

## NON-VOLUNTARY EUTHANASIA

Advocates of legalised euthanasia usually insist that they only want voluntary euthanasia (VE) - they say they are as opposed to the taking of life without the subject's knowledge or consent, that is, non-voluntary euthanasia (NVE), as anyone else. Some do extend their advocacy to some examples of NVE, such as seriously deformed newborns,<sup>1</sup> where consent would not be possible, but this is not usual. It is widely accepted that sufficient protection against the unwanted extension of VE to NVE would be ensured by the inclusion of legal provisions to guarantee this.

As safeguards, clauses are proposed that would require the doctor to be satisfied that the patient's request was freely made and sufficiently informed, that there was no psychological abnormality such as depression, and possibly by requiring psychiatric consultation, that more than one doctor be involved in the decision that it was medically appropriate to take life in the circumstances, and that there be adequate documentation. It is also common to find lawyers who declare that such laws would be feasible to devise, though it is less common to find actual draft laws published for discussion. In one sense, those lawyers are correct when they say such law would be possible - but they stop short of addressing the question of whether they would be safe, in practice. It is uncommon to find any analysis that assesses the effectiveness of the so-called safeguards.

By contrast, overwhelming evidence is now available in the published reports of a number of independent committees of inquiry into the consequences of legalising VE, which all concluded that NO such law could be guaranteed to be safe against the likelihood of abuse. In fact, no committee set up for this purpose has ever reached any conclusion other than prohibition of legalisation. To discover the many reasons why these committees all reached the same conclusion, in three instances unanimously, that every such law would be flawed, the author's paper on the matter may be consulted.<sup>2</sup>

Though the first of these reports appeared in 1994 and the last in 1998, their arguments are so compelling that no criticism of them has ever been published. Until and unless it can be shown that their common conclusion is unwarranted, they must be regarded as having established the truth.

This seems to some to be such an unexpected development, and so contrary to what is confidently often asserted, that it barely seems credible. The commonest and most serious form of abuse of any euthanasia law would be the endangering or the actual taking of the lives of some of the other terminally ill or disadvantaged groups of the sick or disabled who did not want their lives taken. That is, the apparently strict control over the practice of VE would be illusory, and in the worst case, acceptance of VE would lead to the practise of NVE. Additionally, since concealment would be easy to carry out, and hence correspondingly difficult to discover, a truly compassionate society must rate the risk as too high to be acceptable.

This common finding by each committee is consistent with what had already been predicted many times, namely that NVE is such a logical extension of VE that its occurrence should be regarded more as a fulfilled expectation than a matter for surprise. The arguments for VE already encompass the rationale for NVE.

That progression would be logical because, once it had been decided that taking life provided a benefit to one whose quality of life had led him/her to ask for death, it could then be thought

discriminatory and unfair to withhold that supposed benefit from others in a similar plight, just because they did not, or could not, ask. NVE, like VE, is also thought by its practitioners to be compassionate and benevolent, not malicious or malevolent.

Since nobody would take a life they valued, in each instance of VE or NVE the ultimate justification is that the particular life no longer has sufficient value to mandate its continuance. Such reasoning would be incompatible with recognising the equal, inherent dignity of every person, as that dignity is declared in statements of human rights to attach to every life, without exception. That view of human dignity is also the one that provides the basis in criminal law for the provision of universal protection for every innocent human life, without exception. Hence, both practices are radically incompatible both with what needs to be acknowledged if we are to live well and peaceably with each other and with the very notion of justice in society, since justice is founded on and exists to respect equal dignity.

It may be objected that these arguments are theoretical and do not necessarily apply to the actual decision-making required in medical practice at or near the end of life. Thus, it is said doctors are not monsters who would suddenly begin to take life indiscriminately, and the risk of extension of one euthanasia practice to the other is overstated and no more than scare mongering, for which, in any case, there is no evidence. The difficulty with that position is that the evidence for NVE at present is readily found, even though it is carried out in secret and to an unknown extent.

### **The Netherlands**

Dutch euthanasia has been known to be commonly practised since 1973, when a court determined that a doctor, who had killed her mother who was dying and had requested euthanasia, was guilty but that her action was justified. At her trial, evidence was given on her behalf that she was doing no more than what was already common but unpublicised. The court also described circumstances in which it thought that doctors may be excused after euthanasia.

There ensued many years during which the Dutch maintained that euthanasia was closely supervised and controlled by the authorities, while some well informed outsiders maintained that this was certainly not the case, and that abuse was already common and extended as far as medical life-taking without the patient's consent.

During this period, even though VE was the only practice publicly discussed, official support for NVE could be readily found in the Netherlands. The State Commission on Euthanasia in 1987 had recommended that NVE should not be an offence, if carried out in the context of 'careful medical practice', though that term was not defined.<sup>3</sup> In 1988, a Royal Dutch Medical Association (KNMG) working party condoned euthanasia for deformed infants, in some instances thinking it might be compulsory.<sup>3</sup> In 1991, a KNMG committee condoned the killing of patients in persistent coma.<sup>3</sup>

Dutch euthanasia practices were first officially examined in the Rummelink Report of 1991 which was based on medical practice throughout 1990,<sup>4</sup> for which the statistical study was done by van der Maas and others.<sup>5</sup> This study was later repeated and its findings were reported in 1996.<sup>6</sup>

In 1991, by adopting the narrow definition of euthanasia only as 'active termination of life upon the patient's request', there were 2,300 instances of euthanasia in the year of the study, or 1.8% of all deaths. When, however, to these are added instances of life-taking without request and

intentionally shortening the lives of both conscious and unconscious patients, the figures for which are found in the statistical study, the conclusions are dramatically altered.

They now become: 2,300 instances of euthanasia on request; 400 of assisted suicide; 1,000 instances of life-ending actions without patient request; 8,750 patients in whom life-sustaining treatment was withdrawn or withheld without request, 'partly with the purpose' (4,750) or 'with the explicit purpose' (4,000) of shortening life; 8,100 cases of morphine overdose 'partly with the purpose' (6,750) or 'with the explicit purpose' (1,350) of shortening life; 5,800 cases of withdrawing or withholding treatment on explicit request 'partly with the purpose' (4,292) or 'with the explicit purpose' (1,508) of shortening life.<sup>6</sup> Thus, there were up to 23,359 instances of doctors intending, by act or omission, to shorten life. The true incidence of euthanasia could have been as high as 20% of all deaths in the year.

Although the Report stated that the 1,000 instances of 'life ending actions without request' were carried out on incompetent persons 'in their death agony', on the doctors' testimony at interview as described in the Survey, 14% of these patients were competent and 11% were partly so. According to that part of the Survey known as the death certificate study, 36% were competent. While NVE is generally thought of, and defined, as taking the life of an incompetent patient who could not choose at the time, these figures include another and unexpected category of NVE as killing practised on persons who were competent - those who could have been consulted, but were not.

One observer who has closely studied Dutch euthanasia estimated that the Dutch statistics allow for the possibility that there were 'about five thousand cases in which physicians made decisions that might or were intended to end the lives of competent patients without consulting them'. When he tried to obtain a possible explanation for this astonishing practice while he was visiting the Netherlands, he could get none. He was left to conjecture that when a doctor already thought it was appropriate to end the patient's life, he might think it safer not to seek consent, since if it was refused, to proceed would evidently be murder.<sup>9</sup>

In the preamble to its Guidelines for Euthanasia in 1987, the KNMG had written: 'If there is no request from the patient, then proceeding with the termination of his life is juridically a matter of murder or killing, and not of euthanasia'.<sup>10</sup> Using their own society's definition, Dutch doctors were carrying out medical murder in 1991, and have continued to do so ever since.

There followed a period of official inactivity because some of the findings were so unexpected, and because euthanasia was well supported by the community. Euthanasia activists lobbied to have it formally legalised, but without success. In particular, NVE presented a semantic problem because by the official definition, it was not any form of euthanasia. To meet this difficulty, the authorities abandoned their candour of 1987 in favour of an innocuous-sounding acronym, LAWER, 'life-terminating acts without explicit request'.<sup>11</sup> The topic could now be openly discussed as though it were morally, medically and socially neutral, and it was soon to become just another medical alternative available to doctors and the community.

In 1993, authors from the department of Public Health at the Erasmus University could write: 'But is it not true that once one accepts euthanasia and assisted suicide, the principle of universalizability forces one to accept termination of life without explicit request, at least sometimes, as well? In our view, the answer to this question must be in the affirmative'.<sup>12</sup>

In February 1993, new regulations about the medical reporting of euthanasia were issued,<sup>13</sup> but they had little impact, either on reporting or on the practices themselves. The new rules required the reporting of both VE and NVE on the same form. This had the effect of confirming in many doctors the view that both were equally acceptable to the authorities. Indeed, in 1993 the Secretary of Health, referring to these practices, said: 'For a physician, the considerations in these two cases are not essentially different; from the moral point of view, the two actions are not of an essentially different kind'.<sup>14</sup>

In the official 1996 review of developments since 1991, it was concluded that 'euthanasia seems to have increased in incidence since 1990, and the ending of life without the patient's explicit request seems to have decreased slightly'.<sup>5</sup> Later in this paper, the matter of a possible 'slippery slope' associated with euthanasia is discussed, and it is mentioned that some euthanasia supporters insist there is no evidence that it has ever happened or would even be likely to happen. The reader's attention is therefore drawn again to the last quote above, where the Dutch can say simply, in essence, that medical murder (their own term) seems to have decreased slightly in the five years since it was first officially detected. The Dutch have reached the position where medical murder is now entrenched, and is not seen by their authorities as anything that might represent a deterioration in standards or call for correction. Not only have the Dutch become unwilling or unable to recognise the corruption of medicine and law attributable to their acceptance of any form of euthanasia, it seems that neither have some of the Australian supporters.

In 1995, two separate Dutch courts upheld the actions of doctors who had deliberately ended the lives of handicapped neonates with lethal injections, thus providing the first legal endorsement of NVE. In one case, the judge said 'In the decision of active ending of life, Dr Kadjik had acted with scientific responsible insight and in accordance with the medical ethic and accepted norms and in due consideration of due care resulting therefrom; he is entitled to an appeal of force majeure'.<sup>15</sup> To justify what is admittedly an offence, courts in the Netherlands are allowed to decide that it is lawful for a doctor, faced with the alternative of leaving a patient in pain or of giving relief by taking life, to take the 'compassionate' option, by taking life. The doctor is said to be acting under a higher duty.

Most jurisdictions elsewhere regard this so-called dilemma as a fiction, on account of the proven effectiveness of palliative care to control such pain. This was specifically referred to by the US Supreme Court in its historic judgment of November 1996, when Justice O'Connor noted: 'A patient who is...experiencing great pain has no legal barriers to obtaining medication from qualified physicians to alleviate that suffering, even to the point of causing unconsciousness and hastening death'.<sup>16</sup>

The significance of NVE in the Netherlands has now been reduced almost to the point where discussion about it relates only to its detail, while the fact that it is still a major criminal offence by Dutch statute law, as it is elsewhere throughout the world, is no longer given special mention. That its incidence hardly fell between 1991 and 1995, or that it occurs at all, elicits no critical comment. An American psychiatrist estimated that, if NVE had been practised in the US at the same rate as prevailed in the Netherlands in 1990, the figure would have exceeded the 'combined total of all deaths from suicides and homicides' in that year.<sup>17</sup>

## **Australia**

In all Australian states, euthanasia is the crime of murder. In a study by sociologists in South Australia reported in 1994, using an anonymous questionnaire sent to 10% of the medical practitioners in that state, a significant incidence of NVE was discovered.<sup>18</sup> The authors had seeded linked questions in different parts of their questionnaire, so that their association would be less evident to the respondents. 19% of doctors surveyed admitted they had ended life deliberately, and on 49% of those occasions, the answers revealed they had done so without patient request.

This study has not been repeated in Australia, but it is known that there is a high incidence of illegal euthanasia among the gay communities in the large cities, and it is probable that this includes NVE also.

### **United States of America**

In 1998, the results were published of a national survey of the attitudes and practices, concerning assisted suicide and euthanasia, of physicians in the 10 specialties in which doctors are most likely to receive requests for euthanasia.<sup>19</sup> 61% of the 3,102 physicians surveyed responded. Under the heading 'Characteristics of Patients Receiving Assistance' where a request for death had been met, it is reported that '54 per cent of the requests for a lethal injection were made by a family member or partner'. This brought no specific comment from the authors, though it reveals that slightly more than half the medical killing reported by some 1,800 doctors was NVE. Does this mean that, as in the Netherlands, NVE no longer causes surprise in the US, or did the authors not realise that they had uncovered a deeply disturbing state of affairs?

This paper went on: "requests for a lethal injection were characterised as indirect rather than explicit in 79 per cent of cases. Five per cent of patients who received prescriptions and 7 per cent of those who received a lethal injection were described as 'confused 50% or more of the time'". Since all these events were carried out in private and therefore unsupervised, the figures give grounds for great concern about the potential for the uncontrolled extension of the euthanasia practices of some doctors. Because they are done in secret, not even a law to allow VE could hope to prevent such extension.

The opinion that there is no evidence for a 'slippery slope', by which is meant the progression of VE to NVE, is still commonly heard, even though evidence for it is available, as just discussed. When this is pointed out, the response has been that, though this may be so, there is no evidence that one has actually led to the other. This evasive answer fails to offer any explanation at all for the occurrence of NVE, which is, by any legal criterion, medical murder, and shows little concern that it is happening at all. It would seem that, to some, it is more important simply to deny the facts or to denigrate those who draw attention to them, than to lose face by condemning NVE.

Ready proof that the progression of VE to NVE has grounds in logic is available whenever euthanasia becomes a topic for public discussion following the media disclosure of some instance of mercy killing. At such times, radio talk-back programs quickly come round to discussing the plight of the senile, elderly people in nursing homes, how their lives are futile, how they, their families and the public purse would all experience great relief from their demise, and particularly singled out for comment are those who are irreversibly mentally incompetent. This is heard from those who, shortly before, professed to want only VE, and who, I suspect, do not even realise they have made this subtle but significant mental shift.

Two dangerous ideas lie just below the surface of awareness in an unknown number of people in the community, though they are not usually thought proper to be voiced openly: that there are groups of unfortunate people whom society could well do without, and that they cost a lot of money that could be better spent. These ideas are rejected by the usual advocates of VE, as they should be, but those who hold them would constitute a significant problem were legalisation of VE to be voted on. They would cast a vote in favour, but they would not forever be satisfied with VE only, and would be likely to push for its extension to NVE. And if that vote were made reliant on compassion, even though it may be misplaced compassion, these disadvantaged people would often seem to be the most deserving of compassionate release.

It is impossible for those who would have VE legalised to guarantee that such law could or would remain unaltered in the future. When legalised VE had in time caused a lowering of the community's respect for all human life, as it undoubtedly would, and when health costs had escalated to what were seen to be unsustainable levels, as they undoubtedly will, a precedent for the further erosion of protection for human life would already exist, having been created when VE was legalised.

## **Conclusion**

As long as notions of life-taking without consent are simplistically thought to be only associated with some degree of malicious intent, it can be considered insulting to suggest that NVE might also be practised, if VE were legally permitted. Especially is such a suggestion thought to reflect adversely on doctors, who, while they are often criticised on other grounds, are not generally thought to be unprincipled or malicious. But when the actual motivation for NVE, in its practitioners' estimation, is that it is an act of kindness, the risk to the lives of some of the more vulnerable in society then becomes more apparent.

The prospect of NVE then changes from being repugnant and rare to an act that can be thought to be desirable and beneficial, in some circumstances. So regarded, NVE could be confidently predicted to be, in time, virtually inevitable. Any instance of NVE is a case in practice of 'the tendency of a principle to expand itself to the limits of its logic'.

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