



## SUBMISSION

### VICTORIAN PARLIAMENTARY END OF LIFE CHOICES INQUIRY

As a friend of mine once, so succinctly, said: "You just don't kill people!"

#### Introduction

I am making this submission after 48 years in the nursing profession and as someone who has long followed the concerted campaign by euthanasia proponents to introduce patient killing in this country. I am aware there have been something like 13 euthanasia bills introduced in Australian legislatures, all of which have failed because of flawed content and lack of support but I am concerned that out of sheer "legislative fatigue", an attempt to legalise assisted suicide under the guise of *End of Life Choices* may one day succeed in an Australian parliament. I make this submission as an appeal to the Victorian Parliament that Victoria not be that State to legalise patient killing. We all die. Naturally, accidentally or at the hand of another. If we are to live in a safe society, it should not be at the hand of another SANCTIONED BY THE STATE.

As a nurse I was always inspired by the words of Albert Schweitzer who has been called the greatest humanitarian of his time. "*If a man loses respect for any part of human life, he loses respect for all human life.*" He based his personal philosophy on a "reverence for life" and on a deep commitment to serve humanity through thought and action. For his many years of humanitarian efforts Schweitzer was awarded the 1952 Nobel Peace Prize. Albert Schweitzer raised money to establish a hospital in French Equatorial Africa in 1913. Over the years he built a large hospital that served thousands of Africans and used his \$33,000 Nobel Prize to expand the hospital and to build a leper colony.

As a nurse with a long interest in ethics, I am very aware of the historical record of the German euthanasia program. It was out of the ashes of the medical holocaust in Nazi Germany that the Declaration of Geneva was born. **The World Medical Association adopted the Declaration of Geneva as a reminder of the atrocities perpetrated by the physicians in the Third Reich and as a check upon any repetition, anywhere in the world, of the German doctors descent into savagery.** The Geneva Code is a modern reaffirmation of the Hippocratic Oath retaining the "*do no harm*" principle and sanctity of life ethic so deeply etched in the older statement of medical conduct. I frequently refer to the words of the writer George Santanyana in the forward to William Shirer's *The Rise and Fall of the Third Reich*: "*Those who do not remember the past are condemned to relive it.*" With ever advancing medical and nursing science, deliberate patient killing has no place in the end of life choices which society should be providing to its citizens.

In the forward to the recently published (2015) book *Assisted Suicide; The Liberal, Humanist Case Against Legalisation*, by Kevin Yuill, atheist and lecturer in history at the University of Sunderland in the north of England, Brendan O'Neill, described by the UK *Daily Telegraph* as one of Britain's sharpest social commentators, had this to say:

*"Supporters of assisted dying claim very old, very sick and very incapacitated people who have a short period of time left to live must be given the freedom to kill themselves and to have someone assist them in this task. In short, this is all about individual freedom of choice, the exercise of personal sovereignty against legal and medical establishments that would force these unfortunate people to carry on living against their will. However, very often supporters of assisted dying reveal, sometimes unwittingly, that they are motivated fundamentally by social concerns, particularly by the social concern that we can no longer cope with the growing numbers of elderly, frail people, rather than by passionate attachment to the ideal of individual autonomy.*

*Consider one of the most popular pro- assisted suicide newspaper commentaries of recent times*



written by Melanie Reid, a journalist who became a paraplegic following a horse riding accident and published in *The Times*, Britain's newspaper of record, the piece made the case for granting the very ill and the very incapacitated the right to die. It was hailed by assisted suicide campaigners and by secularist thinkers as the 'unanswerable case for the right- to- die', the final word surely, on this hotly contested liberty to end our lives in periods of extreme physical ailment.

However, amidst its pleas for choice and autonomy for the sick, Reid's piece contained the following, extraordinarily revealing sentence : ***"It is ridiculous that an educated society, facing an unaffordable explosion in dementia and age related illness, is still prevaricating over (assisted suicide)"***

What is extraordinary about that sentence is, firstly, that it very clearly expresses an old style euthanistic outlook; it expresses the idea that allowing sick and old people to kill themselves is important because there are **too many of them**, too many elderly folk with dementia, and they are 'unaffordable'. The second striking thing is that this idea seems to have been readily accepted by the numerous campaigners and journalists who praised Reid's piece, certainly in their effusive promotion of the article, none of them sought to distance themselves from that sentence, suggesting either that they agree with it or that they do not consider the promotion of voluntary euthanasia on the basis that society cannot afford to look after certain people, in this case the old and mentally ill, to be remarkable or noteworthy ."

### **No Need For patient Killing...and Advanced Care Directives Are Not Without Risks**

The 1995 publication *The Last Right ? Australians Take Sides on the Right to Die*, which was edited by Simon Chapman and Stephen Leeder of the Department of Public Health and Community Medicine at the University of Sydney, included a contribution from myself. What I wrote then is still valid today. *"Compassionate doctors and nurses provide dignified deaths with adequate and appropriate pain control, nourishment, fluids, bodily comfort, spiritual and family support. Not with a lethal syringe. Families of terminally ill patients who are not getting this should change their doctor and their nurse."* Care of the terminally ill has become a medical specialty and it is significant that Palliative Care Services are universally opposed to the agitation for euthanasia legislation. That said, *Advanced Care Directives* are of great concern and rather than promoted as they have increasingly been, these protocols should instead go under the microscope. This is what a young woman wrote in June 2014 in my local newspaper:

*"A recent article in (Albury- Wodonga) News Weekly promoted Advanced Care Directives (ACD's) as a way to give the terminally ill control over their medical treatment. But reports have emerged of patient's welfare being undermined because they signed an ACD. In one case of which I know, a woman visited her father who was dying of cancer in hospital and found him in a coma caused by a severe case of pneumonia. Staff had withheld antibiotics because his ACD said that if he suffered heart failure, he did not wish to be revived. It is too much to expect of overworked medicos that they should have to interpret these documents. And their interpretation of the patient's wishes has been upheld by hospital authorities even when it is obviously wrong, to the distress of family and friends. Until the law relating to ACD's is changed, I would urge anyone considering signing one to think again."* (Louise Mc Manus , Albury)

I shall be forever grateful that I happened to be at the bedside of my 80 year old sister a year ago when she was hospitalised with a fractured hip. Her recovery was impeded by the fact she had had a heart valve replacement several years before and was on an anti coagulant. The treating doctor, across the bed, addressed an attending nurse to the effect: *"Before I go we must look over the NFR form."* I indicated to the doctor I would like to speak to her outside the room. Politely and calmly I told her: *"My sister has not signed an Advanced Care Directive (and personally I would advise her against doing so) and though she has found this fall a terrible set back, most certainly would want*



to resume her life after the fracture has healed." There was no more talk of *Not for Resuscitation* notices on her bedhead. The doctor readily agreed that she was a spritely, lively lady and under the circumstances that the outcome of a resuscitation attempt could not be predicted, she should be resuscitated....after which "that bridge could be crossed when reached." For the next three months I visited her twice daily to feed her...she was transferred to Rehabilitation Unit, followed by a Healthy Ageing Unit and finally my home, until she was able to go to her own Retirement Village Home nearby. She now travels alone by bus into town almost daily and has happily resumed her old lifestyle. **Central to her recovery I believe, was the maxim which has been instilled into me over many years of commitment to the pro life philosophy "The dying need to be treated as special, not put down like animals"** My sister may well not have categorised herself as "dying" but was certainly reassured that in her suddenly vulnerable state, she was important and was being treated as "special" and not a burden on society. With the exception of a few fanatical idealogues, the cry for assisted suicide is more likely a cry for love and a sense of worth...or at best, an altruistic "not wanting to be a burden to society or (even more sadly) one's children." Parliament can't legislate to ensure children grow up to be appreciative and caring of their parents ..but society, by its good example can imbue in us all this sense that "*The dying need to be treated as special and not put down like animals.*" It is certain that legalising patient killing will not achieve this. Worse, it will give the greenlight to heartless.... and sometimes greedy... offspring to have their burdensome parents and other family members "put down" !

### **Effects of Patient Killing On the Medical and Nursing Profession**

In my contribution to Simon Chapman and Stephen Leeder's *The Last Right ? Australians Take Sides on the Right to Die*, I wanted to know who society would expect to do the patient killing in the event of euthanasia being legalised. "*It isn't fair that people who joined a profession with the noblest of ideals, the preservation of human life, the alleviation of suffering and the promotion of health should find them selves drafted to kill. Reassurances that "only doctors and nurses who believe in euthanasia" will be involved are useless. Euthanasia will divide the profession into "those who do" and "those who don't". Subtle pressure, tensions and suspicions will inevitably result. Will young nurses, as in the case of abortion, find themselves (as one I know of) in the Director of Nursing's office, asked to explain why she refused to be involved " After all, you're not a Catholic so you have no excuse " !!*

This concern is no longer academic. In 2008 the Victorian Parliament, exercising a "conscience vote" for its members, voted away the right of doctors and nurses to exercise their consciences in the participation in abortions. **84% of the submissions to the Victorian Law Reform Commission's Inquiry on the Law of Abortion were against this but were completely ignored. This is ominous for doctors and nurses should the Inquiry on End of Life Choices recommend the legalisation of assisted suicide in Victoria.**

### **Where Euthanasia Has Been Legalised .....**

*"Once the genie is out of the bottle, it is not likely ever to go back in again...I used to be a supporter of the Dutch law but now with 12 years of experience, I take a very different view ....Dr. Theo Boer..The Netherlands*

There is a plethora of researched evidence that where euthanasia has been legalised, principally in the Benelux countries and Switzerland, all the "slippery slope" arguments have come to fruition...the grounds for assisted suicide continue to be expanded. The difficulty in a submission such as this, is to gather all this evidence, so one sample is included and confirmed by the about-face of the above Dr. Theo Boer....who came to prominence with his plea to the United Kingdom to NOT follow the path of his home country The Netherlands,



## Euthanasia In the Netherlands: A Warning to other Countries

### Part 2)

Dr. John Keown

The first part of this article (published in the Summer 2000 issue of National Observer) discussed generally the history and incidence of euthanasia in the Netherlands, as well as the unsatisfactoriness of the official guidelines governing the practice. It is appropriate next to consider the large number of cases in which euthanasia is performed without the consent of those killed.

### Non-Voluntary Euthanasia

Although the Dutch guidelines require an explicit request by the patient, the Surveys disclose that thousands of Dutch patients have been terminated without having made an explicit request. The first Survey, for example, revealed that over 1,000 patients had made no explicit request. On the writers interpretation of the first Surveys figures the total was even higher: there was no explicit request in 5,450 (52 per cent) of the 10,558 cases. Even on the Surveys own interpretation of its figures 27 per cent of patients actively killed were killed without an explicit request that is 1,000 out of 3,700 patients the 3,700 comprising the 2300 cases of euthanasia + the 400 cases of assisted suicide + the 1000 cases with no explicit request).

That non-voluntary euthanasia continued to be widely practised in 1995 was confirmed by the second Survey. 900 patients had their lives actively terminated without explicit request in 1995, only a slight decrease on the 1,000 so terminated in 1990. Moreover, the 14,200 cases in which the doctors primary purpose was to terminate life by omission involved no explicit request by the patient.

### Reporting

How many cases of euthanasia and assisted suicide were reported to the authorities? The first Survey revealed that in over 70 per cent of cases doctors failed to report. Instead, they filled in the death certificate as death by natural causes. They therefore not only breached an important guideline but also committed the offence of falsifying a death certificate. How ironic that, not long before, one leading defender of Dutch euthanasia had claimed that if the situation in Holland was unique, it was perhaps in the wish of physicians to subject their actions to public scrutiny. 14

There has been a gradual increase in the number of cases reported, but its significance should not be overstated. For one thing, the second Survey revealed that the majority of cases (59 per cent) were still not reported. For another, even in the cases which are reported, it must be doubted, in view of our earlier discussion of the lax system of investigation, 15 whether the authorities can realistically hope to detect the doctor who has ignored the guidelines.

### Other Evidence of the Slide

The empirical evidence shows that cardinal guidelines have been breached in practice. Other evidence indicates that they are being relaxed in theory.

In 1994 the Supreme Court held that a doctor could lawfully assist a patient to commit suicide even though the patient was not somatically, let alone terminally, ill. The case involved the prosecution of a psychiatrist, Dr. Chabot, for assisting in suicide a 50 year-old woman. The woman told him she wanted to die because she had lost two sons, one to suicide, the other to cancer. 16

After consulting a number of colleagues, none of whom examined her, Dr. Chabot assisted her to commit suicide. He was convicted, but successfully appealed. The Appeal Court found that the woman had been suffering from a depression in a narrower context without psychotic characteristics, in the context of a complicated grieving process and held that he could avail himself of the defence of necessity. On a further appeal by the prosecution, the Supreme Court restored Dr Chabots conviction, though without sentencing him to any punishment. While agreeing with the Appeal Court that the necessity defence could apply even in the absence of somatic illness, the Supreme Court held that in the absence of such an illness, the doctors opinion had to be supported by an independent colleague who had examined the patient and who had considered the seriousness of the patients suffering and other possibilities for its alleviation. In the absence of such a finding in this case, ruled the Supreme Court, the Appeal Court had not been in a position to find that a situation of necessity had existed.

The case is significant for three reasons. First, it clearly holds that assisted suicide (and euthanasia) may be lawful even in the absence of somatic let alone terminal, illness. Secondly, it confirms that, in the case of somatic illness, consultation is not a requirement (though why it should not be, when the life of the patient hangs just as much in the balance as in cases of mental illness, is unclear). Thirdly, it illustrates how, even in the rare cases in which doctors are prosecuted (barely a handful, if any, each year) they may, even so, escape punishment. The case raised serious



questions about the meaning of a free and voluntary request and intolerable suffering with no prospect of improvement.

The case discomfited the House of Lords Select Committee on Medical Ethics, which was set up by the British Government to examine the euthanasia question amongst other issues, and which reported in 1994. 17 In the subsequent debate on the Report in the House of Lords, the Chairman of the Committee, Lord Walton of Detchant, commented that the members of the Committee who had visited the Netherlands to study its experience of euthanasia had returned feeling uncomfortable, especially in the light of evidence indicating that non-voluntary euthanasia . . . was commonly performed. 18 His Lordship added that they were particularly uncomfortable about this very case.

The Chabot case raised serious questions about the Dutch interpretation of free and voluntary request and unbearable suffering. But even more disturbingly, there is good evidence of official Dutch condonation of non-voluntary euthanasia. It will be recalled that the first Survey disclosed that over 1,000 patients had been killed without explicit request. The reaction of the Rummelink Commission to this statistic was scarcely less startling than the statistic itself. While criticising the killing of those patients among the 1,000 who were competent, the Commission condoned the killing of the vast majority of those who were not.

The Commissions attempted justification is not only factually flawed, it is ethically wanting. The bottom line is, first, that doctors admitted performing non-voluntary euthanasia in a strikingly high proportion of cases, ignoring the cardinal guideline requiring a free and explicit request, and, secondly, that, by condoning this practice, the Commission further undermined that guideline.

The Commission recommended that the law be amended to allow doctors to report such cases just as they are supposed to report cases involving an explicit request by the patient. The Dutch Parliament accordingly passed legislation, as an amendment to the Burial Act 1955, setting out the form of the report the doctor should file with the local medical examiner, a form which explicitly provides for the reporting of non-voluntary euthanasia. The amendment (which came into force in June 1994) did not go so far as to legalise explicitly euthanasia or killing without request, but placed the reporting procedure on a statutory footing and made it clear that it applied to killing without request.

#### Condonation of Non-Voluntary Euthanasia

Unambiguous official condonation of non-voluntary euthanasia came in the form of two decisions of Dutch courts in 1996. In those cases, Dutch Courts of Appeal upheld the acquittals of doctors who had killed disabled newborn babies. The Courts held that the necessity defence can justify even non-voluntary euthanasia. 19 Obviously, this drives a coach and horses through the guideline requiring a free and voluntary request by the patient.

It is doubtful, even if such cases were to reach the Supreme Court, that they would be reversed. For it will be recalled that in its landmark decision in 1984, the Supreme Court ruled that a doctor enjoyed the necessity defence if he acted in accordance with responsible medical opinion measured by prevailing standards of medical ethics. As non-voluntary euthanasia is commonly performed, and as there is a substantial and growing body of Dutch official opinion, medical and legal, that non-voluntary euthanasia can be ethical, it is difficult to see how the Supreme Court could, consistently with its earlier judgment, deny the necessity defence to those acting in accordance with such opinion.

This eventual condonation of non-voluntary euthanasia was predicted by those who appreciate the validity of the logical slippery slope argument. Indeed, its validity was acknowledged by the authors of the van der Maas survey when they wrote in 1993 : 20

[Is] it not true that once one accepts euthanasia and assisted suicide, the principle of universalizability forces one to accept termination of life without explicit request, at least in some circumstances, as well? In our view the answer to this question must be affirmative.

In short, not only is non-voluntary euthanasia widely practised: it is now, at least in certain circumstances, officially condoned.

#### Conclusion

This article has argued that the Dutch experience of euthanasia bears out the validity of the slippery slope argument in *both* its forms, empirical and logical. Within no more than a decade, the so-called strict safeguards against the slide have proved largely ineffective, and non-voluntary euthanasia is now widely practised and increasingly condoned in Holland. The exclusive emphasis on the need for a free and explicit request by the patient, which characterised the campaign to secure acceptance of voluntary euthanasia in the 1980s (even to the extent of shaping the Dutch definition of euthanasia) has, since the early 1990s, given way to an extension of euthanasia to the incompetent on the basis that they are better off dead.

Developments in Holland supply little evidence of a desire to slow the descent, let alone throw it into reverse. In September 1995 it was reported that the Dutch medical association had published revised guidelines which restate the narrow definition of euthanasia; express a preference for assisted suicide over euthanasia; confirm that mental suffering is as acceptable a reason for euthanasia as physical suffering; reiterate the importance of consultation with an independent doctor who examines the patient; and confirm that a doctor may raise the issue of euthanasia if he senses that the patient is unwilling to do so. 21 These revisions amount to little more than tinkering with the Dutch euthanasia engine as it



areers down the slope. And in August 1999 it was reported that the Dutch Government is to introduce a Bill which would effectively legalise euthanasia by affording statutory protection to doctors who comply with the guidelines. 22 The Bill is expected to be enacted.

The Dutch understandably resent comparisons with the Nazis, and any simplistic comparison would be quite unfair. But it is fair to point out that the attempted Nazi extermination of Jews, gypsies and homosexuals had its roots in the acceptance by the German medical profession, long before Hitler came to power, of the concept of the life not worthy to be lived (*lebensunwertes Leben*). 23 The Dutch have embraced the same concept, that certain people are better off dead. As long as they do, there is nowhere on the slope but down.

4 Quoted in Keown, *The Law and Practice of Euthanasia in the Netherlands*, (1992) 108 *Law Quarterly* 51 at page 67.

5 See text at footnote 8, *National Observer*, Summer 2000, page 53.

6 See John Keown, *Physician-Assisted Suicide and the Dutch Supreme Court* (1995) 111 *Law Quarterly Review* 394.

7 Report of the House of Lord Select Committee on Medical Ethics (H.M.S.O.: Paper 21-1 of 1993-1994).

8 (1993-1994) 554 *Parliamentary Debate H.L. (5th Ser.)* 1345 at page 1346.

9 Johannes J.M. van Delden and others, *The Rummelink Study: Two Years Later*, (1993) 23 *Hastings Center Report* 24 at page 26 (footnote omitted).

10 (1995) 346 *Lancet* 833.

11 *The Times*, 11 August 1999.

12 See Robert Jay Lifton, *The Nazi Doctors* (Basic Books, 1986) and Michael Burleigh, *Death and Deliverance: Euthanasia in Germany 1900-1945* (C.U.P., 1994).

*And Dr Theo Boer...*

Boer is also concerned by the growth of euthanasia in the Netherlands.

*'(e)uthanasia and assisted suicide... has trebled from around 1,800 in the early years to 4,829 in 2013.*

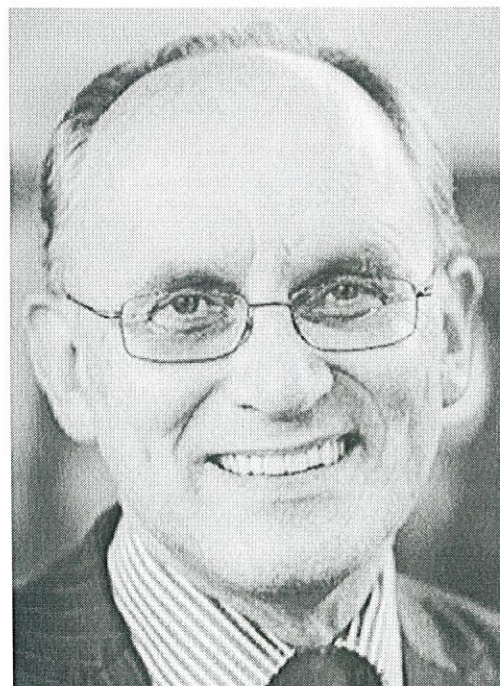
*'Although the vast majority of requests still come from terminally ill cancer patients, the parameters have gradually widened to take in growing numbers of people with conditions such as Alzheimer's disease and psychiatric illness.'*

Boer is further concerned that euthanasia, which was considered a 'last resort' is now considered a right. The Dutch news reported:

*'The debate has changed. Euthanasia is no longer a last resort. It was originally seen as a law that gave doctors rights rather than patients. But we very frequently hear it discussed in terms of a patient's right to euthanasia.'*

Boer also argues that the reasons for euthanasia has changed

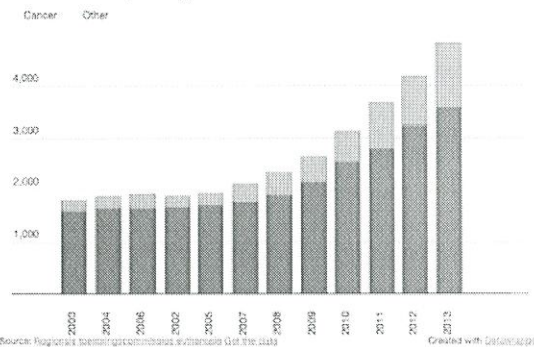
*He has been critical of phenomena such as 'duo-euthanasia', where the partner of a terminally ill patient asks to die with them because he or she cannot*





*face life alone.*

Euthanasia requests granted in the Netherlands since 2002



Doctors are also feeling pressured by euthanasia. According to a study that was published by the Dutch Medical Association (KNMG) last December, 70% of doctors had experienced pressure, while 64% felt it had increased in recent years. The survey did not ask where the pressure came from.

Boer believes that the Dutch euthanasia law should be tightened.

‘We made a number of serious mistakes when we drew up the law,’ says Boer. ‘The problem with

being the first country is that you have no precedent. It’s good on some points, such as transparency and evaluation, but in general it’s nothing for us to be proud of. I worry that if death is seen too quickly as the solution, the value of life is reduced.’

Last November, Boer urged the Dutch government to reform the euthanasia law. He said that people who had months, even years to live were dying by euthanasia.

### **What Message Do Assisted Suicide Campaigns Give The Disabled ?**

Perhaps the most successful campaigners against assisted suicide are the multiple, plucky, in- your-face disabled groups such as *Not Dead Yet*. Dr Jane Campbell, Dr Phil Friend OBE, Dr. Kevin Fitzpatrick OBE, with the support of many other leading disabled people, are organizing a campaign to prevent a change to the law on assisted suicide. They are linking this campaign to the international movement opposing Assisted Suicide for Disabled People.



Whilst they are a breath of fresh air, they should not have to suffer the anxiety and fear these Assisted Suicide Campaigns engender for them.

### **The Right of the Suffering and Terminally Ill to Refuse Burdensome Treatment**

No submission to this Parliamentary Inquiry would be complete without reference to the Victorian Medical Treatment Act of 1988 which guaranteed its citizens the right to refuse burdensome or

futile medical treatment. This has been in effect now for nearly 30 years. Or to the fact that there is a vast difference between doctors and nurses administering SUFFICIENT AMALGESIA TO RELIEVE PAIN AND SUFFICIENT ANALGESIA TO KILL. All too often, end stage analgesia is interpreted to mean "mercy killing" when the intention...and indeed the dose ...is intended simply to relieve pain and discomfort. Given how advanced the calibration of analgesia is today, it is even likely analgesia sufficient to relieve the level of pain does not hasten death. It is disease, not the morphine administered by today's medical practitioners, which kills. As a nurse it always irritated me to have to listen to "shock jocks" on the radio, relaying their mistaken belief that they "*saw the nurse coming with the syringe and knew what was coming*". It conjured up an image of nurses as "angels of death". This is ridiculous. There is a vast difference between the intention to relieve pain and intention to kill. Thirty years after the Medical Treatment Act the euthanasia lobby remains unsatisfied, forever continuing to "push the envelope" and fulfilling the predictions at that time of those concerned about as to how that Act would be interpreted. For example, **there have been disturbing cases in Victoria where basic hydration and nutrition have been declared "extraordinary means" and in one case, a husband taken the decision for his wife that a gastric feeding tube keeping her alive was "burdensome".....or "treatment".... indicating this Inquiry would be well placed to examine evidence of such practices.** I have long considered hydration and nutrition to be the Trojan Horse of Euthanasia. If we are to speak of "burdensome" circumstances, we need to reflect on how painful, how ghastly it is to die of thirst and be vigilant that no dying person in the State dies of hunger or thirst. In this century, hydration, nutrition, antibiotics and analgesia are BASIC, NORMAL measures of medical and nursing care the withdrawal of which should never be employed as a means to causing death. These means are about "comfort" and about ensuring a "good" death !

### Conclusion

I do not remember my mother. She died all too young at 45 years of age, leaving 7 young children, a mere 18 months after her sister-in-law died at 35 years of age leaving four young children. Over the many years I have lived and nursed, I have been privileged to witness marvellous advances in medicine and nursing. Had these two women been alive today, they may well not have died so young. These advances will continue long after my life. Campaigns in support of assisted suicide are a depressing, demoralising nihilistic side- show in today's world....a distraction from the nobility of these two professions. These professions should be left to progress their science and humanitarian efforts. **It is my earnest appeal to the members of the Victorian Parliamentary Inquiry into End of Life Choices, that they NOT turn doctors and nurses into executioners... but instead encourage them in the need for the dying to be "*treated as special and not put down like animals.*"**

(Ms) Denise M Cameron



Tuesday, August 11, 2015

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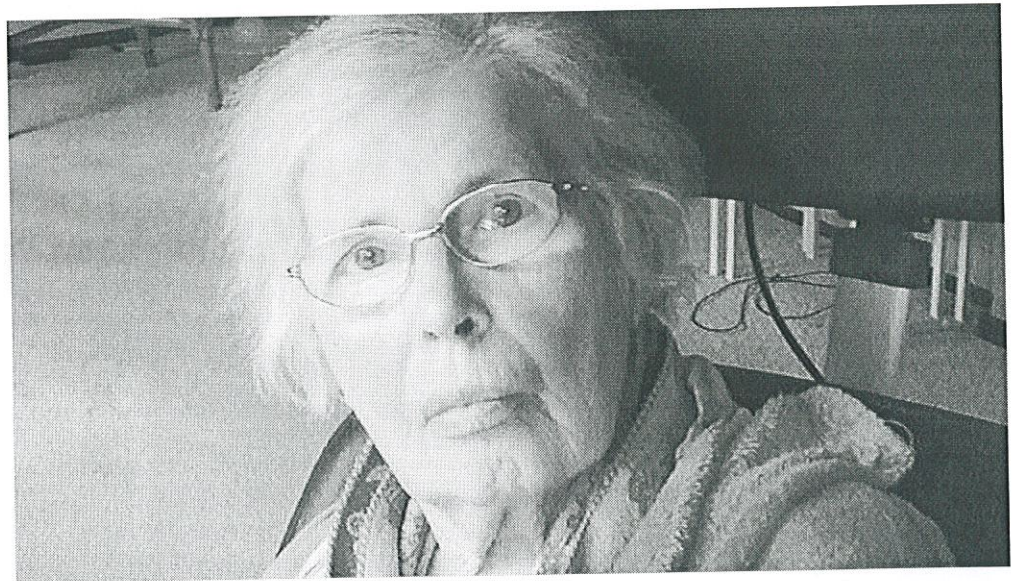
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## Court tussle over right to euthanase Dutch woman with dementia

by Michael Cook | 7 Aug 2015 | (6)

tags: euthanasia, informed consent, Netherlands

*Sorry, we missed this euthanasia story from the Netherlands. It deserves to be more widely known.*



**Cobi Luck on the day of her death.**

An 80-year-old Dutch woman suffering from dementia was euthanased on April 24 after a sternly-worded court order addressed to her nursing home.

The woman, who was later identified as Cobi Luck, had a stroke two years ago. She became paralysed and totally dependent on carers in **Ter Reede dementia specialist care home** in Flushing. But when she asked her son to get the nursing home to organise euthanasia, the director refused. In his opinion, supported by the woman's own doctor and a psychologist, she was not mentally competent.

Ignoring the advice of the nursing home, Ms Luck's family supported her request, so they called in **Levensindekliniek** (the End of Life Foundation). This organisation arranged for two doctors and a psychiatrist to assess her condition. They concluded that she was competent, or competent enough, to request euthanasia. The nursing home refused to release Ms Luck into the hands of Levensindekliniek, so the family sought a decision from a court.

The **position of the nursing home**, which has a Christian inspiration, was that Ms Luck only spoke about euthanasia after her family had paid a visit. She still appeared to enjoy life and made comments which were not consistent with a desire for euthanasia. Its staff knew her well and believed that she was not competent to make such a momentous decision. It stressed that people like Ms Luck were very vulnerable.

Her family found this "outrageous". Their position was that many people never mention their desire for euthanasia unless they are asked. Besides, three doctors had assured them that Ms Luck knew what she was doing. A judge



sitting in an emergency session in Utrecht decided in favour of the family and Levenseindekliniek. Judge Sap told Earl Ter Reede, chairman of the nursing home, that he had to respect the wishes of the woman.

"It's not a question of incapacity. You simply do not want to accept the decision," the judge said. "You are putting yourselves in this situation on your own authority. I am observing the principle that you must respect this woman's wishes. It's the final thing you can do for her."

This was the first time in the history of Dutch euthanasia legislation that an institution had refused to allow a patient to be euthanased. From a legal point of view, the most interesting feature of the case is that the judge gave more weight to the opinion of the doctors at the Levenseindekliniek than the woman's own medical staff because they had "**specialized medical knowledge and experience**".

A day after the court order Ms Luck was taken from the care home and was given a lethal injection at the Levenseindekliniek on April 22.

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