

Professor Margaret Somerville should retract her indefensible 'suicide contagion' claim

Neil Francis

13th April 2017



Rocking the vote for law reform

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Executive summary

Professor Margaret Somerville, currently Professor of Ethics in the School of Medicine at the Catholic University of Notre Dame Australia,^a has enjoyed ongoing publication of her opinions, with few challenges published to date.

Back in 2007, Somerville, then a Professor of Ethics at McGill University in Montreal, Canada, appeared as an expert witness in an Iowa District Court case. The court comprehensively rejected her testimony, determining that she:

"...specifically eschews empirical research and methods of logical reasoning in favour of 'moral intuition.' She has no training in empirical research..."

Professor Somerville, I argue, has again fallen short on empirical research and logical reasoning. To illustrate, I will analyse her claim, published in an opinion piece in ABC Religion and Ethics that:

"...the general suicide rate has increased in every jurisdiction that has legalized assisted suicide."

While her claim may be her own personal opinion, she has presented it expressly stating that she is a Professor of Ethics at her current university of employment, lending the claim perceived authority.

This report demonstrates how her claim and her defence of it are contradicted by multiple sources of empirical government and other primary research evidence. It also demonstrates that she failed to engage appropriate scholarly standards that require the active search for, acquisition and analysis of all reasonably available relevant data in an attempt to answer a particular question.

In making her claim, Prof. Somerville:

- Cites 'supportive' data from lawful jurisdictions while overlooking other data, sometimes even in the same data set, that are inconsistent with her claim;

^a Not to be confused with another Professor Margaret Somerville, who is Director of the Centre for Educational Research at Western Sydney University.

- Cites as supporting evidence an econometric modelling study that did *not* find a statistically-significant relationship between assisted dying law and the general (non-assisted) suicide rate;
- Fails to consider data from all jurisdictions with assisted suicide laws while making a claim about them all — overlooking Switzerland, whose empirical data is clearly at odds with her claim;
- Repeatedly cites non-academic anti-euthanasia lobbyist Mr Alex Schadenberg (who also cites her) as a source of evidence for her claim and who in turn quotes a television source and another lobbyist's opinion to underpin his own beliefs about 'suicide contagion'; and
- Conflates voluntary euthanasia (physician-administration) with assisted suicide (patient self-administration) such that her argument, at least in the context of Belgium and the Netherlands, is substantially about the novel concept of '*euthanasia* contagion' rather than the more familiar 'suicide contagion' expression she uses.

These findings are consistent with the Iowa court's ruling that Prof. Somerville sometimes relies on 'moral intuition' rather than sound empirical research and logical reasoning.

This report also draws a number of connections between those advancing misinformation on assisted dying 'suicide contagion,' and Catholic identity. Catholic identity is *not* a reason to reject arguments, but it does help identify the source of a majority of 'suicide contagion' misinformation.

Finally, I argue that the appropriate course of action for Prof. Somerville is to retract her 'suicide contagion in every jurisdiction' claim.

Table of contents

Introduction.....	5
More 'moral intuition' and weak reasoning?.....	5
The case of Belgium.....	6
A single data point proves nothing.....	7
Netherlands: A selective subset of data.....	7
Blind to complex reality.....	8
Comparing before with after.....	8
The full Dutch story	9
Belgium revisited.....	11
Valid, robust empirical data contradicts claim.....	11
Arbitrary and invalid methods exposed	12
Muddling terms when it helps	12
'Expert' relying on non-expert sources.....	13
Schadenberg blog 1.....	13
Schadenberg blog 2.....	14
Schadenberg blog 3.....	14
<i>None</i> of the provided sources support Somerville's claim.....	15
Similar misinformation from Mr Schadenberg	16
Misinformation about Oregon's state rating.....	16
Selective use of individual data points.....	17
Cherry-picking and statistical variation.....	18
Don't mention Switzerland	20
"No possible safeguards" theory.....	20
Switzerland wholly inconsistent with theory.....	20
Another case of selective data use.....	21
Reluctance to correct or withdraw	22
Conclusion.....	24
Epilogue — No 'ad hominem' arguments	25
References.....	26

Introduction

A well-publicised ethicist has written that:

“Good facts (including, if necessary, research to establish them) are essential to good ethics, which, in turn, is essential to good law.” [Italics are original]

That ethicist was... Professor Margaret Somerville.^{1, Ch. 8}

This report illustrates a case in which Prof. Somerville profoundly offended the principle of ‘good facts.’

Back in 2007, Somerville, then a Professor of Ethics at McGill University in Montreal, Canada, appeared as an expert witness in an Iowa District Court case. The court comprehensively rejected her testimony, determining that she:

“...specifically eschews empirical research and methods of logical reasoning in favour of ‘moral intuition.’ She has no training in empirical research...”²

More ‘moral intuition’ and weak reasoning?

Somerville is now a Professor of Ethics at the Catholic University of Notre Dame Australia in Sydney, and, I argue, has again fallen short on empirical research and logical reasoning.

To illustrate, I will address this statement of hers, recently published in an opinion piece in ABC Religion and Ethics:

“...the general suicide rate has increased in every jurisdiction that has legalized assisted suicide.”³

The underlined clause was, ostensibly, a hyperlink to a source to back up the claim. However, the link pointed merely to another of Prof. Somerville’s Religion and Ethics opinion pieces,⁴ and the cited piece had *nothing* to say about general (non-assisted) suicide rates. In fact, the word ‘suicide’ did not appear in the cited opinion piece.

It was unclear why Prof. Somerville had provided such a meaningless citation for her startling and sweeping claim, so I contacted her by email, pointing out her non-supporting link and asking on what data she relied.

The sources she cited in her reply fell far short of scholarly evidential standards.

An Iowa court found that Prof. Somerville specifically eschews empirical research.

Prof. Somerville made a startling and sweeping claim without providing evidence for it.

The case of Belgium

As a significant part of her 'evidence,' Prof. Somerville said that she was referring to Belgium and the Netherlands, and provided 'data' on them.

For Belgium, she supplied an image of a data table of European standardised suicide rates from 2013.⁵ The table is rather dense, so I've turned the relevant section into a chart (Figure 1).

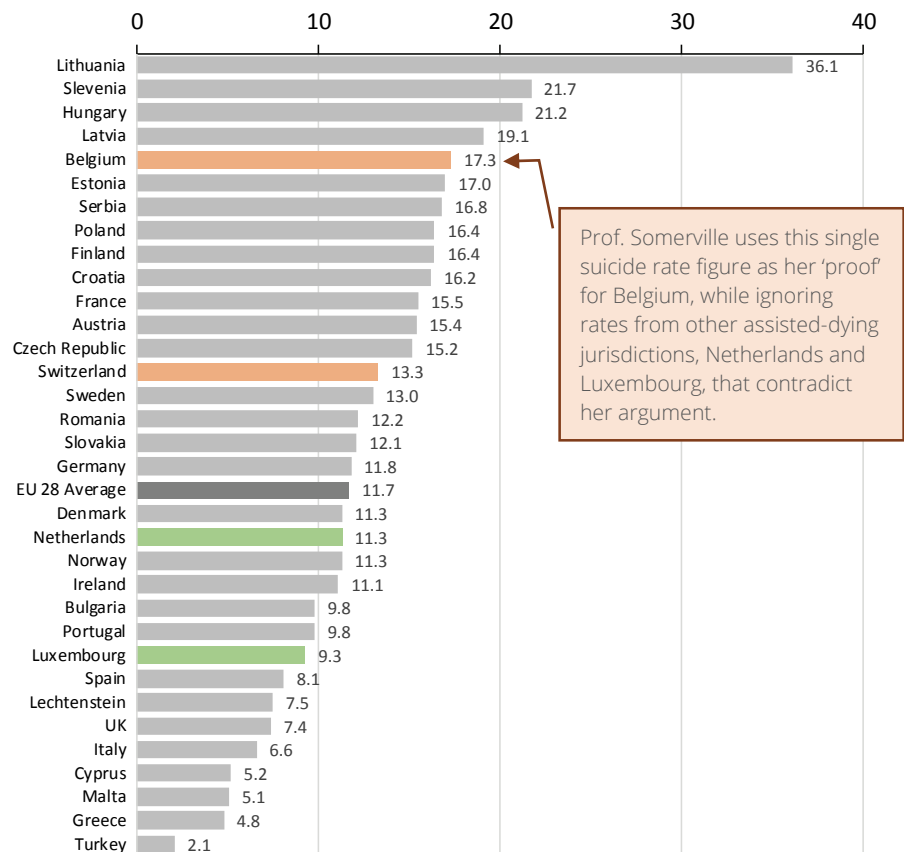


Figure 1: Standardised country suicide rates for 2013 (per 100k population)

Source: Eurostat 2016⁵

Prof. Somerville notices data in her data set that seems consistent with her claim, but doesn't notice data contradicting it.

Prof. Somerville argues that her 'proof' for supposed Belgian suicide contagion — from assisted dying to the general population — is that, in the cited table (the country bars in Figure 1):

"...Belgium comes out above the EU average."

Indeed it does, but that's a remarkably ignorant argument, *especially* from a Professor. By definition, half the countries have to be above the average (at least as a *mean*) and half below it,^b or the average wouldn't be... the average. That's very basic statistics.

^b The chart's *average* bar is the weighted figure for the 28 EU countries, though all 33 countries in the table are included in the chart.

Prof. Somerville doesn't explain, for example, why Lithuania's suicide rate is more than twice Belgium's, and more than three times the EU average, when Lithuania *doesn't* have an assisted dying law.

Nor does she explain why she's overlooked the Netherlands' suicide rate, *below* the average in the very same table, when she expressly calls the Netherlands out on supposed suicide contagion along with Belgium.

Further, there are *four* European countries that had assisted dying laws in 2013 (the year of her general suicide data). The other two are Switzerland and Luxembourg. Of the four, highlighted in Figure 1, two of them are above the average and two below.

A single data point proves nothing

Cherry-picking a single data point to support an argument while ignoring other points in the same data set that contradict it offends the most basic of academic standards.

But even in the absence of contradictory data, a single point-in-time figure can't establish *correlation*, just one of several steps necessary to establish *causation*. When there is a lack of correlation, an argument of causation fails.

To begin establishing correlation in the first instance, it is necessary to analyse 'longitudinal' data: that is, data series along time.

That's what Prof. Somerville starts to do for the Netherlands — while she overlooks in her previous data set that the Dutch suicide rate is *lower* than the EU average.

Netherlands: A selective subset of data

In reply to my request for her sources of evidence, Prof. Somerville also provided 2002–2015 Dutch data for two things: the total assisted dying rate (covering both voluntary euthanasia and assisted suicide), and the general (non-assisted) suicide rate in the Netherlands.^c

I've charted the data in Figure 2, and separately added the 'assisted suicide' rate as well, so that we're comparing like with like (assisted suicide with general suicide).

Note that there's a temporary rise in general suicides around 2005, with very little rise in total assisted deaths, and no rise in assisted suicides, then falling to 2007 as the assisted death rate is starting to rise. Then, from 2008 onwards there is a small rise again in the general suicide rate at the same time there is a large rise in the total assisted dying rate (almost all of which is euthanasia), and a tiny rise in the assisted suicide rate.

^c The Netherlands Euthanasia Act came into effect in April 2002, and 2003 was the first full year of its operation.

Prof. Somerville refers to only one data point, when there are four relevant ones in her data set.

A single data point can't establish correlation, a key step in establishing causation.

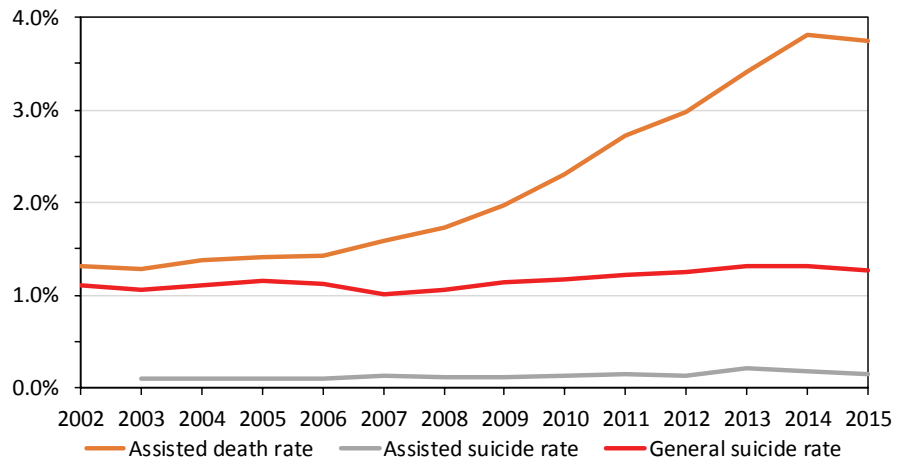


Figure 2: Total assisted deaths, assisted suicide and general suicide in the Netherlands as a percent of all deaths^d

Sources: Belgian government statistics office; Euthanasia Commission annual reports

Despite two separate rises in the general suicide rate, one with a substantial increase in assisted deaths and one without, Prof. Somerville looks at only the second rise as meaningful.

Blind to complex reality

Suicide is a complex phenomenon, comprised of multiple risk and protective factors. Leading risk factors include mental illness, substance abuse, financial distress (unemployment), relationship breakdown and household gun ownership. Indeed, it has been found that the leading historical correlates of suicide rate trends at least in *Belgium* are unemployment and divorce.⁶

Leading protective factors against suicide include easy access to emergency counselling and support services during crisis episodes, social security provisions of the State especially during times of economic recession, reducing pedestrian access to high-risk locations such as train tracks and tall bridges, and negative community attitudes toward suicide.

But to Prof. Somerville, the *only* relevant contributing factor to changes in the general suicide rate is contagion from assisted dying: she fails to mention data about any other potential factors. In other words, something of which she disapproves must be the cause of something else of which society in general disapproves. That's known as 'confirmation bias.'

Comparing before with after

In addition to considering just one possible causative factor, Prof. Somerville also offends a second fundamental principle of analysis.

To establish the first step of possible causation — correlation — you at least have to compare the data from *before* the 'causal' variable's change, with

There are many, complex risk and protective factors in suicide. Prof. Somerville considers only a single risk factor: one that isn't even on the established list.

^d For good reasons, it is standard practice worldwide to calculate general suicide rates as a percent of population (suicides per 100,000 population), not as a percent of all deaths as Prof. Somerville does. But we'll run with Prof. Somerville's calculations for now.

equivalent data *after* its change. Prof. Somerville only looks at data *after* the change.

Now, changes in the Netherlands are a little complex, because for around twenty years prior to its Euthanasia Act, it actively permitted medically assisted dying by *regulation* rather than *legislation*. (Prof. Somerville can't plead ignorance of this fact: in 1997, in an essay she's since republished multiple times, she expressly refers to "*over twenty-five years of de facto legalization in the Netherlands...*")^e 7, p. 120 So you have to consider data from at least as far back as the 1970s, and earlier if possible.

The full Dutch story

Prof. Somerville says that stories about assisted dying are very important.³ So here's the Dutch one, from 1960 onwards (Figure 3).

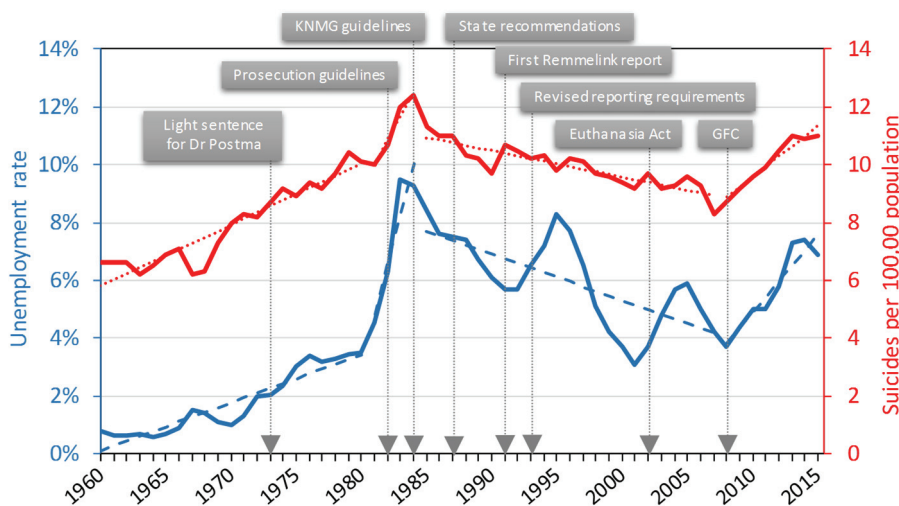


Figure 3: Unemployment, major assisted dying events and general suicide in the Netherlands, 1960–2015

Sources: CBS Statistics Netherlands

Throughout the 1960s and 70s, assisted dying was illegal in the Netherlands. The highest-profile early public coverage of a physician assisted death came with the 1973 prosecution of Dr Postma, a physician who administered a lethal dose of morphine to her mother, paralysed by a cerebral haemorrhage, at her mother's persistent request. Dr Postma was found guilty of manslaughter and given a suspended jail sentence of one week.⁸, p. 51 Throughout this period both unemployment and the general suicide rate rose significantly.

In 1982, after considerable social and legal discussion and further criminal and medical disciplinary cases, the Board of Procurators-General — the most senior prosecutorial authorities in the nation — determined that cases of

^e Prof. Somerville is exaggerating. While there were several controversial court cases about euthanasia in the 1970s, its regulatory practice really commenced in 1984 when the KNMG released guidelines including the justification of necessity and requirements for careful practice.

Dutch euthanasia practice really began in 1984 when the KNMG issued guidelines for doctors.

physician assistance would not be prosecuted provided some general requirements were met. The requirements were not crystal clear for medical practice itself, and the substantive legal grounds were still questionable.^{8, p.61} Both unemployment and the general suicide rate rose substantially.

In 1984, after further high-profile court cases, the Royal Dutch Medical Association (KNMG) published guidelines articulating a justification of necessity and requirements for careful practice, guiding doctors more clearly in assisting patient-requested deaths. This was the point from which an increasing number of doctors felt able to provide assisted dying. As numbers increased, the Dutch parliament commenced an investigation to legalise the practice by statute.^{8, p. 65}

Also during this period, both the unemployment rate and the general suicide rate generally trended downwards, and continued downwards for nearly a quarter century as assisted dying numbers increased.^f

In 1987, the Council of State made further recommendations, and the Government submitted a revised Bill to fully legalise the practice.^{8, p. 75}

In the late 1980s a research Commission was appointed to research and report on physician assisted dying practice. The research Commission tabled its first results in 1991, known commonly as the R Emmelink report.^{8, p. 78} This led the Parliament, in 1993, to legislate a more comprehensive suite of reporting requirements for cases of assistance.^{8, p. 80}

In November 1998, as the annual number of reported cases passed 2,000, five regional Euthanasia Commissions were established to scrutinise every case in detail.¹⁰

Further developments about the principles and details of particular cases continued, culminating in the legislature passing the *Termination of Life on Request and Assisted Suicide (Review Procedures Act)* in 2001.¹¹ The Act came into effect in April 2002.¹² For a further five years, the unemployment and general suicide rates continued to fall.⁸

And then the GFC flared in the second half of 2007. The Netherlands, initially expected to weather the crisis well, was particularly hard hit because certain aspects of its economy which were formally strengths, became substantial weaknesses.¹³ The Dutch economy contracted sharply in 2009, following years of robust growth.⁹ Further, compared with other OECD countries, the

The five regional Euthanasia Commissions were established in late 1998 to scrutinise every reported case.

For nearly a quarter century, as Dutch euthanasia practice increased, the suicide rate decreased: until the global financial crisis.

^f The increase in unemployment in the early 1990s was not the result of retrenchment, but rather an increase of females wishing to enter the labour force: the Netherlands was at the time behind other European countries in female workforce participation. There was also the protective element of an excess supply of credit from 1994 to early 1997, and again between 2003 and early 2008. This would have helped 'soften' economic hardship from transient rises in the unemployment rate in those years. During other periods there was an excess *demand* for credit, particularly strong in 2009.⁹

⁸ Official Government statistics: standardised suicide rates per 100,000 population, not the rate informally calculated by Prof. Somerville.

Netherlands was reluctant to adopt stimulus measures, and those that it did adopt were small and late.^{14, p. 170} Both the unemployment rate and the general suicide rate trended upwards. *This particular date range (from 2008) is the suicide data set that Prof. Somerville used as her ‘proof’ of ‘suicide contagion’ in the Netherlands.*

In statistical terms, variance in the Dutch unemployment rate alone between 1960 and 2015 explains most (80%) of the variance in the Dutch general suicide rate (Pearson’s $r^2 = 0.80$, $p < 0.001$),^h including a long-term downward trend in the general suicide rate in the first nearly quarter century of Dutch assisted dying practice.

Despite this readily-available evidence, Prof. Somerville made no discernible attempt to *test* her own ‘suicide contagion’ theory, instead merely noting an increase in the general suicide rate during the period of the GFC, for which the Netherlands was particularly hard hit, yet attributing the rise in suicides to assisted dying. At the same time, she overlooked her other data showing that the Dutch suicide rate was below the European average in 2013.

The unemployment rate alone explains 80% of the variation in Dutch suicide rates between 1960 and 2015; but Prof. Somerville overlooks it.

Belgium revisited

Now let’s look beyond Prof. Somerville’s single figure for Belgium, and to Belgium’s longitudinal trend data. Given that she had retrieved (some) general suicide trend data for the Netherlands, it’s hard to fathom that she would not have done so for Belgium as well. In any case as it turns out, the Belgian suicide trend data is dramatically unhelpful to her case.

Valid, robust empirical data contradicts claim

Unlike the Netherlands, assisted dying was completely illegal in Belgium prior to its Act, which came into effect in late September 2002.¹² All the online, publicly available government data for unemployment and general suicide in Belgium are presented in Figure 4.

The unemployment rate shows that labour in Belgium, unlike the Netherlands, was unaffected during the GFC. The general suicide rate has substantially dropped since Belgium’s euthanasia Act came into effect.

Indeed, the data indicates that the general suicide rate is decreasing both *faster* than it did before the Act, and *faster* than the fall in unemployment rate since. Comparing the pre- with the post- data, the trends in unemployment and general suicide are statistically similar prior to the Euthanasia Act (1987–2001) ($p < 0.05$), but significantly different after it (2003–2013), ($p = 0.52$). For means, the post- unemployment rate is not significantly different from the pre- unemployment rate ($p = 0.60$), while the post- mean suicide rate is significantly lower than the pre- suicide rate ($p < 0.01$).

Prof. Somerville considers longitudinal data for the Netherlands, but not Belgium. As it turns out, the Belgian data is dramatically unhelpful to her case.

^h All r^2 and p values are calculated using PSPP version 0.10.1.

Robust Belgian data shows the general suicide rate has dropped significantly since its Euthanasia Act came into effect. Does this suggest substitution of violent deaths with physician-assisted deaths for those who qualify?

Prof. Somerville has used arbitrarily differing, invalid methodologies, which have delivered data only favourable to her 'suicide contagion' claim.

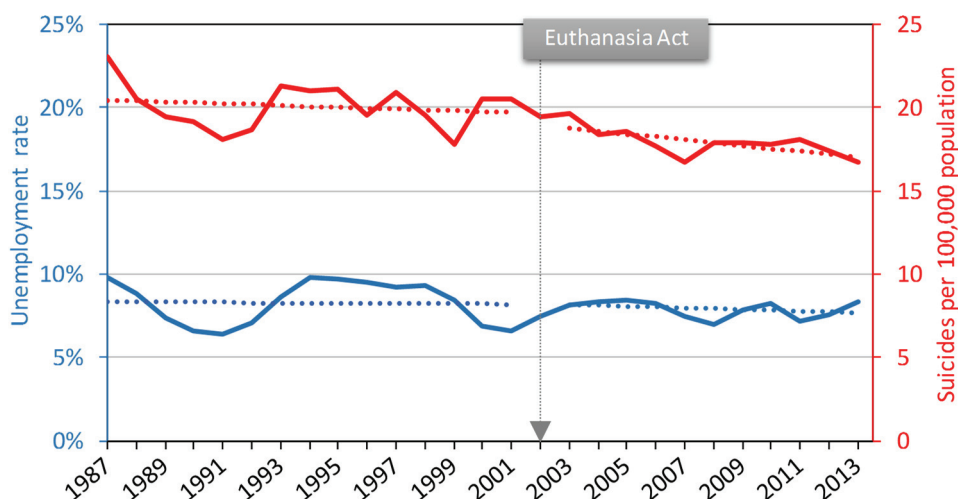


Figure 4: Unemployment and general suicide in Belgium 1987–2013
Sources: OECD Data; Eurostat

The data is heavily at odds with Prof. Somerville's 'suicide contagion' theory. The data may even suggest a substitution of violent suicides with physician-assisted death for some who would qualify under the Act, though further research would be required to confirm such an interpretation.

Arbitrary and invalid methods exposed

In summary, for Belgium Prof. Somerville uses a single data point that seems to support her theory while overlooking robust longitudinal data that clearly contradicts it; yet conversely for the Netherlands, uses a seemingly supportive but invalid subset of longitudinal data while overlooking the equivalent single data point she found with Belgium's, as well as other valid longitudinal data, that contradicts it.

Thus, Prof. Somerville has used arbitrarily differing, invalid methodologies, which have delivered data only favourable to her 'suicide contagion' claim: a serious offence against scholarship. Her claim is directly contradicted by valid empirical evidence.

Muddling terms when it helps

Prof. Somerville says she's very particular about terminology,^{1(Ch. 7)} She defines 'euthanasia' as the administration of lethal medication by one person to another, and 'assisted suicide' as self-administration. Further, when she groups 'euthanasia' and 'assisted suicide' together so as not to laboriously refer to both repeatedly, she groups them as 'euthanasia.' That is, at the start of her arguments she defines her terms as above, and then redefines 'euthanasia' as including 'assisted suicide,' not the other way around.^{e.g. 1(Ch. 7),15}

This is highly relevant because most Belgian (98.0%)¹⁶ and Dutch (94.3%)ⁱ assisted deaths are physician-administered.^j Thus, Prof. Somerville's argument for 'suicide contagion' is further significantly weakened because most individuals using the Act don't 'suicide' according to her own definition: they request and receive 'voluntary euthanasia.'

Therefore, when Prof. Somerville conveniently uses the well-known but erroneous expression 'suicide contagion' for Belgium and the Netherlands, she is actually arguing a case of 'euthanasia contagion'... to the general (non-assisted) suicide rate.

That's a more tenuous argument and suggests either weak logical reasoning, or that Prof. Somerville is unaware that most assisted deaths in Belgium and the Netherlands are not 'suicides' according to her own definition.

'Expert' relying on non-expert sources

That's not the end of it, though.

In her email reply, Prof. Somerville also cited three online blogs as 'proof' of her 'suicide contagion' claim.^k Specifically, she cites three blogs by fellow-Catholic anti-assisted dying lobbyist, Mr Alex Schadenberg. (Mr Schadenberg also liberally cites Prof. Somerville in his blogs.)

This is truly astonishing. Under her academic credentials, Prof. Somerville cites the online opinions of a general lobbyist lacking in relevant scholarly research skills but with whom she agrees, rather than searching for and analysing robust empirical evidence to back her claim.

The three blogs she advanced as 'evidence' are an additional affront to scholarly standards.

Schadenberg blog 1

Her first source is Mr Schadenberg's blog about Theo Boer,¹⁸ a Professor of Healthcare Ethics at a Protestant theological college in the Netherlands, and who is associated with several evangelical Christian associations. When I interviewed Prof. Boer in person in Utrecht in 2012, I found him a thoughtful and engaging fellow.

Nevertheless, Prof. Boer is a self-confirmed sceptic of assisted dying law,¹⁹ and in 2014 changed his mind about the Dutch assisted dying model, from supportive to opposed, in response to the rise in numbers of assisted dying

Prof. Somerville offers no explanation for her 'euthanasia contagion' argument in respect of Belgium and the Netherlands.

It's truly astonishing that an academic would repeatedly cite a lobbyist lacking relevant scholarly research skills as a 'source' to defend her claim.

ⁱ Case data from annual Euthanasia Commission reports.

^j Belgium's Euthanasia Act is just that... a statute which expressly permits euthanasia, but doesn't mention assisted suicide.¹⁷ Nevertheless, because it permits other-person-administration, it is read to include self-administration as well. The Dutch Act expressly permits patient self-administration ('suicide') as well as physician administration ('euthanasia').

^k That includes 'euthanasia contagion': remember that she provided the total assisted death figures for the Netherlands, not just the 'assisted suicide' ones.

Prof. Somerville's first blog citation doesn't provide evidence to support her claim. It merely establishes that two other people (who agree with her) also misunderstood the data.

Prof. Somerville's second blog citation provides no evidence for her claim, either. It's merely a lobbyist quoting another lobbyist's imagination.

cases. He offers no scholarly philosophical explanation (indeed, no explanation at all) as to why he believes it appropriate that 2,000 persons (most of whom have cancer) may choose an assisted death, but 4,000 may not.

Further, in stating as a reason for his change of heart that the Dutch general suicide rate increased by 35% (that's between 2007 and 2013, the period that the Netherlands was hard-hit by the GFC), he committed precisely the same data and logic offences as Prof. Somerville: namely, using a small set of data without looking at the full data set or considering alternative well-known risk factors such as economic distress.

Prof. Somerville's first blog citation therefore doesn't provide evidence to support her claim. It establishes nothing more than she was happy to cite a lobbyist who cited someone who agreed with them, but misunderstood the same way she did.

Schadenberg blog 2

The second blog that she cites is a letter Mr Schadenberg wrote to the press in 2010.²⁰ It's a bizarre piece in which he equates murder-suicide with physician assisted death under Washington (State)'s Death With Dignity Act (DWDA). As 'evidence' for his argument, he cites another blog, no longer available online: but it was a July 2009 opinion piece by Seattle attorney and well-known anti-assisted dying lobbyist, Margaret Dore.²¹ However, Washington's DWDA was passed by ballot in November 2008 and there was no data about assisted deaths at the time of Ms Dore's opinion piece. Ms Dore merely *imagined* potential coercion under the Act.

Steven Pinker, Professor of Psychology at Harvard University has debunked this 'moral intuition' approach, saying that:

"For [slippery slope] hypotheses to justify restrictive laws, they need empirical support. In one's imagination, anything can lead to anything else: Allowing people to skip church can lead to indolence; letting women drive can lead to sexual licentiousness. In a free society, once cannot empower the government to outlaw any behaviour that offends someone just because the offender can pull a hypothetical future injury out of the air."²²

Thus, Prof. Somerville's second citation is a lobbyist's opinion who in turn quoted another lobbyist's opinion about something that the second lobbyist imagined might happen. While it might appeal to Prof. Somerville's 'moral intuition,' it's devoid of actual data and does nothing prove her claim, either.

Schadenberg blog 3

The third blog Prof. Somerville cites is one in which Mr Schadenberg enthuses about an econometric modelling analysis published in an obscure medical

journal.^{1, 23} She also links directly to the journal paper²⁴ in her email, so it's unclear why she cited this Schadenberg blog as well.

Lead author of the modelling analysis is Dr David Jones, Director of the Anscombe Bioethics Centre (formerly the Linacre Centre for Healthcare Ethics) in the UK. The Centre was established by the Catholic Bishops of England and Wales and "*exists to serve the Catholic Church.*"²⁵ His co-author is Prof. David Paton, Chair in Industrial Economics at Nottingham University Business School. Prof. Paton actively supports the Pope's position on sex education in schools,²⁶ and vigorously promotes the Catholic Church.²⁷

While the authors take multiple factors — but miss some important ones, which they acknowledge — into account in their model, it suffers from numerous methodological flaws beyond the scope of this whitepaper (slated for a separate analysis). A SCOPUS search reveals that the study has been cited in the medical literature precisely once since publication: in an editorial about it, published adjacent to the paper itself in the same issue of the same journal.²⁸ The editorial was by Assoc. Prof. Aaron Kheriaty, author of "The Catholic Guide to Depression."

Prof. Kheriaty has widely promoted the Jones and Paton study to the mass media, though his opinion piece about it in The Washington Post²⁹ drew a particularly vigorous rebuttal.³⁰ In contrast, a simple Google search reveals that his editorials have been quoted uncritically online many dozens of times by religious, including Catholic, right-to-life groups.

The modelling study found that when appropriately controlling for state-specific effects (which is mandatory when analysing individual states), there was *no statistically significant correlation* between assisted dying law and the general (non-assisted) suicide rate in the USA states of Oregon and Washington, where physician assisted dying, by patient self-administration, was legalised in 1997 and 2008 respectively.

Therefore, neither the Jones and Paton study, nor Mr Schadenberg's blog of it, furnish evidence to support Prof. Somerville's claim of 'suicide contagion in every jurisdiction.'

None of Mr Schadenberg's three blogs do.

None of the provided sources support Somerville's claim

Thus, *none* of Prof. Somerville's cited sources about Belgium, the Netherlands, Oregon or Washington provide valid empirical evidence to support her claim that "*the general suicide rate has increased in every jurisdiction that has legalized assisted suicide.*" Indeed, some of the empirical evidence contradicts her claim.

*Nor does Prof. Somerville's third blog provide evidence to support her claim. The blog and study she cites found **no statistically significant correlation** between assisted deaths and the general suicide rate.*

Not one of Prof. Somerville's cited sources provided valid empirical evidence to support her claim.

¹ The journal, "The Southern Medical Journal," currently has an official impact factor of 0.9, compared with other journals such as the British Medical Journal (20.0), Lancet (44.0) and the New England Journal of Medicine (59.6).

Similar misinformation from Mr Schadenberg

It's helpful to review Mr Schadenberg's approach to 'evidence' as well, since Prof. Somerville cited three of his blogs. Mr Schadenberg's online profile indicates that he holds a B.A. in History from The University of Western Ontario, but no relevant education or experience in empirical research. His 'methods of analysis' seem remarkably similar to Prof. Somerville's.

Misinformation about Oregon's state rating

For example, in a 2010 blog he relied on mere TV news, rather than primary data, to state that the Oregon suicide rate is "the highest in the United States."³¹

In a similar misinformation case in 2015, a Monsignor of the Catholic Archdiocese of Melbourne testified before a Victorian Parliamentary inquiry that Oregon's suicide rate "is not yet the largest rate in the US, but it's getting there."³²

Both claim a worsening or worst case, and both are evidentially false.

Data from the US Government Center for Disease Control (CDC) shows that Oregon's suicide ranking amongst all states was not the highest since at least 1981, if ever. Further, there was a worsening trend in Oregon's ranking before the DWDA, reversing to an improving trend since the DWDA came into effect (Figure 5). Oregon was among the top ten states for 12 of 16 years immediately prior to the DWDA, but for only 4 of now 18 years since. The difference in trends is approaching statistical significance (ANCOVA2 $p = 0.052$).

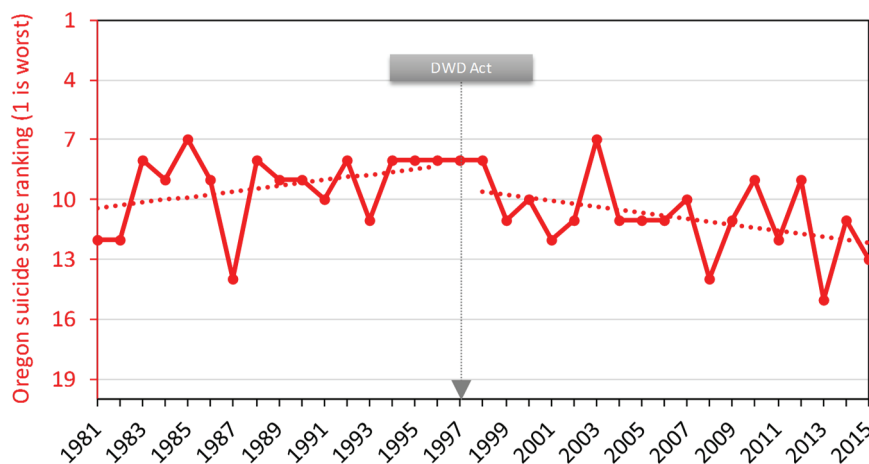


Figure 5: Oregon's suicide rate ranking amongst all states (1 is worst)
Source: CDC Wonder database

Mr Schadenberg reports a claim about Oregon that is evidentially false.

Selective use of individual data points

In another blog, Mr Schadenberg stated that:

“Oregon’s overall suicide rate, which excludes suicide under Oregon’s physician-assisted suicide act,^m is 35 percent above the national average. Moreover, this rate has been increasing significantly since 2000. Just three years prior, in 1997, Oregon legalised physician-assisted suicide. Suicide has thus increased, not decreased with legalization of physician-assisted suicide.”³³

Mr Paul Russell, Catholic publisher of anti-euthanasia blog ‘HOPE’ and who was recruited to the movement by Mr Schadenberg,³⁴ also expressed a similar sentiment:

“In Oregon following the introduction of doctor-assisted suicide, suicide by other methods went up and not down as predicted. This is consistent with suicide contagion or clusters.”³⁵

Given the statement construction, a casual reader would readily assume there were level suicide rates prior to the DWDA, rising from the DWDA’s introduction.

And the same Melbourne Vicar as above testified that:

“We know, for example, since Oregon legislated, that the standard suicide rate has increased remarkably and alarmingly ... when Oregon had a very, very low suicide rate prior to that.”³²

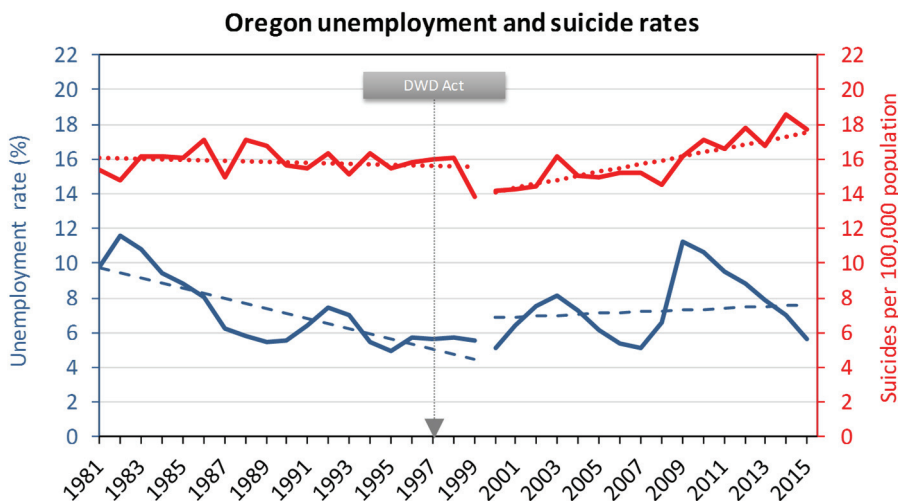


Figure 6: Longitudinal employment and suicide rates in Oregon

Sources: CDC Wonder database, US Bureau of Labor Statistics

^m Oregon does not have a “physician-assisted suicide act.” It has a Death With Dignity Act. It is quite specific about this. The Act itself states that a death under its provision is *not* a suicide — there being major differences between a rational and full informed choice in the face of intolerable and unrelievable end-of-life symptoms, and irrational choices about transient problems.

Mr Schadenberg cherry-picks a single percentage data point, and a subset of longitudinal data, that seem to (but don't) support his 'suicide contagion' argument. Mr Russell does likewise with the longitudinal subset...

...and a Melbourne Vicar makes a false statement about Oregon's suicide rate to a Parliamentary inquiry.

In fact, Oregon's suicide rate was high until 1998, and dropped precipitously in 1999, two years after the DWDA. It is only from this precipitous level that the rate has subsequently increased, following a change of the downward trend in unemployment to upward (Figure 6).

Oregon's unemployment and suicide rates are compared with Oklahoma's in Figure 7. Oklahoma has never had a DWDA, yet otherwise is the USA's most similar state to Oregon. Its state and capital city populations are almost identical, their education levels are both 'moderate,' average household incomes are both 'lower middle class,' and they have similar economic mixes including primary industry, state (Oregon: government, Oklahoma: defence), and professional services. Oklahoma is somewhat more rural overall, and its residents are slightly younger and more religious than in Oregon.ⁿ

In comparison, Oklahoma, the most similar US state to Oregon, had a higher rate of increase in suicides with a lower rise in unemployment than Oregon. It does not have an assisted dying law.

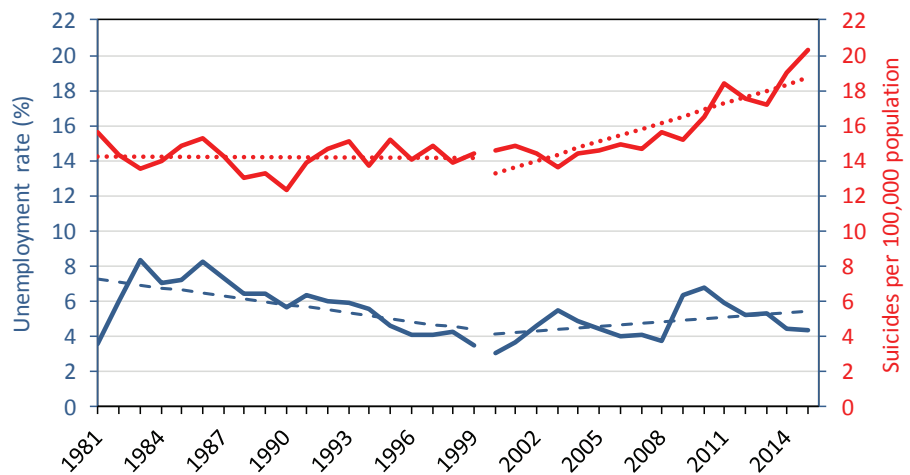


Figure 7: Longitudinal employment and suicide rates in Oklahoma
Sources: CDC Wonder database, Bureau of Labor Statistics

The data shows that trends in Oklahoma's unemployment and suicide rates are similar to Oregon's; *except* that Oklahoma's unemployment rate is overall significantly lower than Oregon's, while suicides since 2000 have climbed faster than in Oregon.

Might the Oklahoma experience suggest a protective effect against suicide of Oregon's DWDA? Given the number of possible risk and protective factors, further detailed research would need to be conducted to reach a conclusion.

Cherry-picking and statistical variation

Mr Schadenberg specifically highlights Oregon's suicide rate for 2013 as 35% above the national average and attributes it to Oregon's DWDA, while he doesn't mention that Oklahoma's suicide rate was 50% above the national average just two years earlier in 2011. Drawing broad conclusions based on a single data point is inappropriate for several reasons, including because the sizes of the test and reference populations are very different.

ⁿ Most data from [Find The Home](#); capital populations from [Best Places](#); urban percentage from [Iowa State University](#); economic mix from [NewsMax](#).

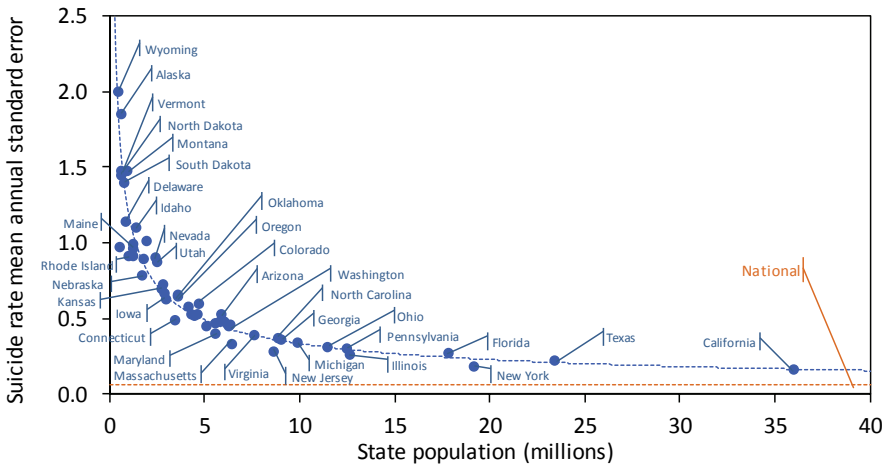


Figure 8: Mean annual standard error of the suicide rate as a function of population size (1999–2003)
 Source: CDC Wonder database

Figure 8 illustrates the degree of statistical variation (standard error of the mean: SEM) in USA national and state suicide data. The smaller the population, the larger the SEM, increasing exponentially as population size decreases. Oregon and Oklahoma’s populations are small, just 1.2% each of the national population, and hence their SEMs are much larger — more than ten times the national SEM.

This statistical variation means that smaller-population state suicide rates *vary* more from year to year than does the national rate. Consequently, a single year’s state comparison with the national average may produce an annual figure that is much higher or lower than the longer-term trend, and therefore potentially misleading.

For example, Figure 9 shows that Vermont’s suicide rate was 44.2% above the national rate in 2011, but only 4.1% above it in 2012, the very next year. (Both these years were prior to its Death With Dignity Act of May 2013.³⁶)

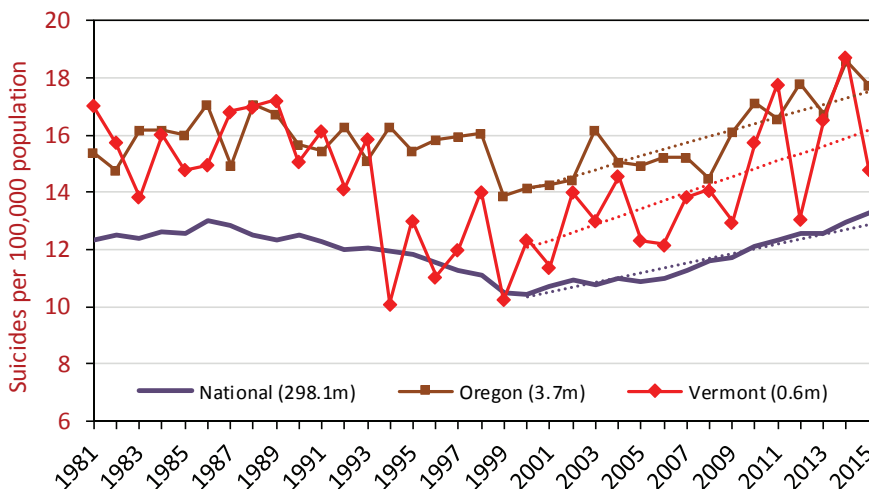


Figure 9: Longitudinal variation in suicide rates — large and small populations compared, with trends since 2000
 Source: CDC Wonder database. Note: (population average for 1999–2003)

In smaller populations like Oregon and Vermont, a single data point can give a misleading picture of the longer-term trend because the variance is much larger than it is for a large population.

Don't mention Switzerland

But perhaps most telling of all is that anti-assisted dying lobbyists, including Prof. Somerville in providing 'sources' for her categorical '*suicide contagion in every jurisdiction*' claim, avoid mentioning Switzerland. For Prof. Somerville that's particularly unscholarly, because that country is a subject of her claim.

Switzerland has the world's oldest assisted suicide law, in effect since 1942. It also has the fewest safeguards of all the assisted dying laws. There are no stipulated conditions for who may qualify for assistance, nor a required process for qualification. There are no specific requirements for reporting assisted deaths to appropriate authorities. Nothing. The law is in fact an exception in Article 115 of the Criminal Code, and says, in its *entirety*:

*"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."*³⁷

That is, the *only* specific requirement as a defence against prosecution for assisting a suicide in Switzerland, is that the assister renders assistance only for non-selfish reasons.

"No possible safeguards" theory

It is fundamental to anti-euthanasia lobbyist argument that no suite of safeguards will ever make an assisted dying law safe. Nevertheless, Prof. Somerville herself, in the face of inevitable law reform in Canada, recommended to the Canadian Parliament that a minimum qualification criterion should be terminal illness with natural death anticipated within four weeks.³⁸

With the Swiss law having no such limit and having been in effect since 1942, the natural consequence according to anti-euthanasia lobbyists is that Switzerland's suicide rate and suicide contagion must be massively higher than anywhere else: utterly out of control.

Switzerland wholly inconsistent with theory

It isn't. Figure 1 shows that in 2013, 72 years after assisted suicide became legal and with only one legal provision, the general suicide rate in Switzerland was moderately higher than the EU average, but lower than many other countries in which assisted dying remains illegal.

Figure 10 shows the general (non-assisted) suicide rate of Switzerland since 1970. The rate rose steadily until the early 1980s. Then, in 1983, two associations were established to provide Swiss residents with an accompanied death: 'assisted suicide' under the law. Exit Deutche Schweiz provides membership and services for German-speaking Swiss residents, and Exit

According to assisted dying opponent 'suicide contagion' theory and the lack of legislated safeguards, Switzerland's suicide rate should be totally out of control. It isn't.

ADMD for French-speaking residents. Neither association provides membership or accompaniment for non-residents.

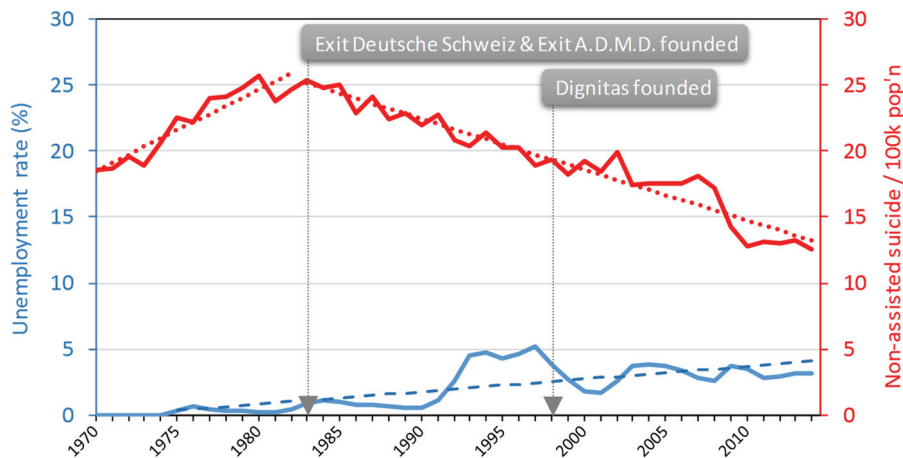


Figure 10: Unemployment and non-assisted suicide rates for Switzerland 1970–2014

Sources: Federal Statistical Office (Switzerland)

In 1998, Dignitas was founded. It provides membership and accompaniment for mostly non-residents, that is, foreigners.

From 1993 onwards, since the two domestic societies were established, the general (non-assisted) suicide rate began, and has continued, a long-term downward trend. The rate continued its downward trend when Dignitas began accompanying foreigner deaths. And this occurred consistently *in the face of a rising unemployment rate*.

While there are complex explanatory factors for suicide rates, the data as it stands very substantially contradicts anti-assisted dying rhetoric about ‘suicide contagion.’

Another case of selective data use

In Jones and Paton’s econometric modelling of possible suicide contagion in Oregon and Washington,²⁴ the authors cite a Swiss statistics office document to report that in Switzerland the range of physical illnesses in general suicides is similar to that reported in assisted suicide cases.³⁹

However, Jones and Paton *don’t* refer to other key data in the report. Figure ‘G7’ of the report is shown in Figure 11.

The data chart shows a careful analysis of general (non-assisted), and assisted suicides (separately) including those of foreigners as well as residents, by the statistics office of Switzerland. This empirical evidence suggests that at the very least there is no suicide contagion, and that there is, possibly, a direct substitution effect from non-assisted to assisted suicide.

Switzerland’s non-assisted suicide rate has been dropping since 1983 when two assisted suicide associations were established.

Prof. Somerville doesn’t mention Swiss data. Jones and Paton cite a Swiss report, but overlook robust data within it that contradicts their ‘suicide contagion’ theory.

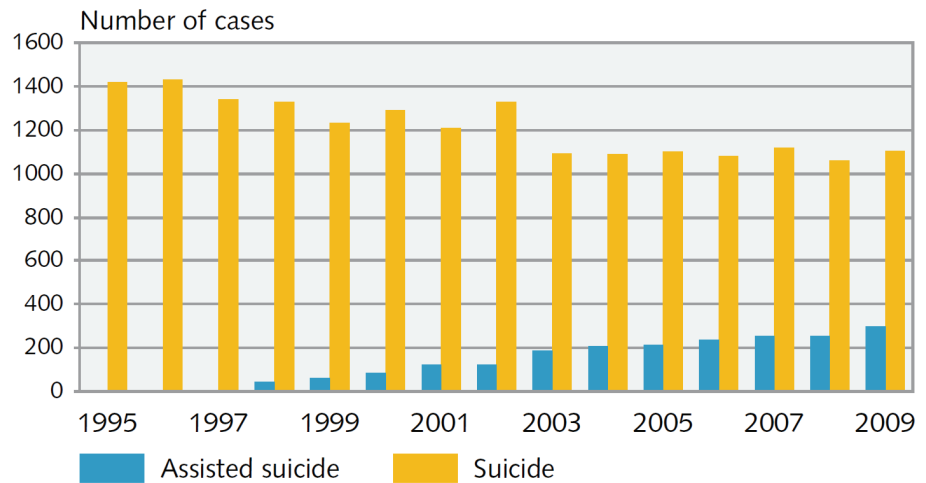


Figure 11: Suicide and assisted suicide cases in Switzerland, 1995-2009
 Source: Federal Statistical Office (Switzerland)³⁹

How was it that three Catholic academics all overlooked robust Swiss evidence contrary to their 'suicide contagion' theory?

The data directly contradicts the 'suicide contagion' proposal that Jones and Paton pursue. They cite the official Swiss document, but don't consider or report this critical empirical evidence within it and of central importance to their investigation.

Neither does Prof. Somerville, while claiming suicide contagion in Switzerland through her universal statement, '*suicide contagion in every jurisdiction.*'

This raises a legitimate question: how was it that three published Catholic academics all pursued a case of 'suicide contagion' theory while overlooking clear and robust evidence at odds with it?

Reluctance to correct or withdraw

Misinformation about suicide contagion by anti-euthanasia campaigners can be difficult to stamp out: campaigners can be reluctant to correct or remove false or misleading information.

For example, in a 2011 public debate with Mr Russell and others at the University of Tasmania, I pointed out Mr Russell's misleading claim about 'suicide contagion' in Oregon and showed the actual data, as it then was, to the audience (Figure 12). I also pointed out a further false statement made by another debate opponent, Mrs Betty Roberts of the Catholic Women's League.

Mr Russell didn't comment on the data, but Mrs Roberts said, "*I'd like to thank Mr Francis for his imaginative graphs.*" Of course, the charts were of empirical evidence, not of imagination ('moral intuition') as Mrs Roberts' and Mr Russell's claims were.

Assisted dying opponents have been historically reluctant to acknowledge, correct or withdraw misinformation.



Figure 12: The University of Tasmania debate teams (above); Presenting the evidence contradicting Mr Russell's claim (below)

Despite clearly having his claim refuted by empirical evidence in public, Mr Russell did not correct or remove the offending blog.

It was not until 2013 when I created a video of the misinformation⁴⁰ and sent it to all members of parliament in South Australia (where Mr Russell lives), and who were at the time debating an assisted dying Bill, that he finally removed the offending blog from his website.

Still, Mr Schadenberg's blog of cherry-picked statistics about 'Oregon suicide contagion' remains online and without correction while Prof. Somerville chooses to cite his various blogs as an 'authoritative' source for her 'suicide contagion' theory.

Mr Russell only withdrew his indefensible 'Oregon suicide contagion' claim when I pointed out its flaws to his own politicians. But Mr Schadenberg's misinformation remains published while Prof. Somerville cites him as an 'authoritative' source of evidence.

Conclusion

Prof. Margaret Somerville has unequivocally claimed that:

"...the general suicide rate has increased in every jurisdiction that has legalized assisted suicide."

Her claim was published with the scholarly by-line, "*Professor of Bioethics in the School of Medicine at the University of Notre Dame Australia.*" The average person would understand the by-line to convey high standards of academic rigour and balance, and therefore be likely to interpret the claim as authoritative. It isn't.

This report documents that in making her claim and in defending it, Prof. Somerville:

- Cites 'supportive' data from lawful jurisdictions while overlooking other data, sometimes even in the same data set, that are inconsistent with her claim;
- Cites as supporting evidence an econometric modelling study that did *not* find a statistically-significant relationship between assisted dying law and the general (non-assisted) suicide rate;
- Fails to consider data from all jurisdictions with assisted suicide laws while making a claim about them all — overlooking Switzerland, whose empirical data is clearly at odds with her claim;
- Repeatedly cites non-academic anti-euthanasia lobbyist Mr Alex Schadenberg (who also cites her) as a source of evidence for her claim and who in turn quotes a television source and another lobbyist's opinion to underpin his own beliefs about 'suicide contagion'; and
- Conflates voluntary euthanasia (physician-administration) with assisted suicide (patient self-administration) such that her argument, at least in the context of Belgium and the Netherlands, is substantially about the novel concept of '*euthanasia* contagion' rather than the more familiar 'suicide contagion' expression she uses.

The empirical evidence is at odds with Prof. Somerville's claim. In some jurisdictions (especially Belgium and Switzerland), the empirical evidence even suggests that lawfully assisted suicide may be substituted for general (non-assisted) suicide for some who qualify for access, though such an interpretation would need to be confirmed via further specific research.

This report also establishes links with other Catholic academics and lobbyists, and others, whose views are strikingly similar to Prof. Somerville's, but equally overlook robust empirical evidence.

I argue that the appropriate course of action for Prof. Somerville is to retract her claim.

Epilogue — No ‘ad hominem’ arguments

For those rightly concerned about ‘ad hominem’ arguments — discrediting of an argument because of who said it rather than what was said — such arguments have been deliberately and properly shunned in this report.

In all cases I have referred to empirical evidence and proper scientific approaches to its analysis as the reasons to reject false and misleading statements.

I have, nevertheless, documented the Catholic affiliation of several persons and institutions making misleading or false claims, or overlooking robust empirical evidence contrary to their theory.

To be clear, a Catholic affiliation is not a substantive reason to reject an argument. The attention I draw to Catholic affiliation in this report is to identify from *where* misstatements about assisted dying largely, though not exclusively, arise.

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