

P.O. Box 17
8127 Forch, Switzerland
Phone +41 43 366 1070
Fax +41 43 366 1079
Email: dignitas@dignitas.ch
Internet: www.dignitas.ch

Sender: P.O. Box 17, 8127 Forch, Switzerland
Joint Committee on End of Life Choices
Parliament House
GPO Box 572
Adelaide 5001
South Australia

Forch, 31st July 2019

**Joint Committee on End of Life Choices
South Australia**

**Submission by
DIGNITAS – To live with dignity – To die with dignity
Forch, Switzerland**

for and on behalf of the 12 South Australian and 160 Australian members of DIGNITAS
submitted in electronic format to jcendoflifechoices@parliament.sa.gov.au

	page
1) Terms and abbreviations	2
2) Abstract	2
3) Introduction	3
4) Who is DIGNITAS and why does DIGNITAS write this submission?	5
5) The freedom to choose time and manner of one's own end in life from a (European) human rights perspective	7
6) Challenges with quality of life, life expectancy and care	11
7) The protection of life and the general problem of suicide	13
8) Suicide attempt prevention – experience of DIGNITAS	16
9) Palliative care	18
10) Arguments of “vulnerable individuals” and a “slippery slope”	19
11) The “Swiss system” of assisted dying: legal and practical aspects	22
12) Conclusion	28
13) Draft Act to introduce assisted dying in South Australia based on the Swiss system of physician-supported accompanied suicide	Appendix

1) Terms and abbreviations

DIGNITAS: an abbreviation, for easier reading, of “DIGNITAS – To live with dignity – To die with dignity”, the name of the Swiss non-profit member society providing this submission

Assisted suicide / accompanied suicide / physician-supported accompanied suicide (abbreviation: PSAS): this is what is made possible for members of DIGNITAS in the frame of Swiss law: a person wishing to put an end to his/her own life commits a carefully prepared and well-thought-of suicide, the medication provided by a (Swiss) physician after assessing the persons' request and medical file, and this person cared for and accompanied by DIGNITAS, generally in the presence of next-of-kin and friends, and usually at his/her home.

Voluntary euthanasia: a person wishing to end his/her own life requests and permits a third person to put an end to his/her life, for example by injection of a lethal medication. This is prohibited in Switzerland, yet legal under certain circumstances and provided by doctors in Belgium, Luxembourg and The Netherlands.

Passive euthanasia: (termination of treatment, “to let die”): ending (or not starting) life-maintaining and life-prolonging therapies, renouncing treatments, waiving food and drink.

Euthanasia: from the Greek, meaning “good, well death”. As this term may relate to different issues, ranging from help at the end of life and putting down animals to the atrocities of the Nazi regime, and as it is a term not describing a specific form of help in dying, it is generally not used in this submission as such.

Palliative care: 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 (as defined by the WHO).

Palliative sedation / continuous deep sedation: usually a medically induced (“artificial”) coma. Generally applied in palliative medicine for patients in a terminal phase, once the patient feels the suffering to be unbearable and explicitly requests the sedation. Example: a patient has given instructions not to be ventilated; an increasing shortness of breath (for example due to lung cancer) is being treated by palliative care, with appropriate dosages of morphine; if this is not sufficient or if the danger of suffocation imminent, which can only be avoided by the not-wanted ventilation, a palliative sedation is induced.

Assisted dying: assisted/accompanied suicide and/or voluntary euthanasia with the support of and/or carried out by doctors/physicians.

2) Abstract

This submission provides information for the discussion on introducing assisted

dying legislation in South Australia. It covers on challenges in today's performance-orientated society, developments which led to an increased wish of the public to have personal choice in end-of-life issues, palliative care, human rights legal aspects, and it describes practical and legal aspects of the "Swiss system" of physician-supported not-for-profit member society's assisted/accompanied suicide, monitored by the Swiss authorities. This submission also shows the connection between assisted dying and "do-it-yourself" suicide- and suicide attempts, how access to legal assisted dying has an impact on reducing the number and tragic consequences of such attempts, and thus contributes to improving public health. Furthermore, this submission provides for a law proposal based on the mentioned "Swiss system". Numerous academic and other publications on the issue of end-of-life-choices are available. Many do not base on actual practical, international long-standing experience / know-how of providing assisted dying combined with suicide attempt prevention and advisory work on advance health care planning, palliative care, etc. This submission does not and cannot cover the issue in all details, but it may fill in on some gaps.

3) 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 2011² 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 some cases, providing any real benefit to their health³ – prolonging life to a point much further in the future than some

¹ In: *Epistulae morales LXX ad Lucilium*

² Congress of Swiss General Practitioners in Arosa, 31 March - 2 April 2011

³ British Medical Journal 2012, <http://www.bmjjournals.org/lookup/doi/10.1136/bmjjournals.103637>

patients would want to bear it. 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 and life 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 had to start choosing 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 suffering and life and the prevention of the negative effects resulting from the narrowing of options. The founding of such associations, in the UK and the USA, dates back to the 1930s.

In Switzerland, 37 years ago, EXIT (German part of Switzerland) was founded, in the same year after EXIT Suisse romande (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 societies such as DIGNITAS followed, the difference between 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 some associations, such as DIGNITAS, has widened to include working on suicide preventive issues directly or indirectly, especially suicide attempt prevention, palliative care, advance health care planning, especially the implementation of advance directives (living will), etc.

Today, EXIT has 120,000 members⁴ and EXIT Suisse romande 29,000. DIGNITAS, together with its independent German partner association DIGNITAS-Germany in Hanover, counts, as of the date of this submission, 10,000 members worldwide of whom 160 reside in Australia, 12 of them in South Australia.

In the over 21 years of DIGNITAS' existence, 32 individuals from Australia, 3 of them from South Australia, have made use of the option of a self-determined self-enacted ending of suffering and life accompanied with DIGNITAS in Switzerland⁵. For all DIGNITAS-members, being assisted and accompanied through the final stage of their life towards their self-chosen end was and is an issue of major importance. DIGNITAS always encourages members to have their next-of-kin and 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 palliative continuous deep sedation, which provides an essential option of relief for the dying, the option of choosing a professionally supported self-enacted death, which is ending one's suffering in the frame of assisted/accompanied suicide, is not (yet) possible in South Australia.

This leads to residents of South Australia having to travel 15,694 kilometres (which is the air-line distance Adelaide to Zürich) when all that he or she wishes is to have

⁴ <https://exit.ch/exit-auf-einen-blick>

⁵ <http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2018.pdf>

the choice of a self-determined dignified end of suffering. Furthermore, the present legal situation in South Australia has the additional appalling effect that the very important support towards the end of life by next-of-kin and 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. On top of it all, these patients, in some cases, will have to travel to Switzerland at an earlier stage, when they still can do so and would be accepted by the airline. If they had the same choice at their home in South Australia, they would carry on living longer.

The issue is approached differently under Swiss law: whilst in Switzerland, like in South Australia, palliative care is established and suicide as such is not a crime, article 115⁶ of the Swiss Criminal Code states:

“Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty.”

The obvious difference is the “selfish motives”: whilst in South Australia the law basically threatens to punish assistance in suicide whatever the motive, Swiss law 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 individuals – made possible by DIGNITAS.

DIGNITAS very much welcomes the inquiry by The Joint Committee on End of Life Choices: it brings the issue of end-of-life-questions to the level where it should be addressed, the legislation. This submission provides some information, on the base of DIGNITAS’ 21 years’ of international experience. DIGNITAS is happy to give oral and further written evidence if the Committee would wish so. Also, the Committee is welcome to visit DIGNITAS.

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

DIGNITAS is a Swiss not-for-profit member society, a help-to-life and right-to-die dignity advocacy group, founded 17th May 1998 by Swiss human rights attorney-at-law Ludwig A. Minelli. Many years earlier, in 1977, he had already founded SGEM-KO, the Swiss Society for the European Convention on Human Rights, a not-for-profit member 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 personal right to end his or her own life. Many years later, in 2011, the European Court of Human Rights (ECtHR) confirmed this opinion in the case of HAAS v. Switzerland, application no. 31322/07 (see further in this submission).

⁶ <https://www.admin.ch/opc/en/classified-compilation/19370083/index.html#a115>

In accordance with its articles of association, DIGNITAS has the objective of ensuring a life and an end-of-life with dignity for its members and of helping other people to benefit from these values. This is reflected in the full name and the logo of the organisation: DIGNITAS – *To live with dignity – To die with dignity*. As one can see, the aspect of a dignified life comes first. It is DIGNITAS’ first and most important task to look for solutions which lead towards re-installing quality of life so that the person in question can carry on living. At the same time, if solutions towards life do not seem to be possible, options for a dignified death are also looked at.

DIGNITAS’ work extends far beyond “assisted dying” and comprises suicide attempt prevention, litigation and political work to further develop laws regarding human rights concerning freedom of choice and self-determination in life and in “last matters”, planning ahead with healthcare advance directives, counselling in palliative care, and so on. DIGNITAS is a protection-of-life, quality-of-life and freedom-of-choice organisation.

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 14⁷. Therefore, the logic consequence for DIGNITAS was 1) to allow non-Swiss residents and non-Swiss citizens to access the possibility of an assisted/accompanied suicide in Switzerland, which obviously includes Australian, and 2) to advocate for implementation of “the last human right”, the practice of Switzerland, in other countries too.

In its over 21 years of operation, DIGNITAS has been involved in several leading legal cases dealing with the “right to die” at the ECtHR and others more and DIGNITAS has been consulted by committees, panels and representatives of parliaments, from England, Scotland, Sweden, Victoria and Western Australia, Canada and others more, with an aim of implementing laws to introduce assisted/accompanied suicide as an additional end-of-life-choice.

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

Clearly, the public is in favour of freedom of choice in these “last issues”⁸. No South Australian 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 and life. Everyone should have access to such option at his or her home, as an additional choice besides palliative care measures (including palliative/continuous deep sedation), having treatment discontinued based on instruction through a personal health

⁷ http://www.echr.coe.int/Documents/Convention_ENG.pdf page 13

⁸ See for example <https://images.theconversation.com/files/166224/original/file-20170421-12658-1twsrk.png?ixlib=rb-1.1.0&q=45&auto=format&w=1000&fit=clip>, the First Report of the UK Select Committee on Assisted Dying for the Terminally Ill Bill <https://publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.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.

care advance directive, and the accompanying of dying individuals. In consequence, DIGNITAS writes this submission in the name of its Australian members, of whom 12 live in South Australia, and for all other people who would like to have such freedom of choice now or in the future.

The core goal of DIGNITAS is to become obsolete, to disappear as soon as possible. When regulations regarding freedom of choice and self-determination in life and life's end similar to those available in Switzerland are implemented in all other countries, nobody will have to turn to DIGNITAS and Switzerland anymore. Nobody shall become a "freedom tourist" or "self-determination tourist" (which is certainly a more appropriate term than the tabloid-style "suicide tourist"). And when the work of organisations like DIGNITAS has been implemented in the health care and social welfare system, such organisations will no longer be necessary.

5) The freedom to choose time and manner of one's own end in life from a (European) human rights perspective

All European states – with the exception of the Vatican, Belarus and Kosovo – have adhered to the ECHR⁹. 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 ECtHR¹⁰ has developed an important 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 South Australia, 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.

In the judgment of the ECtHR in the case of DIANE PRETTY v. the United Kingdom dated 29th April 2002¹², 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:

⁹ The Convention: http://www.echr.coe.int/Documents/Convention_ENG.pdf

Member States: <http://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/005/signatures>

¹⁰ http://www.echr.coe.int/Documents/Convention_ENG.pdf

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

¹² Application no. 2346/02; Judgment of a Chamber of the Fourth Section: <http://hudoc.echr.coe.int/eng?i=001-60448>

“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 3 November 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 to self-determination within the meaning of Article 8 § 1 [of the Convention] includes the right of an individual to decide at what point and in what manner he or she will die, at least where he or she is capable of freely reaching a decision in that respect and of acting accordingly.”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 psychiatric/mental ailment. It further recognized:

“It must not be forgotten that a serious, incurable and chronic mental illness may, in the same way as a somatic illness, cause suffering such that, over time, the patient concludes that his or her life is no longer worth living. The most recent ethical, legal and medical opinions indicate that in such cases also the prescription of sodium pentobarbital is not necessarily precluded or to be excluded on the ground that it would represent a breach of the doctor’s duty of care ... However, the greatest restraint must be exercised: it is necessary to distinguish between a desire to die as the expression of a psychological disorder which can and must be treated, and a wish to die that is based on the considered and sustained decision of a person capable of discernment (“pre-suicide assessment”), which must be respected as applicable. Where the wish to die is based on an autonomous and all-embracing decision, it is not prohibited to prescribe sodium pentobarbital to a person suffering from a psychiatric illness and, consequently, to assist him or her in committing suicide.”

And furthermore:

“The question of whether the conditions have been met in a given case cannot be examined without recourse to specialised medical – and particularly psychiatric – knowledge, which is difficult in practice; a thorough psychiatric examination thus becomes necessary...”

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 ECtHR.

¹³ BGE 133 I 58, page 67, consideration 6.1 (translated): <http://bit.ly/BGE133I58>

On 20th January 2011, the ECtHR rendered the judgement¹⁴ HAAS v. Switzerland and stated in paragraph 51:

”In the light of this case-law, the Court considers that an individual’s right to decide by what means and at what point his or her life will end, provided he or she is capable of freely reaching a decision on this question and acting in consequence, is one of the aspects of the right to respect for private life within the meaning of Article 8 of the Convention.”

In this, the ECtHR 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 ECHR.

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 19th July 2012, the ECtHR 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 own rights he claimed¹⁵. The case had to be dealt with by the German domestic courts again, until the German Federal Administrative Court, in a landmark decision, corrected the lower courts decisions: The general right to personality article 2,1 (right to life) in connection with article 1,1 (protection of human dignity) of the Basic Law (Constitutional Law) of Germany comprises the right of a severe and incurably ill patient to decide how and at what time his or her life shall end, provided that he or she is in a position to make up his or her own mind in that respect and act accordingly. The Court found, even though it was generally not possible to allow purchasing a narcotic substance for the purpose of suicide, there had to be exceptions.¹⁶

In the case of GROSS v. Switzerland, the ECtHR 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.

¹⁴ Application no. 31322/07; Judgment of a Chamber of the First Section: <http://hudoc.echr.coe.int/eng?i=001-102940>

¹⁵ Application no. 479/09, Judgment of the Former Fifth Section:
<http://hudoc.echr.coe.int/eng?i=001-105112>

¹⁶ See the respective press release by DIGNITAS <http://www.dignitas.ch/images/stories/pdf/medienmitteilung-08032017.pdf> (in English); link to the decision by the Federal Administrative Court of Germany: <http://www.bverwg.de/entscheidungen/entscheidung.php?ent=020317U3C19.15.0> (in German)

In its judgment of 14th May 2013¹⁷, the ECtHR 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, the case was referred to the Grand Chamber of the ECtHR by the Swiss government as prior to a public hearing on the case, it became known that the applicant unfortunately had passed away in the meantime. This 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. New judicial reviews are underway, for example, in the UK, by Phil Newby who is terminally ill with Motor Neurone Disease¹⁸ and Paul Lamb, a man paralysed from the neck down after a car accident in 1990.¹⁹

We would like to emphasize that in this context, since the case of ARTICO v. Italy (judgment of 13th May 1980, series A no. 37, no. 6694/74²⁰), 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 com-

¹⁷ Application no. 67810/10; Judgment of a Chamber of the Second Section: <http://hudoc.echr.coe.int/eng?i=001-119703>

¹⁸ <https://www.bindmans.com/news/crowdjustice-campaign-launched-for-phil-newby-who-is-fighting-for-a-law-change-to-die-with-dignity>

¹⁹ <https://www.leighday.co.uk/News/2019/July-2019/Paralysed-man-Paul-Lamb-applies-to-High-Court-to-c>

²⁰ <http://hudoc.echr.coe.int/eng?i=001-57424>

promising said dignity and freedom. In the judgment DIANE PRETTY v. the United Kingdom mentioned before, 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 ECHR, which states that no one shall be subjected to torture or to inhuman or degrading treatment or punishment.²¹ 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 an individual’s right to decide by what means and at what point his or her life will end, 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 and at their home. 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 and dignified manner. Such a method must also consider aesthetic aspects in order to enable relatives and friends to attend the process without being traumatized.

It should be noted that the United Nations Treaty International Covenant on Civil and Political Rights²² states in article 17:

1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.
2. Everyone has the right to the protection of the law against such interference or attacks.

Australia signed (in 1972) and ratified (in 1980) this United Nations treaty²³. Article 17 of this treaty, in its essence, mirrors article 8 of the ECHR. Being that article 8 of the ECHR enshrines the right to decide on time and manner of one’s own end in life, it could be, from this perspective, that the (South) Australian legal situation is in conflict with international law factually applicable in Australia. Though there is no possibility for an individual to deposit a legal complaint, the treaty is monitored by the United Nations Human Rights Council²⁴. Possibly, there is room for development.

6) Challenges with quality of life, life expectancy and care

According to the Australian Institute of Health and Welfare, life expectancy (from

²¹ http://www.echr.coe.int/Documents/Convention_ENG.pdf

²² https://treaties.un.org/doc/Treaties/1976/03/19760323%2006-17%20AM/Ch_IV_04.pdf

²³ https://treaties.un.org/Pages/showDetails.aspx?objid=0800000280004bf5&clang=_en

²⁴ <https://www.ohchr.org/EN/HRBodies/HRC/Pages/Home.aspx>

birth) in Australia has increased over the past approx. 130 years, from 50.8 to 84.6 for women and 47.2 to 80.5 years for men²⁵. This is similar to other industrialised “western world” countries.

The fact is that we live longer and longer. There are many reasons for this: developments in medicine, material prosperity, education, improved hygiene, more awareness of one’s health, etc.

Quality of life, the subjective measure of well-being, is influenced by several factors. Health is one of them, and is arguably the most important. The constitution of the World Health Organisation (WHO) states²⁶:

„Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity“

and furthermore:

„The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition“

Alongside material prosperity and education, self-confidence and the wish for individual fulfilment have been developing; at least in our “western hemisphere” many people can shape their life – in the frame of the legal and social order – the way they want to lead it, the way they feel it to be appropriate in accordance with their personal values.

Without doubt, all this is a wonderful thing. Who does not wish to stay healthy and, at the same, to live longer?

However, this development has also its downsides. Every day we are confronted with the ideal of the slim, omnipotent, suntanned and fit-as-a-fiddle individual. Advertising shows us again and again further possibilities of what we can do good for our mind, our body and our soul. Our performance-orientated society demands personal efforts to increase quality of life. Askew and chubby are “out”, the nose wants to be straightened and the wrinkle smoothed.

We are led to believe that good looks and being healthy are the norm and we act as if we could live forever young and fit. That life is *limited* has faded from our perception. We have “outsourced” suffering to care homes and rehab clinics. Dying is for later and somewhere else, rarely at home: the transition from life to death takes place in hospices, homes for the elderly and palliative care wards of hospitals. It is neatly filed away and sealed off from the pulse of life so that the functions of a well-oiled, performance-orientated society are not impaired. It seems that we have forgotten how suffering and death, just as much as joy and birth, are a part of life.

One day reality catches up with us, often when we are unprepared: we may be con-

²⁵ <https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/life-expectancy>

²⁶ <https://www.who.int/about/who-we-are/constitution>

fronted with a life-crisis, face the consequences of an accident or isolation, we fall ill, we get old and frail.

This leads to a gap: those who seek help due to their suffering are on a roller coaster of feelings; support conveys safety and social reassurance, but also a feeling of dependency. People who seek help are seeking the maximum possible independence, yet they feel helpless because they are unable to act alone. Often, their anger, grief and frustration grow due to the abilities they have lost or the possibilities that are unavailable. One may feel ashamed for not-being-able or not-being-capable anymore.

This then may clash with a problematic situation in the fields of medicine, nursing, psychological therapy and psychiatry as well as social care: sometimes one can see that awareness for the individuality and complexity of the single case is missing or blanked out. The person is not seen as an individual subject but as an object, as a case. In certain circumstances personal elements may stand in the way: ego, striving for power, difficulties accepting the possibility of being rejected as a therapist, etc.

What are the consequences? Some people will turn away from their doctor or therapist and look for another medical professional – and in the best case they will find the treatment which they feel is appropriate. Others might incur a treatment mistake and have to bear the consequences in addition to their initial problem. It is possible that developments in medical science might offer a new approach, a solution. Certainly, in many cases they will get off lightly. But if not? What happens to a person in a reduced physical and emotional state who does not feel that their needs are being met, does not feel that they are being noticed and taken seriously and who plunges into a downward spiral of failure and dwindling hope for improvement? What if the condition further deteriorates until he or she sits at the bottom of a deep hole and only sees the sky up above – and heaven's exactly where he or she wants to go?

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

In the judgment DIANE PRETTY v. the United Kingdom mentioned earlier, the ECtHR 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 20 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 weak nor the vulnerable nor those with insufficient (or even without) health insurance would choose the option of physician-supported assisted/accompanied suicide, but in fact the self-confident, the above-average educated, the strong ones.²⁷

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

²⁷ 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>

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 (voluntary) euthanasia have hardly recognised the fact that, apart from the small number of individuals who, due to their deteriorating health, wish to end their suffering with one of the few available methods (palliative care, assisted dying, rejection of treatment and refusal of food and drink, etc.), there is a problem on a much larger scale which questions the sanctity of life: the general problem of suicide and suicide attempts.

According to the Australian Bureau of Statistics, in the year 2017, there were in Australia 3,128 registered deaths by intentional self-harm (suicides)²⁸. This signifies that on average more than eight individuals die every day in Australia as a result of a suicide attempt. For the years 2015 - 2017, suicide is the leading underlying causes of death in the age group 15 - 44²⁹.

Many industrialised modern states show a high number of suicides. This is, however, “only” the number of statistically registered deaths by suicide. The World Health Organisation WHO estimates that 800,000 people worldwide die by self-harm every year but that “there are many more people who attempt suicide every year”³⁰.

In response to the request regarding information on suicide and suicide attempts in Switzerland from Andreas Gross, then a member of the Swiss National Council, the Swiss government rendered its comments to the parliament on 9th January 2002³¹: 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.

In the year 2010 - 2011, there were 25,887 (non-fatal) cases of hospitalisations due to self-harm (suicide attempts) compared to 2,282 deaths from suicide registered in that year³². This indicates that there are at least more than 10 times more suicide attempts than deaths by suicide in Australia, a failure rate of 9:1. However, the number is quite likely even higher as this record is on those who are admitted to hospital only.

Given the results of the scientific research mentioned before, suicide attempts in Australia, based on the 2017 figure, could be estimated to be up to 156,400 per year. Even if a much lower ratio, based on the hospitalisations mentioned before, that is approximately 10 attempts for every completed suicide is applied, there would still be 31,280 suicide attempts in Australia of which 28,152 fail. As the WHO states, for every [death by] suicide there are many more people who attempt suicide every year,

²⁸ <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm.%20key%20characteristics~3>

²⁹ <https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/leading-causes-of-death>

³⁰ <https://www.who.int/news-room/fact-sheets/detail/suicide>

³¹ Online (in German): http://www.parlament.ch/d/suche/seiten/geschaefte.aspx?gesch_id=20011105

³² <https://www.aihw.gov.au/getmedia/b70c6e73-40dd-41ce-9aa4-b72b2a3dd152/18303.pdf.aspx?inline=true>

more precisely that “there are indications that for each adult who died by suicide there may have been more than 20 others attempting suicide”³³.

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”, “not all people who are hospitalised due to self-harm may have intended to die by suicide” – are simply “thought savers”³⁴. Thought savers are a way to stop thinking about a particular problem without solving it. With a thought saver, one may get rid of the problem, belittling it so that it appears no longer worth thinking about. It is quite significant that such thought savers are very common in relation to the suicide and suicide attempt problem. 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 attract attention to find help, instead of talking before to other people and saying that they need help? In the special case of a suicidal situation, some reasons for the cry for help without words is the taboo on the issue (due to centuries of religious-influenced condemnation of deciding on one’s own end in life), the fear of not being taken seriously and/or being rejected (losing face, deprived of affection), or the risk of losing one’s liberty (due to being labelled as incompetent, mentally ill and put in a psychiatric clinic).

The negative and tragic result of “clandestine”, do-it-yourself 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 economy³⁵;
- 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 drivers;
- psychological problems for next-of-kin and friends of a suicidal person after their attempt and their death;
- personal risks and psychological problems for rescue teams, the police, etc., who have to attend to the scene at or after a suicide attempt;

Referring to the previously mentioned ARTICO-jurisdiction of the ECtHR: no matter whether the risk is 49:1 or “only” 9:1, it indicates that in countries which do not have legal assisted dying, 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

³³ https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

³⁴ An expression created by the American journalist Lincoln Steffens, a friend of President Theodore Roosevelt, see The Autobiography of Lincoln Steffens, Literary Guild, New York, 1931.

³⁵ 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 https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2008-10/suicide/report/index

(further) deterioration of his or her state of health, also harming others. This signifies that the right to end one's life self-determinedly and by own action under the conditions currently found in South Australia and most countries is neither practical nor efficient.

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. More discussion of suicide and the provision of more accurate information about suicide in Australia can only be for the better.

8) Suicide attempt prevention – experience of DIGNITAS

Everyone should be able to discuss the issue of suicide openly with their general practitioner, psychiatrist, carer, 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 institutions³⁶. However, for many people “talking about it” does not suffice: they seek the concrete option of a painless, risk-free, dignified and self-determined end to their suffering and life.

DIGNITAS' experience with all people – no matter whether they suffer from a severe physical ailment and 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, has a very positive effect: they are – and feel that they are – being taken seriously (often for the first time in a long 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 place³⁷. Their suicidal ideas are not rejected or belittled and there is no restraint to discussing these ideas 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 and safe 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 turn to a crisis intervention centre, referring severely suffering ill to the palliative experts at an appropriately

³⁶ In Australia provided for example by LIFELINE <https://www.lifeline.org.au> or the SAMARITANS <http://www.thesamaritans.org.au>

³⁷ See ‘DIGNITAS’ Advisory Concept’ <http://dignitas.ch/images/stories/pdf/diginpublic/referat-rtvd-stockholm-30032019.pdf> page 15 ff.

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 and always with "keeping the door to the emergency exit" open. 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.³⁸

The experience of DIGNITAS, drawn from over 21 years of working in the field of suicide prophylaxis and suicide attempt prevention, shows that the option of an assisted/accompanied suicide, which is putting an end to one's suffering and life without having to face the severe risks inherent in "do-it-yourself (DIY)"-suicide attempts, is a very important method of preventing suicide attempts and suicide. It may sound paradoxical: in order to prevent DIY-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.

The prospect of having access to the option of a self-determined, safe and accompanied end of suffering reduces the risk of such attempts, also because it alleviates the individual's pressure of desperation and feeling of "there is no way out".

Switzerland has a progressive-liberal law which allows access to an accompanied/assisted suicide not only – as is the case in some states in the USA such as Oregon – for individuals who are considered to be terminally ill and within six months of dying.

By comparing statistics published by the Swiss Federal Statistical Office and the Oregon Health Authority, it can be observed that in Switzerland the number of lonely DIY-suicides has decreased significantly³⁹ over the past 20 years whilst in Oregon (and other US-states) it has not⁴⁰. This indicates that broad(er) eligibility criteria for assisted dying results in more effective reduction of the number of DIY-suicides and suicide-attempts.

Without doubt, there are other factors more which influence the number of suicides and suicide attempts. Still, it is a fact that a severely ill individual in Oregon who would not be assumed to die within 6 months is deprived of the choice of legal and professionally assisted dying, and such has no other option than either to wait and continue suffering or take to a DIY-suicide attempt with all the risks of dire consequences as pointed out already.

A real option – that is access to professional assisted dying when someone rationally decides to end his or her suffering and life – 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 in-

³⁸ <http://www.dignitas.ch/images/stories/pdf/statistik-beratungsgespraech-2607-30092010.pdf>

³⁹ <https://www.bfs.admin.ch/bfsstatic/dam/assets/3902308/master>, table G 10, page 3.

⁴⁰ <https://www.arcgis.com/apps/MapSeries/index.html?appid=9c59be59ef7142dfad40d95e3b36f588>

volved in the preparation process and encouraged to be present during the last hours: this gives them a chance to 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. The importance of enabling this process of “saying goodbye together” cannot be underestimated. Almost all assisted/accompanied suicides at DIGNITAS take place in the presence of family members and friends of the patient.

9) Palliative Care

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 21 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”⁴¹. 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 quadriplegics⁴² or patients suffering from a multitude of ailments related to old age⁴³ are generally not *per se* eligible for palliative care and continuous deep sedation because they are not suffering from excruciating pain and/or a life-threatening situation as such. Long-time degenerative neurological diseases 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 a patient’s rational decision to self-enacted end suffering and life are *not* two practices in conflict but in fact they have a complementary relationship

⁴¹ <http://www.theage.com.au/comment/at-lifes-end-we-should-respect-peoples-choices-20140815-104cob.html>

⁴² 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.

⁴³ Such as for example the well-known British conductor Sir Edward Downes

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 terminal cancer, as well as their relatives and friends. As the administrative assessment proceedings involved with the preparation of an assisted/accompanied suicide take quite some time, usually several months, DIGNITAS recommends terminally ill patients to also pursue the option of continuous deep sedation. Thus, DIGNITAS has directed uncountable patients towards palliative care, has given advice how to access the support of specialist doctors, how to implement Health Care Advance Directives 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 ECtHR avoided looking into the aspect of the states' positive duty to protect individuals from inhumane treatment in the context of assistance in dying, but there is room to look into this aspect more closely in future cases⁴⁴.

At this point, being that medical doctors play an important role in improving quality of life, ensuring comfort of the patient and dealing with end-of-life treatment, an excerpt of the Declaration of Geneva of the World Medical Association⁴⁵ deserves mention:

“I solemnly pledge to dedicate my life to the service of humanity”

and furthermore:

“I will not use my medical knowledge to violate human rights and civil liberties, even under threat”.

10) 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 (such as physically disabled) and those who suffer from an impairment of capacity to consent (for example due to dementia) would be classified as vulnerable. However, it is acknowledged – especially in the annual reports of the Health Authority of the US-American State of Oregon⁴⁶ – that assisted/accompanied suicide has nothing to do with “vulnerable” individuals.

⁴⁴ 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.

⁴⁵ <https://www.wma.net/policies-post/wma-declaration-of-geneva>

⁴⁶ Death with Dignity Act annual reports of the Health Authority of the US State of Oregon:
<http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx>

The vulnerable-argument is another thought saver and a stigmatising pretext argument. 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 illness⁴⁷.

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”⁴⁸. 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.

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.”

⁴⁷ Cambridge Quarterly of Healthcare Ethics 2014, <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=9333247&fileId=S0963180114000085>

⁴⁸ Journal of Medical Ethics 2007;33:591-597; doi:10.1136/jme.2007.022335: <http://jme.bmjjournals.com/content/33/10/591.abstract>

There is more research on the issue and publication which point out that there is no such thing as a slippery slope with assisted dying. The findings match the experience in Switzerland, Belgium, and further countries which allow a suffering individual to have professional support for a self-determined end of life.

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 the slippery slope argument in his report “Das Dammbruch-Argument in der Sterbehilfe-Debatte” (“The slippery-slope argument in the assisted dying debate”)⁴⁹: 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.

In Switzerland, despite a progressive-liberal regulation on assisted dying and a 35 year practice of assisted/accompanied suicide by non-profit member societies like DIGNITAS and EXIT in cooperation with Swiss physicians, this option makes for only 1.6 % of all deaths.

Furthermore, based on the experience of the Zürich City Council, it is now known that allowing assisted/accompanied suicide in nursing homes for the elderly does not lead to any rise of such end-of-life choice: of the 1,600 residents in Zürich homes for the elderly, less than ten individuals per year choose to have an accompanied suicide since the authorities allowed associations like DIGNITAS and EXIT access such homes in 2002⁵⁰.

The issue is not whether someone would really make use of assisted/accompanied 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”⁵¹ 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 accompanied 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 time⁵². 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 DIY suicide attempt with all its risks of dire consequences. Overall, only some 3 % of all members make use of the

⁴⁹ in: FRANK TH. PETERMANN, (ed.), Sicherheitsfragen der Sterbehilfe (Safety questions in assisted dying), St. Gallen 2008, p. 125-146

⁵⁰ See the interview with Dr. med. 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>

⁵¹ For an explanation, see ‘How DIGNITAS works’, chapter 1.6, page 8 ff: <http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf>

⁵² Extract of the study (available in German) online: <http://www.dignitas.ch/images/stories/pdf/studie-mr-weisse-dossier-prozentsatz-ftb.pdf>

“final option” at DIGNITAS – even though DIGNITAS accepts people from other countries than Switzerland, people who are not terminally ill and those with psychiatric ailments. The number of assisted/accompanied suicides by DIGNITAS and EXIT has decreased from the year 2015 to 2016, despite the fact that the number of members of these associations was and is rising.

This shows that a progressive-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.

11) The “Swiss system” of assisted dying: legal and practical aspects

The development of humanistic and natural-scientific thinking as well as the growing separation of church and state in the wake of enlightenment, in the 17th/18th century, brought about the decriminalisation of suicide. Before that, for many centuries, due to religious-fundamentalist intolerance and abuse of clerical power, people who had committed suicide were often buried outside of graveyards and sometimes their families were punished, for example by seizure of their estate.

Towards the end of the 19th century, expert committees and parliament discussed a unified Swiss criminal law and with this also the issue of assistance in suicide. It was found for example that a merchant who would have lost his good reputation/dignity due to bankruptcy 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 end his suffering and life so as at least to save his honour. Such an assistance – the officer letting the gun and ammunition and giving instructions – was even considered to be a “Freundestat”, an “act of friendship”, which should not be punished. In those days, each Canton (each Swiss State) had still its own criminal law.

In 1918, this thought were adapted in the draft for a Swiss-wide criminal code and finally came into force on 1st January 1942 as article 115, stating:

“Inciting and assisting suicide

Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty.”

The progressive-liberal base was kept, assistance in suicide remained and still is today exempt from punishment, but it was specified by the aspect that assistance done out of selfish motives should be a criminal act.

As examples for such selfish motives the Federal Council stated: if someone intended to inherit “earlier” or if someone intended “to get rid” of having to support a family member. Clearly, the aim was and is to sanction “pushing” a person towards suicide out of a very immoral motivation.

The legal consequence, in the sense of *e contrario*: to help (assist) another person to commit suicide is not an offence and therefore not punishable 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 not lack capacity of judgment, in plain words: must be competent⁵³.

The Aspect of a severely ill and suffering individual was not really discussed in context of article 115 of the Swiss Criminal Code, but rather in context of article 114 which states:

“Homicide at the request of the victim

Any person who for commendable motives, and in particular out of compassion for the victim, causes the death of a person at that person’s own genuine and insistent request is liable to a custodial sentence not exceeding three years or to a monetary penalty.”

“Homicide at the request of the victim” = voluntary euthanasia. Article 114 of the Swiss Criminal Code thus prohibits voluntary euthanasia, but offers relatively mild penalty if violated.

Based on article 11 of the Swiss Federal Act on Narcotics and Psychotropic Substances and article 26 of the Swiss Federal Act on Medicinal Products and Medical Devices a Swiss medical doctor may prescribe narcotics under certain circumstances. A further element of the legal framework for assisted dying in Switzerland is court decisions, one of the most important the decision BGE 133 I 58 of the Federal Supreme Court mentioned earlier in this submission.

The Swiss Academy of Medical Science SAMS in 2018 issued guidelines on “handling dying and death”, saying that a medical doctor, based on a personal decision, may assist in suicide

At this time, these guidelines by the SAMS are not yet taken on by the Swiss Medical Association (FMH) which is the union of medical doctors in Switzerland, comprising some 95 % of Swiss medical doctors and being the roof for 71 medical organisations. Only then the SAMS guideline could become statutory regulation for medical doctors who are a member of the FMH.

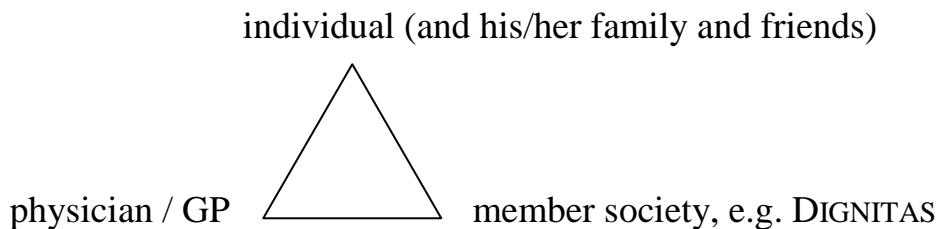
However, both the SAMS and the FMH are private institutions which do not have any power to set law.

⁵³ 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. This approach is also found in the ‘Voluntary Assisted Dying Act 2017’ of Victoria, Australia: “...a person is presumed to have decision-making capacity unless there is evidence to the contrary.”:

http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B320E209775D253CCA2581ED00114C60/%24FILE/17-061aa%20authorised.pdf

Common denominator and in legal practice accepted is that a Swiss medical doctor (physician) 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, a suffering; 2) has seen/spoken the patient and found that he/she really wants to self-determinedly end his/her suffering and life by own action and 3) found that the patient does not show signs of lacking capacity of judgment – therefore found the person to be able to make a rational decision on his/her end of life.

Based on the law and said common denominator, in Switzerland, 35 years ago, a three-party relation assisted dying support system developed:



In the ideal case, a relation develops between the patient, his/her treating physician and a private not-for-profit member's society enabling assisted/ accompanied suicide such as DIGNITAS. That means: a patient experiencing severe suffering, maybe a terminal illness, would be of course under treatment and care of his general practitioner (GP)/physician and/or specialists. In the frame of this relation, the patient could express the wish for an assisted suicide. If the physician agrees, he would assure the patient to help in this venture and recommend that he or she make contact with an organisation like DIGNITAS. Sometimes, a GP would contact DIGNITAS directly, explaining the situation of his or her patient. In any case, the patient would engage in a relation with an organisation like DIGNITAS no matter whether the physician agreed or not with the wish for an accompanied suicide.

The core point is that a medical doctor prescribes 15 grams of Sodium Pentobarbital (20 grams in rare cases of severe overweight of the patient) and gives the prescription to an employee of DIGNITAS. The employee would then fetch the medication from a pharmacy. Generally, the patient never receives the prescription or the medication to take it home. There are a few pharmacies which store/provide Sodium Pentobarbital. 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 (sometimes called companions or befrienders) of the organisation. Family and friends are always encouraged and welcomed not only to attend but in fact to get involved in the preparation procedure right from the start. If the patient does not make use of the medication on that particular day, an employee of DIGNITAS brings it back to the pharmacy.

There is the possibility that a medical doctor prescribes Sodium Pentobarbital *and* does the assistance/accompaniment himself/herself. However, today, being that the professional handling of requests for assisted/accompanied suicide and advisory work on alternative options such as palliative care and continuous deep sedation, voluntary

refusal of food and fluids (VRFF), etc. is established with not-for-profit members' societies like DIGNITAS, physicians will rather leave the handling of preparation and accompaniment to such organisation.

In all cases, the individual 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 rod of a syringe-container filled with the Pentobarbital and thus pumps the medication via a tube into the vein.

Each case of assisted/accompanied suicide is immediately reported to the Swiss police. This prompts them, a state attorney (Switzerland does not have coroners), and an official medical doctor (usually, but not necessarily, one from an Institute of Forensic Medicine) to come to the place of the accompaniment and investigate the case, that is, to check on the sort/manner of death (= ingestion of 15 grams of Pentobarbital), and to find out whether article 115 of the Swiss Criminal Code was violated or not.

Further details of the preparation and the actual course of an assisted/accompanied suicide can be found in the brochure "How DIGNITAS works"⁵⁴.

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 actions in life – not about a third person making decisions on behalf of this individual. It is always the individual who is in charge, who decides which steps within the frame of the law will be taken – until the very last moment.

Since 1998, DIGNITAS has done over 2,500 accompanied suicides, in co-operation with Swiss physicians, for patients from all over the world,⁵⁵ and never has there been a conviction of violation of article 115, let alone article 114, of the Swiss Criminal Code.

It is important to note that the Swiss practice did not lead to a "one-track solution": over these 35 years, a system developed, promoted by DIGNITAS and EXIT, which combines advocating and counselling for palliative care, suicide attempt prevention, health care advance planning (such as advance directives) and the right to choose in life and at life's end. In other words: in Switzerland, so-called right-to-die-organisations have developed into information centres on *all* options to improve quality of life and 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 clear, for example, in votes in the Canton of Zürich, Switzerland, on 15th May 2011: two fundamental-religious political groups brought two initiatives to the people's vote, of which one initiative aimed to prohibit the cur-

⁵⁴ http://www.dignitas.ch/index.php?option=com_content&view=article&id=23&Itemid=84&lang=en

⁵⁵ <http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2018.pdf>

rent legal possibility of assisted suicide entirely whilst the other aimed to prohibit access for non-residents of the Canton of Zürich. The result was a clear message: the public voted by a majority of 85:15 and 78:22 against any narrowing of the current legal status quo⁵⁶. 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 EXIT through inaccurate and hyped tabloid-style press coverage.

In this context one needs to remember that part of the media – especially the tabloids – are notorious for spreading truncated, misleading and false “information” such as there being the option of (voluntary) “euthanasia” at a “DIGNITAS-clinic” where people would receive access to assisted dying on short notice, take “poison” or a “lethal cocktail”, etc., thus showing their irresponsibility towards their actual task of informing the public in an accurate, balanced way. Questions of deliberately or unintentionally ending life have always been subject to sensationalism to which some of the press relates to; some draw their existence merely from offering their followers 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 8th December 2007, stating that the result of such media coverage lies much further within the field of fiction than fact⁵⁷.

DIGNITAS favours the option of assisted/accompanied suicide such as Swiss law allows to practice and for 35 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 not only expresses his or her desire to end his or her life, but undertakes the last act in his or her life him- or herself. In the case of assisted/accompanied suicide in Switzerland, this is drinking it, or opening the valve of a drip, or activating a pain-pump which pushes down the rod of a syringe-container filled with the Pentobarbital and thus pumps the medication via a tube into the vein.
- All actions are based exclusively on the explicit will and rational decision to die 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 pa-

⁵⁶ For links to the official statistics and a choice of media coverage on the results of the votes see: 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).

⁵⁷ Article (in German) online: <http://www.nzz.ch/aktuell/startseite/medienpopulismus-schadet-der-aufklaerung-1.595885>

tient, 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 suicide attempt preventative effect, as already outlined earlier in this submission.

However, these aspects cannot hide the fact that with the Swiss practice of assisted/accompanied suicide, some individuals could be excluded from assistance in dying: there are cases of patients who have lost all control over their bodily functions, 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.⁵⁸ 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 the latter situation, a different approach is already in place to some extent at least: the strengthening and implementation of Advance (Health Care) Directives; sometimes also called Advance Decisions (to refuse treatment) or Living Will.

Based on DIGNITAS' experience, the large majority of requests for an individual's dignified end in life can be covered by assisted/accompanied suicide, implying self-administration of the lethal medication. Implementing a scheme for assisted / accompanied suicide would add a choice for people of South Australia, to have a real option, helping them to soothe fear and despair and regain some control, dignity and hope when faced with severe suffering – something that all people wish for.

One needs to be clear about the fact that only a very small number 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 credo⁵⁹; yet there is another important reason why in fact only a minority of patients would “go all the way” and make use of an assisted/accompanied 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 all humans dislike most. Everyone 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” which brings about fear and despair – this is what

⁵⁸ The ‘Voluntary Assisted Dying Act 2017’ of Victoria, Australia has solved this issue by regulating on medical practitioner administration if the person is physically incapable of the self-administration or digestion of the voluntary assisted dying substance

http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B320E209775D253CCA2581ED00114C60/%24FILE/17-061aa%20authorised.pdf

⁵⁹ http://www.scottish.parliament.uk/S4_MembersBills/Final_version_as_lodged.pdf

members of DIGNITAS state again and again. Legalising assisted/accompanied suicide and voluntary euthanasia is not about “doing it” but about “having the option of doing it”, having a choice.

In the light of all these considerations, DIGNITAS has drafted an Act to introduce assisted dying in South Australia based on the “Swiss system” of physician-supported not-for-profit member societies assisted/accompanied suicide: an “Act to Provide for Accompanied Suicide with Assistance by Registered Charitable Not-for-Profit Organisations (Accompanied Suicide Act – ASA)”, which is submitted in the Appendix as part of this submission.

12) 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 South Australia and in many other countries is indeed “inadequate and incoherent” as the UK Commission on Assisted Dying put it on the front side of its final report⁶⁰. It forces citizens to travel abroad to DIGNITAS 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. DIGNITAS’ articles of association / statutes allow for reduction or even total exemption of paying costs to DIGNITAS⁶¹, however, there are other costs to bear, which results in an unacceptable discrimination against those who are not financially well off.

Even if the journey to Switzerland can be funded in other than personal ways, for example through donations, the person still would have to bear the burden of a long trip to a foreign country which is very strenuous given their deplorable state of health, and, what is even worse, they may have to travel earlier than they would wish for – which constitutes a violation of their right to life –, compared to if they had the same option at home, in order to still be able to cope with the strain. In fact, this aspect of not giving suffering individuals a choice at home and such forcing them to “having to go earlier” constitutes a violation of the basic human right to and sanctity of life.

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 – 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. As pointed out earlier: there are individuals who explicitly would like to add life to their years – not years to their life.

⁶⁰ https://demosuk.wpeengine.com/files/476_CoAD_FinalReport_158x240_I_web_single-NEW_.pdf?1328113363

⁶¹ http://www.dignitas.ch/index.php?option=com_content&view=article&id=11&Itemid=52&lang=en

Australian laws are not yet adequately meeting people's expectations regarding options available at the end of their life because there are Australian who turn to DIGNITAS in Switzerland for help. The legal framework that operates at the end of life in South Australia needs to be reformed.

DIGNITAS calls on South Australia to implement a law which allows a competent individual to have a safe, dignified, self-determined and accompanied end of suffering and life at their own home – full choice on time and manner of one's end of suffering –, which is in fact what a majority of Australians wish for. If this is implemented, as a side-effect the very goal of the DIGNITAS' member society is closer in reach: to become unnecessary. Because, if people in South Australia (and other states too) have legal, practical and efficient option of choice, no citizen of South Australia needs to travel abroad to DIGNITAS anymore.

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 improving quality of life, soothing suffering, and to smaller numbers of failed suicide attempts with all their dire consequences. In this context, we refer to the philosophical and political principles guiding the activities of DIGNITAS⁶² which we feel may well serve as a basis for any consideration of end-of-life-issues.

We close this submission with words by philosopher DAVID HUME⁶³:

„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.“

For any question the Joint Committee on End of Life Choices may have, please do not hesitate to contact us; the board of DIGNITAS – To live with dignity – To die with dignity is happy to give oral and further written evidence if the Committee would wish so. Also, the Committee is welcome to visit DIGNITAS.

Yours sincerely

DIGNITAS
To live with dignity - To die with dignity



Ludwig A. Minelli



Silvan Luley

⁶² See "How DIGNITAS works" chapter 2, page 20: <http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf>

⁶³ DAVID HUME, Of Suicide, <http://ebooks.adelaide.edu.au/h/hume/david/suicide>, in fine.

Draft Act to introduce Assisted Dying in South Australia based on the “Swiss system” of physician-supported accompanied suicide

Act

Draft Act to Provide for Accompanied Suicide with Assistance by Registered Charitable Not-for-Profit Organisations (Accompanied Suicide Act – ASA)

A. Issue

“Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 of the European Convention on Human Rights (ECHR) 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...”

This view was expressed by the European Court of Human Rights (ECtHR) in its decision in the case of Diane Pretty v. the United Kingdom of 29th April 2002. In doing so, the Court touched upon the question of whether the wish of some people for facilitating assisted dying might be a matter that falls under Article 8 of the ECHR, the “right to respect for private and family life”.

Since then, the ECHR has dealt with a series of other cases presenting similar issues. In its decision in one of these cases, Haas v. Switzerland, it recognised the right to decide on the time and manner of one’s own end in life as constituting an aspect of Article 8 ECHR and thus falling within the application of the ECHR as a basic right.

In the public debate on these issues, there has long been a divide between the opinion of a large section of the public and the stance of policymakers. For many years, surveys have shown that in many countries, also in Australia, a clear majority of the public is in favour of making assisted dying legally possible.

It must become possible for those residents of South Australia who want to put an end to their suffering and life for justifiable reasons to do so in a dignified and safe manner at a time of their own choosing and in the presence of their family and friends, in the privacy of their own homes, and to be able to have access to professional assistance for this.

B. Solution

In Switzerland, assisted dying in the form of physician-supported assisted/accompanied suicide by charitable not-for-profit member societies such as DIGNITAS - To live with dignity - To die with dignity has been a practice of 35 years. This, without a specific Law/Act regulating the matter, but with a legal frame consisting of several law articles and court decisions providing a clear legal frame. This “Swiss system”, notably, has been functioning without any of the typical but unfounded pretext arguments having been realised, such as abuse of such system, risks for certain less privileged social groups, “vulnerable people” such as elderly or disabled being pushed to end their days, or a ‘slippery slope’ in the direction of significant rise of assisted dying cases or extending it to voluntary or even involuntary euthanasia. Even after 35 years, only about 1.6 % of all deaths in the Swiss population are attributable to physician-supported assisted/accompanied suicide.

The solution lies in South Australian legal system enacting a law enabling the requirements to be established under which charitable not-for-profit organisations in the territory of South Australia are allowed to provide and perform accompanied suicide in a professional manner. The law should enable accompanied suicide using the gentlest and safest method available, while ensuring that specific quality criteria and safeguards are being met.

The following two aspects in particular are definitive:

accompanied suicide should not be provided by commercial businesses that act as “market players”; and

accompanied suicide needs to be embedded in charitable not-for-profit work premised on suicide as a legitimate act under some circumstances.

These aspects are taken into account by creating a law which sets conditions allowing only charitable not-for-profit organisations in the form of registered member societies (associations in the sense of Swiss Civil Code article 60 ff) to act. This condition does away with the incentive to offer assisted dying in a commercial manner.

Switzerland's experience with this system has been very positive. The Swiss Federal Council (Swiss Government) and the Government of the Canton of Zurich (where DIGNITAS and EXIT have their seat, the latter being Switzerland's biggest help-to-live-and-right-to-die membership society with 120,000 members) – in line with both chambers of the Swiss parliament – have established that this system does not require any additional statutory measures (to prevent abuse). This example shows that “dare to live free!” in seeking a solution to difficult issues may be an eminently reasonable approach. There are no reasons to believe that this approach will be less successful in South Australia than in Switzerland.

The Swiss system of assisted dying, which is based on freedom of choice, personal autonomy and responsibility, is also suited to providing valuable services to society in the area of preventing lonely, risky suicide attempts, of which the vast majority fails, as research evidence shows. This Swiss system strives to embody the principle “as many suicides as justified, as few suicide attempts as possible” and in doing so makes a significant contribution to preventing suicide attempts.

In light of the fact that there is obviously a “system that works”, notably for 35 years now, the South Australian Government – just like representatives of the UK House of Lords, parliamentarians of Sweden, Victoria-Australia, Scotland, Canada, etc. – may be interested to see how this system could be put into law. For this reason, DIGNITAS has drafted an Act, basically a one-to-one image of this Swiss system, which involves 1) a competent individual who wishes to terminate his or her suffering and life, 2) a public member society (not-for-profit membership association) such as DIGNITAS, 3) advisory work / counselling on alternatives to assisted/accompanied suicide such as palliative care and health care advance directives and suicide attempt preventive work in general, 4) medical doctors, 5) a safe medication such as sodium pentobarbital, and 6) state authorities reviewing the accompanied suicide.

C. Alternatives

There are no viable alternatives to providing safe, legal physician-supported assisted dying. The legitimate need and desire for such assistance is justifiable and the public support and demand to have the choice of such option is great – even though only a small number of people would actually make use of it. Any intention to keep professionally assisted dying prohibited (or to narrow access to such option) will lead to the issue not being solved, but the situation made worse. All through history, suicide and assistance in suicide have been reality. No criminal law and no making it a “sin” by religious dogmas have changed anything in this. In fact, by criminalising and banning self-determinedly ending one's suffering and life, the situation remains bad and/or becomes worse: either assistance takes place secretly or people take to drastic measures alone such as jumping off a high building, going in front of a train, shooting themselves, etc. All this with the well-known high risk of failure and dire consequences for the individual and also for third persons (train drivers, emergency rescue teams, etc.), not

to mention the costs for the country's healthcare system and the public in general. Furthermore, prohibiting (or narrowing access to) assisted dying will lead to unlawful discrimination: those who have the means and/or those who are able to travel abroad may find help elsewhere, such as with DIGNITAS in Switzerland, whilst others are forced to put up with what there is or, rather, what there isn't.

From a human rights legal perspective: a law that sets out (narrow) medical requirements for the admissibility of assisted dying on a professional basis must ultimately be at odds with article 8(1) in conjunction with Article 14 of the ECHR and the United Nations Treaty International Covenant on Civil and Political Rights article 17. Since the right to decide on time and manner of one's own end in life, the right to die has been recognised by the ECtHR as a human right, the imposition of medical requirement would result in discrimination against persons who do not satisfy this requirement.

D. Costs

This draft Act, in Section 14, provides for the creation of a Central Supervisory and Documentation Agency collecting data of the activities of the organisations providing accompanied suicide and forwarding complaints to appropriate entities. It could be set up, for example, within the Attorney General's Department of the Government of South Australia. It is assumed that this agency can easily be integrated in the department. The resulting additional expense should be by far outweighed by a significant reduction in the costs incurred by the state of South Australia associated with "common", that is, lonely "do-it-yourself" suicides and attempted suicides with all their well-known serious health consequences and costs to society as a whole.

Draft Act to Provide for Accompanied Suicide with Assistance by Registered Charitable Not-for-Profit Organisations (Accompanied Suicide Act – ASA)

The South Australian Parliament has adopted the following Act:

Article 1

Law on Accompanied Suicide with Assistance by Registered Charitable Not-for-Profit Organisations

Section 1

Purpose of the Act

This Act creates the conditions under which registered charitable not-for-profit organisations may prepare and provide an accompanied suicide as part of the charitable mission of the organisation.

Section 2

Definitions of the terms used

The terms used in this Act are defined as follows:

Organisation: Membership association (member society) registered as a charitable not-for-profit organisation.

Member: Person who has been admitted as a member of an organisation, as defined in this section.

Request: Written expression of a member to an organisation in which the member seeks preparation for an accompanied suicide.

Preparation for an accompanied suicide: Consideration and clarification of whether the self-determined death intended by a member can be justified for health or other reasons.

Provisional green light: Declaration of a medical doctor to an organisation that he or she is in principle willing to issue a prescription for the medication for a member, based on that member's request and the result of the preparation for that member's accompanied suicide, provided that the medical doctor sees the member wishing to die before issuing the prescription and has no doubts concerning the member's mental capacity.

Accompanied suicide: Rendering of assistance to a member wishing to die with the goal of enabling this member to have a dignified, safe and painless self-determined death in the presence of his or her close ones of personal choice.

Assisting person: Persons who on behalf of the orga-

nisation assist a member wishing to die in their self-determined death.

Medication: Pharmaceutical preparations, such as narcotic drugs, individually or combined, in a dosage sufficient to reliably and painlessly result in death.

Aid: Devices, instruments, equipment or release mechanisms that enable a member wishing to die who is not physically able to take the lethal medication without assistance to self-administer the medication, for example, by way of a previously inserted gastric tube or intravenous drip.

Self-determined death: Death by way of self-administration, with or without aid, of a lethal dose of medication prescribed by a licensed medical doctor for use by the member who has requested it.

Medical doctor: a physician, such as a general practitioner, clinician, etc.

Licensed pharmacy: any pharmacy or drug store which is licenced to sell psychotropic substances / barbiturates / sedatives.

Examination of the corpse: Inspection of the corpse of a deceased member to determine whether actions of a third party can be ruled out and therefore self-determined death can be certified.

Medical examiner: public medical doctor officer, a forensic medical doctor, coroner, or a specially trained medical doctor for performing examinations of corpses.

Section 3

Organisation

(1) It is lawful to found an organisation to counsel people considering suicide without a view to any specific outcome, to show them options enabling them to rethink their intention or, if justified, to aid them in realising their wish to die by providing an accompanied suicide. As soon as the organisation is entered in the register for registered associations, it shall be entitled to engage in accompanied suicide in its professional capacity.

(2) Rendering assistance in an accompanied suicide may not be the organisation's only purpose.

(3) The organisation's articles of association (bylaws / statute / charter) must be drafted in a way that the organisation can be lawfully recognised as being charitable / not-for-profit.

(4) In its articles of association, the organisation must set out the amount of ordinary members' dues and any additional members' dues for preparing and conducting an accompanied suicide, if additional dues are to be charged.

(5) The organisation may establish lump-sum fees for other services which may frequently occur in connection with rendering assistance in an accompanied suicide.

(6) The organisation shall ensure that these fees may be reduced or waived for members living in modest economic circumstances.

(7) The organisation shall refrain from aggressive promotion / advertisement for providing accompanied suicide.

Section 4 Counselling / Advisory service

(1) The organisation shall counsel all persons who are considering suicide in an open-outcome manner.

(2) The organisation shall refrain from making any value judgement in respect of a person's wish to die.

(3) The organisation shall discuss with persons considering suicide the problem(s) that has(have) led to their wish to die and shall make suggestions for solutions that enable them to continue living where these suggestions appear useful and feasible.

(4) When it appears that such solutions do not exist or they are rejected by the person considering suicide, the organisation shall be entitled to engage in preparation for assisting the person, after they have become a member, in their self-determined death.

(5) The organisation shall keep, at least, summarised records of such counselling sessions. These records shall enable, at least, statistical data to be collected on the effectiveness of the organisation's work. Individual privacy shall be protected.

(6) The organisation shall provide this counselling to everyone free of charge.

Section 5

Preparation for accompanied suicide

(1) The requirements to be satisfied for the preparation of accompanied suicide are:

a) the person considering suicide has become a member of the organisation;

b) the organisation has received a request from the member specifically asking for preparation in that member's self-determined death;

c) if the member's request is being made for health reasons, the request must be supplemented with documents which provide information on the member's current health status;

d) if the member's request is being made for other reasons, these shall be set out in detail and, where possible, supported by documentation;

e) the request shall include a short biographical sketch / CV providing information about the member's life history, what has occurred to date, and their family situation;

(2) Where the above requirements are satisfied in the opinion of the organisation, it shall forward the request to a medical doctor who is prepared to cooperate with such organisations. After examining the request including any attached documents, the medical doctor shall inform the organisation whether he or she:

a) can give the member wishing to die a provisional green light; or

b) needs additional information to arrive at a decision; or

c) is not able to give a provisional green light.

(3) Where a medical doctor states that he or she is not able to give a provisional green light, the organisation may submit the request to another medical doctor.

(4) The organisation may at any time notify the member wishing to die that the organisation is not able or willing to assist the member in an accompanied suicide.

Section 6

Arranging to provide accompanied suicide

(1) After a member has been given a provisional green light,

a) the member may wait for an indefinite period of time to set an appointment with a medical doctor so that the medical doctor may make a final decision regarding issuing the lethal dose prescription for the qualified member's use;

b) the member may express the desire to consult a medical doctor immediately so that the medical doctor may make a final decision regarding issuing the prescription for the medication, however the member may wait to apply for arrangements with the organisation to have an accompanied suicide;

c) the member may express the desire to consult a medical doctor immediately with regard to a definitive decision and also may apply immediately to the organisation for an appointed time for their accompanied suicide.

(2) The organisation shall comply with the desire of a member within the framework of the possibilities available to it and the medical doctor. The organisation shall ask the member whether the member has discussed the decision with next of kin and/or friends and shall encourage the member to do this,

where reasonable. The organisation shall also ask the member whether anybody of the member's choosing is to be present at the accompanied suicide and if so, who.

(3) During the consultation with a member who has received a provisional green light, the medical doctor shall evaluate:

- a) whether in his or her opinion there are options for a solution enabling the member to continue to live, whether the member knows of these options and whether the member has decided to take advantage of them or not;
- b) whether the member steadfastly maintains the wish for an accompanied suicide;
- c) whether the member appears to be mentally competent;
- d) whether there are other cogent reasons for deciding against going through with an accompanied suicide;
- e) whether the member is physically able to self-administer the medication by oral means, such as drinking it or by way of another action;
- f) if the member is not physically able to self-administer the medication by oral means, the medical doctor shall determine whether the member is capable of operating an aid for the purpose of self-administering the medication;
- g) where there are absolutely no possibilities for the member, by any physical action on his or her own, to initiate the final act of ingesting the medication in any way, the medical doctor shall definitively refuse to issue the prescription.

(4) Where the medical doctor definitively consents to issuing a prescription for the medication, he or she shall forward the prescription to the organisation.

(5) The medical doctor shall document his or her findings in a report which is to be forwarded, together with the prescription, to the organisation.

(6) The organisation shall procure the medication from a licensed pharmacy. The organisation may not give the prescription or the medication to the member. The organisation shall store the medication in a safe place until it is used in the member's accompanied suicide. If the medication is not used, the organisation shall return it to the licensed pharmacy from which it was procured.

Section 7

Assisting persons

(1) The organisation shall ensure that the assisting persons engaged by it possess the necessary training to prevent foreseeable problems arising during an accompanied suicide.

Section 8

Place and participants during an accompanied suicide

- (1) As a general rule, an accompanied suicide shall take place at the residence of the member.
- (2) Where this is not possible and the member does not designate another appropriate location, the location shall be designated by the organisation.
- (3) The member shall determine whether, apart from the assisting persons, other persons are to be present during the member's accompanied suicide.
- (4) When the accompanied suicide does not take place at the residence of the member, the organisation shall ensure that the member provides for what is to be done with personal property remaining at the place of the accompanied suicide subsequent to his or her death.

Section 9

Conducting an accompanied suicide

- (1) To conduct an accompanied suicide, the organisation arranges for the medication and documentation and at least two assisting persons to be present at the agreed place at the agreed time.
- (2) The assisting persons shall ensure that the person they are to assist is identical to the member for whom the medication has been procured.
- (3) The assisting persons shall also ask the member whether he or she continues to wish to die or whether he or she would prefer to revoke the decision. In doing so, the assisting persons shall expressly indicate to the member that they would perceive such a change of mind to be positive, as would the organisation. No other persons may be present in the room while these questions are being asked and answered. If other persons have been sent out of the room before these questions are asked and if they then return to the room, these questions shall be posed to the member once more. If any doubts arise with the assisting persons as to the member's wish to die, or if there is any indication that the member might have affirmed the wish to die after being pressured to do so by any third party, the assisting persons shall discontinue the procedure of the accompanied suicide, indicate their reason for doing so, and make a written report to the organisation.

(4) If the member abides by his or her wish to die, they shall sign the relevant document in which they state this wish, the document also indicating who is present at the member's accompanied suicide.

(5) If the member abides by his or her wish to die, the assisting persons shall ensure that the member is able to self-administer the medicine in the intended manner. If self-administration with the aid of a device is required, the assisting persons shall prepare the device with the utmost care.

(5) The following shall be said to the member before they are given the prepared medication or device enabling them to self-administer the medication: "If you drink this medication (or, for example, push this release mechanism), you will die. Is that what you want?" If the member responds in the affirmative, the prepared medication or the release mechanism is given to the member so they can self-administer the medication.

Section 10

Obligations after the medication has been self-administered

(1) The assisting persons shall ensure that, after the member has drunk the medication or self-administered it with the aid of a device, he or she is continuously monitored.

(2) If there are signs which enable the assisting persons to establish with certainty that death has occurred, they shall report this case of accompanied suicide to the competent police authority and indicate the name of the organisation. The police authority shall notify the medical examiner and ensure that the examination of the corpse takes place without undue delay.

(3) After the assisting persons have determined that death has occurred, the scene with the deceased member shall not be altered by them or any other persons who might be present.

Section 11

Examination of the corpse

(1) The medical examiner shall establish death according to medical principles, ensure that the deceased is identical to the individual named in the documents for the accompanied suicide, and inquire whether the actions of a third party can be ruled out as the cause of death.

(2) If there are any doubts concerning this, the medical examiner shall ensure that the matter is investigated by the competent police authority.

(3) When there are no doubts or they have been ruled out, the corpse shall be released for funeral provided that the public prosecutor raises no objections.

(4) A medical doctor who issues a prescription for accompanied suicide may not act as the medical examiner in the same case.

Section 12

Ensuring proper arrangements for handling the deceased's remains

(1) Generally, the relatives of the deceased member or another person designated in advance by the deceased member shall ensure that the deceased's remains are appropriately taken care of.

(2) Before the organisation assists a member in his or her accompanied suicide, it shall confirm that arrangements have been made for the member's remains. The organisation may be tasked with these arrangements.

Section 13

Maintaining a journal

(1) The assisting persons shall maintain a journal chronicling the accompanied suicide by itemising each step of the protocol, the time each step occurs, and any incidents of particular note.

(2) The journal is to be put in the member's file maintained by the organisation; the medical examiner is to be sent a copy of the journal. The medical doctor who provided the prescription shall also receive a copy.

Section 14

Central Supervisory and Documentation Agency

(1) The medical examiner or the competent police authority shall forward the documentation provided by the organisation to a Central Supervisory and Documentation Agency.

(2) This agency shall review the documentation to ascertain whether the persons acting under this Act comply with its provisions.

(3) When the agency finds that shortcomings or errors have occurred, it shall contact the relevant persons and ensure that the shortcomings and errors are remedied and not likely to occur again.

(4) In the event of serious violations by medical doctors of the relevant provisions, the agency shall report them to the competent medical board for the purpose of examining whether proceedings are to be initiated against these doctors under the professional code of conduct.

(5) Serious violations repeatedly committed by an organisation shall be reported to the registration court competent at the organisation's registered office to examine whether legal action is to be taken against the organisation.

(6) The Central Supervisory and Documentation Agency shall publish annually a report on its findings in respect of its supervisory activities, including statistical figures on accompanied suicide.

Section 15

Legal classification of a death by accompanied suicide

A death that has been brought about by an accompanied suicide shall be deemed to constitute a natural death in respect of population statistics and in terms of civil law.

Article 2

Amendment of the Controlled Substances (Poisons) Regulations 2011

Section 1

In the Controlled Substances (Poisons) Regulations 2011, the following shall be entered:

“Sodium pentobarbital, sodium salt of (±)-5-ethyl-5-(1-methylbutyl)-barbituric acid
The sodium salt of pentobarbital may be prescribed by medical doctors for the purpose of an accompanied suicide in a dose of up to 20 grams; the prescription and the substance itself may not be made available to the member wishing to die themselves but only to the competent organisation. If sodium pentobarbital is or becomes shorted or unavailable for any reason, other substances with the same or similar effect may be prescribed for accompanied suicide”

Section 2

The Government amends the Controlled Substances (Poisons) Regulations 2011 within three months of the promulgation of this Act

Article 3

Entry into Force

This Act shall enter into force on the day following its promulgation

Adelaide, [date] **(signatories)**

Explanatory Memorandum

A. General Part

I.

The wish of people to determine not only the course of their life but also their end of life is not new. And, as early as the 1930s, organisations advocating for the right of people to decide by what means and at what point their own life will end were founded. One in the mid-1930s in England called “EXIT” or “The Voluntary Euthanasia Society”. Another in the USA: on 17 January 1938, *The New York Times* wrote that a “Society for Voluntary Euthanasia” had been founded.

According to historical surveys, 60% of the British people favoured freedom of choice in end-of-life-matters in the 1930s. Since then, as many polls show, support for personal freedom of choice in end-of-life-matters has increased and there is a majority in favour in many countries, also in Australia.

Today, there are some 80 “right-to-die” organisations in many countries around the world, more than 10 of them in Australia.

II.

In view of the democratic principle, which forms the basis of public policy in South Australia, it is not appropriate to rely on Switzerland to offer a way of responding to South Australians’ desires and needs for assisted dying, preventing the pressure in South Australia from becoming too high. South Australians should be able to implement this important decision in their home country, in their homes, and with friends and family at their side.

With several countries around the world having a law allowing assisted dying, some for many years, there is ample experience and information available on assisted dying working in practice today: Switzerland, Belgium, The Netherlands, Luxembourg, the State of Oregon and a few more US-States, Columbia and Canada.

For Australia, the issue is not new: for some time, assisted dying was possible in the Northern Territory and as of recently, Victoria enacted the Voluntary Assisted Dying Bill.

Now, the South Australian legislator can adhere to the publics' wish for having the choice of access to legal assisted dying, by adapting a statutory instrument to its own situation in a meaningful manner, an instrument that has proven itself in a comparable legal system.

This is the goal of this proposed Act.

III.

The proposed Act follows a progressive-liberal principle. The Act is designed to give individuals the possibility of asserting their human right to self-determination, that is the right to decide by what means and at what point their own life will end and to have access to professional help to realise this right in a practical and efficient manner. At the same time, it ensures that the fears and reservations frequently voiced against assisted dying will not materialise.

The proposed Act contains provisions stipulating that organisations which provide for accompanied suicide in South Australia are to be constituted as registered membership associations / member societies, making them subject to South Australian law and regulations for association. The proposed Act also stipulates that these organisations must frame their articles of association in a way that they satisfy the requirements for recognition as a charitable not-for-profit organisation. Apart from the purpose of offering the service of advisory work / counselling in end-of-life issues to anyone and, for members only, where justified, providing for a safe and dignified accompanied suicide, they must establish another purpose that pursues a charitable goal, such as for example suicide attempt prevention. The requirement of a charitable organisation status enables audits to be conducted by the tax authorities to monitor compliance. From the very outset this precludes organisations from taking in revenue other than as appropriate compensation for the work performed by them and not have such monies flow to members of the organisations' governing bodies (i.e. the board) or other members.

In setting out the accompanied suicide procedures of such organisations, the Act is based on the established and proven procedures of the not-for-profit organisations such as DIGNITAS and EXIT in Switzerland. These procedures have been developed and fine-tuned over the course of 35 years. They have been recognised by the Swiss authorities as being properly organised, it being expressly stated that no special provisions going beyond, for example, article 115 of the Swiss Criminal Code are required in

Swiss law. And, no irregularities existed that would require the intervention of the legislator.

The details of these procedures are discussed in Section B. Explanatory Notes below.

IV.

It might be asked why the proposed Act is silent on one question: What should happen if private individuals, cooperative societies or even commercial enterprises were to come up with the idea of offering accompanied suicide in South Australia?

Since the proposed Act permits the medication sodium pentobarbital to be dispensed only to organisations in line with this Act, there is no way for other parties to offer a similar service.

The medication sodium pentobarbital enables a quantitatively comparatively small dose (up to approx. 20 g in approx. 50 cc of water) to be administered; other medication combinations which have been used to date in different countries for assisted dying consist of larger quantities and always presuppose that the person wishing to die is capable of self-administering these quantities by swallowing and ingesting them.

V.

The proposed Act provides for another opportunity to make a significant contribution to resolving a major social challenge that for the most part is not talked about: the issue of the high number of suicide attempts year after year.

It is known that there is a considerable dark figure, that is, the number of suicides which are not detected as such. And there is consensus that the number of suicide attempts which fail is much higher than the number of deaths by suicide.

Whether the number of attempted and failed suicides is 9 out of 10 or 49 out of 50: a failed suicide attempt has serious consequences not only for the person attempting it but also for others. Moreover, suicide attempts that are not seriously meant quite frequently inadvertently end fatally. In conclusion, prevention policy should actually focus on the vast field of suicide *attempts*, not just those actually committed and statistically registered as suicides.

The experience of the "right-to-die"-organisations in Switzerland shows that the availability of people / organisations with whom someone who has become suicidal can talk without fearing loss of their freedom or reputation, and in whose presence they can voice an – objectively even nonsensical – wish to die, has a suicide-attempt-preventive effect.

This applies particularly to suicide among the elderly, which is on the rise throughout industrialised countries, and among younger people who find themselves in a personal crisis.

For this, the proposed Act stipulates that organisations must provide free of charge advisory work / counselling to those seeking help. The funding for this work can be obtained by general membership fees (subscription) as well as special membership fees in relation to when an accompanied suicide is to be prepared or conducted.

The principal charitable / not-for-profit orientation of the statutes / articles of association of these organisations must also enable these services to be made available to individuals who are of modest economic means, and those who do not have funds at all and thus cannot afford to avail themselves of these services at the normal rates.

VI.

The Act deliberately refrains from touching upon the issue of legalising voluntary euthanasia (act of another person administering lethal medication to a person, on this competent persons' explicit request). The issue may, of course, arise when a person wishing to die is physically totally incapable of performing an act of suicide, even if this only involves actuating a specially constructed aid/device. Based on experience with the Swiss system of assisted dying, these cases are so rare in comparison to the others that this issue can remain open for this Act. However, of course, for South Australia's lawmakers nothing stands in the way to regulate on both accompanied suicide and voluntary euthanasia, as for example Belgium has done.

B. Specific Explanatory Notes

Article 1 (Enactment of an Accompanied Suicide Act)

Section 1

Section 1 sets out the purpose of the Act. The Act governs the requirements with which organisations that prepare and conduct accompanied suicide in a professional capacity must comply.

Section 2

Section 2 provides definitions of the specific terms used in the Act.

Section 3

Section 3 contains provisions stipulating how an organisation – registered membership associations (member societies) according to Section 2 – can draft their articles of association so that they are entitled to perform accompanied suicide in a professional capacity for which the medication that is most suitable – which is sodium pentobarbital – is made available.

Subsection 1

Subsection 1 contains a description of the organisation's most important work. The organisation's primary purpose is to provide counselling to people who are thinking of suicide and end-of-life-options. Counselling is to be done open-outcome, that is, without a view to achieving a predetermined specific result. This means that the organisation itself has no preference for either of the two basic possibilities, which are that the person either continues to live or puts an end to their life.

Only if this condition is satisfied can the organisation be credible in the eyes of people who are thinking of suicide, and therefore effectively act as a help-point to counsel people for resolving the issue which brought them to consider suicide and therefore help them to regain quality in life.

This issue previously arose in another context, in abolishing the illegality of abortion, especially in Germany: only those counselling centres prescribed under the law which did not take an up-front disapproving stand on a decision for abortion could be perceived by pregnant women as being suitable for offering counselling.

Subsection 2

Subsection 2 stipulates that in its articles of association an organisation should not only include as its purpose advising, preparation and conducting with regard to accompanied suicide, but it should also

include another purpose. Such as, for example, free-of-charge counselling for suicide attempt prevention, advisory work on how to establish advance care directives, establishing a network of medical doctors specialising in palliative care, etc.

Subsection 3

Subsection 3 stipulates that the organisation's articles of association are to be framed so that it can be recognised as being charitable / not-for-profit.

Consequently, in selecting its second purpose, the organisation is limited to objectives that are deemed charitable. This also prevents the organisation from providing monies to natural persons from its funds for purposes other than appropriate compensation for work or services rendered or goods supplied.

This also averts the risk that an organisation may be used to establish a commercialised form of accompanied suicide. The regulatory supervision by the tax authorities to which charitable organisation must answer is a suitable means to this end.

Subsection 4

The organisation requires funding in order to finance its activities. That is why its articles of association must establish ordinary members' dues (such as a yearly membership subscription) as well as special dues / lump sum fees for the services routinely provided by the organisation in preparing and conducting accompanied suicide. The articles of association may also provide for the receipt of charitable donations from any person, to facilitate the fulfilment of the organisation's charitable mission.

Subsection 5

Apart from its usual services, the organisation also provides additional services that are more or less frequently associated with its usual services. For example, the organisation assumes liability vis-à-vis the medical doctors with whom it cooperates for the payment of their fees for their expert opinions and consultation with members. For this, as with subsection 4, the organisation may set up special dues / lump-sum fees that are collected in advance from a member going through the process of preparing his or her accompanied suicide. Only in this way can amounts payable to the organisation to meet its operating expenses and obligations to various providers be acquired without the risk of having to sue a deceased's estate.

Subsection 6

A key principle for an organisation that provides these services is showing solidarity with people of modest economic means. Consequently, the articles of association are to contain provisions that permit

these persons to pay reduced ordinary and special fees or for these fees even to be waived entirely where these people are destitute. It would be discriminatory to enable only those who have the financial means to pay fees in full to assert the human right and freedom to determine time and manner of one's own end in life.

Subsection 7

In the debate to date, the demand has been sometimes made to prohibit intrusive promotion / advertisement of (accompanied) suicide as an easy way out of a personal crisis. Even though there has never been such advertising, the demand is theoretically still justified. This subsection is designed to satisfy this demand.

Section 4

Section 4 governs the organisation's counselling work.

Subsection 1

This subsection governs the principle of open-outcome counselling offered to persons who are thinking of suicide. Whoever is thinking of suicide must fear being confronted with someone who does not take them seriously, who seeks to deter them of their wish to die in an intrusive manner, or they must fear that an attempt will be made to subject them to forced therapy – that is, if need be, against their express will. Only with open-outcome counselling can someone feel that he or she is being taken seriously in a situation which may arise from a crisis just as much as it may arise after long and careful reflection, and thus will be able to open up after establishing trust with the counsellor. This is an indispensable base for a genuine chance to reach the decision to go on living, provided that the objective conditions for this actually exist.

Subsection 2

Subsection 2 also serves this idea; whoever provides counselling in such cases should refrain from making any value judgement with regard to the person's wish to die.

Subsection 3

This subsection describes how counselling is to take place. First, the cause for the person's wish to die is to be ascertained. Then, a discussion should follow to determine whether there are solutions enabling the person to go on living.

Subsection 4

It is conceivable that, although solutions may exist, these are not accepted. In this case the organisation is to be entitled, but not obligated, to engage in preparation for an accompanied suicide.

Subsection 5

This subsection governs the minimum obligations

regarding record keeping in respect of the counselling services.

Subsection 6

Counselling of this type, which is generally provided to persons who are not (yet) members of the organisation, is to be done free of charge. This is intended to create the basis for the effective prevention of potentially ill-considered suicide attempts.

Section 5

Section 5 governs the preparation of accompanied suicide. In a carefully drafted procedure it is determined whether accompanied suicide can be viewed as justified in a specific case.

Subsection 1

Subsection 1 sets out the requirements that must be satisfied for the preparation of an accompanied suicide. Paragraphs a and b set out two formal requirements: first, the person must be a member of the organisation so that a special personal relationship develops between the person and the organisation; then the person – now a member – must submit to the organisation an explicit request for the preparation of an accompanied suicide. Paragraphs c to e set out material requirements; the result of satisfying them is that the organisation is actually able to examine such a request based on the documents submitted.

Subsection 2

Subsection 2 governs the procedure from the point in time at which the requirements of subsection 1 are satisfied. If in the view of the organisation these requirements are satisfied, it is to forward the request including documents to a medical doctor who has expressed a willingness to cooperate with the organisation.

The medical doctor reviews the request and then informs the organisation of his or her decision. Three alternatives are open to the doctor: the doctor can either approve of the request; the doctor can request supplementary information; or the doctor can reject the request.

If the medical doctor approves the request, this only means a provisional consent to issue the prescription for the member wishing to die; a definitive approval is not possible until the medical doctor has seen and talked to the member. That is why the provisional approval is referred to as the provisional green light in the definitions in section 2. The medical doctor always remains free in respect of the final decision.

Subsection 3

Subsection 3 enables the organisation to submit a member's request to another medical doctor if it is turned down by the first medical doctor. Experience

shows that medical doctors do not all share the same views with regard to questions of life and death. This option also makes it easier for medical doctors to come to a decision free of any constraints.

Subsection 4

This subsection establishes the organisation's option of notifying a member wishing to die at any time that it is not able or willing to assist them in an accompanied suicide. This follows from respect for the right to self-determination on the part of the persons who act on behalf of the organisation. Reasons for not being able or willing could be, for example, if the member wishing to die causes personal frictions such as threatening or harassing the persons who act on behalf of the organisation. In case of such dissolution of the relation between the member wishing to die and the organisation, monies received by the organisation for the service of an accompanied suicide that will not take place must be refunded.

Section 6

Section 6 governs the procedure after the provisional green light has been given by the medical doctor. The member then has various options.

Subsection 1

In paragraphs a to c, this subsection outlines the three available options:

The first one is that upon being notified of the provisional green light, the member simply waits and perhaps later on makes application for proceeding towards an accompanied suicide.

The second option enables the member to swiftly have the provisional green light become definitive by consulting the medical doctor right away and having the medical doctor make his final decision. Then, the member can wait to make an application for further proceedings towards an accompanied suicide. However, it is understood that in order for an accompanied suicide to actually take place, the condition must be satisfied that the member is mentally competent at the time that the medication is actually prescribed and also at the time of ingestion of the medication.

The third option is for the member to consult the medical doctor, followed swiftly by applying for and agreeing on an accompanied suicide to take place as soon as possible.

Subsection 2

As a general rule, the organisation complies with a member's wishes; however, this is limited by the constraints imposed by virtue of the possibilities and capacity with regard to the medical doctor. Furthermore, the organisation should discuss with the member whether he or she has talked about their plans for an accompanied suicide with relatives

and/or friends. If this is not the case, the organisation should try to persuade the member to do this. This is in the best interest of the wellbeing of relatives and friends so that after the member has passed away these individuals need not ask themselves questions that no one is any longer able to answer. However, the member cannot be compelled to inform these third parties; unfortunately there are many dysfunctional families in which it is not possible to talk objectively about serious issues.

Subsection 3 sets out the tasks of the medical doctor to be performed during the consultation with the member.

As to paragraph a, the medical doctor should discuss options with the member that the medical doctor thinks would enable the member to go on living, after which the member can make his or her decision.

Paragraph b requires the medical doctor to verify once again that the member still wishes to die. If the member's wish to die falters during the consultation with the medical doctor, the member cannot be considered to have the required clear and settled wish to end his or her own life.

Paragraph c requires the medical doctor to determine whether the member still appears to be mentally competent. In principle, people who are of age are assumed to be mentally competent unless there are indications that their mental capacity is limited or no longer present. 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. An indication that mental competence might not be given is the situation that the person is suffering from a serious psychiatric illness. However, a psychiatric illness may impact a person's mental capacity but it need not. This is why it is the task of the medical doctor – and of the assisting persons immediately prior to accompanied suicide – to look for such signs and properly interpret them.

As a rule, this takes place by virtue of an appropriate conversation.

Paragraph d sets out other conceivable reasons that militate against going through with an accompanied suicide in a specific case.

A special case of this question is covered in paragraph e: It deals with the situation of a member being physically unable to drink the medication. It must be determined whether he or she can ingest the medication by way of an aiding device.

Paragraph f stipulates that in the absence thereof, no accompanied suicide can lawfully take place.

Subsection 4

This subsection stipulates that the medical doctor must forward the prescription for the medication to

the organisation. The doctor may not give it to the member.

Subsection 5

Subsection 5 stipulates that the medical doctor must document his or her findings. The doctor must forward the resulting report to the organisation. By examining this report, the organisation can determine, if it has not already looked into this matter through direct contact with the member wishing to die, whether the use of an aid is required for the accompanied suicide.

Subsection 6

Subsection 6 stipulates that the organisation (and not the member) is to procure the medication using the prescription provided to it by the medical doctor. If the medical doctor has prescribed a narcotic, a controlled substance, this provision grants the organisation the authorisation to procure it in the prescribed dose for the member and to transport and store it. The organisation is obligated to store the medication in a safe place until it is used. The Act also requires return of any unused medication to the licenced pharmacy from which it was procured.

Section 7

Section 7 covers the topic of those persons assisting in accompanied suicide. They are to be trained by the organisation so that they are able to safely conduct accompanied suicide, even in difficult circumstances. Subsection 1 stipulates in particular that the care is to be taken to prevent foreseeable problems potentially arising during the accompanied suicide. Such foreseeable problems, for example, can be that a member, due to vigorous tremor caused by his or her illnesses (typical for example with Parkinson's disease), would spill the medication.

Section 8

Section 8 concerns the place of and the people present at an accompanied suicide.

Subsection 1

It is the goal to have an accompanied suicide take place at the member's residence, that is, within his or her own four walls: this is the standard location. The goal of the Act is for someone to be able to die at home, which is what most people want. This enables dying to take place in the protection of privacy and in the bosom of the person's family.

Subsection 2

Where this is not possible, the member wishing to die will normally designate the location. If this location should not be appropriate, a location will be designated by the organisation.

Subsection 3

It is also up to the member to determine whether any other persons are to be present at his or her death.

Subsection 4

This provision is relevant if the place of death is not the member's home. If someone dies at home, their personal belongings are not in a foreign place. The purpose of this provision is for the organisation to know what is to be done with the deceased member's personal belongings (clothing, shoes, jewellery, wallet, etc.) when the accompanied suicide has taken place at a location that is not the deceased's home.

Section 9

Section 9 establishes how an accompanied suicide is to take place.

Subsection 1

Accompanied suicide could actually be performed by one assisting person without further ado. However, practice has shown that it is useful when at least two assisting persons are present. This ensures a two-way supervision. It also has the advantage that at all times and especially after the member has passed away, one assisting person can attend to the member's relatives and friends present, and the other can attend to the work involving the member and later the work involving the authorities.

Subsection 2

Subsection 2 specifically stipulates that the assisting persons verify whether the individual who declares to be the member wishing to die is identical to the person indicated in the documents. In other words, an identity check should be performed.

Subsection 3

Subsection 3 stipulates that once more it has to be verified whether the member really wants to die. By including the provision that no other persons should be present in the room, it is ensured that the member can respond freely. When the relatives and/or friends return to the room, the questioning is to be repeated. If there are any doubts whatsoever, the accompanied suicide proceedings are to be stopped. Signs indicating that the member's decision was brought about under pressure exerted by a third party should also lead to the accompanied suicide proceedings being stopped. In these cases, the Act requires that a written report must be submitted by the assisting persons to the organisation.

In this penultimate questioning to determine the member's wish to die – the last and final clarification takes place immediately before the medication is ingested (see Subsection 5 below) – the member is expressly told that he or she is free to revoke their decision to die and that this would be viewed in a

positive light by the assisting persons and the organisation. The member's reaction to this clarification is an important indicator enabling the assisting persons to determine whether the member actually has a clear and settled wish to die. By experience, such questioning and insisting by the assisting person that the member may well rather revoke their wish to go through with the accompanied suicide often leads to a reaction of annoyance from the member, they will object to this "impertinence" as such clarification is sometimes perceived – which is a clear sign that the member's wish to die is clear and settled.

Subsection 4

Subsection 4 stipulates that the member should establish a written suicide declaration, which is a document in which they state that they wish to end his or her own life. Following the firm oral declaration by the member that he or she now wishes to die, this is such confirmed by the member in a written document. The document also lists the persons who are present at the member's accompanied suicide.

Subsection 5

The medication is prepared once the member's wish to die is unequivocally confirmed. The medication is normally drunk as a liquid. If the member is unable to drink the medication, the aid indicated in the medical doctor's report is to be used. The aid is prepared by the assisting persons.

Subsection 6

Subsection 6 stipulates a last and final clarification to determine the member's wish to die. This is done by showing the member the prepared medication or the release mechanism when an aid is used, and explaining that if the member drinks this medication or actuates the release mechanism they will die, followed by asking them if they want this. The member is not given the medication or the release mechanism until he or she has answered this question in the affirmative so that he or she can then perform this last act in their lives on their own. The actions taken by the member then lead to his or her death.

Section 10

Section 10 governs the duties of the assisting persons after the member has self-administered the medication.

Subsection 1

Since the medication, sodium pentobarbital, generally acts quickly – in the vast majority of cases it causes the member to fall asleep within two to five minutes – the member is to be monitored continuously. The sleep onset phase, which causes the member to lose consciousness completely, is fol-

lowed by the dying phase. The assisting persons' duty to monitor the member also continues during this phase.

Subsection 2

When there is subsequently sufficient indication that death has occurred – during their training the assisting persons learn what they must look for – they notify the police, reporting that the death is the result of an accompanied suicide provided by their organisation.

It is then up to the police to ensure that an official examination of the corpse takes place without undue delay; the police notify the medical examiner / coroner.

Subsection 3

Subsection 3 ensures that the scene resulting after the preliminary establishment of death is not changed by the assisting persons.

Section 11

Section 11 deals with the examination of the corpse to be performed after an accompanied suicide. The purpose of the examination is to determine whether death resulted from actions taken by the deceased or whether there is evidence that death might be due to the intervention of a third party.

Subsection 1

The medical examiner, who according to the definitions of Section 1 must be a public medical doctor officer, a forensic medical doctor or a specially trained medical doctor for performing examinations of corpses, first verifies the identity of the deceased person. The medical examiner then certifies the death of the deceased person according to medical principles. This includes determining whether death might have been brought about by the intervention of a third party.

Subsection 2

If there are any doubts in this respect, subsection 2 stipulates that the medical examiner calls in the police authorities, who must then determine how death actually occurred. This Act need not set out how the police authorities are to proceed further in the matter; the police have their own standard operating procedures for such matters.

Subsection 3

However, if there are no doubts that death has come about as a result of actions taken by the decedent, subsection 3 stipulates that the decedent's remains are to be released for funeral. The final decision on this is made by the legally competent public prosecutor.

Subsection 4

Subsection 4 precludes a medical doctor who has issued the prescription in a specific accompanied

suicide from acting as the medical examiner in the same case.

This provision is one of the rules ensuring that the risk of any abuse is kept to an absolute minimum. A system of reciprocal control is also ensured by virtue of the fact that an entire group of people is involved in an accompanied suicide prior and subsequent to the death.

Section 12

Section 12 ensures that proper funeral arrangements are made after the accompanied suicide.

Subsection 1

Since accompanied suicide normally takes place in a member's home, funeral arrangements are assumed by the member's next of kin such as in the case of a death by natural cause. Frequently, the deceased member has made arrangements in advance by designating someone or a funeral home to attend to this task.

Subsection 2

In cases in which the organisation performs accompanied suicide for a member who is alone and has no family, the organisation has discussed this matter with the member during the preparation phase. If the organisation has been tasked with making the necessary arrangements, it assumes this task in place of the (absent) family.

Section 13

Section 13 stipulates that the assisting persons are to maintain a journal. The journal is intended to enable the process of an accompanied suicide to be reconstructed.

Subsection 1

Each individual step in the course of the accompanied suicide, with the respective time, is to be noted in this journal.

Subsection 2

Subsection 2 establishes that the original of this journal is to be stored in the member's file maintained by the organisation; the medical examiner is to be given a copy of the journal. A further copy is to be sent to the medical doctor who issued the prescription, so that he or she is informed of the decease of the member.

Section 14

Section 14 provides for a central supervisory and documentation agency for all of South Australia to be designated by the Department of Justice. This agency is of key importance in collecting data and forwarding complaints to appropriate entities, and through this monitoring the activities of the organisations.

Subsection 1

The documents that are furnished by the assisting persons to the medical examiner or the police after an accompanied suicide are forwarded by the latter to the central agency.

Subsection 2

Subsection 2 stipulates that the central agency is to check the file forwarded to it to determine whether the persons who have acted have complied with the provisions of this Act.

Subsection 3

Subsection 3 stipulates that where shortcomings or errors are detected by the central agency, it will contact the relevant and responsible persons and ensure that the shortcomings are remedied and that the errors are not repeated.

Subsection 4

Subsection 4 stipulates that in the event that the central agency discovers serious violations on the part of acting medical doctors, serious violations are to be reported to the competent medical board. This board must then examine whether profession-legal proceedings are to be initiated against this medical doctor.

Subsection 5

Subsection 5 deals with serious violations that are repeatedly committed by an organisation. In these cases, the central agency must report misconduct to the registration court, which then examines whether legal action is to be taken against the organisation.

Subsection 6

Subsection 6 provides for a significant task of the central agency: it is charged with collecting sufficient statistical data on accompanied suicides, analysing the data, arriving at findings and publishing them. This ensures that this area can be subjected to public scrutiny, while members' privacy is protected.

Section 15

Section 15 stipulates the legal construction of a death that has been brought about by accompanied suicide: that it is to be considered to constitute a natural death in respect of population statistics and in terms of civil law.

This distinction as compared to a “common suicide” is not only significant but essential. Frequently, common suicides can be subsequently unequivocally established as being justified only with great difficulty and uncertainty. An accompanied suicide in line with this Act is a different matter. For the most part, the justification results from the deceased member’s illness or other health impairment and lack of physical integrity. In the case of the elderly it can also consist of being profoundly tired of living

or an unremitting profound sense of loneliness and loss.

Article 2 (Amendment of the Controlled Substances (Poisons) Regulations 2011)

Section 1

Section 1 stipulates that the Controlled Substances (Poisons) Regulations 2011 is to be amended such that the medication sodium pentobarbital is entered in the list which contains substances which have been approved for marketing and prescription. It is explicitly established that this medication may be prescribed by medical doctors in a dosage of up to 20 g for the purpose of accompanied suicide by organisations. It is also stipulated that neither the prescription nor the medication should be made available to an individual, but only to a competent organisation. Additionally, the section leaves room for other substances than sodium pentobarbital, with similar effect, to be used, if sodium pentobarbital becomes shorted or unavailable for any reason. This is necessary because pharmaceutical companies could, on purpose or for any other reason, stop supplying sodium pentobarbital.

Section 2

Section 2 imposes upon the South Australian Government the task of accordingly amending the Controlled Substances (Poisons) Regulations 2011 within three months of the promulgation of this Act.

Article 3 (Entry into Force)

Article 3 provides for the entry into force of the Act on the day following its promulgation since there are no grounds for having the Act go into effect at a later point in time.