EUTHANASIA WEBSITE MATERIAL

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* denotes work still to be done on these sections

1. Introduction

Euthanasia – the intentional killing of a patient by a doctor – is subject to intense debate in many countries and communities all over the world. Should doctors have the power to kill their patients? Is the right to 'choose' more important than the inalienable right to life? What does "death with dignity" really mean? Is euthanasia a compassionate response to suffering? Can legalised euthanasia be controlled?

Each one of us has our own experiences of death and dying. Many of us have seen someone die, or know of someone who has died, and we all have fears which relate to our experiences. Everyone wants a 'good death'. And the biological fact of life is that we must all die. Many people approaching the end of their life say "I've lived a good life and I'm ready to go". And some people, not only those who are dying, say "I am tired of suffering and I want to die". Not all of these statements are accompanied by a wish to be killed, but some are. What should be our response?

The debate is about the law, and laws have far-reaching effects. Laws reflect society's values, and some of those laws are about the protection of human life. So laws which ban the practices of euthanasia and assisted suicide reflect the long-standing and deeply-held conviction that human life is a great good and its protection is the basis of civilised society.

The euthanasia debate is fraught with misinformation and disinformation. For example, many people think euthanasia is simply about switching off life support machines; this is in fact incorrect (see "What euthanasia isn't").

Sometimes it may seem to the public that they have to choose between suffering a painful death or accepting euthanasia and 'dying with dignity'. This is both deceptive and untrue. The opinions of many people are strongly influenced by their fear of being left to die in unrelieved and unrelievable pain. In fact this fear is unfounded, with modern palliative care being able to relieve pain in almost all circumstances. Others may believe that euthanasia will protect them from being subject to unwanted prolongation of life by heroic medical measures. But competent patients have the legal right to refuse medical treatment. In Britain today, every person has the right to receive the palliative care they need.

Debates on euthanasia often emerge when a loss of community is perceived, and at times when individual rights assume greater importance than social obligations (Foley, 1996). Ultimately, what we decide about euthanasia demonstrates our commitment to the inherent dignity of every single member of our community.

> *"Euthanasia advocates have been seduced by death. They have come to see suicide as a cure for disease and a way of appropriating death's power over the human capacity for control. They have detoured what could be a constructive effort to manage the final phase of life in more varied and individualistic ways onto a dangerous route to nowhere. These are not the attitudes on which to base a nation's compassionate social*

policy. That policy must be based on a larger and more positive concern for people who are terminally ill. It must reflect an expansive determination to relieve their physical pain, to discover the nature of their fears, and to diminish suffering by providing meaningful reassurance of the life that has been lived and is still going on."
(Hendin, 1997: 224)

2. What is euthanasia?

Euthanasia, sometimes called "mercy killing", might mean different things to different people.

The word *euthanasia* is derived from two Greek words which mean "a good death" (*eu*, well, and *thanatos*, death).

In the current debate, euthanasia means *the intentional bringing about of the death of a person, by a direct act or by neglect of reasonable care, out of a motive of compassion.*

It is different from other forms of homicide because it is motivated by compassion. The term is usually used in a medical context, referring to the killing of patients by doctors, often but not always by lethal injection.

2.1 What euthanasia is

Euthanasia is intentional killing. It can be done by a direct act, such as a lethal injection or a deliberately lethal dosage of drugs; this is known as *active euthanasia.* It can also be done by the denial of 'reasonable care', including the basic needs of food and water. This is known as *euthanasia by omission or neglect*, where the patient dies of starvation or dehydration, or by being denied something else which should reasonably be provided to them.

2.2 What euthanasia isn't

Patients have a right to refuse treatment, not only if the patient feels it will not be of benefit, but also if the treatment has "unduly burdensome consequences for the patient" – for example if the treatment is physically or spiritually taxing, or prevents one from achieving certain important goals (Gormally 1995).

A common example of this is cases where a cancer patient refuses chemotherapy. Chemotherapy can potentially prolong the life of the patient, but it can also have extremely unpleasant side effects. If the patient dies, the doctor cannot be accused of killing them by not treating with chemotherapy – it is the cancer that has caused their death. Similarly if a terminally ill and competent patient contracts pneumonia, that person has the right to refuse antibiotic treatment.

Much public support for euthanasia is based on a fear of being forced to remain on a life-support machine, and many people believe that euthanasia is about "switching off machines" (Kortlang, 1995). But a life-support machine is an artificial mechanism. If turned off and the patient dies, it is the underlying disease that causes their death.

A competent patient who expresses a wish to reject all medical treatment, from antibiotics to blood transfusions to life-support machines, has a legal right to do so. This has been clearly accepted as morally and legally permissible, and the issue is not controversial (Ashby, 1997).

2.3 Different categories/types of euthanasia:

Debates about euthanasia often involve the use of emotionally-charged terms such as *mercy killing, death with dignity, deliverance* and so on. It is important to understand the meanings of euthanasia and the various types of euthanasia that people may refer to. But in all types of euthanasia, intentional killing is involved.

It is often thought that these different types of euthanasia can be kept separate from one another in law and practice. However, any kind of euthanasia is based on common ground – a judgment about the value of the life of an individual.

It is also important to remember that euthanasia does not involve the refusal of medical treatment by a competent patient.

2.3.1 Voluntary Euthanasia

Voluntary euthanasia refers to euthanasia in cases where the patient has expressed a wish to be killed.

Many euthanasia advocates prefer to use this term because they believe that voluntary euthanasia can be kept separate from other acts of euthanasia – for example *involuntary* or *non-voluntary euthanasia* (Fleming, slippery slopes).

2.3.2 Non-voluntary Euthanasia

This refers to killing a patient, supposedly in that person's own interests, but where the person is either not in a position to have, or not in a position to express, any view on the matter (Glover, 1977).

This might happen to people who the doctors or relatives think may have "lives worse than death" (Glover, 1977). Examples of this might be babies born with terrible abnormalities, or adults who are senile, blind and deaf, or totally paralysed.

2.3.3 Involuntary Euthanasia

Involuntary euthanasia is a concept that is particularly disturbing to most people. It refers to euthanasia in cases when the patient either did not request death at all, when he or she was in a position to make such a request, or when the patient had specifically rejected euthanasia.

This means the killing of a person, supposedly in that person's own interests, in disregard of that person's own view. Or that person might be killed without taking the trouble to find out their view. The important factor is that the person has the capacity to express wishes, but those wishes are overridden (Glover, 1977).

2.3.4 Assisted Suicide

Assisted suicide refers to the provision of a causative agent (usually a medication, but perhaps for example a carbon monoxide tank or plastic bag) to a patient, with the intention that the patient will use the agent to commit suicide.

Physician-assisted suicide specifically refers to cases where a doctor provides the means for the patient to kill themselves, usually medication.

3. Important concepts to understand:

3.1 The right to life

"Belief in the special worth of human life is at the heart of civilised society. It is the fundamental value on which all others are based, and is the foundation of both law and medical practice" (House of Lords Select Committee on Medical Ethics, 1994).

The International Declaration of Human Rights says:

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world…

Everyone has the right to life, liberty and security of person (Article 3).

Everyone has the right to recognition everywhere as a person before the law (Article 6).

And, according to the European Convention for the Protection of Human Rights and Fundamental Freedoms:

"Everyone's right to life shall be protected by law" (Article 2(1) of the European Convention for the Protection of Human Rights and Fundamental Freedoms).

Every human being in the world has a right to be seen as a ‘person’ before the law. In other words, no-one can decide that any particular human or group of humans are not ‘persons’. Everyone has the right to life, and this right is to be protected by law. And this right to life is *inviolable* – it cannot be taken from you –and *inalienable* – you cannot give it away, it is inseparable from you.

For example, slavery is outlawed all over the world. Nobody can sell you into slavery – but you also do not have the right to sell yourself into slavery, even if you want to.

So even when an individual no longer values their life, it is central to freedom, justice and peace that the law and everybody else continues to value it. Their life cannot be taken or given away, regardless of how they feel about their life. The right to life is the ultimate right. This makes sense for many reasons, one of them being the fact that if you have no life, you can have no other rights.

The most important reason, however, is that if some are allowed to give up their right to life, then the capacity for the State to impartially protect the right to life of others, especially the weak and vulnerable, is gravely compromised.

Some people criticise this concept of the right to life, suggesting it is simply a ploy of the pro-life lobby, and suggesting that it is a violation of people’s rights to ‘choose’:

> *“The premise of their argument is that all human life is sacred, whatever its quality or probably duration, whether it is enjoyed or hated by the person who lives it.”*
> *(Warnock, 2001)*

> *“The ‘right to life’ argument loses some of its intuitive appeal when it becomes clear that what is being advocated is closer to a ‘duty to live’ whether you want it or not.”*
> *(Gavaghan)*

But this concept of the inviolable and inalienable right to life is *central to freedom, justice and peace* in the world. It is the foundation of our laws. Without it, ‘choice’ has no meaning, and no other rights exist.

*3.2 Suicide **

In England there are over 4000 deaths from suicide each year (Department of Health, 1999). Suicide is associated with poverty and adverse social circumstances; there is a strong correlation with poor housing low income and mental illness. Adults who are separated, divorced, or have experienced a major loss such as the death of a loved one are at increased risk. And there is evidence that having access to a means of committing suicide – such as firearms or poison – increases risk of suicide.

Suicide is no longer considered a crime in most societies. Therefore a person who attempts suicide will be offered help rather than a jail term. But helping or causing a person to die is a crime even though that person may wish to die.

As the basis of justice in most societies, all people are considered to have equal value before the law, simply because they are humans. This ensures that justice is not dealt out arbitrarily. Suicide prevention programmes are put in place by governments because every life is valued, not simply those who are economically productive, attractive or useful to society. Life and health are good things in themselves, not merely conditions for pursuing other things (Grisez, 1997).

3.3 Eugenics

The term *eugenics* was coined in 1883 by an English scientist, Francis Galton, a cousin of Charles Darwin. The word originated from Greek words, meaning "good in birth" or "noble in heredity". Galton used it to refer to the 'science' of improving human stock by "getting rid of the 'undesirables' and by multiplying the 'desirables'" (Reich, 1995). 'Desirables' included for example people of Nordic descent and those from wealthy families; 'undesirables' included criminals, the mentally deficient, people with disabilities, and those of other races.

After the turn of the twentieth century, eugenics movements appeared in many countries, particularly Britain, Germany and the USA. The social policies that developed as a result of the eugenics movement included restrictive laws about marriage (e.g. between races), forced sterilisation (e.g. of 'imbeciles'), and in Germany, involuntary euthanasia of "the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans" (Alexander, 1949).

After the horrific events of World War II, and the worldwide rejection of extreme Nazi eugenic techniques, most distanced themselves from traditional eugenics. But the theory and the practice of eugenics is still very much alive today. It can be seen in the 'search and destroy' techniques of amniocentesis and genetic testing, followed by abortion for unborn children with defects or disabilities. And it can be seen in the suggestion of euthanasia as a 'right' or even a 'duty' for the very old and ill, or severely disabled people, often expressed as a concern for their quality of life.

3.4 The principle of double effect

Any act has more than one effect. Firstly it has the effect that we want it to achieve. It also has effects which are foreseen but not desired.

Pain-controlling medication is a central component of good palliative care (care aimed at principally at the alleviation of pain, not curing). Some powerful pain-killers, for example morphine, have side-effects such as respiratory depression which some believe may shorten the life of the patient. Euthanasia supporters often exaggerate the side effects of painkillers to suggest that doctors cannot relieve pain without shortening life. However a recent review of palliative care literature shows that pain killers *very rarely hasten death* (Brownstein, 2001).

All medications have side-effects. The important question that a doctor must ask is this: are the side-effects *proportionate* to the benefits of the medication? For example if you had a toothache, your doctor would not give you a drug that would kill the pain but also severely damage your liver. A toothache usually isn't that bad, and certainly not life-threatening, and the doctor could not justify that course of action.

The reason the doctor prescribes morphine is to control the pain. But every medication has side effects, in this case the possibility of depressing breathing. Since the side effect is not intended, and is unlikely to occur at all, then the side effect may be regarded as a reasonable risk to take. Ethically, the principle involved here is the *principle of double effect*, an ethical principle long accepted by doctors, the law, and other professionals.

The principle of double effect defends as morally and legally acceptable the right of doctors to prescribe treatments for a good purpose (e.g. to relieve pain) even if there may be the risk of shortening life. The most simple way to understand the principle is that *what brings about death is not done in order to cause it* (Gormally, 1995).

Euthanasia supporters often argue that the doctor's intention doesn't matter, and that it is only the outcome that is important. This would mean that if a doctor shortens a patient's life with morphine with the intention to kill the patient, he is no more guilty than the doctor who merely wished to relieve a patient's pain.

This is clearly wrong when we consider that a crucial aspect of systems of justice is that courts try to find out what the accused person's *intention* was. For example if a man is killed when hit by a car, the driver may have accidentally hit the man, or he may have been drunk and therefore driving without due care, or he may have intentionally driven into him. Finding out the intention is of central importance when determining guilt, not only in a court of law but in any ethics worthy of the name.

The principle of *double effect* is especially important in the field of medicine because so many medications and treatments have more than one effect on a patient, and doctors must weigh up these effects. To do away with this ethical principle would place doctors in a very difficult position when caring for any patient, but particularly when caring for the terminally ill.

3.5 Intention vs motive

To fully understand the euthanasia debate, we need to understand the difference between *intention* and *motive*.

Intention is what you intend to achieve. *Motive* is the reason behind your intention to achieve this. This difference is important for both the doctor and the patient.

What about the person who wants to commit suicide? If their intention is to die, what is their motive? They may wish to be relieved of mental or physical suffering. They may feel that nobody cares if they are dead or alive, so they feel their life is not worth living. They may see no other way out of a terrible financial situation. If they did not have those problems to deal with, they would not want to be dead.

Similarly the motives of people who ask to be killed must be considered. "Many people with incurable diseases who ask a health-care provider to end their lives do so more as an expression of fear, helplessness or hopelessness than as a serious request for euthanasia" (Cole, 2000). Very frequently, it is reassurance of their continuing worth as a person that is the real reason for patients suggesting that they would be better off dead (Gilbert, 1996).

> *"If the motives of mercy killers are examined, their claim that they did it for the sake of the victim cannot easily be accepted. The real motive may well be that the relative did not want to accept the responsibility of helping the dying person to the end. Often the killer says, "I loved my mother, I couldn't bear to see her suffer!" It is true in such a case that the killer could not bear to see her suffer, but the quality of that love is not so certain."*
>
> *(Ashley & O'Rourke, 1982).*

The authors of a report on euthanasia in the Netherlands in 1991 suggested that no doctor performing euthanasia solely intends to kill – he is always trying to relieve suffering. But, as English academic John Keown points out, "if an heir kills his rich father by slipping a lethal poison into his tea, would they deny that this was murder on the ground that the heir's intention was not to kill and 'can always be described as' trying to accelerate his inheritance?" (Keown, 1995).

What about the doctor who is caring for a dying or suffering patient? If the doctor *intends* to kill the patient, what is the *motive* behind that act? The doctor may claim that the motive was to end the patient's suffering. However the doctor has in fact made a value judgment about that patient, and is motivated by that judgment that the patient's life is no longer worth living. Perhaps the doctor has decided that he himself would not want to live in that state, so death is in the patient's best interests.

Consider also the Nazi practice of euthanasia. They wanted to relieve society of the 'human ballast and enormous economic burden' of caring for the mentally ill, the handicapped, retarded and deformed children, and the incurably ill. But they justified the killing of such human beings by saying that their lives were 'not worth living' and were 'devoid of value' (Gormally, 1995).

3.6 Compassion

People who oppose euthanasia are, strangely, often accused of lacking compassion. Those in favour of euthanasia believe that euthanasia is a compassionate response to suffering. But is it really?

To have *compassion* is defined as "to suffer together with another; to feel pity, to feel sympathy" (Oxford English Dictionary).

> *"Compassion is a curious word. We tend to consider it a virtue, and it would seem to follow that anything done out of compassion must be good. Yet the dictionary defines compassion not as a virtue but as an emotion, a feeling. Plainly it is a feeling which often leads to virtuous conduct, but it may not. The moral framework of someone overcome with compassion may be evil, or there may be misunderstanding of the situation which has evoked compassion.*
>
> *Examples could be multiplied. Granny comforts the little boy with sweets when she finds him crying. Yet in so doing (knowingly or not) she undermines the authority of his mother, since he is crying precisely because she has refused to give him any. Relief workers in situations of famine have always to balance the need for food aid against the danger of creating a culture of dependence and ensuring long-term disaster. The bank clerk turns to fraud to provide for his widowed mother…*
>
> *So while compassion may suggest a course of action, it does not free us from the need to assess it on the basis of moral principle… in itself, it fails to offer a moral account of an action under scrutiny."*
> *(Cameron, 1991: 133)*

In other words, compassion cannot by itself justify a course of action, because it is emotional. The appropriate response is not to judge patients' quality of life from our point of view, and to kill them, even if they wish for death. The decisions that doctors and governments make should fundamentally be formed by ethical principles and not by compassion alone.

Compassion is a good thing – it led to the hospice and palliative care movements - but it emotional and must be constrained by reasoning. Health care professionals and policy-makers are in fact required not to act purely on their feelings of compassion; instead they must use reason to guide their actions.

> *"Compassion is the virtue of being moved to action by the sight of suffering – that is to say, by the infringement of passive freedoms. It is a virtue that circumvents thought, since it presupposes us immediately to action. It is a virtue that presupposes that an answer has already been found to the question 'What needs to be done?', a virtue of motivation rather than of reasoning."*
> *(O'Donovan, 1984)*

3.7 Suffering

Suffering is central to the euthanasia debate. Most people would say that society should not let people suffer unnecessarily.

But many people in favour of euthanasia suggest that the debate is about the sanctity of life *versus* the relief of suffering. This implies that doctors have a duty to relieve suffering which they cannot achieve unless they give up the concept of the sanctity of every human life.

But whose suffering do we seek to relieve? Suffering is *not limited to the patient*. Families, loved ones and professional caregivers also suffer, and in fact “the perceived distress in any one of these groups amplifies the distress of the others.” (Foley). When a person is suffering, their relatives, loved ones, and carers have compassion *(link to compassion page)* for them. This means that they not only feel sorry for their seriously sick loved one, but that they themselves really experience that suffering too. The doctor may also feel that suffering.

There is a danger here. Sometimes we imagine that the patient is suffering more intensely than they really are. Sometimes, when we suffer at seeing or imagining the extent of their suffering, we transfer our own suffering onto the patient. When that occurs, we may mistake a desire to put the patient out of his or her suffering, for putting the patient out of *my* suffering, or to end *my suffering* by ending the life of the patient.

The experience of compassion also relies on the onlooker’s perception of the one who is suffering. A palliative care specialist says “the hospice experience generally is that quality of life which seems completely inadequate to the healthy onlooker is in fact almost always valued highly and clung to tenaciously” (Gilbert, 1996). It is also said by a psychiatrist that “most onlookers rate the quality of life of the ill person substantially more poorly than the patient does, such perceptions predisposing them to a similar fear of loss of dignity” (Kissane, 2000).

There are many aspects of suffering. Common reasons for distress in the palliative care setting include emotional, physical, spiritual, family or social (e.g. housing) problems. Most physical symptoms can be fairly effectively improved in palliative care, but there are other real and difficult issues that many doctors must deal with. Patients as well as their families may express anguish, despair and dread (Kissane, 2000). Doctors must respond to these feelings, as well as to feelings of physical pain, perhaps by seeking the help of other specialists. Otherwise, care for the dying is incomplete.

We must take suffering seriously. Indeed one of the central roles of medicine is the relief of suffering. But there are many elements, and many people, involved in suffering. It is complex and subjective. This requires that ‘compassion’ for the patient’s suffering must not be the ultimate guide to decision-making. We should not let the ‘relief of suffering’ become a smokescreen for easy ethical options (Cameron, 1991: 134).

3.8 Palliative care

Palliative care is about the palliation, or the alleviation, of pain and other distressing symptoms. The term is frequently, but not always, used in the context of dying.

"Palliative care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain… is paramount. Palliative care affirms life… [and] neither hastens nor postpones death."
(WHO, 1990)

Palliative care:

- affirms life and regards dying as a normal process
- neither hastens nor postpones death
- offers a support system to help patients live as actively as possible until death
- provides relief from pain and distressing symptoms
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help those close to the patient cope both during the patient's illness and in their own bereavement
- (Gormally 1999, Gilbert 1996; from WHO, 1990)

Palliative care is a branch of medicine which has developed recently, and which is still not a core aspect of training for doctors (Hendin, 1997). So many doctors, unless they are palliative care specialists, misunderstand palliative care and are ill-equipped to provide it to their patients. Little wonder then that the public also has many misunderstandings about care at the end of life.

For example, many people believe that euthanasia is necessary because the end of life will be a drawn-out period of extreme pain where doctors will continue to prolong life artificially. However, competent patients have a legal as well as a moral right to refuse treatment. Furthermore, modern medicine is extremely effective in controlling pain, and the aim of palliative care is not to hasten nor postpone death, but to care and comfort.

Some advocates of euthanasia create confusion for the public and for doctors in the area of palliative care. It is common to hear pro-euthanasia voices claiming that since many patients receive high doses of opioids and sedatives in palliative care to control pain, and since these drugs can sometimes hasten death, there is no difference between the doctor who aims to control pain and the doctor who aims to kill (Brownstein, 2001). Some also claim that since doctors can decide to stop giving a patient treatment that is burdensome or futile, thereby allowing the patient to die naturally, there is no reason why doctors cannot also actively cause the death of the patient by lethal injection (Ashby, 1997).

This creates confusion about the role of doctors and the expectations of patients. In fact "many doctors still believe that they are causing or hastening the death of patients by this process, despite an extensive and sustained international campaign by the World Health Organisation and a lack of any evidence to support this" (Ashby, 1997).

Confusing killing with the relief of pain is also a strategy used to argue for legalisation of euthanasia. As noted above, many doctors wrongly believe they have shortened a patient's life when their intention was to relieve pain. So when research shows that there is a high incidence of medical decisions at the end of life which supposedly cause death (e.g. Kuhse *et al*, 1997), it is misusing doctors' beliefs about the secondary effects of pain-relief medication, and it is confusing outcome with intention. Such research is intended to show that it is common for doctors to knowingly kill their patients, and therefore euthanasia must be legalised and regulated in medical practice. This distorts the role of the doctor and perpetuates confusion.

In the Netherlands, where euthanasia is effectively legal, care for the dying leaves much to be desired. In a government-sponsored report on euthanasia, Dutch doctors said that palliative treatment in 77% of cases was not preventing intolerable suffering, so euthanasia was seen as the only alternative since palliative care was so ineffectual. Yet 40% of Dutch doctors agreed with the statement that “adequate alleviation of pain and/or symptoms and personal care of the dying patient make euthanasia unnecessary” (Keown, 1995).

Palliative care is the appropriate response to the dying in a civilised society. Certainly, developed countries have little excuse to fail to provide this service. If good care is not available for the dying, and the elderly and terminally ill are left to suffer, the option of euthanasia cannot be said to be a ‘free choice’.

An experienced English palliative care specialist writes the following:

> *The organisation for which I work contributes to the care of 700 people per year and each one is dying from an incurable progressive disease. It is very widely known that no-one in the district with palliative care needs, be they intractable pain or other physical symptoms, psychological distress or spiritual suffering, will be refused help. Almost always hospice admission can be arranged on the day of request and never with more than a few days’ delay. Despite this close involvement with the very patients for whom euthanasia is advocated we do not encounter any persistent rational demand. I am aware that this statement will surprise many people and that it may be disbelieved. Certainly the subject is not avoided in palliative care. The wish for ‘it all to be over’ is sometimes expressed and, more rarely, ‘if I was a dog you would put me down’. When sensitively explored, however, such expressions of distress have never amounted in our experience to a clear repeated request to have a lethal injection administered. (Gilbert, 1996)*

Killing has no part in palliative care. If the public is concerned and fearful about the end of life, about terminal illness and the process of dying, these concerns and fears need to be addressed by improving palliative care services and by providing information to the public.

4. Some history:

4.1 Greece (Hippocrates)

> *"I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them. I will not give poison to anyone though asked to do so, nor will I suggest such a plan… But in purity and in holiness I will guard my life and my art."*
> *(excerpt from the Hippocratic Oath)*

The Hippocratic Oath *(link)* is variously dated between 600 and 100 BC. It is thought that a physician called Hippocrates wrote the Oath and formed a medical school around this distinctive set of ethical principles.

The Oath did not represent the general ethical approach to medicine in ancient Greece at the time it was written. It was controversial (Edelstein, cited in Cameron, 1991). But the Oath and its principles were eventually widely accepted within the Greek medical community, before being spread around the Graeco-Roman world along with Greek medical practice (Cameron, 1991).

Suicide was common and socially acceptable in ancient Greece, and taking poison was the most common means of achieving it. The physician was asked to assist. But the Hippocratic physician rejected this approach to sickness and death. Even though asked to do so, he would not prescribe poison nor ever suggest it, even as a way of resolving the dreadful dilemma of chronic and terminal disease (Cameron, 1991).

Hippocratic medicine is about healing and not harming. The famous medical principle *primum non nocere* (first, or above all, do no harm) is not found in the Oath itself but elsewhere in the body of Hippocratic writing. The prohibition of medical harm, more than anything else, sets the Hippocratic practice apart from that of any other kind of medicine (Cameron, 1991: 60).

Modern Western medical ethics has carried the central ethic of the Hippocratic Oath into the twenty-first century. This core principle of the Oath is the doctor's pledge to do what he or she thinks will benefit the patient, and therefore to do them no harm. This principle is picked up in the Declaration of Geneva (often called the Modern Hippocratic Oath), where the physician swears, "The health of my patient will be my first consideration… I will maintain the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge contrary to the laws of humanity". The International Code of Medical Ethics of the World Medical Association (WMA) says, "A physician shall owe his patients complete loyalty and all the resources of his science". Similarly the postcommunist Russian Oath, the Solemn Oath of a Physician of Russia, has the doctor pledge to work always for the patient's good (Reich, 1995).

The distinctive principles of medicine are therefore to do no harm, to respect human life, and to ensure that the health of the patient is the primary consideration. What happens when doctors abandon these distinctive principles? They put at risk their patients and their profession, as well as their moral integrity.

> *"Once freed from the Hippocratic obligation to confine his role to healing, the physician is fatally compromised. The idea that his freedom to take an open-ended view of his patient's interests can serve those*

> *interests better, since he is freed from a narrow obligation to heal and not to harm, is illusory. His freedom in fact exposes him to competing pressures from which the Hippocratic commitment preserved him. The more diverse the range of moral options, the more complex the decisions he faces, the more unpredictable their outcome…*
>
> *The tradition of healing and the sanctity of life is giving place to another, in which a malleable notion of respect does duty for sanctity, and healing itself is displaced by the 'relief of suffering' as the chief goal of the medical enterprise, all in the service of an undefined 'compassion'. While such a goal may be best realised by healing, it may not. Suffering may be best relieved by acting or failing to act so as to bring about the death of the patient. Human life may be 'respected' by being deliberately brought to a close. These are the radically new options being taken up in contemporary medicine." (Cameron, 1991: pg 132)*

4.2 Nazi Germany

After the atrocities of World War II in Nazi Germany, the nations of the world came together to agree that such things should never happen again. Many atrocities were committed by members of the medical profession, and the Declaration of Geneva (Physician's Oath) *(link)* was written to reinforce the traditional role of doctors as healers.

Many people do not realise that what ended in the 1940s in the gas chambers had far more humble beginnings in the 1930s, in nursing homes, geriatric institutions and psychiatric hospitals all over Germany. The tragedy of Nazi medicine was not only what happened in the concentration camps. The point at which it departed from the humane tradition of Western medicine was in its euthanasia programs. Euthanasia was an integral part of medicine in Nazi Germany (Cameron, 1991).

This practice of euthanasia grew from the eugenics movement, which was influential in Western medical circles from the end of the 19th Century. The German government wanted to rid society of the 'human ballast and enormous economic burden' of care for the mentally ill, handicapped, retarded and deformed children, and the incurably ill. But the reason they used to justify killing such people was that their lives were 'not worth living', or were 'devoid of value'." (Gormally, 1995)

How did this end in the extermination of millions of Jews and others in concentration camps? Leo Alexander, a psychiatrist who worked with the Office of the Chief of Counsel for War Crimes at Nuremberg, described the process in the New England Medical Journal in July 1949:

> *"The beginnings at first were merely a subtle shift in emphasis in the basic attitude of physicians. It started with the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be*

> *included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans.”*
> *(Leo Alexander)*

Propaganda was used in the 1930s to persuade the public to accept the euthanasia program:

> *“Adults were propagandized by motion pictures, one of which, entitled ‘I Accuse’ deals entirely with euthanasia. This film depicts the life history of a woman suffering from multiple sclerosis; in it her husband, a doctor, finally kills her to the accompaniment of soft piano music rendered by a sympathetic colleague in an adjoining room. Acceptance of this ideology was implanted even in the children. A widely-used high-school mathematics text… includes problems stated in distorted terms of the cost of caring for and rehabilitating the chronically sick and crippled.”*
> *(Leo Alexander, cited in Cameron, 1991).*

Those who advocate the legalisation of *voluntary euthanasia* deny that what they campaign for has any connection with the Nazi practice of euthanasia. But this is not an “accident of linguistic association”. Rather, the two are intrinsically linked (Gormally, 1995).

Certainly, at first glance Nazi euthanasia seems much more horrifying than the type proposed today. This is because in retrospect we can see it in its fully developed form, at the point where some people had the power to decide that other people’s lives were worthless and could kill them. The world will probably never see euthanasia practiced as racial discrimination; however modern euthanasia movements discriminate against other classes of people – for example the elderly and the disabled. All forms of euthanasia have a common heart – that of deciding that some people’s lives are of less value than others. This is why voluntary euthanasia can never be separated from involuntary and non-voluntary euthanasia.

Add link to JIF’s opinion piece on Nazi euthanasia:
Projects/Bioethics Research Notes/Content/Opinion Pieces/1201 op.doc
What text should accompany the link?

4.3 The Netherlands

> *“The depenalisation of intentional killing by physicians constitutes, in itself, a serious violation of the legal protection of the life of all citizens.”*
> *(Jochemsen, 2001)*

Those who advocate legalisation of voluntary euthanasia often cite the Netherlands as the test case which proves that it can ‘work’. However the evidence, provided by the Netherlands itself, confirms the fears of those who oppose euthanasia. The main concern is that the legalisation of voluntary euthanasia has given rise to a significant practice of non-voluntary euthanasia – sometimes called a “slippery slope”.

What is the evidence, and why would the Netherlands be on a “slippery slope”?

4.3.1 Euthanasia and the law in the Netherlands

Euthanasia is now legal, according to the Dutch Penal Code. Previously it was technically illegal, but legally tolerated. For example, in 1984 the Dutch Supreme Court decided that a doctor may be justified in killing a patient in certain circumstances. That same year, the Royal Dutch Medical Association issued euthanasia guidelines to its members. Since then, thousands of Dutch people have had their lives intentionally ended by doctors.

The central requirement in the Netherlands for euthanasia to occur is a free and explicit request from the patient. The justification for euthanasia is typically ‘relief of suffering’ (Capron, 1992).

Lower courts have specified the conditions required for doctors to justify euthanasia:

1. The request for euthanasia must come only from the patient and must be entirely free and voluntary.
2. The patient’s request must be well-considered, durable and persistent.
3. The patient must be experiencing intolerable (not necessarily physical) suffering, with no prospect for improvement.
4. Euthanasia must be a last resort. Other alternatives to alleviate the patient’s situation must have been considered and found wanting.
5. Euthanasia must be performed by a physician.
6. The physician must consult with an independent colleague who has experience in this field.

It is crucial to understand that the Dutch definition of euthanasia is different to the usual definition. ‘Euthanasia’ to the Dutch only refers to ending the life of a person *if they explicitly request it*. If a life is ended without a request, they do not consider it to be euthanasia. Elsewhere, this is called ‘non-voluntary euthanasia’ – but the Dutch find this term disturbing (Hendin, 1997), perhaps because it undermines their confidence in the practice of euthanasia.

There is no requirement for the patient to be terminally ill. Furthermore, euthanasia is allowed for young people aged 12 to 16 if they and their parents agree, and 16-17-year-olds are allowed to make their own decision about euthanasia. The patient does not have to be a Dutch resident to receive euthanasia.

There is evidence to strongly suggest that the euthanasia guidelines are not being followed in the Netherlands, and one of these is the requirement to report all cases of euthanasia. In an attempt to remedy this, laws in the Netherlands now require that doctors must report any cases of euthanasia to a regional euthanasia review committee, consisting of a doctor, a lawyer and an ethicist. The committee’s opinion is sent to the public prosecutor. The Dutch government hopes that this new system will make sure more cases are reported. However, a report of the first year of this new system has not resulted in a significant increase in the number of reported cases. And ultimately all reported cases of euthanasia were approved by the committee (Jochemsen, 2001).

The English language text of the Act can be found at www.minjust.nl:8080/a_beleid/fact/suicide.htm.

4.3.2 Are the guidelines being followed?

4.3.2.1 The requirements for euthanasia

The requirements for euthanasia were specified by Dutch courts:

1. The request for euthanasia must come only from the patient and must be entirely free and voluntary.
2. The patient's request must be well-considered, durable and persistent.
3. The patient must be experiencing intolerable (not necessarily physical) suffering, with no prospect for improvement.
4. Euthanasia must be a last resort. Other alternatives to alleviate the patient's situation must have been considered and found wanting.
5. Euthanasia must be performed by a physician.
6. The physician must consult with an independent colleague who has experience in this field.

At first glance, a reader may perhaps feel that these guidelines are sufficient safeguards to ensure that euthanasia is well-regulated and controlled. But are these guidelines being followed? The evidence suggests strongly that they are not.

4.3.2.2 A 'free and voluntary' explicit request

The first two requirements are that the request must be "entirely free and voluntary" as well as "well-considered, durable and persistent". In a government-sponsored 1990 report from the Netherlands, doctors stated that in the 2700 cases of 'euthanasia' there was an "explicit request" in 96%, "wholly made by the patient" in 99%, and "repeated" in 94%.

Interestingly, the survey did not include a question about the voluntariness of the request, and there was no evidence of a mechanism to ensure the request was voluntary. The request was spoken only (not written) in 60% of cases.

A startling finding of the survey was that there were actually 10 558 cases in which a doctor gave medication, or withdrew treatment, with the *primary purpose* of hastening the death of the patient. In 52% of these cases there was *no explicit request from the patient* (Keown, 1995). These cases were not reported as 'euthanasia' because they did not fit the Dutch definition of having an explicit request from the patient.

4.3.2.3 A ‘last resort’ for ‘intolerable suffering’ with ‘no prospect for improvement’

The fourth requirement specifies that euthanasia must be a ‘last resort’. In the report of euthanasia in 1990, doctors said that treatment alternatives remained in 21% of euthanasia cases, but that these were refused by the patient (Keown, 1995). A 1995 survey showed that in 17% of the cases of euthanasia and of life termination without explicit request the doctor still saw other medical possibilities to alleviate the suffering, but nevertheless the patient’s life was intentionally ended (Jochemsen, 2001). Patients who were not presented with alternatives did not always get a second opinion; one third of GPs who decided there were no alternatives had not sought advice from a colleague (Keown, 1995).

The fear that one might experience ‘intolerable suffering’ at the end of life is perhaps one of the strongest motivating factors for people who support euthanasia. ‘Intolerable suffering’ must be present to justify euthanasia in the Netherlands. However these concepts are open to subjective interpretation; there are no precise medical guidelines for assessing this in a patient.

The Lancet (van der Maas *et al*, 1991) documented the most common reasons given by patients requesting euthanasia in the Netherlands in 1990: loss of dignity was mentioned by 57%, pain by 46%, unworthy dying 46%, being dependent on others 33%, tiredness of life 23%. In only ten of 187 cases pain was the only reason given – 5.3%.

Of course ‘suffering’ includes much more than pain. But is there really no prospect of improvement? What if extra social support, or counselling for patient and family, were to be provided? What if the patient is depressed? Although the disease itself may be untreatable, depression certainly is, and in many cases it is the depression which makes people want to die (Balch & O’Bannon). In fact it is essential that depression be treated before a request for euthanasia is even considered; there is no such thing as “free choice” if the patient is “choosing from under a cloud of depression-induced despair” (Cohen, 1998).

There is also evidence that the requirement for “intolerable suffering” may be considered more important by doctors than the requirement for a free and voluntary request for euthanasia. This would help explain some of the killings where the patient did not request to die.

In the 1000 cases where a lethal drug was administered without request, some of the patients were competent (able to express their own wishes). The government-commissioned report said that these acts “must be prevented in future” – but it *defends* other cases of unrequested killing, saying “active intervention” by the doctor was usually “inevitable” because of the patient’s “death agony”, and regards these cases as “care for the dying”. So the ultimate justification in many of these cases was “unbearable suffering” - and *not* an explicit request (Keown, 1995).

4.3.2.4 A second opinion

The final requirement is that the doctor must consult a colleague. In 1990, doctors stated that they consulted a colleague in 84% of euthanasia and assisted suicide cases. There was no explanation of the substance or outcome of these consultations.

Furthermore, in the 1000 acts of termination without request, only 48% of doctors consulted a colleague. This is not surprising, since 40% of GPs said in the survey that they thought consultation of a colleague was not very important (Keown, 1995).

4.3.2.5 Reporting to authorities

A central aspect of the euthanasia law in the Netherlands is that each case must be reported, and recorded as euthanasia on the death certificate.

But a 1995 survey (van der Maas *et al*, 1996) of end-of-life decisions by Dutch doctors showed that only 44% of euthanasia cases were reported (18% in the equivalent 1990 study), and virtually no cases of life termination without request were reported.

And the 1990 survey (van der Maas *et al,* 1991) showed that in 72% of euthanasia cases the doctor certified that death was due to "natural causes". So not only did these doctors fail to comply with the guidelines; they also committed a criminal offence by falsifying a death certificate. The three most common reasons given by doctors for falsifying death certificates were the "fuss" of a legal investigation (55%), the desire to protect relatives from judicial inquiry (52%), and a fear of prosecution (25%) (Keown, 1995).

Importantly the survey showed 1000 cases in which a lethal drug was administered *without request.* These cases were not reported as 'euthanasia' since they did not have the patient's explicit request. In virtually all of these terminations, the deaths were certified as *natural deaths.* The most important reasons given for this were the "fuss" of a legal investigation, the opinion that *death was in fact natural* (43%), and the desire to protect relatives from judicial inquiry (28%) (Keown, 1995).

4.3.2.6 Are the guidelines being followed (will they ever be)?

It is extremely concerning that the most crucial requirement for euthanasia – a free and voluntary request – has not been present in the majority of euthanasia cases. Of course, the unique Dutch definition of 'euthanasia' ensures that these cases are then not recorded as euthanasia, since the explicit request is the defining element. But definitions aside, it is clear that in thousands of cases doctors make decisions to end the lives of their patients without their consent – this is known by all (except the Dutch) as *non-voluntary* euthanasia.

In many cases alternative courses of action are not considered, and often the doctors do not consult a colleague. When they do, there is no information about the quality of those consultations. Low levels of reporting of euthanasia, both voluntary and non-voluntary, is worrying. This is particularly so when requirements are not met – exactly the cases which need to be reported and investigated. But who can expect doctors to voluntarily report a case in which they have ended somebody's life without the required safeguards? A system of self-reported killing can hardly be expected to protect the dead patients, who are the only witnesses.

It is thought by many observers that control of euthanasia in the Netherlands will continue to be impossible (Jochemsen, 2001).

4.3.3 Non-voluntary euthanasia in the Netherlands

4.3.3.1 Does it happen?

In a government-commissioned report of a survey of Dutch doctors, the authors conclude that in 1990 there were 2300 cases of ‘euthanasia’ (voluntary euthanasia) – about 1.8% of all Dutch deaths that year. There were 400 cases of assisted suicide, comprising 0.3% of all deaths. Worryingly, the authors also estimate that in a further 1000 cases (0.8% of deaths) doctors gave a drug specifically to hasten the end of life *without* the explicit request of the patient. While these deaths did not fall under the Dutch definition of ‘euthanasia’ since there was no request from the patient, they can certainly be called cases of *non-voluntary euthanasia*.

Unfortunately, the involvement of Dutch doctors in medical killing does not stop there.

There were also 1350 cases where doctors increased the dosage of palliative drugs and 4000 cases where doctors withheld or withdrew treatment, without request and *with the primary purpose of ending the patient’s life.* Then there were an additional 11 500 cases of increasing drugs or withdrawing/withholding treatment without request and *partly with the purpose of ending the patient’s life.* There were also 5800 cases of withholding/withdrawing treatment *with* the patient’s request, and *with the primary purpose, or with the partial purpose, of ending the patient’s life.*

So, there were in fact 26 350 cases in which doctors intended to shorten the life of their patient. This makes 20% of all deaths in Holland during 1990. And the majority of these, according to doctor’s responses in a survey, occurred without consulting the patient.

(References: van der Maas *et al*, 1991; Keown, 1995)

4.3.3.2 Why does it happen?

It may seem unbelievable that a doctor would intentionally kill a patient without the patient’s explicit request, particularly since this is apparently the most important requirement of the guidelines for euthanasia.

However the fact that this happens – by the admission of the doctors themselves – reveals and confirms on what the entire practice of euthanasia is based.

When asked for euthanasia, doctors in the Netherlands do not always comply, just as you cannot simply ask a doctor for any drug. The doctor must first assess your situation. So an act of euthanasia in the Netherlands requires *the doctor* to decide that the patient’s life is indeed *no longer worth living*, and that death is of benefit to the patient.

The 1991 Lancet report (van der Maas *et al*, 1991) says that “sometimes the death of a patient was hastened without his or her explicit and persistent request. These patients were close to death and were suffering grievously”. The report defends these cases, saying that an “active intervention” by the doctor was usually “inevitable” because of the patient’s “death agony”. In fact these acts were regarded as “care for the dying”.

But a state of being “close to death” is difficult for even doctors to define. Of the 1000 patients who were killed without their knowledge or consent, 21% had a life expectancy of 1-4 weeks, and 7% had a life expectancy of 1-6 months. This does not begin to fall within the survey’s definition. A patient is considered to be ‘dying’ if they have “hours or days” left to live, not “weeks or months” (Keown, 1995).

Furthermore, doctors did not list “agony” or “suffering grievously” as the reason for these acts. The most common answers were the absence of prospect of improvement (60%), the futility of all medical therapy (39%), the avoidance of “needless prolongation” (33%), the inability of the relatives’ inability to cope (32%), and “low quality of life” (31%). Pain or suffering was only mentioned by 30% of doctors (Keown, 1995).

So the ultimate justification for these cases of killing was not a free and voluntary request. When the doctor considers that such factors surpass the patient’s right to life, a judgment is being made about the value of that person’s life. And here lies the heart of the euthanasia debate.

The requirement for a free and voluntary request is merely a safeguard; the real basis for an act of euthanasia is the doctor’s decision, for whatever reason, that the patient’s life is devoid of human value.

4.3.3 Is there a “slippery slope” in the Netherlands?

Many people who are concerned about euthanasia in the Netherlands talk about a ‘slippery slope’. This refers to the ‘sliding’ of euthanasia from initially being *voluntary* to eventually being *non-voluntary*.

No country or state would have enough public support to create a euthanasia law where patients could be killed without their request. Therefore, the requirement for a free and voluntary explicit request is always presented as the most important element of a euthanasia policy. But it has been demonstrated in the Netherlands that euthanasia is ultimately concerned with decisions about the value of life, particularly when patients are ‘suffering’. So an explicit request in fact becomes a secondary consideration.

It is also logical that this would be the case, since euthanasia is not an individual decision made by the patient alone. Euthanasia involves *two people, not one*. It is the intentional killing of a patient by a doctor. So the doctor has to make the final decision about the killing, not the patient.

The Dutch are aware of the ‘slippery slope’ criticism, and are keen to disprove it. The Lancet report in 1991 stated that “many physicians who had practiced euthanasia mentioned that they would be most reluctant to do so again, thus refuting the slippery slope argument”.

> *This begs the question as to why such physicians “would be most reluctant” to practice euthanasia again. Is it that they feel they have done something very wrong? Was it, all things considered, an unpleasant experience, and, if so, in what way? It further begs the question as to how the ‘slippery slope argument’ is refuted. To be “most reluctant” to do so again doesn’t mean that one will not do it again.*

(Fleming, 1992)

In fact the evidence from surveys in the Netherlands *supports* the argument that euthanasia quickly slides from being voluntary to being non-voluntary:

- There is no mechanism to ensure the request is voluntary. In 1990, the request was spoken only (not written) in 60% of "euthanasia" cases (not counting all the other cases of killing not defined as "euthanasia" by the Dutch).
- In 1990, treatment alternatives remained in 21% of euthanasia cases, but these were refused by the patient (Keown, 1995).
- A 1995 survey showed that in 17% of the cases of euthanasia and of life termination without explicit request the doctor still saw other medical possibilities to alleviate the suffering, but nevertheless the patient's life was intentionally ended.
- One third of GPs who decided there were no alternatives had not sought advice from a colleague (Keown, 1995).
- The 1990 survey showed 1000 cases in which a lethal drug was administered *without request.*
- In these 1000 cases some of the patients were competent (able to express their own wishes). The report said that these acts "must be prevented in future" – but it *defends* other cases of unrequested killing, saying "active intervention" by the doctor was usually "inevitable" because of the patient's "death agony", and regards these cases as "care for the dying".
- In 72% of euthanasia cases the doctor certified that death was due to "natural causes" (despite, by definition, the death clearly not being natural).
- There were in fact 26 350 cases in which doctors intended to shorten the life of their patient. This makes 20% of all deaths in Holland during 1990. And the majority of these, according to doctor's responses in a survey, occurred without consulting the patient.

The authors of the 1990 survey argue that no doctor who performs euthanasia does so with the sole intention to kill; rather he or she is always trying to relieve suffering. But this confuses *motive* with *intention*. While relief of suffering may be the motive, the intention is always to kill. Keown (1995) points out that "if an heir kills his rich father by slipping a lethal poison into his tea, would they deny that this was murder on the ground that the heir's intention was not to kill and can always be described as trying to accelerate his inheritance?".

A further argument might be that it is only a few 'maverick' doctors who are killing patients without request. But the majority of doctors admitted that they either had killed without request or would be prepared to do so (Keown, 1995).

Doctors in the Netherlands argued that palliative treatment was not preventing intolerable suffering in 77% of euthanasia cases, so euthanasia was the only alternative. This raises the serious question of the quality of palliative care in the Netherlands (Keown, 1995). And it has been noted that legalising euthanasia tends to "undermine the efforts and creativity of those committed to providing palliative care to a terminal patient", particularly in health care systems with increasing costs relating to aged and terminal care, and increasing pressure to make choices about resource allocation (Jochemson, 2001).

The Dutch argue that the existing guidelines can safeguard the Dutch people against being killed without request. But the existing system cannot be expected to detect doctors who ignore the guidelines, since it relies on individual doctors to expose their own wrongdoing; "… a doctor who has acted in breach of the law is no more likely to admit having done so in his report than a tax evader is likely to reveal his dishonesty on his tax return" (Keown, cited in Fleming, 1992).

So both the evidence and the logic point to a "slippery slope" in the Netherlands, just as critics feared.

4.4 Australia

This section has been drawn from the following paper:

> *Fleming, John I. "Death, Dying and Euthanasia: Australia versus the Northern Territory", in The Dignity of the Dying Person: Proceedings of the Fifth Assembly of the Pontifical Academy for Life, Vatican City, 24-27 February 1999.*

Euthanasia was made legal for a short period of time in the Northern Territory (NT) of Australia. The Northern Territory has a population of about 193 000 (around 1% of Australia's total population).

Australia consists of six states and three territories. The territories, including the NT, were given self-government and a constitution by a Federal Act of Parliament. Under this Act the Territories were able to make their own laws about death and dying. The NT used this Act to legalise euthanasia in 1995. To counter this move, in 1997 the Federal Government changed three Acts of Federal Parliament, which then denied the NT power to make laws about death and dying.

In 1995, the Northern Territory Parliament passed the *Rights of the Terminally Ill Act 1995* (ROTTI) which was an Act "to confirm the right of a terminally ill person to request assistance from a medically qualified person to voluntarily terminate his or her life in a humane manner; to allow for such assistance to be given in certain circumstances without legal impediment to the person rendering the assistance; to provide procedural protection against the possibility of abuse of the rights recognised by this Act."

In 1996 this law was challenged in the Supreme Court of the Northern Territory by the Northern Territory President of the Australian Medical Association, and a prominent Aboriginal leader who was also a Minister of the Uniting Church and chairman of the Northern Land Council. However, they did not succeed.

In late 1996, a bill was introduced into the Australian Federal Parliament to overturn the euthanasia legislation. Parliament voted in favour of this bill, and it was supported by both the Prime Minister and the Leader of the Opposition. In March 1997 this Federal legislation came into effect, and the Northern Territory legislation was overturned.

One of the most important factors in overturning this legislation was the impact of euthanasia laws on the Aboriginal people of Australia, which make up 25% of the population of the Northern Territory. When euthanasia became legal, the Northern

Territory government commissioned an education program in Aboriginal communities on euthanasia. The report of this program (written by a supporter of euthanasia) said that "the level of fear and of hostility to the legislation is far more widespread than originally envisaged… which makes one wonder about the public opinion polling that suggests high support among the NT public for the legislation. One imagines that phone polling doesn't get to too many Aboriginal people".

The report continued to say that the problem "is related to the widespread Aboriginal beliefs about cause of death and that deaths are caused by external agencies such as sorcery, payback, transgression of the Law etc. In simple terms this means that those things non-Aboriginal people may identify as 'causes' such as cancer, HIV-AIDS, car accidents etc. are not seen as such – even by long-term Aboriginal Health Workers."

Furthermore, "the greatest fear and reluctance about the legislation would appear to be coming from Aboriginal Health Workers themselves. They are concerned that their position within their own communities has been or might be irreparably damaged by the existence of the legislation."

In evidence given to the Australian Senate, it was stated that traditional Aboriginal law does not empower the traditional parliament to give an individual the right to take the life of another. Aboriginal law states that death should be by natural causes only, except in the case of capital punishment. The consensus among Aboriginal people was that euthanasia was not "the Aboriginal way". In fact, it was said that "the very fact of the legislation, at least anecdotally, is causing people to be reluctant to present, or to present not as soon as one might, to attend clinics or go to hospital".

In 1997, a new bill was introduced into the Northern Territory parliament, trying to charge a $50 fee for doctors who illegally performed euthanasia but who did so according to the ROTTI conditions. This was rejected because it was clearly an attempt to sidestep the Australian political system.

*4.5 The United Kingdom**

4.5.1 Tony Bland*

*4.6 Oregon, USA**

5. Opinion polls about euthanasia

Euthanasia supporters frequently claim that euthanasia enjoys majority public support. But such claims must be examined carefully. Words are very powerful, and the questions used in opinion polls may not be able to detect exactly what the public believes.

Most people do not have a definition of euthanasia. And most opinion polls, designed to gain maximum support for euthanasia, fail to provide the public with a definition for euthanasia.

For example the Walton Committee (Report of the House of Lords Select Committee on Medical Ethics, chaired by Lord Walton, 17 Feb 1994) was presented with claims that in the UK 79% of the population would like to see voluntary euthanasia legalised. But they took this result with a "pinch of salt" because the question in fact asked "Should the law allow adults to receive medical help to a peaceful death?". This question does not mention *medical killing*. 'Medical help' could refer to palliative or nursing care, and not necessarily a lethal injection. And everyone wants a 'peaceful death'. In fact the UK already provides people with 'medical help' to a 'peaceful death' by way of hospices and palliative care services, which are available to everyone.

Another often-quoted figure in the UK is 86% support for euthanasia. This is based on the proportion of people who agreed that 'euthanasia' should be available for a person who is "incurable, on life support machine, never expected to regain consciousness, relatives agree to euthanasia" (British Social Attitudes Survey, 1997). But as discussed in What euthanasia isn't, switching off a life support machine does not necessarily amount to euthanasia. The machine is an artificial mechanism, and if removed, the underlying disease causes death. Again, the question doesn't refer to a lethal injection.

Opinion polls also play on people's fears. "The public's attitude and knowledge about pain clearly demonstrates their overwhelming concern and fear of pain as a consequence of medical illness, without proper education to understand that it can be appropriately relieved… Patients also do not understand their own right to refuse treatment or to demand that physicians withdraw burdensome treatments." (Foley, 1996).

So many people have been led to believe (wrongly) that at the end of life they will be left to suffer and die in pain, or that doctors will go to extreme measures to extend life. Euthanasia supporters combined this misinformation with the use of phrases like "death with dignity", or "a peaceful death", to imply that a natural death is neither peaceful nor dignified. But today's palliative care allows people to die peacefully and with dignity, and patients have the legal right to refuse treatment.

What euthanasia is *really* about – medical killing, usually by lethal injection – is rarely mentioned in opinion polls and in public pro-euthanasia information. This is deceptive. The public first needs to be correctly informed before they can make decisions about euthanasia policies.

6. Common arguments for legalising euthanasia:

The pro-euthanasia makes use of slogans which perhaps sound appealing at first. But they must always be carefully examined. Phrases which seem reasonable may have some very sinister – or very wrong – meanings.

6.1 "Everyone has a right to die (a basic human right)"

> *The 'right to die' is a good slogan designed to sell euthanasia. Historically, however, it is life that has been considered an inalienable right; death is a biological fact. One could with equal or more justification speak of legalisation as establishing the doctor's right to kill.*
> *(Hendin 1997)*

Modern western societies are very much focused on 'rights'. Documents such as the International Declaration of Human Rights *(link?)* have outlined the basic human rights that all members of the human family have, simply because they are human. Very few dispute these; for example the right to education, health, and most importantly, life.

But some people claim other rights, for example the right to die. What exactly does this mean? Death is inevitable for everyone, so it doesn't make sense for death to be a right that can be violated. What the 'right to die' really means is a demand for a right to choose the time and method of death.

The first point about this 'right to die' is that it is in *direct conflict* with the right to life. The right to life is so central to all other rights that it is both *inviolable* and *inalienable*. This means that not only can no-one take it from you, but *you also cannot give it away*. So, a person who chooses to die is essentially violating their own right to live.

The second point about this 'right to die' is that it implies that the only qualification for euthanasia is simply to ask for it (Cameron, 1991). This raises all kinds of problems. What types of requests are to be taken seriously? What if the person requesting suffers from depression, or are under the influence of drugs? What if someone is pressuring them to ask for death? What if they change their mind? How many people need to witness the request? What about people who cannot communicate – the very young, the very old or the severely disabled?

> *If it is reasonable to claim that killing a person is a benefit to him only if that person no longer has a worthwhile life, then the incompetent as well as the competent stand to be benefited. Why should the inability of the incompetent to request the benefit be deemed a reason for depriving them of it? The difference, then, between voluntary and non-voluntary euthanasia, while obvious enough, is neither deep nor very significant.*
> *(Gormally, 1995)*

The third point is that the 'right to die' slogan does not tell the whole truth about the euthanasia movement. It advocates 'voluntary euthanasia', but voluntary and non-voluntary euthanasia are impossible to separate. Many euthanasia advocates believe strongly that choosing death is not only a right but sometimes a duty:

The duty to suicide occurs when through my continued living lack of autonomy, misery, isolation, uniformity, unfruitfulness, incurability, lameness, pain, insensitivity, disgrace, madness, sin threaten to become the norm for humanity and my suicide is the only means available for me to prevent this.

(Mynen 1982, cited in Fleming, 1992)

Another reason why the ‘right to die’ is problematic is that euthanasia is more complicated than simply choosing to die. Most jurisdictions have removed suicide from criminal law. This means that individuals will not be charged for attempting suicide. However to assist a suicide or to kill someone, even on their request, is quite a different matter. Voluntary euthanasia, as proposed by advocates, is vastly different from suicide because it is really the *doctor* who decides whether the patient’s life will be ended. It does indeed become a ‘doctor’s right to kill’ rather than a patient’s ‘right to die’.

6.2 “It happens anyway, so we need to regulate it”

Some euthanasia advocates argue that since euthanasia is known to occur surreptitiously, it should be legalised and regulated to prevent abuse. There are two reasons why this argument should be rejected.

The first reason is that it is a ridiculous claim to make. We would never accept the legalisation of child abuse, theft or drink driving, no matter how prevalent they were in the community. Why then would it be a different matter for euthanasia, which is a form of intentional killing?

The second reason is that claims of a high incidence of euthanasia are based on flawed research and flawed concepts. This research usually centres around asking health professionals whether they have ever (a) given pain-relieving medication which they think may have hastened death, or (b) decided to stop giving a patient life-prolonging treatment of some kind. As discussed in the sections the principle of double effect and intention versus motive, these are medical decisions which are commonly made and ethically accepted. To claim that they are always decisions to end the patient’s life, whether or not that is what the doctor intended, would be very wrong and damaging to the medical profession, particularly in care for the dying. For example, deciding to cease chemotherapy because it is burdensome and not doing the patient any good can never be an equivalent decision to giving the patient a lethal injection.

6.3 “ It is an issue of self-determination and autonomy”

Respect for patient autonomy is at the heart of good health care. But autonomy is never absolute. It must be balanced with responsibilities, and it must never violate the rights of others. For example, can the principle of autonomy ever override the principle of not taking another person’s life? Once a person is dead, no further autonomy exists for them. So euthanasia is not a simple matter of self-determination and autonomy.

It is also very difficult to reconcile the idea of autonomy with the relief of suffering. To honour every wish of every patient, euthanasia cannot be based on relief of suffering, or any other criteria for that matter, except for a request. This raises the questions of why people might request euthanasia.

Specialists and researchers who work with AIDS patients, cancer or depression help to illustrate this difficulty. Their observations suggest that it may be grossly negligent to assume that a request for euthanasia is simply an expression of the patient's autonomous decision to die:

- Research into euthanasia requests amongst AIDS patients showed that "euthanasia and assisted suicide were not desired as ends in themselves. None of the participants, including the most adamant supporters, desired euthanasia or assisted suicide outside of the circumstances that led to their perceptions of loss of self… These experiences also suggest that the decisions to have euthanasia or assisted suicide … could change with meaningful changes in individuals' social circumstances, independently from disease progression" (Lavery *et al*, 2001).
- A specialist in geriatric psychiatry notes that "there is no lack of data showing that cancer patients who express wishes to die no longer express these wishes when pain medication is adequate or when effective antidepressant therapy has been achieved" (Cohen, 1998).
- "Even though the disease itself may be untreatable, the depression is treatable, and it is the depression, not the disease, which makes such persons suicidal" (Balch & O'Bannon).
- "Depression must always be treated because there is no such thing as 'free choice' or 'volitional choice' if the patient is choosing from under a cloud of depression-induced despair" (Cohen, 1998).
- "When a patient says that he or she wants to die, there is narrative evidence to suggest that this statement paradoxically might indicate loss of autonomy rather than a dignified expression of self-determination" (Horton, 2000).

How does this idea of 'autonomy' fit into the landscape of terminal illness and care for the dying? Herbert Hendin, a Dutch doctor who is opposed to euthanasia, suggests that the concept of autonomy as an argument for euthanasia "will seem persuasive mainly to those removed from actual patient care":

> *For those individuals who respond to every life crisis with depression, panic, and the desire to die, does the fact that the crisis is now serious or the illness terminal demand that we heed their request to die because it is consistent with their character? For others the panic that accompanies serious or terminal illness is not in keeping with their prior life or character. When that panic is addressed it usually subsides, and the request for death disappears. When the panic is not addressed but rather hidden by both doctor and patient behind the slogan of "death with dignity" or when the request is rationalised as the "autonomous" desire of an individual, the patient dies in a state of unrecognised terror.*
> *(Hendin, 1997)*

If euthanasia were to be legalised merely on the basis of patient autonomy, what kinds of checks and balances would be in place to (a) prevent abuse and (b) ensure death is what the patient really wants? Here lies the crucial difficulty. Euthanasia is intentional killing, and therefore one person has to *decide* to end the life of another. Rather than being an issue of patient autonomy, it is the *doctor's decision* to end a life. The Dutch guidelines, which are supposed to ensure an autonomous decision, have proved so far to be inadequate and to allow killing of people who did not request it. Professor René Diekstra, a leading Dutch authority and advocate for assisted suicide for many years, was "troubled that his vision of providing relief from irremediable suffering while preserving autonomy was lost in the realities of euthanasia in the Netherlands" (Hendin, 1997). The evidence is seen in the slide from voluntary euthanasia based on an explicit request to non-voluntary euthanasia based on a doctor's decision about the value of the patient's life (see 4.3.3 Non-voluntary euthanasia in the Netherlands).

A final point about autonomy and self-determination is about why such principles are to be valued.

> *"To be autonomous means to be self-governed or self-determining in the conduct of one's life. But what exercises of this capacity are genuinely valuable and, as such, to be respected? Only those exercises of the capacity which really make for our flourishing and well-being. Of course this answer assumes that there are objective, knowable conditions of human flourishing, so that it can be shown that some of our choices undermine rather than make for human well-being… Given that autonomy is to be valued precisely in so far as it makes for our genuine fulfillment, there are no general grounds for respecting every kind of self-destructive choice"*
>
> *(Gormally, 1995).*

6.4 "It is purely a personal decision"

Supporters of euthanasia might imagine that the decision to die is a very personal one and does not have any harmful effects on other people. But in fact this is untrue. At least one other person is involved in the euthanasia decision – usually the patient and the doctor.

Euthanasia is not simply a form of suicide. It involves doctors killing patients. The doctor has to answer for what he does, and he has to have a good reason for ending a life. He cannot simply say that the patient asked him to. Rather, he will "advocate some variant of the judgment that the patient no longer has a worthwhile life" (Gormally, 1995). So euthanasia is not merely a personal decision.

It is also wrong to assume that a request for euthanasia will always come solely from the patient, under no coercion, and for the 'right reasons'. A UK palliative care specialist (Gilbert, 1996) says that most requests for euthanasia come from

- people imagining their own future suffering (and are ignorant about prognosis and palliative care)

- relatives and friends who find the dying of their loved one terrible to witness
- relatives and friends wishing in retrospect that things could have been different.

In Oregon, USA, physician-assisted suicide was legalised for several years. One writer makes the following observation:

> *There seems to be an increasing trend for patients who opt for lethal medication to do so out of their concern to avoid being a burden to others. From 1998 to 2000, the proportion of those who died after receiving prescriptions or lethal medications and who felt they were a burden to family, friends, or other caregivers rose from 2/16 (12%) to 7/27 (26%) to 17/27 (63%) for each successive year. The importance of the context in which these decisions are made was revealed most explicitly among those who died with the assistance of Jack Kevorkian. Contrary to the Dutch and Oregonian experience, his patients were more likely to be female, divorced, or never married, and suffering a recent, but non-terminal, decline in health status.*
>
> *(Horton, 2001)*

And the Remmelink Report (a report on euthanasia in the Netherlands) found that the doctor was often the person who first raised the subject of euthanasia with the patient (Hendin, 1997). What effect would this have on the voluntary nature of the patient's decision?

6.5 "No-one should force their belief system on anyone else"

The argument that euthanasia is a personal decision is followed by the claim that no-one should force their belief system on anyone else. This of course is based on the assumption that no-one is wrong and no-one is right, that people can make their own minds up and do what is 'right for them'.

Need a couple of paragraphs on right and wrong?

But as with many other ethical issues, those who speak against them are often criticised or coerced into silence. Doctors and academics in Netherlands who dissent from the common support for euthanasia are silenced, for example by editors in medical journals, or by threats to sue, or by being called "reactionary fundamentalists" or right-wing religious fanatics (Hendin, 1997).

Furthermore, the chief inspector of public health in the Netherlands stated that if a doctor did not agree to perform euthanasia on a patient who requested it and did not refer the patient to another doctor who would, he was guilty of malpractice. Since some doctors object to euthanasia on ethical grounds, this compulsion to make a referral "coerces them and violates all prior assurances that no doctor need participate in the euthanasia process" (Hendin, 1997).

Also, there is evidence from the Netherlands that many patients are being killed without requesting death (see 4.3.3. Non-voluntary euthanasia in the Netherlands). Hendin notes that public policy must take into account the effect it has on the entire community, rather than simply being based on personal beliefs:

> *Wise social policy dictates that a personal choice for euthanasia cannot outweigh all other considerations, including the palliative care now available and the needs of the vast number of patients who, if legalisation occurs, will die inappropriately, just as in the Netherlands.*
> *(Hendin pg 215)*

6.6 "It is compassionate"

See section 3.6 Compassion

6.7 "It is the only alternative to prolonged suffering"

Many euthanasia advocates would have people believe that prolonged and painful suffering is likely to occur at the end of life, and that euthanasia is the only way to deal with it. Indeed they probably believe this themselves and fear it greatly.

The first argument against this is of course that modern palliative care can deal very effectively with pain, and is constantly improving the way doctors deal with patients who are nearing the end of life.

Secondly, pain and suffering do not diminish the value of a person's life. While a terminally ill patient may feel that their 'quality of life' is compromised, their life is of equal value to a healthy person. Supporters of euthanasia argue in terms of being 'on the way out', so to speak, and suggest it to be pointless to continue living, for example:

> *The phrase 'terminal illness' suggests a way of looking at death, not at the moment of brain death, but as a process lasting some period of time; once this more realistic view is embraced, and the fact of dying accepted by the individual, the doctors and the relatives, what can be gained by ensuring that the process of dying is prolonged as much as possible?*
> *(Voluntary Euthanasia Society of Scotland)*

However a 'terminally ill' person has not lost their humanity. And doctors do not have a duty to unnecessarily prolong dying. They also do not have a duty to hasten death. Rather, they have a duty to care.

7. Reasons why euthanasia should never be legalised:

7.1 It rejects the basis of just laws – that everyone is equal.

> *The depenalisation of intentional killing by physicians constitutes, in itself, a serious violation of the legal protection of the life of all citizens.*
> *(Horton, 2001)*

Euthanasia law in the Netherlands, and those proposed elsewhere, supposedly rely on a free and explicit request as the fundamental requirement. But this alone cannot guarantee a patient will be killed. Just as a doctor would not give a patient drugs without making a judgment about their health, so also a doctor will not agree to euthanasia unless he or she has made a judgment. This judgment concerns *the value of that patient's life*. If the doctor feels that the patient's life is in any way worth living, they will not agree to euthanasia. And deciding that a patient's life is no longer worthwhile is equivalent to deciding that the patient is no longer of value.

This raises serious problems in societies where justice is achieved by assuming that all human beings, simply by being human, are of equal value. It is a direct attack to the cornerstone of our law to decide that an individual has a life that is no longer worth protecting. Euthanasia is "a type of killing, therefore, which cannot be accommodated in a legal system for which belief in the worth and dignity of every human being is foundational" (Gormally, 1997 internet article).

This is not only a legal and philosophical argument. It can be seen in practice in the Netherlands, where euthanasia apparently based on an explicit request slides into euthanasia based on a doctor's judgment of the worth of a patient's life (see 4.3.1 Euthanasia and the law in the Netherlands). This evidence, provided by the Netherlands government itself, bear witness to Thomas Hobbes' observation that "to voluntarily agree to be killed threatens the right to life of other members of the community as well" (Fleming, 1992).

7.2 If voluntary euthanasia is legalised, the barrier to non-voluntary euthanasia will have been removed.

Supporters of voluntary euthanasia claim it can be controlled, so that the law will not allow euthanasia which might violate autonomy (Fleming, 1992). But there are several reasons why the legalisation of voluntary euthanasia will remove the barrier to non-voluntary euthanasia.

Firstly, both voluntary and non-voluntary euthanasia are based on the belief that some lives are not worth living. Usually it is the perception of suffering that leads some to believe that a person's life is no longer worth living (see 3.7 Suffering). But others have different criteria for judging whether a human being should die. Some philosophers, for example, believe that involuntary euthanasia is morally right in particular circumstances. Peter Singer, an Australian bioethicist, says that “when the death of a defective infant will lead to the birth of another infant with better prospects of a happy life, the total amount of happiness will be greater if the defective infant is killed. The loss of a happy life for the first infant is outweighed by the gain of a happier life for the second. Therefore, if killing the haemophiliac infant has no adverse effect on others, it would according to the total view, be right to kill him” (Singer, 1989).

Secondly, a ‘right to die’ based on autonomy and freedom of choice implies that death can be a benefit. But it would be inconsisten with this reasoning to deny the ‘benefit’ of death to people who are incapable of asking, such as the very young, the very old, those with dementia, etc. So just as a doctor in the Netherlands decides that a patient who requests euthanasia would benefit from it, since the patient does not have a worthwhile life, the doctor may also decide to provide this ‘benefit’ and ‘right’ to a patient who has not asked for it if the doctor feels that this patient also does not have a worthwhile life.

How does the link between voluntary and non-voluntary euthanasia manifest in practice? We can see direct evidence of this occurring in the Netherlands – see section 4.3.3: Non-voluntary euthanasia in the Netherlands.

Even some who support euthanasia are concerned. Professor René Diekstra, a Dutch authority on and advocate for euthanasia, said he was “troubled that his vision of providing relief from irremediable suffering while preserving autonomy was lost in the realities of euthanasia in the Netherlands. He was disturbed that a system he had helped to father wrongly put to death more people than the relatively small number who met Dutch criteria for appropriate euthanasia or assisted suicide. He thought there would be a backlash when the public eventually realised what was happening” (Hendin, 1997).

Many Dutch residents also understand the link, and fear it. The Dutch Patients’ Association, with about 60,000 members, takes inquiries from people wanting to know if a particular hospital is likely to put them to death without consulting them. The Association distributes a “passport for life” for patients to carry, indicating that in medical emergencies they do not want their life terminated without their consent (Hendin, 1997).

7.3 Euthanasia undermines the role of doctors and the practice of medicine.

> *It is an important part of the duty of the state to maintain a framework of law which is conducive to an essential profession such as medicine functioning well in the interests of citizens.*
> *(Gormally, 1997)*

To perform euthanasia requires that the doctor *decides* to do so; he or she is a partner in the decision, along with the patient.

While some claim that the doctor-patient relationship is changing, such that the doctor's duty of care is negotiated according to the patient's values (Chaney, 2001), doctors still still in fact have a broader social role. Horton (2001) says that "the acceptance of euthanasia as a treatment option is incompatible with the fundamental role of the physician as healer who is unconditionally devoted to respect for the life of his patients. Since the physician's role and the extent of his or her competence is regulated by law, such a fundamental change in the physician's competence concerns society as a whole and cannot be considered as a private matter for patients and physicians". The medical profession is well aware of the need to preserve their societal role; for example physicians have not participated in capital punishment for centuries because this would compromise their role as healers (Hendin, 1997).

A change in the role of doctors would be destructive to the practice of medicine: "Doctors will not inspire trust unless patients are confident that doctors (1) are for no reasons disposed to kill them, and (2) have no inclination to ask whether a patient is worth caring for or treating, rather than asking what care or treatment might benefit the patient" (Gormally 1997, internet). Euthanasia would, in fact, change the whole landscape of health care.

Lawmakers must also realise that doctors too have weaknesses. Reports from the Netherlands revealed that Dutch doctors were often prepared to make false statements (Fleming, 1992). For example in 72% of euthanasia cases the doctor certified that the patient died a natural death when in fact they were intentionally killed (van der Maas *et al*, 1991).

Euthanasia laws would require doctors to be honest in their reporting – remember that in the case of euthanasia, the doctor must account for what he has done, and the only witness is dead. Some researchers who advocate legalisation of euthanasia claim that many doctors perform euthanasia despite it being illegal, and that legalisation would help to protect patients and enable transparency of medical practice. But these researchers cannot explain why doctors should be any more law-abiding if voluntary euthanasia were to be legalised (Fleming, 1992).

Even making room for doctors to make a conscientious objection does not fit well with euthanasia laws based on autonomy. In the Netherlands, "the chief inspector of public health… declared that if a doctor did not agree to perform euthanasia on a patient who requested it and did not refer the patient to another doctor who would, he was guilty of malpractice and should be brought up on disciplinary charges" (Hendin, 1997).

> *Once freed from the Hippocratic obligation to confine his role to healing, the physician is fatally compromised. The idea that his freedom to take an open-ended view of his patient's interests can serve those interests better, since he is freed from a narrow obligation to heal and not to harm, is illusory. His freedom in fact exposes him to competing pressures from which the Hippocratic commitment preserved him. The more diverse the range of moral options, the more complex the decisions he faces, the more unpredictable their outcome… The tradition of healing and the sanctity of*

life gives place to another, in which a malleable notion of respect does duty for sanctity, and healing itself is displaced by the ‘relief of suffering’ as the chief goal of medical enterprise, all in the service of an undefined ‘compassion’.
(Cameron, 1991)