Euthanasia and physician-assisted suicide: recent developments and ethical analysis

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1. Introduction

This report briefly documents recent developments in euthanasia and assisted suicide legislation in various countries. It is followed by a reflection on philosophical aspects of euthanasia and assisted suicide.

2. Recent developments

2.1 Australia

Recently two events have brought euthanasia into the media spotlight in Australia.

Firstly politicians in New South Wales overwhelmingly defeated the Rights of the Terminally Ill Bill 2001, by 26 votes to nine.[1] The bill was introduced by Greens MLC Ian Cohen.

Secondly an elderly woman's plea for death became a pawn for Exit, a pro-euthanasia lobby group, and Dr Philip Nitschke. Nancy Crick, a 70-year-old woman with bowel cancer, publicly stated that she planned to kill herself in the presence of family and friends on April 10th 2002. With the help of Exit and Dr Nitschke, Mrs Crick documented her daily life on the internet (www.nancycrick.com). Pro-euthanasia campaigners were selling copies of her front door key in order to frustrate attempts by police to arrest people who assisted in her suicide. However the publicity stunt was temporarily upset when Mrs Crick checked into a private hospital on April 2nd for palliative care.[2] When she returned home with a palliative care program she postponed her suicide plan; she recently announced that she will take her life before the end of the Australian winter.[3]

A survey published late last year suggested that more than a third of a sample of Australian surgeons used drugs to hasten death without request from the patient. Fifty-six percent of surgeons who provided a lethal dose did so without the patient's request (20.4% of the sample, 139 surgeons). The authors concluded that "legal and moral distinctions based solely on a doctor's self-reported intention are problematic".[4] The Australian Medical Association will debate whether to support euthanasia at a national conference in May.

2.2 Belgium

A bill legalising euthanasia was passed by the Belgian Senate in October 2001, and the House of Representatives is expected to also pass the bill, so that Belgium may

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[1] "NSW Parliament rejects euthanasia bill" ABC News Online 22 March 2002 (http://www.abc.net.au/news/australia/nsw/metnsw-22mar2002-15.htm)
[2] "Terminally ill woman makes last effort to prolong life", ABC News Online, 2 April 2002
[3] "Palliative care fails to restore grandmother's desire to live", ABC News Online Monday 29th April 2002. www.abc.net.au/news
[4] Douglas C, Kerridge I, Rainbird K *et al* "The intention to hasten death: a survey of attitudes and practices of surgeons in Australia" *Medical Journal of Australia* Vol 175: 511-516, 19 November 2001

follow in the footsteps of The Netherlands.[5] In 2000 The Lancet published a survey of end-of-life practices in Belgium which has been used, as with Australia and The Netherlands, to argue that since euthanasia probably occurs covertly it should be regulated[6]. In the Journal of Health Law[7] Broeckart provides a detailed description of the events leading up to the drafting of the current euthanasia bill. In particular he mentions the importance of the 1997 elections in which the Christian-Democratic coalition was defeated, and also in which the liberal, socialist and green parties finally formed a coalition. Broeckart notes that "the ink on the coalition agreement was still wet when the first euthanasia bills were submitted". The coalition aims to decriminalise euthanasia; however the Christian-democratic parties object, wanting to leave the Penal Code unchanged, and allow a prior ethical assessment and euthanasia only for terminally ill patients with unbearable pain.

2.3 Britain

Diane Pretty, who suffers from motor neurone disease, unsuccessfully appealed to the British courts to allow her to seek assistance to die. Specifically she sought immunity for her husband, whose assistance she wanted to commit suicide. The House of Lords also ruled against her claim of a 'right to die' in November 2001. In late April 2002 the European Court of Human Rights ruled that there was no 'right to die' and that the British government was not subjecting her to 'inhuman or degrading treatment' by forbidding assisted suicide.

2.4 Colombia

In the late 1990s a lawyer challenged the adequacy of Colombia's anti-euthanasia laws in the Colombian Supreme Court, in an effort to provide further protection for the elderly and infirm. The action backfired, however, when in 1997 the Court ruled that "no person can be held criminally responsible for taking the life of a terminally ill patient who has given authorization to do so". Exceptional in this case is the fact that Right to Die activists did not prompt the action; it came "out of the blue".[8] The Court urged Congress to make provisions under which euthanasia would be legal. Some argued that the ruling had effectively legalised euthanasia; however euthanasia remains illegal. The Colombian Senate rejected the Court's interpretation.[9]

2.5 Hawaii

The Hawaii State House passed a bill to legalise assisted suicide, modeled on Oregon's Death With Dignity Act, in early March. It has been stalled in the Senate by Health and Human Services Committee Chairman David Matsuura, who wants to

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[5] Australasian Bioethics Information 9/11/01

[6] Deliens L, Bilsen J, et al. "End-of-life decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey", *The Lancet* 25 November 2000, 1806-1811.

[7] Broeckaert B, "Belgium: Towards a Legal Recognition of Euthanasia", *European Journal of Health Law* 8: 95-107, 2001.

[8] Liz Townsend, "Colombia's highest court legalizes euthanasia", National Right to Life News. www.euthanasia.com/colum2.html

[9] Raimundo Rojas, "Euthanasia in Colombia", *Spotlight on the Americas*, www.nrlc.org/news/2001/NRL06/rai.html

instead pass a bill to ensure that living wills and other advance directives are followed.[10] But Governor Ben Cayetano, in favour of the bill, has called for the Senate to move ahead with a vote on the bill.[11] Medical organisations oppose the bill.

2.6 Japan

Japan faces the issue of euthanasia from a unique angle. Rihito Kimura discusses euthanasia and advance directives using historical, medical and legal perspectives[12]. Autonomy is gaining in importance as Western culture influences Japanese medical practice. But in contrast to Western individualistic thinking, the family plays a central role in treatment decisions, and patients have traditionally not been told details of their illness. Euthanasia appears to be part of a desire to avoid unwanted aggressive treatment. In Japan's paternalistic medical environment the advance directive is seen by some as an answer to avoiding burdensome treatment, although currently those advance directives have no legal status.

Two test cases are also described by Kimura. One of particular significance is a precedent set as far back as 1962, in which a son poisoned his terminally ill father on the father's request. The son was jailed for four years; however the court identified six conditions under which euthanasia would be legal:

- the patient's situation must be regarded as incurable with no hope of recovery; also death must be imminent;
- the patient must be suffering from unbearable and severe unrelievable pain;
- the act of killing must be undertaken with the intention of alleviating the patient's pain;
- the act should be done only if the patient himself or herself makes an explicit request;
- euthanasia should be carried out by a physician, although in special situations another person's assistance may be permitted;
- euthanasia must be carried out using an ethically acceptable method.

These conditions have not been applied by any court since then. Rihito believes that while public opinion seems to favour euthanasia, the medical profession remains strongly opposed. Supporting the latter assertion, two research articles were published last year addressing euthanasia amongst Japanese health professionals. It is noteworthy that Dr Helga Kuhse, a pro-euthanasia academic of Monash University in Australia, co-authored one article and provided suggestions for the other.

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[10] Lynda Arakawa "Assisted suicide bill likely to fail", The Honolulu Advertiser, Saturday March 23 2002, http://the.honoluluadvertiser.com

[11] "Governor calls for vote on Death With Dignity bill", *The Hawaii Channel*, April 17 2002. www.thehawaiichannel.com.hon/news

[12] Rihito Kimura "Death, Dying, and Advance Directives in Japan: Sociocultural and Legal Point of View", in *Advance Directive and Surrogate Decision Making in Transcultural Perspective*, Baltimore: Johns Hopkins University Press, 1998.
Also find at http://kenko.human.waseda.ac.jp/rihito/licht_adv8.html

One of these two articles concludes that "Japanese health care practitioners who support VE ethically and/or legally are in the minority".[13] The same paper also points out that "some Japanese doctors and patient families tend to think that they themselves would want to die without aggressive life-sustaining treatment but that they would want their patients or family members to survive as long as possible". However the authors conclude that "in order to guarantee a patient's freedom and autonomy, to make every step of the procedure transparent, and to prevent abuse, Japan ought to establish legal regulations for informed consent, truth-telling and various end-of-life interventions, including VE [voluntary euthanasia]".

The second paper presented doctors' reactions to a hypothetical situation in which voluntary euthanasia was legal, a patient had requested euthanasia but the family was opposed.[14] The authors found that "the majority of responding doctors would not respect the patient's wishes for VE even in a situation where VE could be legally performed", and continue with a discussion of possible consequences of doctors overriding patient requests. They conclude by arguing that it is impossible that "acting on the decision of the family at the expense of the patient shows respect for his or her philosophy of life or guards his or her best interests".

2.7 Oregon[15]

Since 1997 Oregon law has allowed terminally ill patients to request a lethal dose of drugs, under the condition that two doctors confirm they have less than six months to live and the patients are mentally competent. The drugs must be self-administered.

In late 2001 Oregon experienced brief respite from its physician-assisted suicide (PAS) law. Attorney-General John Ashcroft ruled that federally-controlled substances cannot be used for non-medical purposes including assisted suicide. Ashcroft had not 'overturned' Oregon's law – rather, he was interpreting and enforcing a federal law. However a federal judge (District Court Judge Robert Jones) overruled the decision, claiming that each state can decide for itself what is a "medical purpose".[16]

The US Supreme Court determined in 1997 that assisted suicide is *not* a right protected by the Constitution. Major medical organisations (for example the American Medical Association and the American Nurses Association) agree. In effect, then, the court rulings represents a clash between state and federal authority. For pro-lifers the issue is whether or not the Federal administration can overrule state

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[13] Atsushi Asai, Motoki Ohnishi, Shizuko Nagata *et al* "Doctors' and nurses' attitudes towards and experiences of voluntary euthanasia: survey of members of the Japanese Association of Palliative Medicine", *Journal of Medical Ethics* 2001; 27: 324-330

[14] Atsushi Asai, Motoki Ohnishi, Akemi Kariya *et al* "Euthanasia and the Family: an analysis of Japanese doctors' reactions to demands for voluntary euthanasia" *Monash Bioethics Review* Vol 20 No 3, July 2001, pp 21-37

[15] For a detailed analysis of Oregon's law and reports see: Foley K and Hendin H, "The Oregon Report: Don't Ask, Don't Tell" *Hastings Center Report* May-June 1999, pp 37-43. Further useful comment can be found in *Physicians for Compassionate Care Friend of the Court Brief on Oregon vs. Ashcroft et al*, www.pccef.org/articles/art20.htm

[16] ProLife Infonet, "Judge backs Oregon assisted suicide law". Source: Associated Press, April 17 2002

authority in order to protect the lives of its citizens. But Judge Jones rebuked Ashcroft for attempting to "stifle" nationwide debate on assisted suicide.[17]

Since the law came into effect, at least 91 people have died as a result of lethal doses prescribed by physicians. Opinion polls show public support is highest for assisted suicide in the case of intractable pain.[18] However none of these cases features uncontrollable pain as the primary motive. More important for these patients was the worry of being a burden to family members – this motivation increased in importance from 12% of PAS patients in 1998, to 26% in 1999, and 63% in 2000.[19]

Not Dead Yet, and other disability advocacy groups, filed a brief in support of Ashcroft's decision. Not Dead Yet believes that "safeguards" in the Oregon law have been shown to be ineffective. The law requires that patients have been assessed by a doctor to have less than six months to live but "the lapse of up to 466 days from initial request for assisted suicide to death shows that people with non-terminal disabilities are receiving lethal prescriptions in violation of the Oregon law".[20]

2.8 The Netherlands

On April 1st 2002, euthanasia became legal in The Netherlands, rather than being technically illegal but not punishable in circumstances of 'force majeure' (necessity). Key points in the new law include the following:

- incompetent patients can be killed if they have written a statement in advance requesting euthanasia.
- teenagers aged 16-18 may receive euthanasia, not necessarily with the agreement of a parent or guardian.
- children 12-16 years old may receive euthanasia with the agreement of a parent or guardian.
- the doctor must hold the conviction that the patient's suffering is lasting and unbearable.
- all cases will be reviewed *after* the death of the patient.
- the law does not prohibit doctors from administering euthanasia to non-residents.

Concerns about "euthanasia tourism" are claimed to be addressed by the Dutch law which insists doctors and patients must have a close relationship. But Dr Phillip Nitschke, a prominent Australian euthanasia advocate, said he is considering flying some of his terminally ill patients to the Netherlands, saying an adviser to the Dutch Health Minister Els Borst told him a foreign patient could achieve this relationship on the internet.[21] And an Italian representative of a Dutch euthanasia group has been

[17] *ibid*
[18] Physicians for Compassionate Care, Media Release March 21 2002
[19] Oregon's Death with Dignity Act Annual Report 2000.
Find at www.ohd.hr.state.or.us/chs/pas/year3/ar-tbl-3.htm
[20] Diane Coleman, President of Not Dead Yet (cited in ProLife Infonet "Ashcroft defends motion against Oregon's assisted suicide law", February 21 2002). Statistics from *Fourth Annual Report on Oregon's Death with Dignity Act*. Find at www.ohd.hr.state.or.us/chs/pas/ar-tbl-3.htm
[21] "Doctor's group to debate euthanasia", Courier-Mail 3 April 2002, http://news.com.au/common/story_page/0,4057,4062096%255E3102,00.html

investigated on suspicion of helping terminally ill people travel to the Netherlands for euthanasia.

In December a Dutch doctor was convicted of helping a man who was "tired of life" to die in 1998. The court therefore demonstrated its opinion that being tired of life falls outside the accepted reasons for euthanasia; however no prison sentence was given because the court ruled that he had acted out of compassion for his patient. Euthanasia advocates felt the conviction was wrong, that the act fell within the guidelines, or that the guidelines needed to be relaxed further to include being tired of life.[22] This was viewed as a test case to define the limits of euthanasia; perhaps observers could conclude that while euthanasia did have limits, the court did not take them seriously enough to sentence the doctor found guilty.

The UN Human Rights Committee has recently criticised the Dutch law. The committee is concerned that the system could not detect and prevent cases of coercion, that the law could lead to routine mercy killings, and particularly that children aged 12 to 16 were now eligible for euthanasia with parental support.

3. A reflection on voluntary euthanasia and physician-assisted suicide

In recent years the push for legalisation of voluntary euthanasia and physician-assisted suicide has strengthened, making ground in some cases and losing ground in others. The European Court of Human Rights ruled in April 2002 that there is no right to die. The US Supreme Court has also ruled that Americans have no constitutional right to die.[23] So individual states and countries are left to deal with legislative issues regarding euthanasia and assisted suicide. Legal precedents have proved to be very important in shaping public opinion, particularly in The Netherlands, Japan, Oregon, and Colombia. Cases of individuals seeking euthanasia or assistance in suicide are 'adopted' by euthanasia lobby groups in order to stimulate debate and put pressure on legislators and the judiciary.

For the pro-life lobby it is useful to understand the intricacies of the debate in various countries, and to have an understanding of the ways in which euthanasia and assisted suicide have been legalised or tolerated. It is important to see how a close analysis of particular cases exposes the philosophical assumptions of euthanasia advocates.

There are two general arguments used in favour of legalised euthanasia and assisted suicide. One is the ending of unbearable physical and/or psychological suffering in the case of terminal illness, and the other is to enhance individual autonomy. The arguments are differentiated because (a) someone who is suffering physically or who is terminally ill may *not* want to die, and (b) someone who is *not* terminally ill or

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[22] Pro-Life Infonet Friday December 7th, 2001 (Source: Reuters December 6 2001)
[23] *Vacco et al* v. *Quill et al*: The US Supreme Court ruled in 1997 that New York's prohibition on assisting suicide does not violate the Fourteenth Amendment's Equal Protection Clause. See: http://supct.law.cornell.edu/supct/html/95-1858.ZS.html

suffering physically may want to die. A government may decide to combine the two concepts to create what they believe to be a tight, safe law – e.g. The Netherlands, where suffering has to be coupled with an explicit persistent request.

But pro-lifers are vindicated in their predictions that (a) some people who are suffering and do *not* want to die may be killed anyway, and (b) it is not only those who are terminally ill or experiencing intractable pain who will receive euthanasia.

The evidence for this is in the official reports and the media. Many in The Netherlands have been killed without their request because *the doctors* perceived them to be suffering[24]. A Dutch doctor was not sentenced for killing a patient who was tired of life, and Dutch Health Minister Els Borst has indicated support for this reason for euthanasia.[25] In Oregon, where physician-assisted suicide (PAS) is legal, no patients have received PAS with the primary motive of pain relief[26]; but 63% in 2000 were motivated by the desire not to become a burden to family and friends.[27] The 'terminally ill' requirement has been done away with officially in The Netherlands and in practice in Oregon with, in some cases, up to 466 days lapsing before taking the lethal dose.[28]

Why can't euthanasia and assisted suicide be controlled, even where the law requires an explicit request along with intolerable suffering? One reason is that suffering and impaired autonomy have a symbiotic relationship. Autonomy is undermined by the existence of suffering.

Suffering is a fact of life. Accepting this does not devalue research, treatment, pain relief, and avoidance of burdensome therapies. But it is true that almost nobody attains health according to the widely-used World Health Organisation's definition; "not merely the absence of disease or infirmity", but rather, "a state of complete physical, mental and social well-being".

How is suffering measured? Dutch doctors assess whether the patient's suffering is tolerable; in other words they form an opinion. Yet this is subjective. A palliative care specialist says that "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".[29] It is also said by a psychiatrist that "most

[24] van der Maas P J, van der Wal G, *et al*, "Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995", *New England Journal of Medicine*, Vol 335 (22), November 29 1996, pp 1699-1705
[25] Don Feder "Assisted Suicide – The Death of Decency", Creators Syndicate April 10 2002; Prolife Infonet 15th April 2002.
[26] Physicians for Compassionate Care, Media Release March 21 2002
[27] Oregon's Death with Dignity Act Annual Report 2000, www.ohd.hr.state.or.us/chs/pas/year3/ar-tbl-3.htm
[28] Fourth Annual Report on Oregon's Death with Dignity Act, www.ohd.hr.state.or.us/chs/pas/ar-tbl-3.htm
[29] Gilbert , James. "Palliative medicine: a new specialty changes an old debate", in Euthanasia: death, dying and the medical duty, ed. Dunstan G R and Lachmann P J, Royal Society of Medicine Press Ltd, London 1996

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".[30]

At the same time as calls for euthanasia and assisted suicide heighten, research continues to illuminate the heartbreak of suicide and its associated risk factors and predictors. A study of the Hemlock Society's database shows that mercy killings are most likely to be administered by men for women[31]. Most unnatural deaths in people with mental illness are by suicide.[32] Adolescents who kill themselves invariably have an underlying psychiatric disorder.[33] Depression and hopelessness are the strongest predictors of a desire for hastened death among terminally ill cancer patients.[34] Depression, not disease, makes people suicidal.[35] And it must always be treated because free choice is meaningless when the patient is choosing "from under a cloud of depression-induced despair".[36]

Such research reiterates what we already know, that suffering affects an individual's ability to make rational decisions. This understanding is reflected in law. Suicide is no longer a crime. In other words the law will not punish one who attempts suicide. It is understood that the suicidal person's capacity for rational thought has been compromised, and that the criminal process is not an appropriate way to deal with them. Similarly, when a patient asks 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". [37]

But regardless of the patient's capacity to make an autonomous decision, in reality the final choice does not rest with the patient. In the end 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

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[30] Kissane, David (Consultant Psychiatrist, Centre for Palliative Care and Director of Palliative Medicine, The University of Melbourne, Australia). "Distress, Demoralisation and Depression in Palliative Care" *Current Therapeutics* June 2000, pg 14-19

[31] Colleen Burher, "Women shown as typical mercy killing targets", *The Collegian* 25th October 2001. Find at http://collegian.colostate.edu/home

[32] 18.75% of mentally ill deaths due to suicide in Denmark between 1973 and 1993; Hiroeh U, Appleby L, et al. "Death by homicide, suicide, and other unnatural causes in people with mental illness: a population-based study", *The Lancet* Vol 358, December 22/29 2001; pp 2110-2112

[33] Zametkin A, Alter M, Yemini T, "Suicide in teenagers: assessment, management, and prevention", *JAMA* 286 (24) December 26 2001, pp 3120-3125

[34] Breitbart W *et al* "Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer" *JAMA* December 13 2000, 284 (22): 2907-2911

[35] Balch B J and O'Bannon R K *(a)*, "Why We Shouldn't Legalise Assisting Suicide; Part III What about the Terminally Ill?", www.nrlc.org/euthanasia/asisuid3.html

[36] Cohen, Bernard (specialist in geriatric psychiatry at St Vincent's Hospital, New York), "Commentary: The Moral High (Low?) Ground of Assisted Suicide", *Psychiatric Times*, February 1998, Vol XV Issue 2. www.mhsource.com/patient/p980205.html

[37] Horton, Richard, "Euthanasia and assisted suicide: what does the Dutch vote mean?" *The Lancet*, Vol 357, April 21 2001 pg 1221-1222

irremediable suffering while preserving autonomy was lost in the realities of euthanasia in the Netherlands".[38]

This is why the "slippery slope"[39] is a reality. Autonomy is eroded by suffering, and the final decision rests with the doctor, whose opinion is subjective. From a genuine desire on the part of the doctor to relieve suffering, some patients will undoubtedly be killed without their consent.

Pro-lifers point out the 'slippery slope' to warn legislators and communities against tolerating euthanasia and assisted suicide. But the pro-euthanasia advocate or voter may only see problems to be ironed out with tighter legislation, better reporting procedures, or improved palliative care and mental health services. Why isn't the 'slippery slope' argument – now substantiated with evidence – enough to change people's minds?

Perhaps the answer is that euthanasia advocates are motivated by fear of their own future, when they might lose their dignity and autonomy. This is a fate worse than death to them. They forget that each human being has intrinsic dignity simply by being alive. This is at the heart of human rights activism, which calls for the treatment of each and every person as equal before the law.

For those who support euthanasia based on the right to choose, is there any tragedy in suicide? What of suicide's companions – depression, loneliness, and mental illness? Why are women more often the victims of mercy killings? Must free choice for the many come at the expense of a few sad lives?

For those supporting euthanasia as a compassionate law to alleviate suffering, what is the role of autonomy? Is a suffering patient really free to choose? Do they accept a doctor's decision that an individual's existence is worse than death, even when that individual is unable to request death? Should society pass judgment on which lives are worth living – or should society seek to affirm and defend all life?

Many people may not think past the slogans that seem to make sense; 'death with dignity', 'compassion in dying', 'deliverance' or 'the right to choose'. A task for pro-life activists is to challenge the concepts of autonomy and suffering which underpin the euthanasia movement. When carefully examined, these two notions collapse into one; the autonomy of the doctor. Sadly for the many victims, we now have the evidence to prove it.

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[38] Hendin, Herbert, "Seduced by Death: doctors, patients, and the Dutch care", WM Norton and Company, New York 1997.

[39] For a comprehensive account of the slippery slope in The Netherlands, see Fleming , J I "Euthanasia, The Netherlands and Slippery Slopes", *Bioethics Research Notes Occasional Paper No. 1, June 1992.* Adelaide, Australia.