ISSUE BRIEF

Should We Legalize Voluntary Euthanasia and Physician Assisted Suicide?

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The people of the state of Washington recently voted to legalize physician-assisted suicide. Was that a good idea? Should other states follow? Should voluntary euthanasia (VE) and/or physician assisted suicide (PAS) be legalized? When the arguments are examined, and the experience in the Netherlands and Oregon is considered, the answer is a decisive "no."

I. Choice

Those favoring legalization often argue as follows: *The choice of when and how to die is one of the most personal and private decisions we can make. Who are we to deny a patient's request to die sooner rather than later?*

However, the mere fact that I have chosen something simply cannot *justify* what I have chosen. Our laws have long illustrated this truth. For example, they prohibit a range of choices to harm others, from murder to assault. Further, our laws prohibit not only choices which harm or risk harming *others*: they sometimes also prohibit choices to harm or risk harming *ourselves*, such as by snorting cocaine or driving without a seatbelt, as well as conduct which may involve *no risk* of physical harm to oneself or another, such as incest and bestiality.

Further, if respect for choice were the key, why should VE/PAS not be available to *anyone* who autonomously requested it? Why deny VE/PAS to a patient who was terminally ill but who was *not*

suffering at all? Why deny VE/PAS to a patient who was suffering but who was *not terminally ill*, such as someone with severe arthritis? Why deny VAE/PAS to people who were not sick but who wanted to die for *other reasons*, such as the loss of a beloved spouse, or animal, or because of long-term unemployment? In short, the argument from autonomy contains a "slippery slope," and the slope is precipitous.

Most advocates of VE/PAS do not propose that VE/PAS should be available just because the patient has made an autonomous request, since they propose that

only a *doctor* should be allowed to decide whether to grant the patient's request. Yet no responsible doctor would provide VE/PAS just *because* the patient asked for it any more than a doctor would remove a kidney just because the patient asked for it. Doctors would have to come to their *own* judgment about whether the patient's autonomous request should be granted. And how would the doctor decide, other than on the basis of a judgment that the patient's life was indeed no longer worth living ?

Yet, the lives of *all* patients are worthwhile. Although terminal illnesses such as cancer can reduce a person to *experiencing* undignified circumstances (such as incontinence) this does not mean that the person *loses* their inherent dignity or worth.

This is, moreover, no "private" decision. The question whether some citizens (doctors) should be allowed to kill other citizens (patients) is a decision with profound ramifications for the safety and well-being of the whole community, not least its most vulnerable members.

Finally, *just how autonomous* would requests for VE/PAS be? How many patients would be in a position to make a balanced and informed decision? Illness, particularly terminal illness, renders us not only physically but also *psychologically* vulnerable. There is a clear link between requests for VE/PAS and clinical depression. In a statement on PAS in 2006, the Royal College of Psychiatrists, based in London, observed:

In the general population, suicidal thoughts and urges are common symptoms of depression, and serious suicidal thoughts rarely arise apart from depression… Studies using systematic assessments in terminally ill patients have clearly shown that depression is strongly associated with the desire for a hastened death, including the wish for PAS or euthanasia… *Once a person's depression is treated effectively, most (98-99%) will subsequently change their minds about wanting to die.* [emphasis added][2]

II. Compassion

Advocates for VE and PAS also argue: *According to the principle of "beneficence" we sometimes have a duty to benefit others. VAE/PAS should, therefore, be made available to terminally ill patients as a way of putting an end to their suffering.*

But this argument also fails. The duty of doctors and nurses to benefit their patients is not a duty to end their suffering *at any price*. How can putting an end to someone's existence be a *benefit* to them? They are no longer alive to experience

any supposed "benefit"! The fact that the pain and suffering experienced by patients is bad does not mean that their *lives* are bad.

Compassion (which means to "suffer with") is of course a laudable emotion. But a laudable emotion cannot justify immoral *actions*. Compassion for the sick no more justifies killing them than compassion for the poor justifies robbing banks to redistribute wealth. True compassion respects the equality-in-dignity of all patients and seeks to alleviate their suffering in ways that respect their dignity and, where suffering cannot be further alleviated, to show solidarity with them by standing by them and furnishing what support we can. Killing is the ultimate abandonment.

The principle of the sanctity/inviolability of life holds that it is wrong intentionally to kill the innocent; it does not require that we preserve life at all costs. Patients have every right to refuse medical treatment, even life-prolonging treatment, if it would be futile or would prove too burdensome. All human lives are worthwhile but not all medical treatments are worthwhile.

The argument that we have a duty to benefit the terminally ill, and express our compassion, by granting them VE/PAS tempts us, just like the argument from autonomy, onto a steep "slippery slope." If it is right to give a terminally ill patient a lethal injection to end their suffering when they request it, why is it not right to give a lethal injection to end a patient's suffering when the patient *cannot* request it?

Further, many people suffer who are not terminally ill. If it is right to give lethal injections to those dying from cancer, why is it not right to do likewise to those suffering from illnesses which are not terminal?

VE/PAS are, in any event, not the only answer to the suffering of the terminally ill: there is the real alternative of *palliative care*. The evidence from palliative care experts-those who devote their professional lives to the care of the terminally ill and whose expert opinion must surely carry great weight in this debate-is that patients can die with dignity, their passage eased by palliative care, without VE/PAS. VE/PAS are therefore not only unethical; they are *unnecessary*. For example, in England in 2006, over 70 percent of members of the Royal College of Physicians (and over 95 percent of those in the specialty of palliative medicine) agreed with the following statement:

[W]ith improvements in palliative care, good clinical care can be provided … and ...patients can die with dignity.[3]

It is true that *much* more needs to be done to make quality palliative care available to all. However, given the necessary political will, this is an attainable goal. Further, there is a real risk that decriminalizing VE/PAS would distract from this

urgent goal. Why fund palliative care, it would surely be asked, if there were a "quicker, cheaper fix"?

III. The Netherlands

Advocates also point to the experience of the Netherlands to reassure us: *The evidence from the Netherlands, where VE and PAS have been legally permitted since 1984, confirms that VE and PAS can be brought out into the open and subjected to effective control.*

But the evidence is to the contrary.

Under Dutch law, VE and PAS are legally permitted at the "explicit request" of the patient to put an end to "unbearable suffering." The law requires the doctor before performing VE/PAS, to consult with an independent doctor and, after performing VE/PAS, to call in the local medical examiner and file a report. *Nevertheless, the iron reality is that the Dutch guidelines have been widely flouted, that the Dutch have slid down the slippery slope, and that they have done so with remarkable rapidity.*

Since 1990 four Dutch government-sponsored surveys of end-of-life decision-making by Dutch doctors have been carried out (covering 1990, 1995, 2001 and 2005 respectively). *The surveys have shown that in thousands of cases doctors have broken the legal and professional guidelines regulating VE/PAS*, not least the requirement that doctors report each case to the authorities. The first survey showed that in 1990 over 80 percent of cases went unreported and were instead illegally certified by doctors as deaths from "natural causes." The latest survey shows that, in 2005, 80 percent of cases were reported, but that 20 percent of cases were still illegally certified as death from "natural causes."

The first survey disclosed a widespread incidence of non-voluntary euthanasia. *In 1990 no fewer than 1000 patients were given a lethal injection without having made an explicit request.* The latest survey shows that although in 2005 the figure was lower, still 500 patients were given a lethal injection without request.

Now the Dutch authorities warn that patients may be euthanized *unless they make it clear that they do not want it*. If further evidence were needed of the Dutch slide from euthanasia on request to euthanasia without request, it is supplied by the fact that in the 1990s Dutch courts held that doctors who had given lethal injections to disabled babies had acted lawfully. More recently, pediatricians and prosecutors have drawn up guidelines to regularize this practice of infanticide.

IV. Oregon

Finally, advocates, hoping to ignore the experience of the Netherlands, point to Oregon. They say: *The experience of PAS in Oregon, where it has been legally practiced under the state's Death With Dignity Act since, is reassuring. The law contains strict safeguards against abuse. Moreover, the number of cases reported by doctors to the relevant authority (the Oregon Department of Human Services) has been very low and there is no evidence of abuse in practice. Oregon shows that PAS can be effectively regulated.*

The Death with Dignity Act (DWDA) allows an "adult" (defined as an individual over 18) with a "terminal disease" (defined as "an incurable and irreversible disease" that has been "medically confirmed" and will, "within reasonable medical judgment" produce death within six months) and who is "capable" (defined as being able to make and communicate healthcare decisions) to request PAS.

At first sight the DWDA might appear to provide adequate safeguards against abuse. However, as leading US health lawyer Professor Alexander Capron has noted, the safeguards are "largely illusory."

The Act requires:

(a) *the involvement of two physicians; that the patient be referred for counseling if either physician thinks the patient may be psychologically disordered, and that the attending physician inform the patient about alternatives including pain control.*

However, neither of the physicians need be the patient's regular physician and, if they are not, neither need consult the patient's regular physician. Moreover, there is nothing to stop the patient "shopping around" to find two compliant physicians. Nor need either physician have *any* expertise in psychiatry or in palliative care.

(b) *that the patient's written request be witnessed and that the attending physician file a report with the Oregon Department of Human Services.*

The requirement that two witnesses attest that to the best of their knowledge the patient is capable, acting voluntarily, and not coerced can hardly be described as a strict safeguard. It could be satisfied if one signatory *were a beneficiary of the patient's will* and the other *were the beneficiary's best friend*. It could even be satisfied by two strangers invited in off the street!

As for the requirement that the attending physician file a report with the ODHS, there is no guarantee that all doctors file reports or that the reports they file are accurate. The ODHS itself has admitted that it is not an investigatory agency, that

it cannot know the extent to which PAS is practiced outside the DWDA, and that reports which are filed could be a "cock and bull story." There is no guarantee, therefore, that the low incidence of PAS suggested by the DOS's annual statistical reports is accurate. Moreover, the Oregon law's reporting requirement is even weaker than in the Netherlands: in Oregon there is no requirement that the physician be interviewed by the local medical examiner as part of the reporting process.

Conclusion

In short, no compelling reasons have been advanced to legalize voluntary euthanasia or physician assisted suicide. The arguments based on either "choice" or "compassion" lead logically to generalized killing. The experience in the Netherlands and in Oregon gives no assurance that euthanasia or assisted suicide can be legalized without extensive abuse. A far better response to human suffering would be to ensure the widespread availability of high quality palliative care.

[1]This paper is based on Prof. John Keown's FRC *Insight* paper "Should We Legalize Voluntary Euthanasia and Physician-Assisted Suicide? A Review of the Ethical Arguments and of the Empirical Evidence from the Netherlands and Oregon.

[2] *Statement from the Royal College of Psychiatrists on Physician-Assisted Suicide* (2006) http://www.rcpsych.ac.uk/pressparliament/collegeresponses/physicianassistedsuicide.aspx. para 2.4

[3] http://www.rcplondon.ac.uk/news/news.asp?PR_id=310 (Original italics. Last accessed 11 September 2007). In another survey in England only 2.6 percent of doctors replied that a relaxed law would have facilitated the management of their patients. Clive Seale, "National Survey of end-of-life decisions made by UK medical practitioners" (2006) 20 *Palliative Medicine* 3, 6-8.