

The Sex-Based Risks

OF EUTHANASIA AND ASSISTED SUICIDE FOR WOMEN





What are Euthanasia and Assisted Suicide?

The term ‘euthanasia’ has developed in law to refer to the active, intentional ending of a patient’s life by the administration of a lethal drug, at the patient’s request. ‘Assisted suicide’ is where a health professional intentionally helps a patient to end their life by providing drugs for self-administration, at the patient’s request. ‘Voluntary assisted dying’ (VAD) is the term used by pro-euthanasia advocates to describe these practices.

Euthanasia and assisted suicide are distinct from a situation where extraordinary or disproportionate means of sustaining a patient’s life are withheld or rejected (i.e. high risk surgery for a patient dying of cancer). In this situation the intention is to reject or withdraw the burdensome treatment, not to kill the patient.

Euthanasia and assisted suicide are similarly distinct from a situation where a patient is given medication in order to alleviate their suffering, even if this *risks* hastening their death. Here the intention is to *alleviate the patient’s suffering* via the medication, not to *kill* them via the medication.

Why Women May be Uniquely Vulnerable to Euthanasia and Assisted Suicide Laws

There is a growing body of feminist academic literature that raises concerns about the rights and wellbeing of women and the impact that sex may have on decisions regarding the end of life (see Wolf, 1996; Raymond, 1999; Canetto & Hollenshead, 2000; Parks, 2000; Platt, 2000; Allen, 2002; George, 2007; Callahan, 2015). Health care that is responsive to women is important and if there is the potential for sex-based risks in legalised euthanasia and assisted suicide regimes, then this urgently requires further consideration and research, in situations both where legislative change has already occurred, and where it is being considered.

While eligibility under some euthanasia and assisted suicide legislation requires that a patient must be suffering from a terminal illness from which they are expected to die in a matter of weeks or months, the concern for women is that the final decision to end their lives may nevertheless be influenced by the following sex-based risk factors, which challenge the rhetoric of “choice”:

1.

Women tend to live longer than men and so are more likely to develop diseases and disabling conditions, or experience elder abuse and discrimination, both of which could motivate the desire for euthanasia and assisted suicide. The Australian Law Reform Commission’s report on elder abuse recognised that women are significantly more likely to be victims than men and that neglect of older women could be as high as 20% (ALRC, 2017: 37).

2.

Women are also more likely to experience the death of a partner or spouse due to their relative longevity, and to be deprived of this support and companionship in older age. A 2013 Australian study found that living alone is an important predictor of suicide in older adults (De Leo, 2013). A 2016 American study found that loneliness was a key motivation behind euthanasia and assisted suicide requests of patients with “psychiatric” disorders in the Netherlands (Kim, 2016: 362). 70% of the cases reviewed were women and 76% were 50 years or older (Kim, 2016: 362). One woman in her 70s “without health problems” said she experienced life without her husband who had died one year earlier, as a “living hell” and “meaningless” (Kim, 2016: 364).

3.

Women have less economic resources when they are older (Herald Sun, 2017), the time when decisions about euthanasia and assisted suicide are most likely to occur. This entrenched economic disadvantage limits their options for care and means they are more likely to face other adversities such as homelessness, being unable to leave violent relationships due to financial insecurity and the general struggles associated with financial hardship, all of which could influence a decision for euthanasia or assisted suicide. Women also receive less care assistance from family members than men and are more likely to have to pay for assistance even if their partner is still around (Roscoe, 2001: 444). Such economic disadvantage disproportionately affects women and there is evidence that it does influence requests for euthanasia and assisted suicide (Emmanuel, 1998: 510).

4.

Women are arguably more self-sacrificial and less assertive than men, whether by nature, socialisation or simply in terms of society's ideals about femininity (Callahan, 2015: 112; George, 2007: 18-22). They may thus be more likely to decide for euthanasia and assisted suicide to spare their loved ones the burden of caring for them, or to be persuaded that their life is unworthy of other's care and their family's resources. In a study of assisted suicides where the majority of cases were women, the fear of being a burden was a prominent reason for deciding for death (Canetto & Hollenshead, 2000). The ethic of self-sacrifice was summed up by a friend of one of the suicides who said: "She felt it was a gift to her family, sparing them the burden of taking care of her" (Canetto & Hollenshead, 2000: 180).

5.

Women demonstrate a stronger preference for more structured, passive methods of suicide, with significant physician participation (George, 2007: 7), and it is clear that increasing numbers of women decide to die when offered the more passive options of euthanasia and assisted suicide (George, 2007: 25). The rate of assisted death by women in the Netherlands is nearly five times that of the usual female self-inflicted suicide rate (CBVDS, 2016; RTE, 2016: 8). One explanation for this might be that decisions for euthanasia and assisted suicide fit in with cultural expectations of women as passive and compliant, and play out sex-based expectations of subordination and dominance in a profession where physicians are still predominantly male (George, 2007: 23-27). One study has warned that the structure and passivity of euthanasia and assisted suicide "will create a sense of obligation on the part of a woman, especially one who subscribes to stereotypical sex roles to complete a physician-assisted death towards which she may be initially ambivalent" (Kaplan, 2002: 42).

6.

Women are more likely to attempt suicide than men as they are more prone to psychological problems such as depression (The Guardian, 2015). Men are more likely to die by suicide as they often use more violent methods such as hanging or suffocation, whereas women tend to use nonviolent means, such as overdosing (The Guardian, 2015). However, if euthanasia and assisted suicide are enshrined into law, women's preference for more passive methods of suicide coupled with their higher tendency to attempt suicide could have a harmful compounding effect on women's decisions to die. This may already be evident in the 2016 American study reviewing euthanasia and assisted suicide cases of patients with psychiatric disorders in the Netherlands, in which 70% of the cases reviewed were women (Kim, 2016). Belgium and the Netherlands are among a handful of countries that allow euthanasia and assisted suicide for psychiatric disorders (including, for minors) – an ethically fraught and hotly contested practice. While mental illness does not qualify a person for euthanasia or assisted suicide in the Australian states that have legalised the practices, neither does it disqualify them.

7.

Female euthanasia and assisted suicide need to be considered within the context of pervasive male violence against women, particularly against intimates(George, 2007: 15). Research indicates striking similarities between the broader patterns of male violence against women and at least one form of assisted death: 'mercy killing' (George, 2007: 15). There is a higher incidence of female mercy killings, mostly by men, who are most often the woman's partner, often without consent from the female victims (George, 2007: 15-18). They are also characterised by the same themes of domination, possessiveness and control which characterise other killings of women by men (George, 2007: 18). The prevalence of violence against women in Australia (particularly intimate partner violence) is concerning, with at least one woman a week being killed by a partner or former partner, and one in three Australian women having experienced physical violence since the age of 15 (Our Watch). Thus, when it comes to the legalisation of euthanasia and assisted suicide, it is vital that we understand the dynamics at work and whether the dynamics underlying other forms of sex-based violence and unbalanced power relationships that result in the deaths of women, may sometimes also underlie female euthanasia and assisted suicide (Wolf, 1996: 284-285).

8.

Women's historical and ongoing experience of power imbalance and domination could 'play out' in a clinical relationship and influence their decision for euthanasia and assisted suicide (George, 2007: 25). The medical profession is traditionally paternalistic and still predominantly male, and a male physician's cooperation with a woman's request for euthanasia or assisted suicide could reflect entrenched sexism and sex-based roles (George, 2007: 25). Similarly, women's preferences for more structured, passive deaths at the hands of their (more often than not) male physicians could be an indication of sex-based dynamics at play (George, 2007: 27). One example of such dynamics at play in the clinical relationship is in a study of euthanasia and assisted suicide in the United States (Meier, 1998: 1195). Relative to men, women died in circumstances where their requests were less likely to be explicit, less likely to be at their personal request and more likely to be initiated by family members or partners (George, 2007: 6).

9.

The majority of high profile euthanasia and assisted suicide cases are female (George, 2007: 1, 25). Given the persistence of sex-based stereotypes and inequality, this raises the question of whether women are being used to portray euthanasia and assisted suicide because it "seems right" that women would passively and compliantly sacrifice themselves to prevent being a burden on their loved ones (whether consciously or not). It also raises concerns as to what kind of influence such media portrayal could have on women's decisions to request euthanasia and assisted suicide, and whether such depictions of women could be self-fulfilling.

10.

Autonomy and choice is often the principal argument used for euthanasia and assisted suicide but these insights challenge the presumption that women who decide for euthanasia and assisted suicide are always exercising autonomy (George, 2007: 18). Biological factors, structural inequalities, disparities in power, social and economic disadvantage and cultural stereotypes that may underlie the decisions of some women are sex distinctive and challenge the rhetoric of choice (George, 2007: 2, 8). Even if there is a smaller incidence of women deciding for euthanasia and assisted suicide than men, the concern remains that the reasons behind their decisions could suggest a lack of autonomy (George, 2007: 2). By legitimising and increasing access to methods of suicide which appeal to women, the risk is that for some women a legalised regime will compound oppressive socio-cultural influences and facilitate the last of many non-choices (George,

General Concerns around Instituting Euthanasia and Assisted Suicide as Standard Medical Practices

The *normalisation of suicide* and what facilitating it in some instances but not others says about the different value society places on certain lives.

The *risk of coercion or pressure* from partners, other family members, health professionals and the patient themselves if they have come to feel like a burden on others. This can be difficult to detect.

The *risk of non-voluntary euthanasia*, when euthanasia is performed on a person who does not have the capacity to make the decision themselves, and *involuntary euthanasia*, when euthanasia is performed against a person's will. Both have occurred in jurisdictions where euthanasia is legalised (Cohen-Almagor, 2003).

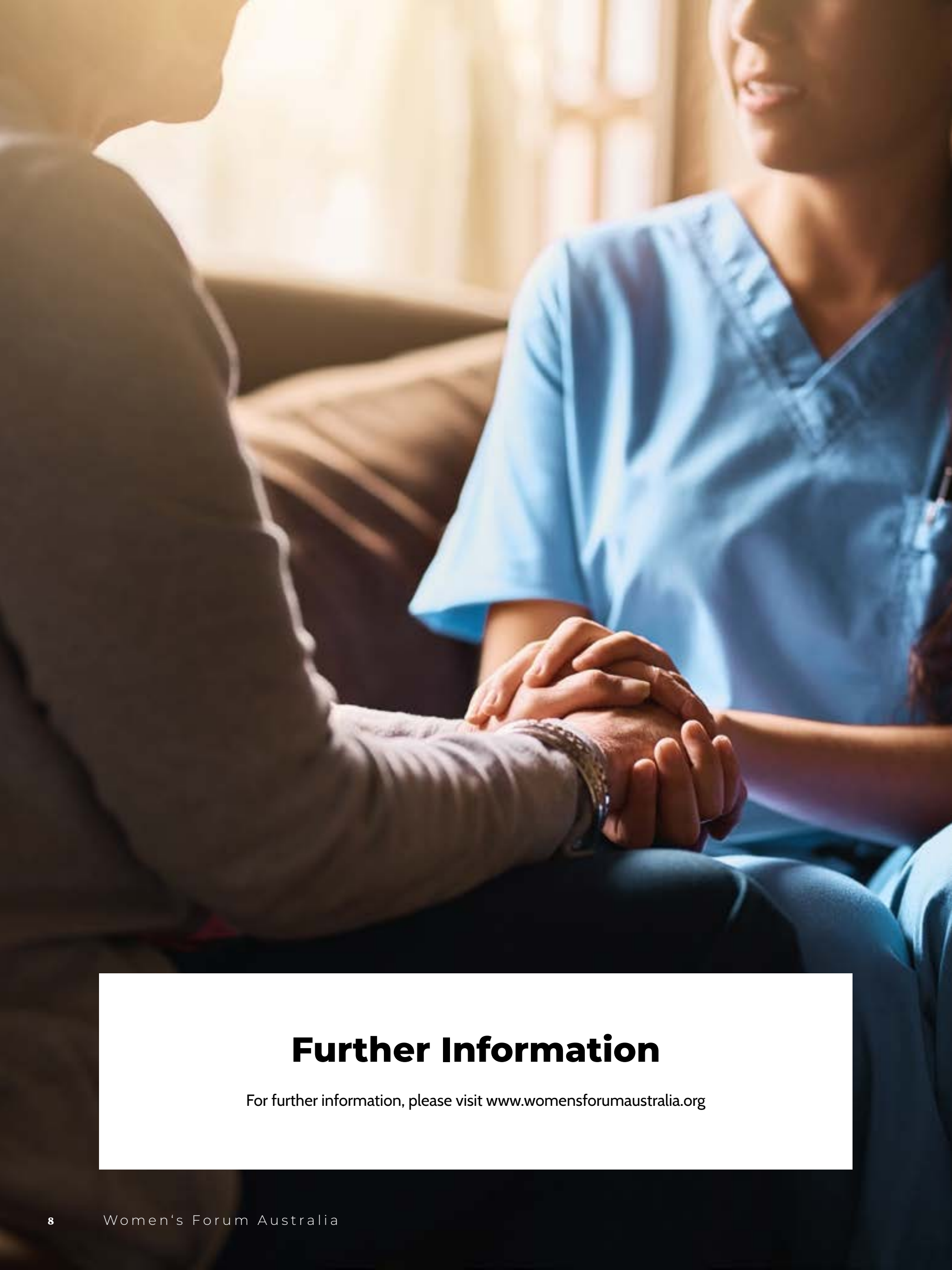
The *future expansion of the conditions for eligibility* as demonstrated overseas (aka 'bracket creep'). Laws that once required a patient to have a terminal illness and to be over a certain age now allow euthanasia and assisted suicide for certain minors, psychosocial conditions, disability, and for those who are simply tired of life.

The *fallibility of medical diagnoses/prognoses* and the potential for a person's life to be mistakenly ended based on inaccurate medical information.

The *diminished capacity of patients* who are facing terminal illness and experiencing severe suffering and the question of whether or not they are able to give truly informed consent to their lives being ended.

The potential *adverse impact on palliative care development* when it is less burdensome, both economically and socially, to end a patient's life.

The ability of physicians to end the lives of their patients *fundamentally changes the nature of the physician-patient relationship* from one of healing and pledging to "do no harm" to one where physicians may take their patients' lives. This may damage the relationship of trust and care between physicians and their patients and ultimately undermine the integrity of the medical profession.



Further Information

For further information, please visit www.womensforumaustralia.org

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Much of this Research Note is based on an article by Dr Katrina George titled, 'A Woman's Choice? The Gendered Risks of Voluntary Euthanasia and Physician-Assisted Suicide'. Dr George was a former director of Women's Forum Australia.

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