge.[34]

The experience of DIGNITAS, drawn from over 17 years of working in the field of suicide prophylaxis and suicide attempt prevention, shows that the option of an assisted/accompanied suicide without having to face the severe risks inherent in commonly-known suicide attempts is one of the best methods of preventing suicide attempts and suicide. It may sound paradoxical: in order to prevent suicide attempts, one needs to say 'yes' to suicide. Only if suicide as a fact is acknowledged, accepting it generally to be a means given all humans to withdraw from life and also accepting and respecting the individual's request for an end in life, the door can be opened to 'talk about it' and tackle the root of the problem which made the individual suicidal in the first place.

A 'real' option will deter many from attempting/committing suicide through insufficient, undignified means. Furthermore, at DIGNITAS, in the preparation of an assisted/accompanied suicide, next-of-kin and friends are involved in the preparation process and encouraged to be present during the last hours: this gives them a chance to mentally prepare for the departure of a loved one and thus give their support and affection to the suicidal person until the very end of life.

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[33] See 'The counselling concept of DIGNITAS', http://www.dignitas.ch/images/stories/pdf/diginpublic/referat-how-dignitas-safeguards-eth-21072014.pdf page 10 ff.

[34] http://www.dignitas.ch/images/stories/pdf/statistik-beratungsgespraeche-2607-30092010.pdf

7) Arguments of 'vulnerable individuals' and a 'slippery slope'

At this point, we need to take a look at the two main arguments of opponents to legislation of any form of assisted dying: they argue that this could pressure 'vulnerable' individuals to end their life, for example because they would be pushed by loved ones not to be a burden on them anymore. And it is suggested that legalisation would create a 'slippery slope', an unstoppable increase in numbers. The general understanding may be that individuals under the age of 18 or 16, people who are dependent on medical care and those who suffer from a loss of capacity to consent (for example due to dementia) would be classified as vulnerable. However, it is now acknowledged – especially in the annual reports of the Ministry of Health of the US-American State of Oregon[35] – that assisted suicide has absolutely nothing to do with 'vulnerable' individuals. Besides, the 'vulnerable' argument is another 'thought saver' and a pretext argument which distracts from further looking into the pressing social issue: the problem that those who become suicidal are often facing barriers. This, because there is still a taboo surrounding the topic of suicide, the fear of being put in a psychiatric clinic and thus being deprived of freedom and the fear of having his or her suicidal thoughts denounced, belittled, ignored or dismissed. In fact, these individuals are the really vulnerable ones and their situation will certainly not be improved by thought savers, pretext arguments and upholding the taboo.

The Journal of Medical Ethics carried the article "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in vulnerable groups"[36]. The topic-related relevant part of the abstract of this article states as follows:

> "Background: Debates over legalisation of physician-assisted suicide (PAS) or euthanasia often warn of a 'slippery slope', predicting abuse of people in vulnerable groups. To assess this concern, the authors examined data from Oregon and the Netherlands, the two principal jurisdictions in which physician-assisted dying is legal and data have been collected over a substantial period.
>
> Methods: The data from Oregon (where PAS, now called death under the Oregon 'Death with Dignity Act', is legal) comprised all annual and cumulative Department of Human Services reports 1998–2006 and three independent studies; the data from the Netherlands (where both PAS and euthanasia are now legal) comprised all four government-commissioned nationwide studies of end-of-life decision making (1990, 1995, 2001 and 2005) and specialised studies. Evidence of any disproportionate impact on 10 groups of potentially vulnerable patients was sought.

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[35] Death with Dignity Act annual reports of the Department of Human Services of the US State of Oregon: http://public health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx

[36] Journal of Medical Ethics 2007;33:591-597; doi:10.1136/jme. 2007.022335: http://jme.bmj.com/content/33/10/591.abstract

> Results: Rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured (inapplicable in the Netherlands, where all are insured), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations. The only group with a heightened risk was people with AIDS. While extralegal cases were not the focus of this study, none have been uncovered in Oregon; among extralegal cases in the Netherlands, there was no evidence of higher rates in vulnerable groups.
>
> Conclusions: Where assisted dying is already legal, there is no current evidence for the claim that legalised PAS or euthanasia will have disproportionate impact on patients in vulnerable groups. Those who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges."

Furthermore, not every individual who may be seen by third parties as vulnerable would personally share this view. One needs to bear in mind: there is a fine line where protection turns into undesired paternalism. Such paternalism very much applies to psychiatry, which has a long-standing view that a desire to die is a manifestation of mental illness, whilst in fact patients who secure and utilise a lethal prescription are generally exercising an autonomous choice unencumbered by clinical depression or other forms of incapacitating mental illness.[37]

As to the 'slippery-slope' argument, DIGNITAS adheres to a statement of the full professor ('Ordinarius') for law ethics at the University of Hamburg, Germany, Dr. iur. REINHARD MERKEL, who looked into this argument in his report "Das Dammbruch-Argument in der Sterbehilfe-Debatte" ("The slippery-slope argument in the euthanasia debate")[38]: in this report he emphasized that arguments of this nature have always been the most misused instruments of persuasion in public debates on controversial subjects. They have always been the probate residuum of ideologists and demagogues.

Furthermore, based on the experience of the Zürich City Council, we now know that allowing assisted/accompanied suicide even in nursing homes for the elderly does not lead to any rise of such end-of-life choice: of the 16,000 residents in Zürich homes for the elderly, only zero to three assisted/accompanied suicides per year have taken place since the authorities allowed associations like EXIT, DIGNITAS and others to access such homes in 2002[39].

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[37] Cambridge Quarterly of Healthcare Ethics 2014, http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=9333247&fileId=S0963180114000085

[38] in: FRANK TH. PETERMANN, (ed.), Sicherheitsfragen der Sterbehilfe (Safety questions in assisted dying), St. Gallen 2008, p. 125-146

[39] See the interview with Dr. Albert Wettstein, former Chief of the Zürich City Health Service (available in German) online: http://www.derbund.ch/schweiz/standard/Natuerlicher-als-mit-Schlaeuchen-im-Koerper-auf-den-Tod-zu-warten/story/13685292?track

The issue is not whether someone would make use of assisted suicide: in fact, the majority of members of DIGNITAS who have requested the preparation of an accompanied suicide and who have been granted the 'provisional green light'[40] do not make use of the option after all. Based on a study on our work, research into 387 files of members of DIGNITAS, who – through the given procedure in our organisation – received a basic approval from a Swiss physician, a 'provisional green light', that he or she would issue the necessary prescription for an assisted suicide, 70 % did not contact DIGNITAS again after such notification. Only 14 % made use of the option of an assisted/accompanied suicide, some after quite a long time[41]. For many, the prospect of such a prescription signifies a return to personal choice at a time when their fate is very much governed by their suffering. It enables many to calmly wait for the future development of their illness and not to prematurely make use of an accompanied suicide, let alone take to a 'clandestine' suicide attempt with all its risks and dire consequences.

This shows that a liberal solution, which entirely respects the individual who wishes to end his or her suffering, offers more sophisticated results than action which in such situations deprive individuals of their dignity, personal freedom and responsibility for themselves.

8) The 'Swiss model' as an example to meet Victorians expectations regarding medical options available at the end of their life

Switzerland has a liberal tradition. After decriminalisation of suicide during enlightenment in the 17th - 18th century, in the 19th century expert committee and parliament discussed the issue of assistance in suicide and found that a gentleman who would have lost his good reputation/dignity due to some incident should be able to ask a friend, who is officer in the army, to let him a gun and to show him how to use it so that he could properly end his misery. It was considered to be a 'Freundestat', an 'act of friendship', an assistance which should not be punished. In those days, there was not one criminal code for Switzerland, but each Canton (each Swiss State) had its own criminal code.

This aspect of assistance/help which should not be punished was also taken into consideration when discussions started about a criminal code for all of Switzerland. In 1918, in its comment (a so-called federal council dispatch) accompanying the proposal for a Federal Criminal Code, the Federal Council (which is the Swiss government, consisting of 7 members, each head of one department) stated that if the aforementioned assistance was done with selfish motives, it should be punished. As examples for such selfish motives the Federal Council referred

[40] For an explanation, read the general info-brochure of DIGNITAS, page 6 - 7: http://www.dignitas.ch/images/stories/pdf/informations-broschuere-dignitas-e.pdf

[41] Extract of the study (available in German) online: http://www.dignitas.ch/images/stories/pdf/studie-mr-weisse-dossier-prozentsatz-ftb.pdf

to situations such as if someone greedily intended to inherit 'earlier' or if someone intended 'to get rid' of having to support a family member. Thus, the initial aim/purpose of the regulation was upheld and additionally specified. It took many more years for the Swiss Federal Criminal Code to be finalised in 1937 and to come into force on 1 January 1942. The legal consequence (in the sense of 'e contrario') of the specific article 115 in the Swiss Criminal Code is: anyone can help (assist) any person to commit suicide as long as (s)he who helps does not have selfish motives in the sense of the examples stated above. Of course, in these specific circumstances of being assisted, the person self-determinedly ending his or her life must have legal capacity of judgment, in plain words: must be competent.[42]

Up until today, Switzerland has not set up a specific law, a specific act/bill, regulating the procedure of assisted/accompanied suicide. However, with the development of modern medicine and consequently the founding of the two EXIT members' societies in 1982, a practice developed which today enjoys acceptance with the authorities and the public.

Common denominator and in legal practice accepted is that a Swiss medical doctor can prescribe the psychotropic substance Sodium Pentobarbital for the purpose of an assisted suicide, if he/she 1) checked the medical file = found that there is some medical diagnosis/suffering, 2) has seen / spoken the patient and found that he/she really wants to self-determinedly end his or her own life and 3) found that the patient does not lack mental competence to make a rational decision to do so. In practice, the medical doctor would prescribe 15 grams of Sodium Pentobarbital powder and give the prescription to an employee of DIGNITAS. The employee would then fetch the medication from a pharmacy. The medication is then used in the frame of an assisted/accompanied suicide, usually at the home of the patient (living anywhere within Switzerland), in the presence of one or more employees of the organisation. Family and friends are always encouraged and welcomed to attend the proceedings. Generally, the patient never receives the prescription or the medication to take home, such as it is the case in the US-State of Oregon. If the patient does not make use of the medication on that particular day, the employee of the organisation brings it back to the pharmacy.

There is also the possibility that a medical doctor prescribes the Sodium Pentobarbital and does the assistance himself/herself.

In all cases, the patient must do ingestion himself/herself, which is drinking it, or opening the valve of a drip, or activating a pain-pump which pushes down the

[42] Swiss law bases on the assumption that up front everybody is assumed to have capacity of judgment; this, unless there are clear signs that such is not the case (such as the person being delirious due to drugs or having hallucinations due to a psychiatric ailment) – article 16 of the Swiss Civil Code https://www.admin.ch/opc/en/classified-compilation/19070042/index.html#a16 This matches common law which recognises – as a 'long cherished' right – that all adults must be presumed to have capacity until the contrary is proved.

rod of a syringe-container filled with the Pentobarbital and thus pumps the medication via a tube into the vein.

Details of the preparation and the actual course of an assisted / accompanied suicide can be found in the booklet 'How DIGNITAS works'[43]

At this point, it is important to stress that all this is about the personal decision of a competent individual assuming responsibility for his or her own life – not about a third person making decisions on behalf of this individual. It is always the patient who is in charge, who decides which steps will be taken – until the very last moment.

Despite such non-state-regulated practice, there is no misuse and even after 30 years of such assisted dying practice being an option, numbers of Swiss patients making use of this are at a rate of under 1 % of all deaths per year; the most recent available figures, of the year 2013: 64,961 deaths – 587 assisted suicides.[44]

The Swiss practice did not lead to a 'one-track solution': over these 30 years, a system developed, promoted by all five Swiss 'right-do-die' organisations such as DIGNITAS, which combines palliative care, suicide attempt prevention, advance directives and the right to choose in life and at life's end. In other words: 'right-to-die' organisations have developed into information centres on *all* options to soothe and/or end suffering. To little surprise, in its publication "National Strategy Palliative Care 2013 - 2015", referring to the Federal Council report "Palliative Care, Suicide prevention and organised assistance with suicide" of June 2011, the Federal Office of Public Health FOPH acknowledged that "*nowadays, in society primarily suicide assistance organisations are seen to be a possibility to ensure self-determination at the end of life*".

This public attitude was made very clear, for example, in votes in the Canton of Zürich, Switzerland, on 15 May 2011: two fundamental-religious political groups brought two initiatives to the people's vote, of which one initiative aimed to prohibit the current legal possibility of assisted suicide entirely whilst the other aimed to prohibit access for non-Swiss citizens and non-residents of the Canton of Zürich. The result was a clear message: the public voted by an impressive majority of 85:15 and 78:22 against any narrowing of the current legal status quo[45]. This result is even more notable in the light of the fact that a large part of the media had tried for years to scandalise the work of DIGNITAS and other such organisations through inaccurate, tabloid-style press coverage

In this context one needs to remember that part of the media – especially the tabloids – are notorious for spreading nonsense such as there being the option of (voluntary) "euthanasia" at a "DIGNITAS-clinic" where people would take "poi-

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[43] http://www.dignitas.ch/index.php?option=com_content&view=article&id=23&Itemid=84&lang=en
[44] http://www.bfs.admin.ch/bfs/portal/de/index/themen/14/02/04/key/01.html
[45] For links to the official statistics and a choice of media coverage on the results of the votes see online: http://www.dignitas.ch/index.php?option=com_content&view=article&id=26&Itemid=6&lang=en (on the website, scroll down to the comment/entry of 16 May 2011).

son" or a "lethal cocktail", etc., thus showing their irresponsibility towards their actual task of informing the public in an accurate, balanced way. Questions of life and death have always been subject to sensationalism. Deliberately or unintentionally generating life just as well as deliberately ending life can be well considered as the primary sensation to which the media has related to for centuries. Today's media – and even some politicians –draw their existence from offering their consumers a daily motive for emotional outrage. The late Zürich full professor in sociology, KURT IMHOF, pointed this out in an interview that he granted the "Neue Zürcher Zeitung" (NZZ) on December 8th, 2007, stating that the result of such media coverage lies much further within the field of fiction than fact[46].

DIGNITAS favours the option of assisted/accompanied suicide such as Swiss law allows to practice and which the Swiss 'right-to-die' associations have been offering to their members for over 30 years now. In summary, assisted accompanied suicide implies the following:

- The individual is respected in his or her request to have an end to his or her suffering.
- This request is explicitly expressed by the individual, not only once but several times during the process of preparation and re-confirmed even in the final minute prior to the assistance. (In the case of accompanied suicide in Switzerland, this is the moment prior to handing over the lethal drug to the individual).
- The individual expresses his or her desire to end his or her life not only verbally but undertakes the last act in his or her life him- or herself. (In the case of accompanied suicide in Switzerland, this is the action of the individual actually drinking the lethal drug or absorbing it in another form such as feeding it him- or herself through a PEG-tube or intravenous).
- All actions are based exclusively on the explicit will of the individual.
- With assisted/accompanied suicide, the individual always has to do the last act himself or herself; without such final act of the individual, there will be no ending of life. Thus, the taboo of ending someone's life actively (on request by the patient, which would be voluntary euthanasia or even without such request which would be non-voluntary, active euthanasia) does not have to be broken.
- Access to the option of an assisted/accompanied suicide has a very important, yet all too often overlooked suicide attempt preventative effect, as already outlined earlier in this submission.

However, these aspects cannot hide the fact that with of assisted/accompanied suicide 'only', some individuals would be excluded from assistance in dying: there are cases of patients who have lost all control over their bodily functions,

[46] Article (in German) online: http://www nzz.ch/aktuell/startseite/medienpopulismus-schadet-der-aufklaerung-1.595885

including the ability to swallow, so that they would not be able to self-administer the lethal drug in any way and therefore voluntary euthanasia would be the only option. Furthermore, an individual in a coma or suffering from advanced dementia would not be able to express his or her will, would not have sufficient capacity to consent and/or simply would not be able to do the last act which brings about the end of suffering and life him- or herself; however, for these situations, a different approach is already in place to some extent at least: the strengthening and implementation of the already wide-spread and widely accepted Patient's Advance Decisions (also called Patient's Advance Directives or Patient's Living Will). Still, based on DIGNITAS' experience, the large majority of requests for an individual's dignified end in life can be covered by assisted/ accompanied suicide. It would add a choice for Victorians, to have a real option helping to shake off despair and regain some hope, control and dignity when faced with severe suffering – something that not only Victorians wish for.

Still, one needs to be clear about the fact that only a very small minority of individuals would actually make use of an assisted/accompanied suicide. First of all, for many, medical science offers relief, and second – as late Member of the Scottish Parliament Margo MacDonald's rightly put it in her first proposal for an Assisted Suicide Bill for Scotland – for some people the legal right to seek assistance to end life before nature decrees is irrelevant due to their faith or credo[47]; yet there is a third important reason why in fact only a minority of patients would 'go all the way' and make use of an assisted suicide: it's the fact that 'having the option gives peace of mind'. Having no hope, no prospect, not even the slightest chance of something to cling on is what we humans dislike most. We would like to have at least a feeling of being in control of things. Faced with a severe illness, patients usually ask their doctor: "will I get better?" or: "how much more time do I have?" but an exact medical prognosis is generally difficult if not impossible as the course of disease is different with each individual. In this situation, having options, including the option of a self-determined ending of suffering and life in the sense of an 'emergency exit', can lift the feeling of 'losing control'; this is what members of DIGNITAS tell us again and again. Legalising assisted suicide and voluntary euthanasia is not about 'doing it' but about 'having the option of doing it'.

9) Conclusion

No one should be forced to leave his or her home in order to make use of the basic human right of deciding on the time and manner of the end of his or her life. The current legal status of assisted dying in Australia and in many other countries is not only "inadequate and incoherent" as the UK Commission on Assisted Dying put it on the front side of its final report[48], the situation is in fact a disgrace for any country which would be considered a part of the modern and

[47] http://www.scottish.parliament.uk/S4_MembersBills/Final_version_as_lodged.pdf
[48] http://www.demos.co.uk/publications/thecommissiononassisteddying

democratic Western world. It forces citizens to travel abroad in order to have freedom of choice. In this context it should be pointed out that only individuals with at least a minimum of financial resources – something that certainly not everyone in Australia has – can afford to travel to Switzerland in order to make use of the option of a self-determined end of suffering and life, which is an unacceptable discrimination against those who are not so well off. DIGNITAS' statutes allow for reduction or even total exemption of paying costs to DIGNITAS,[49] however, the person still would have to bear costs for travelling, accommodation, etc. besides bearing the burden of a long journey which is even more strenuous in a deplorable state of health.

"No one shall set upon a long journey without having thoroughly said goodbye to loved ones and no one shall set upon such journey without careful preparation". At a time in which lonely suicides among older people, in particular, are increasing sharply – as a result of the significant increase in life expectancy and the associated health and social problems of many men and women who have become old, sick and lonely – careful and considered advice in matters concerning the voluntary ending of one's own life is gaining relevance. There are individuals who explicitly would like to add life to their years – not years to their life.

Are Victorian laws adequately meeting people's expectations regarding medical options available at the end of their life? No, they are not. Because there are still citizens of Victoria and other Australian States who turn to DIGNITAS for help. The legal framework that operates at the end of life in Australia needs to be reformed, as it states in the report 'The right to choose an assisted death: Time for legislation?' Indeed, the fact that a peaceful, assisted death is illegal, while much worse alternatives are legally available and much more easily accessible, is disgraceful[50].

DIGNITAS calls on the State of Victoria (and other States too) to implement laws which allows a competent individual to have a safe, dignified, self-determined and accompanied end in life at their own home – full choice on time an manner of one's end of suffering –, which is in fact what Victorians wish for. If this is implemented, the very goal of the DIGNITAS-organisation is closer in reach: to become obsolete. Because, if people in Australia have real and legal choice, no Australian citizen needs to travel to Switzerland and become a 'freedom-tourist' (which is a term certainly more appropriate than 'suicide-tourist') and thus DIGNITAS is not necessary anymore for them.

Legal certainty is the base for the functioning of a (democratic) society. DIGNITAS supports projects to implement freedom of choice in 'last matters', as these lead to less suffering, especially to smaller numbers of failed suicide attempts, with all their dire consequences. In this context, we refer to the philosophical

[49] http://www.dignitas.ch/index.php?option=com_content&view=article&id=11&Itemid=52&lang=en
[50] http://www.australia21.org.au/wp-content/uploads/2013/08/J2056-Assisted-Death-Report_WEB.pdf

and political principles guiding the activities of DIGNITAS[51] which we feel may well serve as a basis for any consideration of end-of-life-issues.

We close these considerations with words by DAVID HUME, one of the most famous philosophers of the last 300 years[52]:

> „If Suicide be supposed a crime, 'tis only cowardice can impel us to it. If it be no crime, both prudence and courage should engage us to rid ourselves at once of existence, when it becomes a burthen. 'Tis the only way, that we can then be useful to society, by setting an example, which, if imitated, would preserve to every one his chance for happiness in life, and would effectually free him from all danger of misery."

Yours sincerely

DIGNITAS
To live with dignity - To die with dignity

[redacted] [redacted]

Ludwig A. Minelli Silvan Luley

[51] See the booklet/brochure „How DIGNITAS works": http://www.dignitas.ch/index.php?_option=com_content&view=article&id=23&Itemid=84&lang=en

[52] DAVID HUME, Of Suicide, http://ebooks.adelaide.edu.au/h/hume/david/suicide , in fine

Note: all internet links in foot notes (re-)accessed July 29th, 2015.