

EUTHANASIA

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Even though euthanasia is a common topic for general discussion, its real nature and significance are complex and, not surprisingly, it is therefore often misunderstood. A popular view is that it would be simple to introduce a law for change, if only there were the will. It is also often claimed that most people in the community support the idea, and that it is chiefly due to the opposition of those who hold and rely on their religious beliefs that it has not already been enacted. In this and the subsequent papers in this series, no arguments will be used that depend on religious adherence. It will be shown that legalised euthanasia would be a denial of justice and would be highly dangerous to many others in the community who did not want their lives taken.

Euthanasia has moral, social, human rights, medical and legal implications, all of which will be addressed, though not exhaustively, in these papers. First, since the word means different things to different people, the definitions provided here are those commonly used in the international literature and contain all its elements.

Definitions.

Euthanasia is the intentional taking of the life of another person, by act or omission, for compassionate motives. It is

voluntary when a person has requested it for him/herself

non-voluntary when there has been no request or consent, and

involuntary when it is carried out despite an expressed wish to the contrary.

Assisted suicide occurs when one person supplies the means of self-killing to another, with the intention that they will be used for that purpose.

Euthanasia is a form of homicide - even if legalised, it would be legalised homicide. Intention is central to the concept. There is no euthanasia unless the death is intentionally caused by what was done or not done. Thus, some medical actions that are often labelled *passive euthanasia* are no form of euthanasia, since the intention to take life is lacking. These acts include not commencing treatment that would not provide a benefit to the patient, withdrawing treatment that has been shown to be ineffective, too burdensome or is unwanted, and the giving of high doses of pain-killers that may endanger life, when they have been shown to be necessary. All those are part of good medical practice, endorsed by law, when they are properly carried out.

Though it is not always easy to make the distinction between the intended consequences of an act and those that are foreseen but not intended, and some people

may then think there is no distinction, it is nonetheless real, and important to make it. It provides the ethical justification for some of the necessary actions of doctors in certain complex situations near the end of life, for example, when appropriately removing medical treatment that has been shown to be useless. When continuing medical treatment would be futile, that is without any known predictable benefit, it is both legal and ethical to withhold it or remove it with the intention of ceasing the needless prolongation of inevitable dying, even though death may be foreseen as a consequence. (In passing, it can be mentioned that terminally-ill patients are rarely attached to life-support systems, such as ventilators. The issue of the removal of life-support is separate from euthanasia).

It is sometimes said that intention cannot be tested, but there is a simple test to apply to clarify the matter of intent when dealing with euthanasia . Ask the question ‘What would then be done if the patient did not die?’ If treatment was withdrawn and the patient didn’t die, he or she would then receive all necessary care until eventual natural death. If a lethal injection didn’t work, further doses would be given until the patient died. One risks death and the other seeks it.

Some object to the word ‘killing’ as applied to euthanasia as ‘emotive’, but it is simply descriptive of what is being proposed, that is, ‘to take the life of’. Nobody becomes emotionally upset when they read that ‘Mr So and So was killed yesterday when hit by a speeding car’. The term ‘mercy killing’ is accurate and inoffensive. On the other hand, while euthanasia is technically the crime of murder, this word may be offensive because its motive is usually not malicious, but compassionate.

Morality.

This word is used here in its secular sense of things that are right or wrong, and has no particular relevance to any religious doctrine. The whole of the criminal law is devoted to things that are matters of wrongdoing, accepted by Australians and every world community. Since euthanasia is the taking of innocent life, innocent referring to those who pose no present or future threat to others, it is above all a moral issue, and to ignore this distorts the discussion from the outset.

But many in society say they have become unhappy with notions of objective morality as a standard to which all are required to conform, while at the same time they cheerfully accept standards in other walks of life, since standards represent all that stands between order and chaos. There must be some good reason why every nation in the world in recent centuries has regarded taking the life of an innocent as the greatest crime, deserving of the greatest penalty, and that it has been universally realised that, in order to protect everyone equally in the community, especially the weakest, there are no exceptions to this rule. In fact, although the law does not attempt to define human values, it implicitly accepts that innocent human life has the highest possible value.

If, as a society, we cannot agree that it is wrong to take innocent life, that natural rights need respect and protection, and that the frailties of mind and body imposed by serious illness render the sick peculiarly vulnerable to manipulation by others who may resent them for social reasons, on what can we certainly agree? If we cannot

agree on the morality of anything, then the law can be dispensed with, except in so far as it represents self-interest or mob rule.

Social.

One of the functions of government is to take all necessary measures to protect the lives of all its citizens, especially the lives of its weakest members. There is no precedent anywhere for a government to take any action to positively discriminate between its citizens or to positively endanger any human life. A law to enable euthanasia would select a group of people from whom the current universal protection would be withheld, by allowing their lives to be taken legally. That would create a precedent that does not presently exist, which, like all precedents, may be later amended, if that were thought desirable. No lawmaker could offer any guarantee that the new law could not or would not be changed later, including in ways that he/she would not approve of.

A law to allow the taking of innocent life would undoubtedly lower the community's standards of respect for human life, at least in some quarters. Once the first hurdle had been cleared by permitting some lives to be taken, should some new factor arise to create a new crisis, for example, if the cost of medical care for the aged or the disabled rose to what were thought to be unsustainable levels, an easy solution would already be to hand. It would be logical to extend the original provisions to cover the new position. If this is thought to be far-fetched, know that the reason why every organisation in Australia that represents the interests of disabled people vigorously opposes euthanasia is because they see that such logic may well prove irresistible. This stand is justified by their sad awareness that the disabled are already the subjects of significant levels of public and private discrimination, abuse and contempt, and would provide an easy and defenceless target for health economic rationalists.

Why is euthanasia wanted?

No-one should disregard the terrible plight of those dying people who are now suffering uncontrollably without any prospect of relief other than death, natural or induced. The claim that these are the very people for whom euthanasia is wanted must be examined.

The classic picture drawn is of a person with advanced terminal illness, probably cancer, whose pain has reached levels at which it can no longer be controlled, and for whom there are no alternative prospects for relief. The pain of cancer is severe to moderate in about two thirds of its sufferers, and in these, pain can be well controlled in all but a small fraction, often set at about 3-5%, by known methods when they are properly used. In fact, almost this level of pain control is within the competence of all doctors who have been trained or educated. This means there should be, if every doctor who was caring for dying patients was correctly using the necessary methods, only about 2-3% of patients whose problem was really difficult, and requiring high levels of competence by experts.

But this is not what one sees. What is observed is that many patients are dying with poorly controlled pain, when the doctor has not known how best to proceed and has not sought help from experts. This situation can be wrongly used to argue for

euthanasia, but euthanasia should never be regarded as the answer to inadequate care. Whatever one's views about euthanasia, a satisfactory standard of care for the dying is the right of the community to expect of all its doctors, and the responsibility of authority to ensure is provided. What is called unrelievable pain is usually only what an individual doctor has not been able to relieve and has not consulted an expert.

An Australian Professor of Law and Ethics has correctly seen the real elements in this issue, when she said that unrelieved pain does not call for euthanasia - it calls for an expert to be brought in to relieve the pain, and then to look at the circumstances to see whether the first doctor(s) should be charged with negligence.

Palliative care

This is the present standard of medical and nursing care for terminally ill patients. By means of team work, using a range of skills when these are needed, it includes the management of pain, both physical and emotional, other difficult symptoms, honest dealing, the inclusion of family and friends, effective communication so that the patient and his family are well informed about the illness and its possible treatments, and are offered support across a range of issues, especially those of most relevance to the patient. It should be clear from this description that the commonly observed situation falls far short of what is known to be achievable. The reasons for this shortfall are many, but all are capable of elimination or improvement.

Palliative care seeks neither to prolong life nor to shorten it artificially. It respects life, holding that, when death is inevitable, the provision of comfort is the prime responsibility. It is wrong to shorten life intentionally and to prolong it unnecessarily, without good cause, when it is in the patient's best interests to die. A patient's choice to refuse unwanted treatment, for any reason other than suicidal, must always be respected. It is important that everyone knows that it is their right, protected by law, to refuse any treatment they do not want.

While the usual focus is on pain, the emotional turmoil that almost always accompanies severe pain needs also to be dealt with energetically. Pain will seldom be well controlled in the presence of acute anxiety, so this combination of factors should be regarded as a medical emergency to be brought under control as quickly as possible. Anxiety must be replaced by security and a confidence that the carers will never abandon the patient, no matter what may lie ahead. Patients deserve to be given the understanding of their illness and its significance that they want, because it is their right to know.

'Communication can make the difference between a composed, functioning person who is able to make the best of his life and one whose days are filled with despair...this is a formidable responsibility'.

People who request euthanasia often suffer from a lack of human relationships and understanding. Simply responding to such a request may be considered the final rejection in a series of abandonments through lack of human attention and loving concern.

Rather than take any steps to legalise euthanasia, and certainly before it were even considered, since it is now known that such a law that could not be made safe from abuse so as to endanger the lives of those who did not want to die, steps are urgently needed to see that every doctor who treats seriously ill patients is well instructed in modern methods of care. The community is entitled to expect that no patients are left in unnecessary severe pain and that doctors will be held accountable, if necessary, for this.

By the supporters of euthanasia, it is claimed that legalised euthanasia would strengthen the doctor/patient relationship, since some dying patients would be comforted to know that the ultimate remedy for any problem was available - that is, by removing distress by removing life. This may be true for the small minority of those who would take advantage of such a law, (the advocates of euthanasia concede that only a few would wish to avail themselves of it), but it ignores what the rest might think. If doctors were empowered to take life, a sick patient could never be certain what were the doctor's views about his/her future, especially as it is known that euthanasia laws would always be open to abuse.

The common reasons to want legalised euthanasia are:

(a) the compassionate relief of pain and suffering. The more aware supporters of euthanasia now realise that this reason has lost its former clout, on account of the quality of good palliative care.

(b) respect for human rights. For many, this is now the commonest reason to promote euthanasia.

(c) protection for doctors who behave 'compassionately', by performing euthanasia outside the law at present, as though they had the corner on compassion. They wish to continue but with legal protection, and

(d) assist in the containment of health costs. This is the least 'worthy' of reasons, but it is the one with the most potential for future abuse, if the costs of health care for the aged and the disabled continue to rise to what may be seen as intolerable levels. To some, it would then seem that legalised euthanasia would provide a ready solution.

Human Rights.

Although it may seem self-evidently logical that consideration of the right of every person equally to respect for his/her life would be the first matter to address in a discussion of human rights, not only is this usually not so - it is commonly omitted altogether, in favour of emphasis on personal autonomy. This paper will discuss both rights, in their correct order.

In 1948, the United Nations defined and proclaimed human rights, in the hope that they would thereby be better understood and secured in future. Hence, its Universal Declaration of Human Rights declared that 'the foundation of freedom, justice and peace in the world' is the 'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family'. Further, 'everyone has the right to life' and 'all are equal before the law and are entitled without any

discrimination to equal protection of the law'. This Declaration was supplemented by more specific proclamations, including the 1966 International Covenant on Civil and Political Rights, Article 6 of which states: 'Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life'.

Words such as 'equal', 'inherent', 'inalienable', 'without discrimination' and 'arbitrary' were meant to define the essence of natural rights, particularly that they do not depend on circumstance or personal preference. Natural rights are not taken away and, just as importantly, are not given away. The right to life is to be protected by law, invariably and equally, and life is not to be taken for reasons based on opinion. The right to one's life is thus declared to be the fundamental natural right, on which every other right depends for its existence and its validity.

Autonomy is the right of every person to decide freely the course of his/her own life, within the limits set by the competing genuine rights of others, and it will oblige compliance only when it respects those other rights. That is, autonomy involves both the privilege of choice and the duty to restrain one's choice, when that is required. Autonomy is misunderstood or misrepresented when it is assumed to apply to whatever an individual may happen to want sincerely, or when it is assumed that the significance of the consensual killing of voluntary euthanasia is a private matter, with no harmful consequences for others. Both assumptions are wrong.

The essence of autonomy lies in what is chosen, not in the fact that choice is being made, though the opposite is the implied understanding of much of the current use of the word, including its use in relation to euthanasia. Individuals have no entitlement at all to be given what they happen to want - that would be nearer to self-indulgence than self-determination.

The degree to which personal choice is to be respected is dependent on what is chosen. An appeal to autonomy clearly does not validate a choice to kill another person, because no-one has any right to do that. Similarly, since the right to request death at the hands of another is not found in any code of ethics or law, or in any statement of rights, it also cannot be a proper exercise of autonomy. Not only that, but it would directly conflict with the most fundamental natural right to life, the undoubted privilege of everyone, without exception. This is not to say that arguments for euthanasia based on other criteria do not exist, but that they do not include an appeal to human rights in general, and autonomy in particular.

It is often heard that euthanasia is a matter of personal choice only, and therefore should be nobody else's business. It is extraordinary that, while at least two persons are involved in euthanasia, both of whom will have to make an autonomous decision, only the autonomy of the patient is discussed. The doctor is a separate moral agent, with autonomous responsibility for his or her own actions, particularly those with undoubted moral content, but his or her autonomy totally escapes examination. What makes it extraordinary is that the doctor's autonomy will always be the more dominant and important, since euthanasia will not take place without a consenting doctor.

This omission conceals two important points - first, the means by which the doctor's decision is reached. Since, in the same circumstances, different doctors would come to different conclusions about the need for euthanasia, medical agreement to carry out euthanasia must reflect that doctor's personal values. But because the right to life is a universal entitlement not to be made subject to arbitrary judgment, that could not be just.

Second, the great difference between the doctor and the suffering patient in their capacities to make autonomous judgments. Patients with life-threatening illness often have greatly impaired capacity to make rational judgments about complex matters. Potent emotions, such as fear, anguish or despair, are frequently present, though when they are recognised and treated adequately by competent doctors, the reason for a request to be killed will often disappear. To accept requests for death at face value without providing adequate care would be a form of patient abandonment, by taking advantage of their vulnerability in such states. In so doing, their autonomy would be abused, in the name of honouring it. By contrast, the doctor must be presumed to be rationally capable of decision-making, prepared to have his or her decisions scrutinised, and prepared to take both moral and legal responsibility for them.

Thus, the euthanasia debate, when it relies on human rights, is presently distorted in two important ways - it neglects the genuine right to life and it relies on an erroneous concept and application of autonomy.

Opinion polls.

The claim that a majority of Australians want euthanasia legalised is far from being established.

On the basis of public opinion polls, it is repeatedly claimed that some 70-80% of Australians support legalised euthanasia. The recent passage of the Andrews Bill in the Senate was followed by an outpouring of hostile sentiment, on the grounds that the views of the majority had been disregarded. Over a long period, the public had been encouraged by the media to accept opinion poll results as a reasonable basis for this perception. The fact was not widely known that our parliamentarians had reached the same conclusion as every other committee of inquiry, and if it had been known, it still would probably have been repudiated because of a conviction that the presumed view of the majority should have been respected.

Opinion polls were developed to test views about political issues, but euthanasia is essentially a moral matter, since it is about taking human life. Would anyone place credence on opinion polls about theft, defamation, cheating or assault, and use the results to try to change the law? When the issue is as complex as euthanasia, no valid conclusions can be drawn from polls when the respondents' understanding of the subject is both unknown and unknowable. To use such results as an argument to change the criminal law is both foolish and dangerous.

Morgan polls have been asking the following question regularly since 1962: 'If a hopelessly ill patient, in great pain, with absolutely no chance of recovering, asks for a lethal dose, so as not to wake again, should the doctor be allowed to give the lethal dose?', and the number in favour has increased from about 50% to nearly 80%. As

one commentator said, it would be hard for an uninformed person to say 'no' to that question without feeling negligent, dogmatic or insensitive.

But when the current ability of good palliative care to relieve the severe pain of terminal illness is known, though it is also known tragically not to be sufficiently available, the same question could be more accurately put: 'If a doctor is so negligent as to leave a terminally-ill patient in pain, severe enough to drive him/her to ask to be killed, should the doctor be able to compound that negligence by killing the patient, instead of seeking help?' The question is really about medical standards, not euthanasia.

It cannot be doubted that most of the community's views on euthanasia have been derived from the media, which almost without exception, give a partial, if not a distorted, picture. When public opinion polls show that many people are in favour of euthanasia, the media, which have created this very opinion through their advocacy and lack of balance, then cite these figures as evidence of the need to change the law to allow it! Such behaviour is self-serving, and contrary to both truth and justice.

If such issues could really be settled satisfactorily by opinion polls, parliaments could be largely dispensed with, in favour of endless polling (and that would include referenda). Even Helga Kuhse, one of the most prominent Australian advocates for euthanasia has said: 'If there are good reasons why the people shouldn't have (legalised euthanasia), then the government shouldn't give in to the people, even if ninety per cent want a change in the law'.

The many reasons why any euthanasia law would be unsafe and why the community would be disadvantaged by it are the subject of the paper *The Legalisation of Euthanasia*.

The most serious possible abuse of legalised euthanasia would be the extension of voluntary to non-voluntary euthanasia, the so-called 'slippery slope'. While many do not regard this as likely, or even possible if a law were properly drafted, this is not so. The subject is treated more fully in the paper *Non-voluntary euthanasia*.