Assisted suicide and the death penalty: Shared public policy concerns

The proposition currently being considered by the Andrews Labor Government is to legalise assisted suicide for persons who are "*suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable*."

This proposal would require a carve-out for doctors, pharmacists and family members who assist a suicide from the current laws on assisted suicide, and in some cases, murder.

Assisted suicide laws raise some of the same concerns raised by laws permitting the death penalty.

CRUEL AND UNUSUAL PUNISHMENTS

The Eighth Amendment to the Constitution of the United States prohibits the infliction of "cruel and unusual punishments".

Sodium pentobarbital, marketed as Nembutal, is one of the drugs most frequently prescribed by physicians writing a prescription for a lethal dose of drugs for the purpose of assisted suicide (34.25% of cases in Oregon[1]).

Since 2011 sodium pentobarbital has been used by several States in the United States in the execution of prisoners. David Waisel, MD, an anaesthesiologist, has testified about the use of this drug in executions:*… as the lethal injection commenced Mr. Blankenship jerked his head toward his left arm and made a startled face while blinking rapidly. He had a "tight" grimacing expression on his face and leaned backward. Shortly thereafter, Mr. Blankenship grimaced, gasped and lurched twice toward his right arm. During the next minute, Mr. Blankenship lifted his head, shuddered and mouthed words. Three (3) minutes after the injection, Mr. Blankenship had his eyes open and made swallowing motions. Four (4) minutes after injection, Mr. Blankenship became motionless. About thirteen (13) minutes after the injection, Mr. Blankenship was declared dead. Again, his eyes were open throughout.*

Based on his lurching toward his arms and the lifting of his head and the mouthing of words, I can say with certainty that Mr. Blankenship was inadequately anesthetized and was conscious for approximately the first three minutes of the execution and that he suffered greatly. Mr. Blankenship should not have been conscious or exhibiting these movements, nor should his eyes have been open, after the injection of pentobarbital.

Given prior executions of Brandon Rhode and Emanuel Hammond in September 2010 and January 2011, respectively, during which these inmates reportedly exhibited similar movements and opened their eyes (Rhode's eyes were open throughout the execution process), Mr. Blankenship's execution further evidences that ***during judicial lethal injections in Georgia there is a substantial risk of serious harm such that condemned inmates are significantly likely to face extreme, torturous and needless pain and suffering***.[2]

EUTHANASIA & ASSISTED SUICIDE

Similar painful and distressing complications have also been observed in cases of euthanasia and assisted suicide. In the Netherlands, complications occurred in 3% of cases of euthanasia, including spasm or myoclonus (muscular twitching), cyanosis (blue colouring of the skin), nausea or vomiting, tachycardia (rapid heartbeat), excessive production of mucus, hiccups, perspiration, and extreme gasping. In one case the patient's eyes remained open, and in another case, the patient sat up.

In 10% of cases the person took longer than expected to die (median 3 hours) with one person taking up to 7 days.[3]

In Oregon, in 2016 one in nine (8.1%) of those for whom information about the circumstances of their deaths is available either had difficulty ingesting or regurgitated the lethal dose.[4]

The interval from **ingestion of lethal drugs to unconsciousness has been as long as one hour** while the interval from ingestion to death has ranged from 1 minute to as long as 104 hours (4 days and 8 hours).[5]

In 2005, "One patient became unconscious 25 minutes after ingestion, then regained consciousness 65 hours later. This person did not obtain a subsequent prescription, and died 14 days later of the underlying illness (17 days after ingesting the medication).[6] Since 2005 five other people have been reported as regaining consciousness after ingesting the supposedly lethal medication.[7] In 2012 "*one patient ingested the medication but regained consciousness before dying of underlying illness ... The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion*".[8]

ONE INNOCENT DEAD IS ONE TOO MANY

Many people hold the view that the death penalty may be justified in a particularly horrific case. However, such people may still reject the reintroduction of the death penalty because they are not convinced that any proposed regime would ensure that not even a single innocent person is put to death wrongly by the State.

The same test should be required for any regime claiming a safe approach to assisting the suicide of certain Victorians. The overwhelming evidence from other jurisdictions is that this high standard cannot be met. There is no assisted suicide regime that can guarantee that not a single person who is being coerced, or who is suffering from treatable depression, is helped to commit suicide or killed by being administered a legally prescribed lethal dose of medication.

(Of course some assisted suicide proponents like British neurosurgeon and advocate for assisted suicide Henry Marsh have argued that it does not matter **"Even if a few grannies get bullied into [assisted suicide], isn't that the price worth paying for all the people who could die with dignity?"**[9])

INALIENABLE RIGHT TO LIFE

We do not allow duelling or fights-to-the-death or death by being cannibalised even if a person were to attempt to freely waive the right to life. We won't impose the death penalty even on a murderer who requests it. Nor do we allow people to waive the inalienable right to liberty by selling themselves into slavery. **Allowing one category of Victorians to waive the inalienable right to life in order to be killed by assisted suicide should likewise be rejected as a practice which would undermine the inalienable right to life of all Victorians.**

CONCLUSION

As with capital punishment, it is possible to imagine particular cases where assisted suicide seems the only proper response. However, careful consideration of all the public policy issues leads to the conclusion that it is not safe.

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[1] Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2016, Table 1. Characteristics and end-of-life care of 1,127 DWDA patients who have died from ingesting a lethal dose of medication as of January 23, 2016 [sic = 2017], by year, Oregon, 1998-2016,* p.9, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf

[2] State of Massachusetts, County of Suffolk., *Affidavit of David B. Waisel, MD*, p. 2-3, http://www.reprieve.org.uk/media/downloads/2011_06_28_PUB_Waisel_Affidavit_FINAL_DRAFT.pdf?utm_source=Press+mailing+list&utm_campaign=26dcb1127c-2011_06_30_Waisel_pentobarbital&utm_medium=email

[3] Groenewoud J, et al. (2000) "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands", *New England Journal of Medicine*, Vol 342, p. 551-556, http://content.nejm.org/cgi/reprint/342/8/551.pdf

[4] Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2016,* p.10, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf
Note that from 2010 reports of complications were only recorded if a physician was present at the time of administration so percentages for complications artificially decline as complications are listed as "unknown" for the majority of cases in which no physician was present.

[5] Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2016,* p.11, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf

[6] Department of Human Services, Office of Disease Prevention and Epidemiology, *Eighth Annual Report on Oregon's Death with Dignity Act*, p. 13, https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year8.pdf

[7] Oregon Health Authority, *Death With Dignity Act, Year 14 - 2011*, p. 6, footnote 12 https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf

[8] Oregon's *Death With Dignity Act Year 15-2012* p. 2, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf

[9] Z. Chustecka , " Renowned Neurosurgeon on Assisted Dying and His 'Suicide Kit'" *Medscape*, Apr 27, 2017, http://www.medscape.com/viewarticle/879187

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