'THE RIGHT TO DIE' AND 'RATIONAL SUICIDE': RESPECTING HUMAN RIGHTS FOR ALL OR A CLAIM FOR PRIVILEGE BY THE STRONG? THE CASE FOR THE STATUS QUO

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I represented the Care Alliance, one of the three interveners in the *Seales* case. In this paper I seek to place the debate in a clearer factual context, and step through how the ‘rights’ argument shifted during the case. My conclusion is that the ‘rights’ argument put forward by advocates for assisted suicide and euthanasia is not valid, and that there is a real risk that the voices and particular world view of those in positions of strength and power who support a change in the law are simply drowning out the voices of the less able.

**Opposition to assisted suicide is not ‘hardline religious’ or ‘fringe conservative’**

Despite being described (along with other opponents to euthanasia and assisted suicide) on the *Lecretia’s Choice* Facebook page as a collective of “fringe conservative groups and the more hardline religious groups”, the Care Alliance is a broad-based coalition including organisations such as:

- Hospice New Zealand
- Australian & New Zealand Society of Palliative Medicine
- Palliative Care Nurses New Zealand
- Euthanasia-Free New Zealand
- Nathaniel Centre (bioethics)
- Not Dead Yet Aotearoa (advocates for the disabled)

The Care Alliance presented evidence in *Seales* about the concerns of the disabled community. All the Care Alliance’s other expert witnesses in palliative care and bioethics were asked to give evidence for the Crown.

None of the evidence from the Care Alliance was faith-based, but the continuing characterisation of the opposition to assisted suicide as hardline religious and fringe conservative reflects an interesting approach by the advocates for a change in the law. The characterisation is a ‘dog whistle’ intended to belittle the concerns of those who support the status quo, and to avoid answering those concerns by characterising them as ‘religious-and-therefore-nonsensical’ and unworthy of attention by ‘right-thinking’ progressive liberals. Given who these concerns are raised by and how serious and well supported the concerns are, this is a disturbing feature of the public discourse, as well as being somewhat ironic in the context of a debate which purports to promote human rights.

The evidence filed by the Crown and the Care Alliance in *Seales* is publicly available. It is extensive and demonstrates that assisted suicide and euthanasia are very strongly opposed nationally and internationally by the medical and nursing professions, palliative care experts and practitioners, ethicists, disabled groups, those concerned with elder abuse and youth suicide, and many others.

The question of whether New Zealand should change the law in this area is important and complex. Whether or not each person agrees in the end with their position, the concerns of those
who oppose assisted suicide and euthanasia should be taken seriously and not written off on the basis of prejudice or facile assertions that they are overstated or unfounded. As Lord Sumption said in *Nicklinson*:³

> It is plain from the expert evidence … that there is a diversity of opinion about the degree of risk in relaxing or qualifying the ban on assisted suicide, but not about its existence. **The risk exists and no one appears to regard it as insignificant.** There is a reputable body of experienced opinion which regards it as high. … The real question … is how much risk to the vulnerable we are prepared to accept in this area in order to facilitate suicide by the invulnerable.

**Assisted suicide is not necessary to avoid people dying in agony**

Advocates for change assert that the Court in *Seales* held, as a matter of fact, that palliative care cannot address all physical pain, and therefore that people are dying in agony. This is not correct.

First, the Court in *Seales* did not, and could not, reach any such conclusions. *Seales* was argued and decided on points of statutory interpretation: the evidence before the court was strictly limited, and none of it was subjected to cross-examination. The case was heard urgently and Ms Seales’ counsel strongly opposed any external intervention, resulting in further limitations to the evidence available to the Court.⁴

More importantly, however, the expert evidence *from both sides* was clear that in the worst case scenario palliative sedation (which is temporary and fully reversible) was available to address intractable physical pain.⁵

As Justice Collins noted,⁶ Ms Seales’ concerns were more directed to the loss of physical capacity, behavioural changes and psychological changes inherent in the dying process, which could not be fully ameliorated: palliative care cannot change the fact that the patient is dying, or indeed prevent the dying process with its attendant loss of physical and mental capacities.

However, the palliative care experts who gave evidence for the Crown also emphasised that a key objective of the holistic approach in palliative care is helping the person and their whanau come to terms with the process of dying, and that good palliative care can be incredibly effective and life affirming in achieving this goal. As Dr Donnelly expressed in her affidavit for the Crown:

> My firm view is that allowing a person to go through the process of a natural death is better for the patient and their family. In the process of dying there is much living to be done, and I have witnessed time and time again how much people grow through this process. This is what holds those of us who work in palliative care: we witness this growth and hope and transformation so often, and we have the privilege of helping it, and walking along side those who make this journey. We work hard and work to increase our skills and develop the knowledge in this area because we see what huge benefits it delivers to people, in this most vulnerable period of their lives.

We who work with the dying every day are not romanticising this process: this is what we see. Palliative care is effective. It is the appropriate and compassionate response to the needs of this group of the most vulnerable people in society.
Assisted suicide is about fear and control

The question that needs to be asked is why now, with access to the best medical and palliative care that has ever been available, are some sectors of society calling for the state to facilitate suicide or euthanasia of the dying and/or the irremediably ill? From the evidence in Seales, the answer appears to be about the fear of losing control, and the fear of becoming dependent, disabled, reliant on others, of being ‘less’ than the person was when they were well. As Justice Collins explained in Seales:7

Ms Seales’ desire to control the final stages of her death is a common trait amongst those in society who consider themselves to be successful and driven … [people like Ms Seales find the effects of such illnesses] particularly intolerable because of the loss of autonomy and inability to manage their lives is directly contrary to the things they value.

Ms Seales’ evidence is direct and to the point.8 She said: “As my death has become more inevitable, I constantly worry that it could be slow, unpleasant, painful and undignified. I worry that I will be forced to experience a death that is in no way consistent with the person that I am and the way that I have lived my life” 9

As Ms Seales said, facing this, it would help to know that she had the choice to be able to say “enough is enough” and to be able to die peacefully at a time of her choosing.10 Ms Seales’ fears will resonate strongly with people with a similar life experience. There is a real fear of becoming frail, incapable, demented, dependent on others. And there is always the fear that we might live so long that there will be no one around to become dependent on, that there will be no one to care for us, and we will be at the mercy of perhaps poorly paid and badly trained strangers.

Assisted suicide is seen as a way of keeping at least the appearance of control over our lives: if we have this option, we get to control the end – we might not use it, but it is then our decision as to how things play out. Even facing death and disability, our sense of personal autonomy is preserved. Why shouldn’t the magic of modern pharmaceuticals be used for this therapeutic choice, when it could make such a difference?

This is the basis of the rights argument in Seales: denying the choice of assisted suicide or euthanasia is cruel and degrading treatment. Refusing to allow this option of control forces people to consider early suicide – a breach of the right to life.

The ‘rights’ argument: step one – the absolute prohibition on killing and assisted suicide are over-broad

Step one of the rights argument looks to be straightforward: it is argued that the prohibitions against assisted suicide and euthanasia are necessary to protect the vulnerable, but are drafted too widely.

The reasons for the ‘bright line’ absolute prohibition against assisted suicide and euthanasia are well summarised by Justice Wild in R v Faithfull.11
the principle of sanctity of life to ensure that the rights of the weak, the vulnerable and the handicapped are not diluted or overlooked.

In step one of the rights argument presented in favour of assisted suicide and euthanasia there is no challenge to this statement: these are acknowledged as being important and true concerns. Rather, the advocates of change argue that the prohibitions are simply too wide, because they also apply to people like Ms Seales, who didn’t need this protection. Ms Seales’ evidence summarises this well. As she said:¹²

I would like to reassure the Court that none of those general concerns [outlined in the Crown’s evidence] apply to me. As I have always done throughout my life, I continue to know my own mind, and to trust myself to make informed choices for sound reasons. … I have not been coerced … I have not been influenced by any of my doctors’ views … I am neither depressed nor mentally compromised … I can make an informed choice … I have lived my whole life as an independent and intellectually engaged person …

And this is the first crack in the rights argument:

In Seales it was argued that the bright line in the law that emphasised the value of all human life to ensure the protection of the vulnerable, was over-broad because it applied to people like Ms Seales, who was not in a disadvantaged group and was not vulnerable.¹³ The argument is that the prohibition ought not to apply to people who are not disabled, not frail and elderly and subject to the pressure of feeling a burden, to people who have caring not abusive families, who are educated and independent and sufficiently well off. Those people do not need protection from social pressure or actual coercion.

But what does that distinction really mean? The ‘rights’ argument is that access to assisted suicide is so important that its denial is a denial of the right to fundamental human dignity, the right to life, the right not to be subjected to cruel and degrading treatment. But is it only supposed to be available to people like Ms Seales? Because they are strong and independent and educated and well supported? That is the basis on how the law should decide who can access assisted suicide and who cannot? Well-off, well-educated people with good supportive families can have this, and the disabled, the frail, the lonely and the vulnerable can’t? That is not a human right. That is a claim for privilege.

The Court of Appeal in New Mexico in an August 2015 decision rejecting assisted suicide in that state described this as “the exclusionary defects in the plaintiffs’ proposed right to aid in dying”. The Court went on:¹⁴

… we decline to recognize an inferred fundamental right benefiting only a select few New Mexicans. … The selective discrimination embodied within Plaintiffs’ concept of aid in dying is constitutionally unsound for recognition as a fundamental right …

The ‘rights’ argument: step two – no one needs the protection of the bright line any more

This position, of assisted suicide only being available for the strong and well-off – the ‘driven and successful’ minority referred to in Seales – is clearly too difficult to take very far. And the ‘rights’ argument now jumps: the proposition that the ‘right to die’ is only for the well-off shifts to a wider argument that everyone of sound mind is entitled to access assisted suicide, and that it would be offensive for the law to question anyone’s assessment of their own autonomy.
The beginning of this process was apparent in *Seales*: while the evidence focused on Ms Seales’ own ‘unique’ circumstances, and the legal argument focussed on the law being over-broad, the relief sought would have legalised assisted suicide in due course for every mentally competent adult. (Noting that in accordance with New Zealand’s obligations under the United Nations Convention on the Rights of Persons with Disabilities our legislation enshrines a strong presumption of competence, so the group excluded would be very small indeed.) The Court also recognised the issue, noting that Ms Seales’ self-assessment that she is not vulnerable must be respected, and that the Court should not make assumptions as to vulnerability, as “to do otherwise would devalue respect for the principle of individual autonomy”.

So how does the rights argument now try to address the fundamental concerns that underlie the bright line in the criminal law, summarised above in *Faithful*? The rights argument no longer says that these concerns are valid but the law is over-broad. Instead, the argument is now that these concerns are not valid, and that the protection of the law is unnecessary for anyone, except those who are entirely mentally incompetent. How is this extraordinary position justified? By two assertions: first, that the concerns are overstated and/or simply unfounded; and second, that we can design a regulatory regime that that fully addresses these risks for everyone.

Now the significance of characterising opposition to assisted suicide as ‘hardline-religious-therefore-nonsensical’ becomes apparent, as does the importance of actually listening to those who have genuine well-founded concerns and not accepting facile assurances that ‘there is no evidence of harm’.

**Assisted suicide is not harmless**

There was extensive evidence from both New Zealand and international experts in *Seales* on the harms and risks in assisted suicide and euthanasia. This evidence is expert, considered and thorough.

The evidence in *Seales* post-dates the decision of the Canadian Supreme Court in *Carter*, which is routinely cited to support the assertion that assisted suicide is generally harmless. It is also worth noting that Canadian Supreme Court in *Carter* declined to itself re-consider the evidence, but relied on the findings of the lower court judge on the limited evidence before her (the Judge having excluded a substantial body of relevant evidence as inadmissible). The Canadian court also restricted itself to the very narrow question of whether legalising euthanasia/assisted suicide would result in vulnerable people being induced to commit suicide, and excluded all other risks and harms as irrelevant.

The same evidence that was considered in *Carter* was reviewed by the High Court of Ireland in *Fleming* and by the UK Supreme Court in *Nicklinson*. Both courts concluded that the true position was the opposite of the view reached by the Canadian court. The approach of the Canadian courts can also be contrasted to the conclusions reached by the Scottish and UK Parliaments, who conducted a far more in-depth and wide ranging analysis and rejected proposals to change the law.

The United Nations Human Rights Committee and the United Nations Committee on the Rights of Persons with Disabilities have also expressed concerns about the impact on the disabled and the vulnerable in those countries where euthanasia/assisted suicide is legal. This paper does not have space to review these concerns in any sort of detail so I have focused on just one area where the Care Alliance gave evidence – the impact on the disabled.
The impact on the disabled

One of the more disturbing aspects to this case was the characterisation of the day-to-day lives of disabled people as lacking fundamental human dignity. In support of the argument that the ban on assisted suicide constituted degrading treatment, counsel for the plaintiff submitted that the increasing level of physical disability and dependence on others for her personal care “endured” by Ms Seales “would humiliate and debase her”, was “gravely humiliating”, and that denying assisted suicide “forced [her] to endure degradation”.25

Ms Seales and her supporters were entitled to express their views on what does and does not constitute basic human dignity. The problem is that they then assert that society as a whole should agree with them, and that their view should be enshrined in law.

Put simply: at the heart of arguments for assisted suicide is a belief that some lives – lives that are physically or intellectually compromised – are not worth living. That attitude devalues the lives of disabled people. The casual and perhaps unthinking equating of physical and intellectual disability with lack of human dignity in the legal argument in Seales is perhaps a telling demonstration of the dangers that the disabled community face with this law change.

Legislating this concept would significantly undermine the rights of the disabled. Just touching on some of the main areas of concern:

• The concept of ‘rational suicide’ for those becoming disabled and dependent through illness, advocated by Geddis and others,26 is an affront to their right to be recognised as having the same fundamental human dignity as everyone else;
• The legitimisation of the view that lives like theirs are not worth living undermines their struggle for equality and respect as equally valuable members of society, which is at the heart of the UN Convention;
• The legalisation of assisted suicide and euthanasia creates real risk to their equal access to health care and other support services, places their lives at risk,27 and directly discriminates against them in their right to access the same suicide prevention measures that are provided to the well and able.
Baroness Jane Campbell’s statement in the debate in the House of Lords on proposals to legalise assisted suicide was put before the Court in *Seales*, along with a wide range of evidence from disability organisations here and in other jurisdictions. Baroness Campbell said:  

My Lords, I have fought for autonomy the whole of my life. I have fought for that for myself and for others. I do not want this Bill.

First, I must declare a very important interest. This Bill is about me. I did not ask for it and I do not want it but it is about me nevertheless. Before anyone disputes this, imagine that it is already law and that I ask for assistance to die. Do your Lordships think that I would be refused? No; you can be sure that there would be doctors and lawyers willing to support my right to die. Sadly, many would put their energies into that rather than improving my situation or helping me to change my mind. The Bill offers no comfort to me. It frightens me because in periods of greatest difficulty, I know that I might be tempted to use it. It only adds to the burdens and challenges which life holds for me.

However, it is not just about me.

My story is echoed by the majority of disabled and terminally ill people in Britain today. …

Supporters of the Bill argue that there is a hard and fast distinction between terminal illness and disability. I can tell you absolutely that there is not. We, the folk this Bill claims to serve, know that. The Bill purports to offer choice—the option of premature death instead of pain, suffering and disempowerment—but it is a false choice. It is that of the burglar who offers to mug you instead. …

I have spent my life developing ways to prevent people in vulnerable situations feeling powerless and burdensome. … I am afraid that assisted dying will bring back outdated beliefs that devalue disabled and terminally ill people, when we have tried so hard to get away from them. Small wonder then if some
succumb to those beliefs and see premature death as the only answer. Small wonder if family, friends, doctors and others see it as their duty to support that goal. It appears easier, cheaper, quicker – and it is.

... Death is seen as a release from pity, for both the giver and the receiver, but there are far better ways of responding. We must put our energy into providing the best support, be it medical, social, practical or emotional, to help disabled people and terminally ill people. We are nowhere near there yet. Helping people to live with dignity and purpose must surely be our priority. Disabled people and terminally ill people do not deserve pity. They deserve so much better.

In response, the plaintiff filed evidence from Mr Patston, who said that these concerns are patronising and that he personally does not have such a low sense of self worth. He said this:

... there are many people with unique function (disabled people) who vehemently oppose the legalization of voluntary euthanasia ... my view is that if you are enough of a martyr to think like that, you may well be better off dead.29

That was the answer of the plaintiff’s team in Seales to the concerns of the disabled community.

The voices that need to be heard

If human rights are to be taken seriously then the voices of the disabled communities and the voices of the more vulnerable groups who are less vocal, less articulate and less well represented need to be sought out and heard.

The warnings from the palliative care doctors and nurses practising in this area need to be taken seriously.

Those concerned with the impact on youth and elder suicide of normalising the concept of ‘rational suicide’ need to be heard.30 In this context it needs to be noted that the Chief Coroner announced in July 2015 that New Zealand’s suicide toll over the previous year was the highest on record,31 and that severe loneliness and isolation among the elderly is recognised as an increasing problem in this country.32

The voices and perspectives of Maori need to be heard. The voices and perspectives of Pasifika and immigrant and refugee groups need to be heard.

Those concerned with already high levels of elder abuse and neglect need to be heard.

The advocates for a change in the law are proposing a fundamental shift in the way society regards and cares for those of us who are frail, dying and disabled. Such a change should not be made on the basis of abstract and questionable ‘rights’ analyses, or on the basis of giving primacy to the particular world view espoused by those with the strongest and most powerful voices.

A perfect regulatory regime?

Finally, the wishful thinking of those who claim that New Zealand can design an effective regulatory regime that will protect everyone needs to be recognised as just that – wishful thinking.

First, the harms to the disabled, to suicide prevention, to the abuse of the elderly, to the practice, ethics and effectiveness of palliative care, and the change to society’s view of the fundamental value of all human life, are all inherent in such a change in the law. These flow from the simple
act of lifting the bright line and enshrining in the law the concept that some lives are worth protecting and others are not. No regulatory regime will mitigate these.

Second, the idea of a fully effective regulatory regime is pure fantasy: no regulatory regime is ever 100% fully effective, and in this context even a single failure means someone has died because the state lifted the protection that would have saved them.

New Zealand has a serious problem with elder abuse and neglect, and an estimated one-quarter of elderly and disabled people who are dependent on their carers suffer serious psychological abuse. Despite best endeavours, no regulatory regime has been able to solve this. There is no basis at all for confidence that a regulatory regime around assisted suicide and euthanasia would achieve better success, let alone be 100% fully effective. Further, as Dr Kleinsman noted in his evidence for the Crown:

... The availability of state-sanctioned ‘mercy killing’ in this environment will create additional pathways for abuse and neglect, and put at risk the lives and security of these highly vulnerable groups.

There also needs to be a realistic appraisal of what is actually happening in the jurisdictions where assisted suicide or euthanasia have been legalised. Claims that regulation is ‘working’ there need to reflect the low level of supervision and public reporting, and the very low standards of what these jurisdictions consider to be acceptable. This is discussed in detail in the Crown’s evidence in Seales. Issues include:

- The Netherland’s Regional Euthanasia Review Committee reported without concern in its 2013 review that 97 people with dementia were euthanised in the year under review, along with 42 people with mental illness. Euthanasia without explicit request from the patient is increasing;
- The same report records that the Committee did not reprimand the certifying physician for failing to even see the patient before agreeing that euthanasia was appropriate, because the physicians “were able to convince the Committee that the chances of the independent physician reaching a different conclusion [had he seen the patient] were zero”;
- The supervising agency in Belgium approved the euthanasia of two deaf adults on the basis that they were also going blind, and an adult in his 30s diagnosed only with autism; while a clinic that euthanised a woman suffering from tinnitus was reprimanded for being “careless”;
- Belgium has now lifted all age restrictions and allows euthanasia of children; the Netherlands currently allows euthanasia over the age of 12 but allows euthanasia of babies under a different protocol; assisted suicide in Oregon is increasing significantly as the practices normalise;
- Official reports in Oregon show an increasing rate of people citing being a burden or having financial worries as factors in their request for assisted suicide, which does not apparently cause concern in that jurisdiction (noting that 60% of requesting patients in 2014 did not have private health insurance);
- In Oregon there is an absence of safeguards after the patient has received the prescription. There is no reporting or control over when or how the patient administers the drug: authorities have no visibility as to the person’s mental state at the time or even whether the administration was voluntary;
- Oregon’s rate of ‘unassisted’ suicide in the general population is 41% higher than the national average, and is the second leading cause of death in those aged 10-34; the Netherland’s official statistics agency reported in 2013 that the suicide rate in the general
population has “grown dramatically” over the past five years, with a 30% increase from 2008 to 2012.47

Endnotes

1 All the evidence in Seales is publicly available: see http://carealliance.org.nz/about/seales-v-attorney-general/ and http://lecetria.org/you-can-help/seales-v-attorney-general/affidavits
2 http://carealliance.org.nz/about/seales-v-attorney-general/
3 Nicklinson v Minister of Justice [2014] UKSC 38 at [225]–[229].
4 Seales v Attorney-General (intervention) [2015] NZHC 828.
5 The statement at paragraph [47] of the judgment that palliative care “may not ameliorate her physical pain” is made with reference to Ms Seales’ expert witness statements, which confirm the availability of palliative sedation as a last resort for the rare cases of intractable pain. See (with reference to footnote 29 in the judgment) the affidavits of Munglani at [23], Smalies at [31]–[32] and Ashby 1 at [14]–[17]. Ms Seales’ oncologist and GP did not suggest that she would face intractable physical pain: see Dr Y 1 at [15] and 2 at [7], Dr X 1 at [15]–[16] and 2 at [3], and Dr Owens similarly addressed only the emotional and psychological effects of illness and the dying process: see [9]–[10].
6 At [39].
7 At [54].
8 Ms Seales’ evidence is available at http://lecetria.org/you-can-help/seales-v-attorney-general/.
9 First affidavit at [48].
10 First affidavit at [42], second affidavit at [11].
12 First reply affidavit at [6]–[10].
13 Noting that the palliative care experts for the Crown were of the firm view that all people with a terminal illness can be considered vulnerable, particularly those who have lived strongly independent lives. See for example Dr Donnelly at [57]–[69] and [75]–[88].
15 Morris v Brandenburg 33,630 (N.M. Ct. App. 2015) at [44]–[47].
16 At [80]–[81].
17 http://carealliance.org.nz/about/seales-v-attorney-general/
19 See Carter (Supreme Court) at [105]–[109].
20 As noted by the UK Supreme Court in Nicklinson v Minister of Justice [2014] UKSC 38 at [224].
21 See for example Carter at [99].
22 Fleming v Ireland [2013] IESC (Ir SC)19 at [92]–[105] (rejecting analysis of British Columbia trial judge whose factual findings were deferentially endorsed by the Supreme Court); Nicklinson v Minister of Justice [2014] UKSC 38 at [224]–[229]
24 UNHCR 2009 Concluding Observations on The Netherlands report CCPR/NLD/CO/4 at [7], 2001 Concluding Observations (CCPR/CO/72/Net at [5(d)]), and the 2014 Follow-up to Concluding Observations (discussing a progress report by the special rapporteur) at www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=14430&LangID=E: “With regards to the Netherlands, Mr. Salvioli said that the Committee would, in the absence of further information provided by the State party, reiterate its recommendation that the Netherlands reviewed its legislation on euthanasia in light of the Covenant’s recognition of the right to life.” UNCRPD 2014 considering the initial report from Belgium stated: “The Committee identified euthanasia as a very problematic area of disability rights”: see www.ohchr.org/ru/NewsEvents/Pages/DisplayNews.aspx?NewsID=15073&LangID=E.
25 Plaintiff’s submissions 18 May 2015 at [5.79]–[5.82].
See Gill No, we don’t think our doctors are out to get us: Responding to the straw man distortions of disability rights arguments against assisted suicide Disability and Health Journal 3 (2010) 31-38.


See summary in Dr Kleinsman’s affidavit at [133]–[150].

www.staff.han.nl/national/health/69920289/Suicide-toll-reaches-highest-rate-since-records-kept.


Noting that there are strong concerns expressed by former supporters that the regimes are not “working well.” See for example Professor Boer ‘Don’t make our mistake: An assisted suicide bill goes to Lords, Dutch Watchdog who once backed euthanasia warns UK of ‘slippery slope’ to mass deaths’, The Mail, May 7 2015, at www.dailymail.co.uk/news/article-2686711/Dont-make-mistake-Assisted-suicide-bill-goes-Lords-Dutch-regulator-backed-euthanasia-warns-Britain-leads-mass-killing.html.


See Dr Kleinsman’s affidavit at [170]–[178].

www.telegraph.co.uk/news/worldnews/europe/belgium/9801251/Euthanasia-twins-had-nothing-to-live-for.html

www.washingtonpost.com/opinions/where-the-prescription-for-autism-can-be-death/2016/02/24/8a00ec4c-d980-11e5-81ae-7491b969e7df_story.html


Dr Kleinsman at [179]–[140].

Oregon Public Health Division, Oregon’s Death with Dignity Act 2014

See also the further discussion in Dr Kleinsman’s affidavit at [182]–[191].
