

Dieter Birnbacher  
Edgar Dahl  
*Editors*

International Library of Ethics, Law, and the New Medicine 38

# Giving Death a Helping Hand

*Physician-Assisted Suicide  
and Public Policy.  
An International Perspective.*



Springer

## GIVING DEATH A HELPING HAND

# INTERNATIONAL LIBRARY OF ETHICS, LAW, AND THE NEW MEDICINE

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# **Giving Death a Helping Hand**

## **Physician-Assisted Suicide and Public Policy. An International Perspective**

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# Preface

Interest in euthanasia has continually grown during the last decades all over the world, especially in the industrialised countries with their high standards of medical care. This growing interest seems to be in exact proportion to two tendencies: the increased capacities of modern medicine to maintain life-functions in states of terminal disease and severe impairment of bodily and mental functions; and the tendency of physicians to preserve life in situations of imminent death at the cost of severe suffering and loss of independence. Despite the evident similarities of the problems underlying the wish for euthanasia in all industrialised countries one finds striking differences in the extent to which this wish is recognised and reflected in public policy. A number of factors seem to work together to produce very different political responses to the widely held wish to make use of means by which, to quote Francis Bacon, "the dying may pass more easily and quietly out of life": cultural factors such as religion and the historical experience of the abuse of euthanasia in the hands of reckless physicians; the Hippocratic tradition forbidding any physician to use the means of medicine to actively bring about the death of a patient; and the great differences in the amount of pressure national "right-to-die"-societies have been able to put on legislators to make euthanasia a legally protected patient right. While in Great Britain the "Voluntary Euthanasia Legalisation Society" was founded in 1935, and in the USA the "Euthanasia Society of America" in 1938, most societies of this kind were established only some time after the Second World War, and in most countries – with the possible exception of the Netherlands and Switzerland – their political influence is still limited.

Euthanasia has many faces, and correspondingly diverse are the proposals coming from relevant patient groups, right-to-die-societies and other movements for the legal and institutional framework in which euthanasia is practically carried out. While the Hospice movement has defined its identity by the rejection, as a matter of principle, of active euthanasia and assisted suicide, the objectives of most euthanasia societies, at least in the long term, go a good deal further and include the legalisation both of (physician-) assisted suicide and of active euthanasia under what might be called the "paradigmatic euthanasia conditions": (1) The patient is in an irreversible state of terminal illness, (2) The patient suffers intolerably, (3) The patient explicitly wishes to die, (4) This wish is not only momentary but also constant. Demands for the legalisation of active euthanasia, however, have been notoriously

unsuccessful. In most industrialised countries, not only active euthanasia on request but also physician-assisted suicide is still either illegal and punishable by law or prohibited by the physicians' professional codes. At present, a legally regulated practice of active euthanasia exists only in the Netherlands and in Belgium, a legally regulated practice of physician-assisted suicide only in the Netherlands (where it is rarely practised), in Switzerland and in the state of Oregon, USA.

Prognoses are always a risky affair. But there seem good grounds to predict that if it comes to choosing between methods of last resort for severely suffering patients physician-assisted suicide will prove more acceptable as a method of last resort than active euthanasia both to patients, to legislators and to the general public. From the perspective of patients, physician-assisted suicide seems preferable to active euthanasia because it is a more unambiguous expression of the patient's autonomous will. From the legislator's perspective it seems preferable because it is less liable to misuse and abuse than active euthanasia where the physician takes a more active part. A further pro-argument is the consideration that the availability of assisted suicide, instead of shortening the life of a patient, might even prolong it. The certainty to be able to end one's life whenever one seriously wants to end it is often observed to lead to a heightened tolerance of temporary suffering and to effectively reduce the temptation to end one's life in a period of acute crisis. Only a small fraction of those who actively procure to themselves the means to end their life actually put these means into use.

Public policy on physician-assisted suicide has recently gained an unprecedented dynamic. In some European countries, especially in Switzerland and Germany, we are witnessing a largely unexpected change in the attitude of public bodies towards physician-assisted suicide, partly motivated by the wish to take the edge off the pressure for legalisation of active euthanasia. In Switzerland, where physician-assisted suicide has been legal for more than a hundred years, the Swiss National Ethics Commission in the field of medicine, in its statement of 2005, demanded that physicians and other medical staff assisting patients to commit suicide under conditions of irreversible suffering are exempted from moral reproach by their profession. In Germany, the *Deutscher Juristentag*, the assembly of German lawyers, after discussing the legal issues of euthanasia in its 2006 session, voted with a clear majority for the motion that the traditional disapproval of physician assisted suicide by the medical profession should make room for a more differentiated view. Physician assisted suicide should be tolerated as a legally and ethically sound procedure in cases of patients suffering from symptoms that palliative medicine is insufficiently able to alleviate. In 2005, a legislative proposal by a number of distinguished law professors had been published making a similar point. Though no doctor should be under an obligation to provide assistance in cases in which a patient in severe distress earnestly considers suicide, the professional code should no longer sanction physicians for providing assistance. Physicians unwilling to give assistance should be encouraged to transfer the patient to other physicians willing to give assistance whenever possible. It remains to be seen how far these suggestions from the legal quarter will be taken up by the medical community and its official representatives, especially against the background of an increasing "death tourism" from Germany to Switzerland.

The present volume focuses on public policy issues related to physician assisted suicide. Though public policy and legal issues are inextricably bound up with the ethical problems posed by the relevant practice, the book makes no attempt to deal with the ethical pros and cons of physician-assisted suicide directly and systematically. The contributions making up its first part show, however, that the public policy and legal issues related to physician-assisted suicide raise ethical problems of their own, such as the problem of whether maintaining the status quo in countries where assisted suicide is a criminal offence is consistent with the far more liberal regulation of withholding or withdrawing treatment in similar cases.

This book is divided into three parts. Part one addresses policy issues raised by physician-assisted suicide. Gerald Dworkin, a philosopher of the University of California at Davis, is presenting the case for legalization of physician-assisted suicide. He is doing so by challenging the common assumption that there is a morally and legally relevant difference between the firmly established practice of termination of medical treatment and the practice of physician-assisted suicide. Neil Levy, a philosopher at the University of Melbourne, questions the widely-held view that legalization of physician-assisted suicide is the first step on to a “slippery slope” that will inevitably lead us from physician-assisted suicide to involuntary euthanasia to the dreaded horrors of the Nazi era. German philosopher Dieter Birnbacher of the University of Düsseldorf analyses the moral justifications for the professional opposition to physician-assisted suicide, as expressed in the Declaration of the World Medical Association, the Guidelines for Assistance in Dying of the German Medical Association or the Code of Conduct of the Council on Ethical and Judicial Affairs of the American Medical Association. Margaret Pabst Battin, a philosopher at the University of Utah, explores the prospect of a cultural change on attitudes towards death and dying, predicting a future where physician-assisted suicide will be considered to be a proper part of medical practice and where patients will take control over the timing and manner of their own death. Timothy E. Quill, a palliative care specialist at the University of Rochester, Bernard Lo, a doctor of internal medicine at the University of California in San Francisco, and Dan W. Brock, a moral philosopher at Harvard University, compare the clinical and ethical differences of voluntary stopping eating and drinking, terminal sedation, physician-assisted suicide and voluntary active euthanasia. They consider all four practices to be acceptable palliative options of last resort and argue that the morality of these practices should be determined on the basis of the patient’s wishes and not on the basis of dubious distinctions, such as the classification of “active vs. passive” or “intended vs. unintended” acts.

Part two of the book offers a detailed analysis of the current legal standing and practice of physician-assisted suicide in various countries. American psychiatrist Linda Ganzini of the Oregon Health and Science University in Portland and German philosopher Edgar Dahl of the University of Giessen summarise the experience of nine years of physician-assisted suicide under the Death with Dignity Act in Oregon. John Griffiths from the School of Law at the University of Groningen compares the practice of physician-assisted suicide in the Netherlands and Belgium arguing that voluntary active euthanasia should only be offered if a patient is unable to resort to physician-assisted suicide. German legal scholar Gabriele Wolfslast of the



University of Giessen describes the rather complicated judicial status of physician-assisted suicide in Germany's criminal law. Alan Rothschild of the University of Melbourne reviews the most recent legislative reforms on end-of-life issues in Australia. Sheila McLean of the University of Glasgow describes the current law in the United Kingdom and comments on the ongoing debate over Lord Joffe's "Assisted Dying for the Terminally Ill Bill".

The third part of the book comprises narratives by professionals who have been involved in end-of-life issues for many years. The Dutch anaesthesiologist Pieter Admiraal of the Reinier de Graaf Hospital in Delft offers a personal account on how he got involved into the debate over voluntary active euthanasia and physician-assisted suicide and how he devised the world's first guidelines on the use of drugs for a humane and dignified death. Elke Baezner-Sailer, the former President of the Swiss Right-to-Die-Society EXIT, describes the practice of assisted suicide in Switzerland and the new guidelines on "Caring for Patients at the End of Life" by the Ethics Committee of the Swiss Academy of the Medical Sciences. Ludwig Minelli, the President of the Zurich based Swiss Right-to-Die-Society "Dignitas", presents some personal notes on how to improve suicide prevention and how the European Convention on Human Rights can be interpreted to include the right to an autonomous and dignified death.

We hope that the contributions to this book will further the public debate over physician-assisted suicide and will help to create legal efforts that will enable terminally-ill patients all over the world to die in a way that is consonant with their own values.

# Contents

<b>Preface</b> .....	v
Dieter Birnbacher and Edgar Dahl	
 <b>Part I Physician-Assisted Suicide and Public Policy</b>	
 <b>Should Physician-Assisted Suicide Be Legalized ?</b> .....	3
Gerald Dworkin	
<b>Slippery Slopes and Physician-Assisted Suicide</b> .....	11
Neil Levy	
<b>Physician-Assisted Suicide and the Medical Associations</b> .....	23
Dieter Birnbacher	
<b>Safe, Legal, Rare? Physician-Assisted Suicide and Cultural Change in the Future</b> .....	37
Margaret Pabst Battin	
<b>Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia</b> .....	49
Timothy E. Quill, Bernard Lo, and Dan W. Brock	
 <b>Part II Physician-Assisted Suicide – An International Perspective</b>	
 <b>Physician-Assisted Suicide in Oregon</b> .....	67
Linda Ganzini and Edgar Dahl	
<b>Physician-Assisted Suicide in the Netherlands and Belgium</b> .....	77
John Griffiths	
<b>Physician-Assisted Suicide and the German Criminal Law</b> .....	87
Gabriele Wolfsplast	

**Physician-Assisted Death. An Australian Perspective** ..... 97  
Alan Rothschild

**Assisted Dying: The View from the United Kingdom** ..... 113  
Sheila A.M. McLean

**Part III Physician-Assisted Suicide – Narratives from Professional and Personal Experience**

**Physician-Assisted Suicide: A Doctor’s Perspective** ..... 131  
Pieter Admiraal

**Physician-Assisted Suicide in Switzerland: A Personal Report** ..... 141  
Elke M. Baezner-Sailer

**The European Convention on Human Rights Protects the Right of Suicide** ..... 149  
Ludwig A. Minelli

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**Part I**  
**Physician-Assisted Suicide**  
**and Public Policy**

# Should Physician-Assisted Suicide Be Legalized ?

Gerald Dworkin

## 1 Physician-Assisted Suicide and the Law

Let us assume, for the sake of argument, that we can find a plausible case for the view that it is morally permissible for medical caregivers, under certain conditions, to either provide their patients with means or information, so that they can take their own lives, or kill their patients. Let us assume, further, that patients have a moral claim to non-interference with such assistance.

Having established this much still does not settle a number of different issues concerning public policy. Questions such as: Should the law recognize such a claim? Should the institutions of medical practice, such as hospitals, have rules which require action in accordance with such a claim? Should the codes of the medical profession include such rules? Ought the profession sanction professionals who violate such claims? This class of questions is one about institutionalizing a right to aid in dying.

In the case of physician-assisted suicide, as in other cases, there are a variety of forms that institutionalization might take and the arguments appropriate to some may not hold, or carry as much weight, for others. For example, consider the issue of the legalization of physician-assisted suicide. This might encompass any of the following measures:

- (1) Maintaining the status quo – where assisted-suicide is illegal – but, explicitly or tacitly, encouraging prosecutors to exercise their discretion not to prosecute.
- (2) Maintaining the status quo, but allowing as a defense to a prosecution the defense of merciful motive.
- (3) Maintaining the status quo, but allowing consideration of motive to play a role with respect to sentencing.
- (4) Legalization of physician-assisted suicide.

Each of these policies may have different symbolic significance, different anticipated consequences, different probabilities of setting precedents. I am going to focus

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on the legalization issue only. If physician-assisted suicide were to be legalized, then for most patients *in extremis* their needs for an end to their suffering would be met. It is true that those who are not able to take measures to end their own life would not be helped, but since there is another option open to them – the refusal of nutrition and hydration – they would not be without any recourse.

## 2 The New York State Task Force on Life and the Law

One of the most thoughtful arguments put forward against the legalization of any type of medically-assisted dying is that contained in the report of the New York State Task Force on Life and the Law.<sup>1</sup> Although the task force consisted of individuals with different views about the morality of individual instances of medically-assisted dying, it was unanimous in its recommendation that the laws of New York State prohibiting assisted suicide and euthanasia not be changed. While there may be arguments that the report failed to consider, the list of arguments is sufficiently thorough that if we fail to find them persuasive we will have some confidence in our judgment that physician-assisted suicide ought to be legalized.

The Task Force's reasons to oppose legalization are the following:

- 1) Prohibitions on physician-assisted suicide are "...justified by the state's interest in preventing the error and abuse that would inevitably occur if physicians or others were authorized to...aid another person's death." (68)
- 2) "...to the extent that laws prohibiting physician-assisted suicide and euthanasia impose a burden, they do so only for individuals who make an informed, competent choice to have their lives artificially shortened, and who cannot do so without another person's aid...very few individuals fall into this group... (71)... legalizing... assisted suicide for the sake of these few – whatever safeguards are written into the law – would endanger the lives of a far larger group of individuals, who might avail themselves of these options as a result of depression, coercion, or untreated pain." (74)
- 3) "...laws barring suicide assistance...serve valuable societal goals: they protect vulnerable individuals who might otherwise seek suicide assistance... in response to treatable depression, coercion, or pain; they encourage the active care and treatment of the terminally ill; and they guard against the killing of patients who are incapable of providing knowing consent." (73)
- 4) Dependence of the patient on the physician and his recommendations. If we allow physician-assisted suicide, then although nominally the request must originate from the patient, physicians will exercise a degree of coercion and/or persuasion that is illegitimate. This is particularly likely in the current context where there is growing concern about increasing health care costs. "... it will be far less

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<sup>1</sup> *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*. The New York State Task Force on Life and the Law, New York, May 1994. All quotes are from this report unless otherwise noted.



costly to give a lethal injection than to care for a patient throughout the dying process.” (123)

The right of the competent patient to refuse or withdraw from medical treatment is firmly established in American jurisprudence.<sup>2</sup> My general strategy is to see if the differences which clearly exist between refusal of treatment and physician-assisted suicide warrant a difference in their treatment by the law. My claim will be that if the above arguments are good arguments against physician-assisted suicide, then they are equally good against allowing patients to refuse treatment. In both cases the physician may exercise a degree of control and influence which denies the autonomy of the patient’s choice. If a physician can manipulate the patient’s request for death, he can manipulate the patient’s request for termination of treatment. If the patient’s death is cheaper for the system, then it is cheaper whether the patient commits suicide or is withdrawn from a life-support system.

### 3 The Argument from Eligibility

One argument for distinguishing physician-assisted suicide and withdrawal/withholding is that the number of patients in a position to request withdrawal/withholding of care is much smaller than the pool of patients “eligible” for physician-assisted suicide, so that even if abuse is possible in both cases, the scope for abuse is much greater in the case of physician-assisted suicide. As I have heard this claim put forward in many conversations, “all of us are eligible for physician-assisted suicide.”

But whether this is true depends essentially on how the notion of “eligible for physician-assisted suicide” is being used. Opponents use it in such a fashion that if I enter a hospital to have a hangnail removed, I am eligible for assisted-suicide. But that is just silly. The relevant pool is the class of persons who will be patients suffering from a terminal or incurable, intractable illness, who will be competent and who are not in a position to die of withdrawal or withholding of medical care. The relevant empirical evidence is that this pool is not larger but smaller than the w/w pool. The Dutch statistics show that some 22,500 patients die as a result of non-treatment decisions whereas only 3,700 die as a result of physician-assisted suicide and euthanasia together.<sup>3</sup>

In any case, it is not as though defenders of the right to refuse treatment have argued that the potential for abuse is outweighed by the benefits of allowing refusal. Rather, they have argued that patient’s have a right to refuse treatment. But we are assuming for the purposes of this argument that patients also have a moral claim to the aid of a willing physician in assisted suicide. To argue that the potential for abuse means that we should not institutionalize that claim means that the legitimate moral claim of an individual to assisted suicide must be forfeited because of the possibility

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<sup>2</sup> This has not always been the case. It was quite common for many years for physicians and judges to treat such refusals as equivalent to suicide or homicide.

<sup>3</sup> Dan Brock was instrumental in clarifying my thoughts on this issue.

that *others* may abuse or be abused by such permission. Why does such an argument go through in the case of assisted suicide but not in the case of the claim of a patient to refuse treatment?

Here is one response. It is true that many of the same slippery-slope arguments, and ones about people being pressured, can be raised about withholding/withdrawal cases. But in those cases we have to accept the risks because to deny an individual the right to be withdrawn from a course of medical treatment, e.g., a respirator, is to claim the right to forcibly impose an unwanted invasion of the body upon a competent individual. It is to commit battery. Whereas to deny persons a right to assistance in dying is simply to leave them in the same state we found them in. That difference explains the asymmetry in public policy.

I concede that this is a morally relevant difference between the two situations. The question is how much weight does it carry. What is the significance of the fact that the denial of the right to removal of life-support involves an invasion of the body, whereas denial of assistance in dying does not? What is at stake in both cases *in the context of end of life decisions*, is the ability of a patient to end great suffering, and to control the manner of their death. It seems arbitrary for the society to allow one but forbid the other on the grounds that the denial of the former has an *additional* bad feature in one case but not the other.<sup>4</sup>

It is true that if what were at stake were less important, e.g., if the reason a person refused a medical treatment, say, a spinal tap, were simply a fear of needles, the right not to have invasive treatment might require us to not impose a treatment even though this will adversely affect the patient's health status. Whereas we might refuse their request to drive them home so as to avoid having the treatment. One might feel one doesn't have to cooperate with a foolish patient.

If one feels doing anything to enable a patient to die is wrong then it is a consistent view to think that one has to do so in the case of withdrawing life-support but not in assisting suicide. So I am not arguing that mere consistency requires that the two cases be treated alike. I am claiming that if one has reason to accept the claim that sometimes enabling a patient to die is desirable, then the asymmetry at issue is not one which requires disregarding the possibility of abuse in one case but not in the other.

The asymmetry might be exactly the thing to point to if one supposed that it made a moral difference. For example, if one thought that in sticking a feeding tube into you against your will I use you as a means (to your own good) but if I refuse you food (against your will) I do not do so. But if Kant is right that sometimes one uses a person as a means just as much when one refuses to help them accomplish their ends as when one thwarts their ends, then this distinction will not be determinative.

Another way of looking at this issue is to see that even if we are dealing with issues of what should be legal or not, i.e. issues of public policy rather than morality per se, the fact that we are limited in whatever we do by moral considerations means

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<sup>4</sup> It should be noted that the right not to have compulsory intervention on one's body is not an absolute right in any case. We require compulsory vaccinations and compulsory donation of blood samples in criminal investigations.

that we must be able to address an argument to those whose conduct we wish to restrict. In particular, we must have an argument that we can present to the patient who wishes to end an existence he regards as intolerable. Is it sufficient to say to him “Look, there are dangers to others down this path. Others may misuse this option.” Well, perhaps not, the objector in question concedes, since he does not think that reply sufficient to address the complaint of the person who wishes to end his existence by being withdrawn from the respirator. But, he goes on, there is an additional fact in that situation, i.e. we would be invading his body if we denied him his relief. But while this may show that we are required to ignore the issue of abuse in the former case it does not show that we are not also required to do so given a willing doctor and a patient basing a claim on us (to respect autonomy and for relief of suffering).

#### **4 The Gap Between the “Ideal” and the “Real”**

“Public policy cannot be predicated on an ideal when the reality will often be quite different, with serious, irreversible consequences for patients.” (131)

The argument here is that the decision to accept or reject the patient’s request for suicide is one which requires great skill and sensitivity, a demanding and time-consuming process, and a detailed knowledge of and acquaintance with the patient. Few doctors are likely to have these skills and knowledge. For every Timothy Quill there will be many Jack Kevorkians.<sup>5</sup> This is true, but again one must note that all this holds for the decision as to whether to accept a patient’s refusal of treatment. Practice is undoubtedly at some remove from the ideal in these cases as well. And the consequences for the patient are often as serious and as irreversible.

#### **5 The Symbolic and Practical Significance of Prohibiting Physician-Assisted Suicide**

“... the ban against assisted suicide and euthanasia shores up the notion of limits in human relationships. It reflects the gravity with which we view the decision to take one’s own life or the life of another, and our reluctance to encourage or promote these decisions. . . By legalizing the practices, we will blunt our moral sensibilities and perceptions.” (132)

Again, confining our attention to physician-assisted suicide, we have already as a society made the decision to decriminalize attempted suicide. Neither suicide nor attempted suicide is a crime in any state. To some extent the decision reflects the fact that we think such acts are often committed by persons who are less than fully rational, to some extent we do so to avoid the stigma for the person and her family,

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<sup>5</sup> T.E. Quill, “Death and Dignity: A Case of Individualized Decision Making.” *New England Journal of Medicine*, 324 (1991), 691–694.

but for many the policy reflects the fact that we believe that, in some circumstances, people ought to have the liberty to end their lives. We think that autonomy extends to the decision about continued life as well as decisions within a life.

Such decisions, while they may be grave, are also decisions that are up to each individual person. Even if we do not believe this to be true for all cases of suicide, we may believe this is so, and particularly true, for decisions made by person in the last stages of terminal illness, or in medical conditions which threaten their dignity and autonomy. Why then by legalizing this kind of assisted-suicide do we “blunt our sensibilities and perceptions”? Again, it is important to remember that we currently regard it as legitimate for physicians to give their patients increasing dosages of morphine for their pain, even while knowing that such dosages increase the risk of death. We also allow physicians to withhold cardio-pulmonar resuscitation knowing that this will certainly result in the patient’s death. We also allow terminal sedation, where the patient is put into a coma and eventually dies of lack of food and water.

Have these practices blunted our sensibilities and perceptions? If they have not, would the step to allowing a doctor to prescribe medicine, at the request of the patient, knowing that the patient intends to use them to commit suicide, be much more likely to do so? What is the evidence for this proposition?

## 6 Drawing the Line

“Most proposals to legalize assisted suicide have rejected terminal illness as the dividing line because it would not respond to many circumstances that can cause the same degree of pain and suffering. Yet as long as the policies hinge on notions of pain and suffering they are uncontainable; neither pain nor suffering can be gauged objectively or subjected to the kinds of judgments needed to fashion coherent public policy. Moreover, even if the more narrow category of terminal illness is chosen at the outset, the line is unlikely to hold for the very reasons that it has not been selected by advocates of assisted suicide – the logic of suicide as a compassionate choice for patients who are in pain or suffering suggests no limit.” (132)

There *is* a problem about how exactly to draft the legislation for reforming existing laws prohibiting assisted suicide. Unless one wants to legalize all acts of assisted suicide, and there are legitimate reasons for being hesitant about this – particularly questions of fraud and duress – one has to distinguish a subset of assisted suicide. One part of the distinction is implied by the term physician-assisted suicide, i.e. that the assistance is provided by a physician. But since one does not want to condone all physician-assisted suicides one needs further criteria. As the quotation suggests, the restriction to cases of terminal illness, while being an effective way to draw the line, does not allow relief to many individuals who are suffering but not terminal. There have been a number of suggestions put forward which, if not perfect, seem adequate to meet the above objection. One such provided by a group of physicians in the *New England Journal of Medicine*, suggests the requirement of terminal

or incurable illness, together with acute suffering.<sup>6</sup> Another suggestion, made by Professor Kluge of the University of Victoria, suggests the presence of an incurable, irremedial disease or medical condition, and that the patient experiences the disease or condition as incompatible with her fundamental values.

The general idea behind both proposals is that there is some medical condition present, that the condition is not capable of cure or effective palliation, and that the patients experience their condition as not allowing them to lead the kind of life they regard as meaningful or worthwhile. Why the legal system would have a harder time dealing with these notions than with the kinds of issues that have arisen with respect to withdrawal of life-support, termination of artificial hydration and nutrition, doctrines of proxy-consent and substituted judgment, is not apparent.

I leave open for now the important question of what role – if any – advance directives should play in allowing competent persons to request euthanasia if they are no longer sufficiently competent to participate in assisted suicide. Those worried about dangerous slides along the slippery slope see this as the entering wedge (mixed metaphors intended). Whether the arguments for this extension are sufficiently similar to those for assisted suicide to make it equally legitimate, or whether blurring the distinction between those currently able to make a request for aid-in-dying and those who are not is too fraught with peril, are matters for extended treatment. All I hope to have shown in this discussion is that the arguments opposing the legalization of assisted suicide advanced by its most thoughtful opponent are not persuasive.

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<sup>6</sup> *New England Journal of Medicine* (July, 1994).

# Slippery Slopes and Physician-Assisted Suicide

Neil Levy

## 1 Introduction

Opponents of physician-assisted suicide (PAS) often argue that we must never permit the practice because doing so would constitute a first step onto a slippery slope.<sup>1</sup> Once we are on a slippery slope, we cannot prevent ourselves from sliding all the way down to the bottom, which in this context means moving from permitting PAS to acquiescing in, or being unable to prevent, practices that are morally wrong. We shall inevitably proceed, slippery slopers argue, from strictly regulated PAS to voluntary active euthanasia, then involuntary active euthanasia and eventually even to the killing of babies suffering from relatively minor disabilities. Since at least some of these practices are clearly wrong, we cannot justifiably step onto the slippery slope at all.

In this paper, I shall argue that the slippery slope argument against PAS fails. If there is a genuine, well-founded risk of finding ourselves on a slippery slope, then it is not a risk we can avoid by forbidding PAS. PAS does not represent the *first* step onto the (alleged) slippery slope, but is instead itself a segment of that slope, and moreover one found well below the summit. We find ourselves on the slippery slope well before we confront decisions about PAS. Worse, the flat ground which precedes the slope is not itself ethically accessible: the decision not to step onto the slope requires the sacrifice of moral goods too important for it to be acceptable. Any possible legislative or policy regime that is ethically permissible places us on

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<sup>1</sup> Notice that in focusing attention on slippery slope arguments, I assume – along with the proponents of these arguments – that PAS is otherwise justified. If PAS is wrong on other grounds, then the slippery slope argument is redundant. Opponents of PAS commonly think it is wrong on other grounds; nevertheless, if they resort to slippery slope arguments they commit themselves to accepting that it is otherwise permissible (if only for the sake of examining the consequences if it were). Accordingly, I shall assume throughout the paper that PAS is justified, or would be justified but for the slippery slope argument.

the slippery slope. If, therefore, descent down the slope is inevitable once we are on it, we must resign ourselves to our fate.

Fortunately, descent down the slope is not inevitable – which is equivalent to saying that there is no slippery slope at all. Though there may be genuine pressures which might cause us to widen the scope of our end-of-life policies, and which could conceivably push us in the direction of ethically unjustifiable practices, these are pressures which can be resisted. Indeed, they are the kind of pressures which we routinely resist.

Proponents of slippery slope arguments against PAS envisage two different kinds of pressures which might be thought to push in the direction of illegitimately widening the scope of end-of-life policies. These pressures are either *rational* or they are *nonrational*. I shall examine each in turn.

## 2 Rational Pressures on the Slippery Slope

The argument that there are rational pressures which might force us down the slippery slope goes like this: whatever justifications are presented in favor of PAS apply equally well to voluntary active euthanasia, or to euthanasia with surrogate decision making, or even to the involuntary killing of the mildly disabled. If, therefore, we permit PAS, we shall be rationally compelled to permit these further practices. Therefore, we had better not permit PAS.

Suppose, for instance, the right to PAS were to be justified in the name of the dignity of patients. That is, we say that terminally ill patients have a right to have their request for an early painless death honoured in cases in which the progression of their disease is incompatible with their dignity as human beings. In that case, we shall be rationally compelled to grant the right to death to other patients, who are not terminally ill, when they suffer from conditions (physical or psychological) that are not compatible with their dignity as human beings. We may even find ourselves compelled to acquiesce in the deaths of disabled infants, when their disability is incompatible with the dignity of rational beings. In that case, we shall have found ourselves sliding down the slope, from practices that are morally justifiable to practices that are morally abhorrent.

We should not think, the argument continues, that there is something special about the justification of PAS in the name of dignity, which makes it especially vulnerable to illegitimate extension. The same phenomenon can occur with other plausible justifications for PAS. Suppose we justify it in the name of patient autonomy. In that case, we shall find ourselves compelled to acquiesce in the killing of autonomous human beings whenever they request it, no matter what their reason for requesting death. If we are obliged to honour the autonomous requests of the terminally ill, just because they are autonomous requests, we are equally obliged to honour the autonomous requests of the merely frivolous. Once again, we find ourselves at the bottom of the slope, engaging in practices that are morally unacceptable.

The rational version of the slippery slope argument is quite common in the literature on PAS. John Arras presents us with a particular clear example: “the logic of the case of PAS, based as it is upon the twin pillars of patient autonomy and mercy, makes it highly unlikely that society could stop” its illegitimate extension once it is introduced.<sup>2</sup> The faith proponents of this line of argument show in the force of reason is rather touching. Nevertheless, and even if we accept that reason has this power over human affairs, the fear it expresses is misplaced.

Proponents of rational compulsion argument against PAS face the following dilemma. Either it is true that there are (all things considered) rational pressures on us to expand the scope of the right to die or it is not. On the first alternative, then we *ought* to expand the scope of the right; so doing does not represent a slide down the slope because the envisaged extension is morally and rationally justified. This is not a result to be feared; on the contrary, we ought to welcome the extension of morally justified practices to more people in more circumstances. On the second alternative, things are crucially different, because the envisaged extension of the practice is morally *un*justified. In that case, however, the first premise of the rational slippery slope argument against PAS is false; it is not in fact the case that the considerations which justify PAS also justify the extension of the practice. In that case, then, for all that rational slippery slope argument has shown, we have no reason to expect the extension of our end-of-life practices to other cases in which they would be wrong.

Let me illustrate. Suppose, first, that whatever considerations justify PAS actually justify its extension to cases (supposedly) lower down the slope. If PAS is justified (here a success word) by appeal to dignity, then, let’s assume, nonvoluntary euthanasia is likewise justifiable on the same grounds. Or if PAS is justified by our obligation to respect patient autonomy, then perhaps assisted suicide for any agent, ill or otherwise, who autonomously requests it is equally justifiable. What is supposed to be wrong with that? Are we to be deterred from giving a right to one group of persons who are entitled to it, for fear that another group, who are equally entitled to it, will claim it? Surely we want people to be able to exercise all their morally justifiable rights, if they so choose. I cannot see how this is supposed to be an objection to PAS. If anything, it counts as an argument in its favor: we should recognize the right to PAS, because this will lead to other agents, who are currently being denied their rights, having their valid claims upheld.

It is likely that opponents of PAS do not reject it for fear that it will lead to other morally justified practices. Instead, they worry that it will lead to unjustified end-of-life practices. Let us therefore suppose that the assumption we made above, that the considerations which justify PAS for the terminally ill also justify the extension of a right to die to other cases, is false, and that therefore it would be wrong to extend this right beyond PAS. There is some relevant difference between the cases, which is sufficient to show that they ought to be treated differently. Perhaps, for instance, it

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<sup>2</sup> John Arras, “On the Slippery Slope in the Empire State: The New York State Task Force on Physician-Assisted Death”, *American Philosophical Association Newsletters* 95 (1996): 81.



is the conjunction of autonomy and dignity that justifies PAS, making its extension to non-autonomous patients (such as mildly handicapped infants) illegitimate, as well as ruling out those who are not suffering from a serious illness since their dignity is not under threat. Or perhaps compassion does the work in sorting out cases; we are justified only in acquiescing to the autonomous requests of people in severe pain, since only in this kind of case are the patients the legitimate recipients of our compassion. In that case, though, the first premise of the rational slippery slope argument is false: there are in fact rational grounds upon which to distinguish between cases. Since these grounds exist, we have no reason to think that we shall be rationally compelled to extend the right to die beyond its legitimate bounds.

Indeed, the more opponents of PAS insist upon the potential harms of the practice – the more successful they are in showing that the consequences they fear await us at the bottom of the slippery slope are indeed objectionable – the more they *weaken* the rational slippery slope argument. If it really is the case that the consequences are so dire, if the practices into which we are buying if we embark on this course of action are really so abhorrent, then it is relatively easy to distinguish between justifiable and unjustifiable kinds of killing. In that case, however, then the first premise of the rational slippery slope argument is not only false; it is obviously false, and no one in their right mind would ever think that the justifications which can be invoked in some cases of assisted suicide could equally permit these abhorrent practices.

The weakness of the rational version of the slippery slope argument, at least as I have presented it, is so obvious that it is permissible to suspect that I have not been fair in setting it out. However, I cannot myself come up with a way of strengthening it. Perhaps the idea lying behind some versions of the argument is some confusion regarding justification by way of rights and justification by way of consequences. Perhaps, that is, opponents of PAS fear that the right to die might be extended from cases in which it is all-things-considered justified, to cases in which it would be justified by reference to the rights of the patient, but is nevertheless unjustified because of its consequences for other people. Since, however, consideration of consequences is itself a rational and a moral ground for distinguishing between cases, it is false to think that there is any rational pressure to expand the scope of a right when doing so would entail disastrous consequences for others. Liberty rights are always constrained by others' security rights. If this confusion lies behind the rational version of the slippery slope argument, we can understand why some people have advanced it, but the argument is by no means strengthened.

The rational slippery slope argument therefore fails.

### 3 Nonrational Slippery Slopes

Proponents of slippery slope arguments against PAS have never relied solely on the rational version of the argument. Instead, they have frequently invoked nonrational

pressures, as well as or instead of rational pressures.<sup>3</sup> The idea is this: even if there are clear grounds upon which to distinguish between justifiable and unjustifiable end-of-life practices, there are nonrational pressures which will work to ensure that if we permit the former, we shall find ourselves acquiescing in the latter.

Notoriously, plausible mechanisms which would explain how and why we are impelled down the slippery slope are hard to come by. Nevertheless, there are some suggestions that might fit the bill. Here is one: suppose that, as a matter of fact, courts are reluctant to convict or to impose custodial sentences upon people who break laws in situations which closely resemble cases in which similar actions would have been legally permissible (this is an empirical hypothesis, and should be tested empirically; nevertheless, the suggestion is plausible enough to be accepted as a working hypothesis).

Now, suppose we permit PAS in cases in which a number of conditions are jointly satisfied (for instance, the patient is mentally competent, is suffering from a terminal illness that causes great suffering, has been examined by a mental health professional and found not to be suffering from treatable clinical depression, has not been placed under undue pressure to ask for death and has continuously expressed the wish to be allowed to die over some specified period of time). In that case, it is likely that if physicians help patients to die in circumstances in which most, but not all, of these conditions are satisfied, courts will be lenient. But if courts are lenient in this kind of case, they thereby establish a precedent; effectively, they create a situation in which PAS is permissible in cases in which most, but not all, these conditions are satisfied. As a result, physicians find themselves working under a new set of rules, which becomes the accepted way of doing things. In this new situation, however, courts will be lenient upon offenders who take life in situations which closely resemble the new regulatory regime – say, cases in which only one or two of the above conditions is satisfied. As a result, yet another new regulatory regime becomes entrenched, and a new, even more lenient, set of conditions is created governing permissible killing. Once the courts adjust to this new set of conditions, however, we shall find killings even more distant from those originally envisaged becoming routinely accepted. After enough iterations of this regulate/adjudicate cycle, we shall find that our doctors have a license to kill anyone whose life they deem to be a burden, to themselves, their family or to society at large. We shall be on the verge of the death camps.<sup>4</sup>

<sup>3</sup> Indeed, R.G. Frey identifies the slippery slope argument with its nonrational form: “we are supposed to be led down this slope of taking life by *empirical* means” (R.G. Frey, “The Fear of a Slippery Slope”, in Gerald Dworkin, R.G. Frey and Sissela Bok, *Euthanasia and Physician-Assisted Suicide* (Cambridge: Cambridge University Press, 1998), p. 46; emphasis added). As we have already seen, the rational form of the slippery slope argument is sometimes encountered. However, Frey may be right in thinking that this form is the more common.

<sup>4</sup> This is the kind of nonrational mechanism that Wesley Smith fears will legitimize the illegitimate: “This is a classic example of the slippery slope phenomenon. Once the killing of one group, the unconscious, was permitted, those killed in actual practice included another group, the conscious. When it became clear that the guidelines were not being adhered to, the guidelines were expanded rather than enforced more rigorously, which formally legitimized practices that a few years before

Suppose that the envisaged mechanism is plausible, and really is likely to carry us down to the bottom of the slippery slope (this is a supposition that I shall soon give reasons to reject, but let us accept it for the moment). In that case, we had better make sure that we do not step onto the slope at all. It is bad news, in that case, if we cannot justifiably avoid the slippery slope. But that is precisely our situation, I shall claim.

Let us examine the nonrational slippery slope argument as it is propounded by Wesley Smith. Smith bases his cases against PAS, or any other active form of euthanasia, on a distinction between two kinds of care for patients: *humane care* and *medical treatment* (42–43). Humane care refers to “basic nonmedical services that each human being is absolutely entitled to receive in a medical setting”, such as warmth, shelter, food and water. Medical treatment, on the other hand, consists of “actions taken by doctors or other health-care professionals whose purpose is to provide a medical benefit to the patient”, like surgery, medication and diagnostic tests. Now, this distinction is important for Smith’s argument because, he believes, patients have a right to refuse medical treatment, and doctors have a duty to accede to patients’ autonomous refusals of such treatment. Thus, a patient may refuse to take medication, or to be subjected to operations or diagnostic procedures, or may request that a respirator be turned off, and the doctor is bound to comply with these requests, *even if so doing causes or hastens the patient’s death*. But patients have no such right to have their demands for the withdrawal of humane care honoured; indeed, physicians have a duty to provide such care, *regardless of the wishes of the patient*.

Patients may request that life-support machinery be turned off and doctors have a duty to comply. But patients have no right to request that their food or warmth be withdrawn, and doctors have a duty to provide such nonmedical goods. Humane care must be provided to all patients, whether they want it or not. So doctors can allow patients to die of their pre-existing illness, but cannot allow them to die from (deliberately-induced) hypothermia, starvation or dehydration. This is Smith’s line in the sand; this is what separates permissible (even, in certain circumstances, obligatory) allowing to die from impermissible killing.

Smith puts a lot of weight on this supposedly clear distinction between medical treatment and humane care. I suspect that it is a distinction that will not bear the weight he places upon it. Why is tube-feeding – the provision of elements normal bodies require for continued life and health – humane care, whereas artificial respiration – likewise the provision of elements normal bodies require for continued life and health – medical treatment? Both involve the direct provision of goods that patients are usually able to provide for by themselves, both require advanced technology and the assistance of technicians. However, I am prepared to grant Smith the distinction; from the point of view of the nonrational slippery slope argument, nothing turns on it. What matters here is that, *even on the assumption that the distinction*

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had been deemed completely unacceptable” (Wesley J. Smith, *Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder* (New York: Times Books, 1997), p. 50).

*Smith draws is impregnable to rational criticism*, the act of drawing it places Smith himself on the very slippery slope he hopes to avoid.

To illustrate: let the distinction between humane care and medical treatment be clear, intuitive and invulnerable to counterexamples. Let it be expressed in laws, regulations and policies governing medical care which are themselves clear and unambiguous. Will abuses nevertheless occur? That is, will physicians sometimes act outside the guidelines? Let us suppose, first, that they will, and that physicians, crusading and open or secretive, will cause or be complicit in the deaths of patients in ways that violate the guidelines, and that they will sometimes come to trial as a result. How will courts treat these physicians? According to *Smith himself*, and to other proponents of the nonrational slippery slope argument, how they are treated will depend upon how closely the circumstances in which they acted resemble those in which withdrawing life-sustaining treatment is permissible or obligatory. If, for instance, the patient did not autonomously request the withdrawal of medical treatment, since she was no longer competent to do so, but there was good reason to believe that she would have wanted it withdrawn, or if the decision was made by a surrogate acting out of love for the patient, then we can expect courts to be lenient. Similarly, if what was withdrawn was not medical treatment at all, but – at the autonomous request of the patient – humane care that closely resembles medical treatment (perhaps extra warmth as a treatment for hypothermia, or tube-feeding), then once again we can expect the courts to be lenient. But if courts are lenient in this kind of case, then (by the nonrational slippery slope argument) they create a new *status quo*, effectively a new regulatory regime which is less restrictive than the one Smith believes justified. If physicians then act slightly outside this new regulatory regime, courts will be lenient once more. The slide down the slippery slope will begin to gather speed.

It doesn't matter, for the nonrational slippery slope argument, whether the distinction Smith draws is in fact rationally impregnable or not. It matters only whether there are circumstances that *resemble* those in which it allows or requires physicians to acquiesce in the requests of patients in the knowledge that doing so will result in their deaths, without actually *being* such circumstances. If there are (and how could there not be?), the mechanism identified will go to work, and we will slide down the slope.

Perhaps Smith will reply that regulations which enact his distinction would not be abused, or that courts would not in fact treat physicians who act just outside the guidelines leniently. Perhaps he would be right. But what reason is there to think that abuses will not occur when the regulations enact *his* distinctions, and not, say, those of Brock, or of other supporters of PAS?<sup>5</sup> Why think that courts would be lenient in one kind of case, and not another (when the same circumstances that are supposed to trigger leniency – resemblance to the permissible – are present in

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<sup>5</sup> For Brock's distinctions, and the reasons underlying them, see Dan W. Brock, "A Critique of Three Objections to Physician-Assisted Suicide", *Ethics* 109 (April 1999): 519–547; and Charles H. Baron, Clyde Bergstrasser, Dan W. Brock et al. "A Model State Statute to Authorize and Regulate Physician-Assisted Suicide", *Harvard Journal of Legislation* 331 (1996): 1–34.

both)? Remember, the nonrational slippery slope argument against the latter set of distinctions is not that they are logically unsound in some way, but that no matter how clear and rational, they will be overwhelmed by *nonrational* forces.<sup>6</sup> Why think that only the distinctions of proponents of PAS will be overwhelmed in this way, and not those of opponents? Unless Smith can point to a relevant difference between his distinction and those of supporters of PAS – and frankly I doubt very much that such a distinction exists – if there are mechanisms which would overwhelm the latter, then we can expect the former to fall just as quickly.

We might put the point in another way. Smith argues that “[o]nce killing is deemed an appropriate response to suffering, the threshold dividing ‘acceptable’ killing from ‘unacceptable’ killing will be continually under siege” (21). (He defines “killing” very widely, so that allowing to die, for example in cases in which tubefeeding is withdrawn, counts as killing). Suppose this is so. Then that is bad news not only for the supporters of PAS, but also for Smith. For Smith himself has conceded that killing (so understood) is an appropriate response to suffering in some cases. His distinctions are under siege, as much as anyone else’s. Once we are on the slope, we begin to slide down, no matter where we begin.

It is easy to see a way in which an opponent of PAS could avoid the argument just outlined. If allowing that killing is ever acceptable *ipso facto* plants our feet on the slippery slope, we should deny that killing is ever acceptable. I can think of two ways in which this line of thought might be developed, but neither will succeed. First, we might emphasise the killing/letting die distinction, holding that letting die is sometimes permissible, but that killing *never* is. I don’t think this will work, simply because the killing/letting die distinction seems vulnerable to the non-rational mechanism that we just saw overwhelming the medical treatment/humane care distinction. That is, whether or not the killing/letting die distinction is rationally defensible (I take no stand on the question) there will be cases of killing which *resemble* cases of letting die closely enough for the mechanism to go to work. So long as a distinction is controversial enough to provoke debate, such borderline cases are an everpresent possibility – and of course the killing/letting die distinction is extremely controversial. This distinction will therefore be overwhelmed, just like any other.

Second, we might attempt to draw the line even further back, so as to avoid stepping onto the slope at all. We might maintain that *neither* killing nor letting die is ever permissible. We might argue, that is, that doctors can never kill nor act or omit to act in any way that will likely result in the death of a patient. Suppose (counterfactually, I suspect) we can fully articulate this position without relying upon any distinctions which are vulnerable to being overwhelmed by nonrational slippery slope mechanisms. In that case, we would indeed have avoided the problem we have just sketched for Smith, but only at a cost too high to pay: we would

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<sup>6</sup> “The carefully shaded moral distinctions in which the health-care intelligentsia and policymakers take so much pride are of little consequence in the real world of cost-controlled medical practice, in busy hospital settings, and among families suffering the emotional trauma and bearing the financial costs of caring for a severely brain-damaged relative”, Smith, *Forced Exit*, p. 49.

have sacrificed patient autonomy for the sake of avoiding the slippery slope. Patient autonomy may not be the only moral good at stake in the debate over PAS (as many ethicists and philosophers have argued).<sup>7</sup> Nevertheless, it is certainly a good that is in play, and to which we are morally required to give some weight. If we argue that physicians ought to ignore patients' autonomous requests to be treated in one way rather another, or not to be treated at all, in favour of their own judgment of what is in the patients' own best interests, then we argue for an unrestricted paternalism. We avoid the Scylla of the nonrational slippery slope, but only by crashing headlong into the Charybdis of paternalism.

The lesson is this: if the nonrational slippery slope argument is in fact sound, then anywhere we draw the line is either too soon or too late. It is too soon if it fails to give due weight to patient autonomy, but it is too late if it recognizes patient autonomy since we then find ourselves already on the slippery slope. Once we are on it, of course, a more or less rapid descent is inevitable. To put the point in another way, the nonrational slippery slope is a problem for *everyone*, opponent or supporter of PAS alike, so long as their view is ethically acceptable in other ways.

## 4 Slippery Steps

The rational slippery slope argument fails because we ought to welcome, not fear, the extension of moral rights to those who are entitled to them. But the nonrational slippery slope argument is as much a problem for opponents of PAS as for its supporters, and therefore cannot be legitimately used by the former to bludgeon the latter. Opponents of PAS had better avoid reliance upon slippery slope arguments in making their case.

In conclusion, I want to re-examine the nonrational slippery slope argument, this time not to ask whether opponents of PAS can avoid it, but to ask how likely it is that the mechanism it identifies will actually overwhelm our carefully drawn distinctions (whether those of opponents or those of supporters). Recall, the mechanism identified was supposed to work as follows:

Courts will be reluctant to impose harsh sentences, perhaps even to convict, agents who act in circumstances that closely resemble those in which similar actions would have been permissible.

But the failure to punish or to convict agents who act in such circumstances effectively broadens the scope of the guidelines or legislation, thereby imposing what amounts to a less restrictive regulatory regime.

When considering future cases, courts will take into account not what the regulations or legislation actually say but the less restrictive regime they have themselves

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<sup>7</sup> For one influential statement of the argument that PAS concedes too much weight to autonomy, see Daniel Callahan, "When Self-Determination Runs Amok," *Hastings Center Report* 22 (March/April 1992): 52–55.

brought into existence, thus leading to a further loosening of restrictions (alternatively, the less restrictive regime may be recognized and enshrined by legislatures).

How plausible is it that this mechanism will actually function in the manner outlined? Though the mechanism sketched in not implausible, there is good reason to think that it will not in fact function in this way. The evidence comes from the generality of the mechanism: if it would overwhelm guidelines regulating PAS, it should be equally corrosive elsewhere. It seems equally likely that it would overwhelm any number of distinctions in criminal and civil law. The distinctions recognized by courts and legislatures, distinctions which separate murder from self-defence, sanity from insanity, recklessness from negligence and negligence from taking due care, all of these are equally prone to coming under the same pressure, since borderline cases are familiar with regard to all (as well as with regard to a great many other distinctions). If the mechanism was the problem that many opponents of PAS made out, we ought to have seen a more or less rapid expansion of the conditions under which, say, killing is permissible, legalization of PAS or no. There should prove to be many routes down the slope from the virtuous society to the death camps.

But of course, we have not slid down the slope. A great many of the distinctions mentioned above seem to be enforced with as much zeal as they ever were; some, like the insanity defence, are actually more restrictive today in many jurisdictions than at other times in the recent past. The predicted slide has failed to occur. But why not? At which step has the mechanism broken down?

We ought to answer this question empirically if we can. Nevertheless, even in the absence of the data we need, it is possible to advance some plausible speculations. I suspect that, as a matter of fact, Smith and other slippery slopers are right in thinking that courts tend to be lenient in borderline cases. They really do sometimes impose very light sentences in cases in which the circumstances closely resemble those in which the action would have been permissible. In effect, they thereby create a situation in which certain cases, which fall just outside the guidelines, are legally tolerated. However it seems false to say that courts then go on to take these borderline cases into account in deciding where the borders are. That is, courts do not go on to redraw the guidelines in dealing with further cases. Instead, they refer to the promulgated legislation – not the facts on the ground – in deciding what cases closely resemble, without actually being, permissible endings of life. We slide down not a slope, but a single step. We tolerate acts which fall just beyond the guidelines, but we do not tolerate expansion of the guidelines.

It is because of the slippery step phenomenon that as a matter of fact our laws governing, say, murder have not become less and less restrictive. Though courts act mercifully on occasion, neither they nor the legislature routinely regard these decisions as calling for a change in the rules or guidelines. We slide down but a single step.

Now, I think it is clear that the slippery step phenomenon ought to be taken into account when we debate the ethics of PAS. When we draw the line, we should do so in the knowledge that we will likely permit not only the cases that our carefully drawn distinctions capture, but also some that fall just outside the guidelines. But

we do not need to fear that the borders will continue to expand beyond that point. One step more, and then we stop.

Slippery slopers are therefore quite right to point out that legalizing PAS may have the consequence of allowing more than we legalize. But that just means that we must pay careful attention to what we permit and what we thereby allow. It is not a decisive argument against PAS, all by itself. Instead, it requires us to turn our attention once more to the considerations which always ought to have been foremost in the debate: what does respect for patient autonomy, compassion for suffering, respect for dignity, as well as awareness of the possible consequences of our laws for third-parties and innocent bystanders, require of us? There is no way to avoid the hard questions and the detailed debate, here as elsewhere. There is no slippery slope.



# Physician-Assisted Suicide and the Medical Associations

Dieter Birnbacher

## 1 Introduction

The starting point of the following remarks is a number of beliefs that are far from universally shared but for which there is here not the place to argue: first, that an established, but strictly controlled, practice of physician-assisted suicide in desperate and irreversible end-of-life situations is ethically preferable to a practice of voluntary euthanasia; second, that an established, but strictly controlled, practice of physician-assisted suicide is ethically preferable to a medical system that does not make provisions for physician-assisted suicide or even regulates against it. Underlying these beliefs is the conviction that a patient who finds himself in a condition in which he suffers unbearably and irreversibly should have a choice. He should have a chance to choose, in the last moments of his life, the option most consonant with his personal beliefs and attitudes, instead of being forced to accept the option which is most likely to be offered to him by the medical system, viz. the option of terminal sedation.

Though terminal sedation, a prolonged process of dying in a state of reduced consciousness or complete unconsciousness is highly efficient in allowing a patient to die without suffering, it is a fact that a large number of patients in the relevant condition do not accept it, or accept it only as the second best alternative. From the perspective of these patients, terminal sedation has a number of features that make it appear inferior to assisted suicide. Unlike assisted suicide, terminal sedation does not express, in the unmistakable way suicide does, the autonomous will of the patient. Furthermore, it means to impose on relatives and friends the prospect of a prolonged process of dying, taking days or even weeks.

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## 2 The Nearly Unanimous Rejection of Physician-assisted Suicide in Professional Medical Codes

Given these considerations, it is deeply disturbing to find that the prospects of a practice of controlled physician-assisted suicide to become reality seems anything but good. At the moment, at least, physician-assisted suicide is explicitly prohibited either by legal sanctions or by the milder but no less efficacious sanctions of professional law and professional ethics in the overwhelming majority of countries. In a dissertation of 1990, the German lawyer Karl Michael von Lutterotti passed in review the professional codes of the most important countries of the world and found none that tolerated physician-assisted suicide apart from the well-known exception, the Netherlands, where at that time, however, the legal prohibition of assisted suicide was still officially upheld.<sup>1</sup>

There are, however, significant differences not only in the severity with which physician-assisted suicide is banned in different societies but also in the mechanisms by which this ban is enforced. Interestingly, the most striking discrepancies are to be found among neighbouring European countries. Whereas physician-assisted suicide in euthanasia situations is no longer legally punishable in the Netherlands and in Belgium, and punishable only if undertaken for selfish reasons in Switzerland, not only assisting suicide but even the attempt to assist suicide is punishable in Austria, which implies, among other things, that the operation of right-to-die societies is more severely restricted in Austria than in most other countries. In Germany, on the other hand, assisted suicide is not generally punishable as a criminal offence because of a long-standing legal tradition according to which an accessory action is only punishable if the action to which it is accessory is itself punishable. This general permission pertains also to physicians. In practice, however, the legal situation is more complicated since the physician, according to received, though more and more contested opinion, is legally expected to prevent the death of the patient as soon as the patient, after having committed suicide, is fallen into a state of unconsciousness. This amounts to the paradox that in contrast to assisting suicide, which is not illegal for a physician, the physician may very well be punishable for not resuscitating the patient whose suicide he has assisted. It also leads to human paradox that the physician is well advised not to accompany the patient in his self-imposed death in order to avoid legal consequences, thus leaving the patient alone in a situation in which more than in any other he may need human support.

Though approximately equally liberal in the legal regulation of physician-assisted suicide, Germany and Switzerland differ significantly in the extent to which physician-assisted suicide is tolerated in practice. The reason is not, as one might think, that physician-assisted suicide is differently treated in the respective professional codes of these countries, but rather, that regulatory propositions of a very similar wording are given different interpretations in both countries. Whereas the

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<sup>1</sup> Lutterotti, Karl Michael von: *Ärztliche Handlungsanleitungen im Grenzbereich zwischen Leben und Tod in strafrechtlicher Sicht*. Diss. Freiburg i. Br. (1990).

regulations of the Swiss professional code are given a “liberal” interpretation according to which physician-assisted suicide is not categorically prohibited but is left to the conscientious decision of the individual physician, the respective passages of the German professional code are interpreted as a categorical condemnation of physician-assisted suicide, even in situations in which physician-assisted suicide might be resorted to as an alternative to active euthanasia.

In the history of the relevant guidelines of the German Medical Association, the verdict on physician-assisted suicide as being incompatible with long-standing medical ethos is a continuing theme. The Guidelines for the Assistance in Dying of 1993 explicitly regulate that a physician assisting a patient’s suicide in a situation of terminal and subjectively unbearable disease is acting against medical ethics (*unärztlich*), and the Principles for the Assistance in Dying issued in 1998 and 2004 make the same pronouncement, only giving it a slightly different wording. The relevant sentence of the preamble of the latter guideline reads:

Active euthanasia is prohibited and punishable even if carried out on the patient’s demand. A physician’s participation in suicide contradicts the medical ethos and may be punishable.<sup>2</sup>

With regard to their content, the Principles are in full accordance with the declaration of the World Medical Association issued on occasion of its 44th assembly in 1992:

Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically.<sup>3</sup>

The documents have, however, very different functions. Differently from the declaration of the World Medical Federation, which is just a declaration and nothing else, the Principles of the German Medical association, like those of other national associations, are at least indirectly accompanied by sanctions. Though the Principles do not justify sanctions directly, they play an important indirect role. By defining what is ethical and what is unethical for a physician, they give substance to the provision of most codes of professional law to sanction physicians who act in “unethical” or “undignified” ways.

That is why the reference to the potential punishability of physician-assisted suicide in the Principles is highly ambiguous. The wording of the last sentence quoted leaves it open whether it is intended to point to the *fact* that physician-assisted suicide involves a risk of criminal sanctions by the legal system, or whether it *posits* this risk in its own right, i.e. threatens these sanctions itself. Despite the fact that the regulatory status of the “Principles” is decidedly lower than the status of guidelines or directives, this latter interpretation is not excluded. By declaring physician-assisted suicide unethical, the Principles do not only threaten German physicians with a

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<sup>2</sup> Bundesärztekammer: Grundsätze der Bundesärztekammer zur ärztlichen Sterbebegleitung. Deutsches Ärzteblatt 95, A-2366 / B-2022 / C-1898 (1998). Bundesärztekammer: Grundsätze der Bundesärztekammer zur ärztlichen Sterbebegleitung. Deutsches Ärzteblatt 101, A 1298–1299 (2004).

<sup>3</sup> World Medical Association: Statement on Physician-Assisted Suicide. Adopted by the 44th World Medical Assembly Marbella (1992), <http://www.wma.net/e/policy/p13.htm>.

loss of professional reputation but also with the risk of being summoned before a professional court and be subjected to a graded scale of sanctions the severest of which is the loss of their doctor's licence. That this threat is not only symbolic was shown by the case of Julius Hackethal in 1988, a surgeon well-known for his critical positions in regard to officially approved medicine and a prolific writer of popular medical books. Hackethal who not only practised physician-assisted suicide in the case one of his own patients with an advanced stage of facial cancer but made it public in a more or less demonstrative manner, was subsequently sued for "unethical behaviour" by the professional court of the Bavarian Medical Association, with the result that the Court recommended to the appropriate authorities to withdraw his doctor's licence. (According to German law, the medical associations are not entitled to withdraw the doctor's licence themselves.) The Bavarian authorities, however, did not follow the court's recommendation, probably because Hackethal pledged in writing to refrain from carrying out acts of euthanasia not covered by professional guidelines in the future.<sup>4</sup>

Because of the verdict on physician-assisted suicide in the Principles (and, formerly, Guidelines) of the German Medical Association the factual situation with regard to physician-assisted suicide is hardly different in Germany from the situation in countries in which physician-assisted suicide is prohibited by law. The situation in Switzerland is fundamentally different because of a more liberal climate of opinion. Though the wording of the corresponding medical guidelines is very similar to that of the German Principles, the received interpretation of these guidelines is that of a demarcation between the range of activities in which the physician acts *qua* physician and other activities in which the physician acts *qua* citizen with special medical expertise. One of the advisors of the group that drew up the guidelines issued in 2005, Zurich based theologian Johannes Fischer, argues that the Swiss Academy of Medical Sciences cannot prohibit physicians to participate in physician-assisted suicide as long as the practice is legal for every Swiss citizen.<sup>5</sup> This kind of argument seems to have been the basis of the generous way in which the Swiss Academy has tolerated the co-operation of physicians with EXIT and other Swiss right-to-die societies despite the injunction in the relevant guidelines that physician-assisted suicide is "not part of a physician's activities".

That this statement does not imply a prohibition of physician-assisted suicide has also been made clear by the *Empfehlungen zur Suizidbeihilfe* of the Swiss National Ethics Commission in the field of medicine of April 2005:

If assisted suicide were of a physician's activities, every physician would be under an obligation to comply with a corresponding competent patient's request.<sup>6</sup>

<sup>4</sup> Koch, Hans-Georg: Länderbericht Bundesrepublik Deutschland. In: Albin Eser and Hans-Georg Koch (eds.): Materialien zur Sterbehilfe. Eine internationale Dokumentation. Freiburg i. Br. (1991).

<sup>5</sup> Fischer, Johannes: Die Schweizerische Akademie der medizinischen Wissenschaften zur Suizidbeihilfe. *Ethik in der Medizin* 16 (2004), 165–169.

<sup>6</sup> Nationale Ethikkommission im Bereich Humanmedizin (NEK-CNE), Schweiz: Beihilfe zum Suizid. *Empfehlungen zum Thema Suizidbeihilfe*. *Jahrbuch für Ethik und Wissenschaft* 11 (2006), 491–497, 495.

This recommendation takes even the further step to demand that physicians and other medical staff are exempted from moral reproach by their profession.<sup>7</sup> Even more striking is the courage, of these recommendations, to acknowledge that there are conditions under which even the suicide wishes of patients suffering from mental diseases cannot be discounted, such as suicide wishes expressed in a “symptom-free interval of a chronic disease” that cannot be counted as direct expressions or symptoms of disease.<sup>8</sup> Another factor involved is a circumstance that deserves more detailed attention, the *ambiguity* of the wording given to the verdict on physician-assisted suicide by many medical associations.

### 3 Ambiguities

A close reading of the declarations by which physician-assisted suicide is condemned by medical associations shows that they leave more room for interpretation than the declarations condemning active euthanasia. Many of these declarations give the impression of being deliberately expressed more or less ambiguously.<sup>9</sup> Typical examples are the statement of the Swiss guidelines of 1995 quoted above to the effect that physician-assisted suicide “is not part of the physician’s activities” (“kein Teil der ärztlichen Tätigkeit”),<sup>10</sup> and the statement of the guidelines of the German Society of Surgeons of 1996 that

though suicide, in this country, is not unlawful and advice given to that effect is not punishable, giving information about how to commit suicide is not part of the physician’s professional duties (“gehört nicht zum ärztlichen Behandlungsauftrag”).<sup>11</sup>

Both statements are ambiguous because they can be understood either as a down-right prohibition of physician-assisted suicide or as the negation of a positive duty of the physician to comply with a patient’s request for assistance with an intended suicide. In the first interpretation, the physician is put under an obligation not to assist suicide. In the second, he is freed from an obligation to assist suicide.

There are parallels for both interpretations in other relevant German guidelines. The restrictive interpretation according to which physician-assisted suicide is strictly prohibited is clearly intended by the German Society of Surgeons in saying in their guidelines of 1979:

<sup>7</sup> Nationale Ethikkommission Schweiz 2006 (fn. 6), 496.

<sup>8</sup> Nationale Ethikkommission Schweiz 2006 (fn. 6), 494.

<sup>9</sup> Foppa, Carlo: Svizzera: il tabù della morte tra suicidio assistito ed eutanasia. *Bioetica* 12 (2004), 588–608.

<sup>10</sup> Schweizerische Akademie der Medizinischen Wissenschaften: Medizinisch-ethische Richtlinien für die ärztliche Betreuung sterbender und zerebral schwerstgeschädigter Patienten. *Schweizerische Ärztezeitung* 76 (1995), 1223–1225.

<sup>11</sup> Deutsche Gesellschaft für Chirurgie: Leitlinie zum Umfang und zur Begrenzung der ärztlichen Behandlungspflicht in der Chirurgie, in: Deutsche Gesellschaft für Chirurgie. *Mitteilungen Heft 5/1996*, 364–371.

Active assistance with suicide, e.g. by handing over a lethal poison, is against a physician's duties. This is not meant to imply a principled moral evaluation of suicide.<sup>12</sup>

The liberal interpretation that whenever a patient asks for assistance in suicide, the physician is not under any obligation to offer assistance, is intended by one of the resolutions of the German Convent of Physicians (Deutscher Ärztetag) of 1981:

It is the opinion of the Deutsche Ärztetag that no physician can be obligated to comply with a patient's request for euthanasia. (Vorstand der Bundesärztekammer et al. 1988, 164).<sup>13</sup>

It has already been pointed out that the liberal interpretation of the statement that physician-assisted suicide is "not part of the physician's activities" has been generally adopted in Switzerland. It is no wonder, therefore, that it is also adopted in the new Swiss guidelines. This proposal breaks new ground in leaving the decision to carry out physician-assisted suicide to the individual physician, thus explicitly legitimising the actual Swiss practice. The text in full reads as follows:

According to article 115 of the criminal law helping someone to commit suicide is not a punishable offence when it is done for unselfish reasons. This applies to everyone. As to physicians, their concern should be to alleviate their patients' symptoms at the end of life and to support their patients. It is not one of his duties to offer suicide assistance on his own initiative, but, on the contrary, to relieve the suffering underlying potential suicide wishes. Nevertheless, there may be end-of-life situations in which the patient asks for help in committing suicide and persists with this wish. In this limiting situation the physician can be confronted with a conflict that he finds hard to resolve. On the one hand assisted suicide is not part of a doctor's task ("nicht Teil der ärztlichen Tätigkeit"), because this contradicts the aims of medicine. On the other hand, respect for the patient's will is fundamental for the physician-patient-relation. This dilemma situation requires a personal conscientious decision on the part of the physician. The decision to assist suicide in a concrete case is to be respected as such a decision. In any case, the physician has the right to refuse to comply with the patient's request.<sup>14</sup>

What is new in these guidelines is that physician-assisted suicide is for the first time recognised as part of a physician's activities. Though the decision to participate in physician-assisted suicide is left to the conscience of the individual physician, making it an object of explicit regulation means that it is taken to be part of medical practice. While the Swiss guidelines of 1995 implicitly tolerate physician-assisted suicide but, at the same time, define it as lying outside the physician's proper sphere of activity, the new guidelines explicitly count it among the accepted activities of a physician *qua* physician. Given the actual Swiss practice, this is an important

<sup>12</sup> Deutsche Gesellschaft für Chirurgie: Resolution zur Behandlung Todkranker und Sterbender. *Anästhesist* 28 (1979), 357.

<sup>13</sup> Vorstand der Bundesärztekammer, Wissenschaftlicher Beirat der Bundesärztekammer, Zentrale Kommission der Bundesärztekammer zur Wahrung ethischer Grundsätze in der Reproduktionsmedizin, Forschung an menschlichen Embryonen und Gentherapie (eds.): *Weissbuch Anfang und Ende menschlichen Lebens – Medizinischer Fortschritt und ärztliche Ethik*. Köln 1988, 164.

<sup>14</sup> Schweizerische Akademie der Medizinischen Wissenschaften: *Betreuung von Patienten am Lebensende*. *Schweizerische Ärztezeitung* 86 (2005), 172–176.

step towards more honesty and transparency. At the same time, the new guidelines introduce new ambiguities.

One ambiguity is that, on the one hand, the new guidelines make it clear that the phrase “is not part the physician’s activities” is not to be understood as a prohibition of physician-assisted suicide, but only as the denial of a corresponding obligation. On the other, they still take it for granted that physician-assisted suicide is inherently in conflict with the physician’s duties and the aims of medicine. The first part of the ambiguity follows from the fact that the guidelines explicitly enumerate a number of activities which are not only part of the physician’s typical *activities* but which part of his *duties* in end-of-life-situations, namely therapy, relief of suffering, and accompanying the patient. Obviously, the contrast intended is that between activities to which the physician is obligated and activities which, though within his range of special competence, fall outside his range of duties. The implication is that physician-assisted suicide, though falling within the range of the physician’s competence does not fall within the range of his professional duties. On the other hand, the guidelines seem to presuppose that a physician confronted with a patient requesting physician-assisted suicide necessarily or typically finds himself in a “conflict, which he finds hard to resolve”. However, if such a conflict is hard to resolve, it must be for reasons other than the reasons given by the guidelines itself. Since these do nothing to condemn physician-assisted suicide the conflict cannot be a conflict between conflicting norms of the same professional code. What, then, are the conflicting norms in this case? Obviously the conflict assumed to exist is a conflict between an assumed principle to respect a patient’s autonomous choice (which is taken to be part of the physician’s professional duties) and principles of the physician’s personal morality incompatible with respecting the patient’s autonomy in this special case. Such a conflict can arise in two different ways. First, as a conflict between a moral prohibition to actively participate in an action that hastens the death of a patient and a moral *right* to assist a patient’s suicide in a case of irreversible suffering, second, as a conflict between the same prohibition and a moral *duty* to assist a patient’s suicide in a case of irreversible suffering. The guidelines do not clearly indicate what kind of conflict is meant. The wording of the guidelines suggests, however, that the authors are not thinking of a conflict between a moral right and a moral duty but of a conflict between two moral duties. They seem to construe it as a conflict between a principle of personal morality that *excludes* physician-assisted suicide and a principle of professional morality that *demand*s physician-assisted suicide. The implicit principle assumed seems to be that there is a professional *duty* to respect the patient’s autonomy not only in the negative sense of not treating the patient against his expressed or presumed will but in the positive sense of actively assisting him in carrying out an autonomous choice provided this is not contrary to his own interest. Only this can be intended by the statement that “respect for the patient’s will is fundamental for the physician-patient-relation”.

The same thought that is still rather implicit in the new guidelines is made more explicit in the recommendations of the Swiss National Commission. These recommendations make it clear that the physician should assure himself that the patient’s will is not made ineffective by unfavorable circumstances:

the well-considered personal decision to take one's own life should not be thwarted by the rules of an institution, the personal conscience of the individual physician or an particular nursing team. The possibility should be provided to be assigned to a different doctor or a different institution.<sup>15</sup>

If this is the horn of the dilemma the physician finds himself in (the other being his personal moral principles rejecting suicide assistance) the principle underlying this horn is definitely to be welcomed. The principle seems not only to be an extremely reasonable one; it is also crucially relevant for the situation under discussion. It seems indeed that a good case can be made for a moral obligation (and not only for a moral right) of the physician to assist the patient whenever the patient depends on the physician to exercise his autonomy. This condition obtains in many end-of life situations where the patient is no longer able to effectively exercise his autonomy, so that, without the physician's assistance, the patient's right to autonomy would be empty. There are, however, obvious limits to an obligation to make a patient's autonomy effective. One central limiting condition is that the patient's autonomy is exercised to his own benefit.

This means, however, that the explanation given for the conflict between personal and professional norms in the new guidelines is at least misleadingly expressed. Respecting the wishes of the patient in a situation in which physician-assisted suicide is an option does not simply follow from a general duty to respect the patient's wishes. An obligation of this general description is not recognized, neither by the professional medical code nor in general morality. The physician is not in general under an obligation to follow the patient's wishes irrespective of how reasonable these are, how far complying with these wishes is in the patient's own interest and how far others may be negatively affected by it.

Another kind of ambiguity to be found in some other relevant guidelines is that though physician-assisted suicide is rejected, the rejection is relativised by cautionary clauses. Some guidelines indicate that the topic of too controversial among physicians to pass a definite judgement on it or that though the guidelines reject physician-assisted suicide this verdict may be subject to revision in the near future. An ambiguity of this kind is characteristic of the guidelines of the American Medical Association of 1992. Though physician-assisted suicide is categorically rejected, the rejection is considerably weakened by modifying clauses:

While in highly sympathetic cases physician assisted suicide may seem to constitute beneficent care, due to the potential for grave harm the medical profession cannot condone physician-assisted suicide at this time. . . . Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary.<sup>16</sup>

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<sup>15</sup> Nationale Ethikkommission Schweiz 2006 (fn. 6), 495.

<sup>16</sup> Council on Ethical and Judicial Affairs, American Medical Association: Decisions near the end of life. JAMA 267 (1992), 2229–2233.



## 4 Justifications

The first thing that has to be said about the justifications given by medical associations for their prohibition of physician-assisted suicide is that they are mostly lacking. Obviously, most associations do not think that giving reasons is necessary in this case, given the verdict on physician-assisted suicide in traditional medical deontology, especially in the Hippocratic tradition, and the verdict on suicide in traditional Christian morality. In Germany, nothing in the way of justification can be found in any official document, and relevant utterances of officials are remarkably laconic on the point. In a recent publication, Eggert Beleites, chairman of the committee of the German Medical Association responsible for drawing up the relevant guidelines, writes:

It is the view of the Association that a legal regulation of medical end-of-life decisions and a loosening of the prohibition of physician-assisted suicide are not advisable.<sup>17</sup>

Sometimes, highly unspecific consequentialist arguments are given, as in the explanatory commentary annexed to the guidelines of the Swiss Academy of Medical Sciences of 1995:

Fear of being subject to states of severe pain and to be a burden to one's environment towards the end of life sometimes tempts people to make provisions for carrying out assisted suicide in a situation of this kind. However, palliative care and analgesic measures, competently administered, can, as a rule, prevent unnecessary suffering and can reduce this fear. Though assisted suicide is not punishable if done without selfish motives (cf. Art. 115 of the criminal code) strict reservations have to be made from a medical point of view. Apart from a rejection of suicide on religious or philosophical ("weltanschaulich") grounds, which may influence the conscientious decision of the responsible physician, the dangers of misuse resulting from a general acceptance of physician-assisted suicide are evident.<sup>18</sup>

Obviously, this explanation is more of a refusal of a justification than a justification. (What is striking, too, is that the statement presupposes that the philosophical creed of physicians is always against and never in favour of assisted suicide.) It is far from evident what the "evident" dangers of misuse are. The most plausible guess is that what is meant is the danger that physician-assisted suicide is carried out in situations other than situations of unbearable and irreversible suffering, and that loosening the prohibition might become a door-opener for physicians assisting suicidal patients in situations in which suicide prevention rather than suicide assistance is called for.

More specific consequentialist arguments are advanced in the guidelines of the Council on Ethical and Judicial Affairs of the American Medical Association of 1992. These arguments essentially refer to two kinds of risks; first the risk that the patient might be pressurised into choosing physician-assisted suicide:

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<sup>17</sup> Beleites, Eggert: Über die Diskussion in der deutschen Ärzteschaft zum Thema "Aktive Sterbehilfe". In: Klaus-M. Kodalle (ed.): *Das Recht auf ein Sterben in Würde*. Würzburg (2003), 43–50, 49.

<sup>18</sup> Schweizerische Akademie der Medizinischen Wissenschaften: *Medizinisch-ethische Richtlinien für die ärztliche Betreuung sterbender und zerebral schwerstgeschädigter Patienten*. Schweizerische Ärztezeitung 76 (1995), 1223–1225, 1225.

Physician assisted suicide . . . has many of the same societal risks as euthanasia, including the potential for coercive financial and societal pressures on patients to choose suicide.<sup>19</sup>

second, the risk that physician-assisted suicide is carried out in cases that do not meet the criteria laid down in potential guidelines, or in which it is difficult to find out whether the criteria are met:

Determining the criteria for assisting a patient's suicide and determining whether a particular patient meets the criteria are as problematic as deciding who may receive euthanasia.<sup>20</sup>

Both arguments are well known from public discussion, not only in the United States.<sup>21</sup> Are these consequentialist arguments good arguments?

It must be admitted that loosening the prohibition on physician-assisted suicide is necessarily bound up with a lowering of thresholds and a certain risk of misuse, especially the risk that physician-assisted suicide is carried out in situations other than those originally envisaged. With a permission of physician-assisted suicide physicians might be tempted to assist suicide not only in cases of irreversible suffering in end-of-life situations but also with patients without terminal illness who are tired of life or with patients suicidal from neurotic or psychotic causes.

In this respect, a lowering of the threshold against physician-assisted suicide seems clearly more risky than an acceptance of terminal sedation. Though the fact that in physician-assisted suicide the patient himself is ultimately the active part might suggest that the principle of self-determination is more firmly secured in physician-assisted suicide than in terminal sedation, the risk that the practice oversteps its intended limits seems higher with physician-assisted suicide. In theory, the dangers of misuse are more grave in terminal sedation than in physician-assisted suicide. In practice, it is less realistic that they materialise. It is hardly to be expected that a physician makes someone undergo terminal sedation who is in perfect health. It is less unrealistic to expect that a physician provides a lethal poison to a person who is in perfect health but happens to be suicidal.

These risk arguments are, however, far from decisive. They are plausible only to the extent

1. that it is impossible to control a potential practice of physician-assisted suicide and to limit it to clear cases of irreversible suffering; and
2. that the remaining risks of misuse are morally so devastating that they are not compensated by the expected benefits.

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<sup>19</sup> Council on Ethical and Judicial Affairs, American Medical Association: Decisions near the end of life. *JAMA* 267 (1992), 2229–2233, 2233.

<sup>20</sup> *Id.*

<sup>21</sup> See, e.g., Vollmann, Jochen: Die deutsche Diskussion über ärztliche Tötung auf Verlangen und Beihilfe zum Suizid. Eine Übersicht medizinethischer und rechtlicher Aspekte. In: Gordijn, Bert and Henk ten Have (eds.): *Medizinethik und Kultur. Grenzen medizinischen Handelns in Deutschland und den Niederlanden*. Stuttgart-Bad Cannstatt (2000), 31–70, 54 ff.

Neither of these conditions seems to me to be fulfilled. The history of the practice of physician-assisted suicide in Oregon shows that it is perfectly possible to institute a practice of physician-assisted suicide under close controls and with clear limitations. The Oregon experiment also shows that the risk that patients are pressurised into asking for physician-assisted suicide is not greater than with uncontroversial end-of-life practices such as termination of treatment. Furthermore, it is far from evident that the benefits resulting from a limited practice of physician-assisted suicide are offset by inevitable cases of misuse. That the benefits might be substantial is, ironically, hinted at in the explanatory commentary of the Swiss guidelines of 1995, when it declares that “palliative care and analgesic measures, competently administered, can *as a rule*, prevent unnecessary suffering”. If these measures succeed only *as a rule*, what about the cases in which these measures do not work? How can the authors of the guidelines be sure that the “unnecessary suffering” caused by the unavailability of euthanasia and physician-assisted suicide in these cases is more acceptable ethically than a limited risk of misuse? It should be borne in mind, furthermore, that the benefits of instituting a limited practice of physician-assisted suicide are largely indirect. More people are benefited by a practice of physician-assisted suicide than those few who find themselves in situations in which physician-assisted suicide is an option of last resort. The main benefit of a practice of physician-assisted suicide is not the direct one of its actual use but the indirect one of its availability. Its main benefits accrue to those who want to be sure that this option will not be closed to them in the future.

If the consequentialist arguments mentioned in the guidelines are insufficient to maintain the verdict on physician-assisted suicide, do the deontological arguments fare better? Deontological arguments are only rarely appealed to in the official documents, but one important one is contained in the guidelines of the American Medical Association:

Physician assisted suicide, like euthanasia, is contrary to the prohibition against using the tools of medicine to cause a patient’s death.<sup>22</sup>

This argument is echoed by the passage in the recent Swiss guidelines to the effect that “assisting suicide is . . . contrary to the aims of medicine”. This argument cannot be countered by consequentialist considerations since it might be put forward and accepted even in the face of overwhelming evidence that a practice of physician-assisted suicide is overall beneficial. Its weakness, however, is that it takes one of the legitimate aims of medicine, the preservation of life, as a moral absolute, sacrificing other, no less legitimate aims of medicine such as the relief of suffering. The aim to relieve suffering is as universally recognised as the restitution of health and the preservation of life, and there is no medical code that treats any one of these aims as strictly non-negotiable. The widespread acceptance of termination of treatment on the patient’s request shows that even the aim of preserving life is not absolute but can be balanced against other aims such as reducing suffering and respecting self-determination.

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<sup>22</sup> Council on Ethical and Judicial Affairs.

What, then, is so special about physician-assisted suicide that it must be excluded as a last resort in cases of irreversible suffering whereas a termination of treatment under the same circumstances is nearly universally accepted? Is it the active role played by the physician? This cannot be the crucial factor because the physician often plays an active role even in the “passive” termination of treatment, e.g. by actively disconnecting a respirator. In addition, in physician-assisted suicide the role of the physician, even if active, is essentially indirect. The step beyond the point of no return is taken by the patient. Is it the fact that in physician-assisted suicide death is directly intended instead of being taken into the bargain as an inevitable but unintended consequence? This, again, cannot be the crucial difference because termination of treatment in end-of-life situations is usually carried out with the same intention. Death is hastened as a *means* to reducing suffering, not as an unintended *consequence* of a termination of treatment, and a means to some further end is necessarily intended whenever the end is intended.

In sum, there seem to be no good reasons why the verdict on physician-assisted suicide should be maintained by medical associations. Participation of physicians in a patient’s suicide cannot be considered to be inherently incompatible with a physician’s integrity,<sup>23</sup> nor is it likely to destroy or to endanger patients’ trust in their physicians’ integrity. On the contrary, trust in physician-patient relationships is likely to suffer more by a doctor’s refusal to assist a patient in killing himself in desperate end-of-life situations than by active participation.<sup>24</sup> This, at least, appears to be the view taken by patients. According to a representative survey carried out in November 2003, 84% of Germans assented to the statement “If my general practitioner assists a patient with an untreatable disease to commit suicide this would not reduce my trust in him”.<sup>25</sup>

It should not be overlooked, however, that there are good reasons to view assisted suicide not as the best but the second best option among the means of last resort, and that priority should be given to terminal or palliative sedation as a means to peaceful and dignified dying.

This priority can be justified, I think, only from a societal perspective and not from the perspective of the individual patient. From the perspective of a patient who finds himself in a state of severe suffering which proves resistant to palliative measures, it is difficult to formulate a clear ethical preference for one of these procedures. Which of the procedures is preferable depends to a high degree on individual attitudes. A clear advantage of the option of terminal sedation is that it does not in all cases mean a point of no return but that it can be administered in a way that makes it reversible so that the patient has a chance to decide anew about termination of treatment after having regained consciousness. The fact that

<sup>23</sup> Cf. Momeyer, Richard: Does physician assisted suicide violate the integrity of medicine? *Journal of Medicine and Philosophy* 20 (1995), 13–24.

<sup>24</sup> Cf. Miller, Franklin G. and Howard Brody: Professional integrity and Physician-Assisted Death. *Hastings Center Report* 25 (1995), No. 3, 8–17.

<sup>25</sup> DGHS (Deutsche Gesellschaft für Humanes Sterben): Aktuelle forsa-Umfrage Press release November 2003.

this possibility exist in terminal sedation is of importance especially if sedation is given in a situation in which the patient is incompetent and in which sedation makes him regain competence so that he is only then in a position to make use of his right to self-determination and to decide about the option of a final termination of treatment. If, as Richard Momeyer has argued, respecting the self-determination of the patient does not only mean to respect his will, but also to give him an opportunity to express and to carry out his will, the chance of regaining competence is a clear ethical advantage.<sup>26</sup>

This advantage is, however, absent if the patient is anyway decided to want his life ended. In this case he may have two reasons to prefer assisted suicide. First, with an act of suicide he openly expresses for others and for himself the autonomy of his decision. Second, he saves his relatives the potential burdens associated with a prolonged process of dying. The first aspect will be important for patients who want to determine themselves the exact time of their deaths. Though terminal sedation will, in general, be administered on the patient's explicit consent, it lacks the symbolic confirmation of the patient's will to take the end of his life in his own hands characteristic of suicide. For many patients it will also be important not to confront their relatives with a prolonged dying process. Even if treatment is terminated immediately after sedation, the process can take a number of days.

What tells in favour of giving priority to terminal from a societal perspective is based on the assessment that the risks of abuse and misuse are easier to avoid with terminal sedation than with assisted suicide. Though at a first glance it might seem that the value of patient self-determination is much better safeguarded by a practice of assisted suicide than by a practice of terminal sedation, there is much to be said against this picture. Critics of terminal sedation like David Orentlicher may well be right in pointing to the fact that the risks of terminal sedation in combination with termination of treatment are more to be feared than the risks of assisted suicide, since in terminal sedation the crucial causal factors do not lie with the patient but with the physician. But this is true only in theory. In practice, it is hardly imaginable that an incompetent patient, or a patient who does not want to die, might be forced to commit suicide, whereas it is imaginable that a patient in an advanced state of dementia is sedated and let die against his will.<sup>27</sup> It seems improbable that a physician sedates a completely healthy person in order to give him an opportunity to die by lack of hydration. It is much less improbable that a physician provides a healthy person with a substance to allow him to die by suicide.

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<sup>26</sup> Momeyer, Richard W. (1988): *Confronting Death*. Indiana University Press, Bloomington, 81.

<sup>27</sup> Cf. Orentlicher, David (1998): *The Supreme Court and Terminal Sedation. An ethically inferior alternative to Physician Assisted Suicide*. In: M. P. Battin, R. Rhodes, A. Silvers (eds.): *Physician Assisted Suicide. Expanding the Debate*. Oxford University Press, New York, 301–311, 307 ff.

## 5 A Constructive Proposal

What might a more satisfactory professional regulation of assisted suicide look like?

The first condition would be to limit the permissibility of physician-assisted suicide to euthanasia situations, i.e. to situation in which a patient suffers irreversibly and unbearably (according to his or her individual standards), and in which alternative means of reducing suffering are not in sight or are rejected by the patient.

The second condition would be that differently from the Swiss directives, the permissibility of physician-assisted suicide should not be subject to the condition that “the disease of the patient ... justifies the assumption that the end of life is near”. With such a narrow conception of euthanasia patients would have to do without assistance who are faced with a longer period in which they would have to live under circumstances which they personally find unacceptable and who therefore are in a specially unfortunate condition.

At least the further conditions (which are part of the Swiss directives) would have to be included:

1. alternative possibilities of assistance have been discussed and applied to the extent they were requested by the patient,
2. the patient is competent, his or her request is well-considered, has been formed without external pressure and permanent. This was examined by a third person.

This third person need not be a physician according to the Swiss directives. But, in order to make the condition more operational, I think that this third person should be a psychiatrically competent person, either a psychiatrist or a physician with psychiatric experience.

A further condition which was originally proposed by the American psychiatrist Quill (particularly to distinguish his position from that Jack Kevorkian's) should perhaps be added, namely that “assisted suicide should be based on a genuine relationship between physician and patient”.<sup>28</sup> A similar condition has been introduced into the recent recommendations of Swiss National Commission:

As the decision to assist a patient's suicide is a case-by-case decision oriented at the individual person and situation of the suicidal patient, careful balancing of pros and cons is required ... This is possible only on the basis of an intensive and extended relationship and not on the basis of a short or single contact with the suicidal person.<sup>29</sup>

<sup>28</sup> Cf. Quill, Timothy (1993): *Death and Dignity*. W. W. Norton, New York, 171 f.

<sup>29</sup> Nationale Ethikkommission Schweiz (fn. 6), 497.

# Safe, Legal, Rare? Physician-Assisted Suicide and Cultural Change in the Future\*

Margaret Pabst Battin

## 1 Introduction

Cultural change is well recognized in the recent history of death and dying in the contemporary world. In the wake of Elizabeth Kübler-Ross' 1969 work *On Death and Dying*, not only has it become socially acceptable to talk about death and dying with someone who is terminally ill, but, as traditional religious and legal strictures loosen, it is becoming possible for a person facing death to consider what role he or she wants to play in the forthcoming death. The United States has seen rapid evolution in attitudes and practices about death and dying over the last several decades, beginning with the early legal recognition in the *California Natural Death Act* (1976) of a patient's right to refuse life-prolonging treatment in the face of terminal illness, to the increased public awareness of issues of personal autonomy in dying, raised by Derek Humphrey's how-to book of lethal drug dosages, *Final Exit*, to new sensitivity to physician roles in aiding dying, both in the maverick social activism of Dr. Jack Kevorkian and a New York grand jury's refusal to indict the respected physician Timothy Quill. This process of cultural evolution has reached legal recognition: in 1997, the U.S. Supreme Court jointly decided the cases *Washington v. Glucksberg* and *Vacco v. Quill*, and while it held that physician-assisted suicide is not a constitutional right, it by implication also decided that states are free to make their own laws in this matter. Indeed, Oregon has made it legal for a physician to provide a terminally ill patient who requests it with a prescription for a lethal drug, thus bringing above ground the practical manifestation of a long process of cultural change.

Cultural change like this draws on many factors, including changes in medical technology, in the epidemiology of death, and social and legislative recognition of civil and personal rights in many other areas. Of course, cultural change is not

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unidirectional; although Oregon legalized physician-assisted suicide, Maryland, among others, made it a felony. But it is possible to discern a pattern of increasing attention to end of life issues and, I believe, to the issue of individual self-determination in the matter of dying.

The story does not end here. This is the most important fact about cultural change – the fact that it is an ongoing process, one which we view only from some intermediate point. What I want to explore in this paper is the prospect of cultural change in the future, and the possibility that physician-assisted suicide may come to look very, very different from the desperation move that it is taken to be now.

## 2 The Way it Looks Now

Observe the current debate over physician-assisted suicide: On the one side, supporters of legalization appeal to the principle of autonomy, or self-determination, to insist that terminally ill patients have the right to extricate themselves from pain and suffering and to control as much as possible the ends of their lives. On the other, opponents resolutely insist on various religious, principled, or slippery-slope grounds that physician-assisted suicide cannot be allowed, whether because it is sacrilegious, immoral, or poses risks of abuse. As vociferous and politicized as these two sides of the debate have become, however, proponents and opponents (tacitly) agree on a core issue: that the patient may choose to avoid suffering and pain. They disagree, it seems, largely about the means the patient and his or her physician may use to do so.

They also disagree about the actualities of pain control. Proponents of legalization insist that currently available forms of pain and symptom control are grossly inadequate and unsatisfactory. Citing such data as the SUPPORT study<sup>1</sup> and many other works, they point to high rates of reported pain among patients, including terminally ill patients, inadequately developed pain-control therapies, physicians' lack of training in pain-control techniques, and obstacles and limitations to delivery of pain-control treatment, including restrictions on narcotic and other drugs. Pain and the suffering associated with other symptoms just aren't adequately controlled, proponents of legalization insist, so the patient is surely entitled to avoid them – if he or she so chooses – by turning to earlier, humanely assisted dying.

Opponents of legalization, on the other hand, insist that these claims are uninformed. Effective methods of pain control include timely withholding and withdrawal of treatment, sufficient use of morphine or other drugs for pain (even at the risk of foreseen, through unintended, shortening of life), and the discontinuation of artificial nutrition and hydration. When all other measures to control pain and

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<sup>1</sup> The SUPPORT Principal Investigators, "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients," *Journal of the American Medical Association* 274 (20) (1995): 1951–1998. According to the SUPPORT study, about 50% of conscious dying hospitalized patients were reported by family members to have experienced moderate to severe pain at least 50% of the time in their last 3 days of life.



suffering fail, there is always the possibility of terminal sedation: the induction of coma with concomitant withholding of nutrition and hydration, which, though it results in death, is not to be seen as killing.

Proponents laugh at this claim. Terminal sedation, they retort, like the overuse of morphine, is functionally equivalent to causing death.

Despite these continuing disagreements about the effectiveness, availability, and significance of current pain control, both proponents and opponents in the debate appear to agree that *if* adequate pain control were available, there would be far less call for physician-assisted suicide. This claim is both predictive and normative. *If* adequate pain control were available, both sides argue, then physician-assisted suicide would be and should be quite infrequent – a “last resort,” as Timothy Quill puts it, to be used only in exceptionally difficult cases when pain control really does fail. Borrowing use of an expression used by President Clinton to describe his view of abortion, proponents insist that physician-assisted suicide should be “safe, legal, and rare.” Opponents do not believe that it should be legal, but they also think that if it cannot be suppressed altogether or if a few very difficult cases remain, it should be very, very rare. The only real disagreement between opponents and proponents concerns those cases in which adequate pain control cannot be achieved.

What accounts for the opposing sides’ underlying agreement that physician-assisted suicide should be rare is, I think, an unexamined assumption they share. This assumption is the view that the call for physician-assisted suicide is what might be called a *phenomenon of discrepant development*: a symptom of the disparity in development between two distinct capacities of modern medicine, the capacity to extend or prolong life and the capacity to control pain. Research, development, and delivery of technologies for the prolongation of life have raced far ahead; those for control of pain lagged far behind. It is this situation of discrepant development that has triggered the current concern with physician-assisted suicide and the volatile public debate over whether to legalize it or not.

The opposing sides both also hold in common the view that what would lead to the resolution of the problem is whatever set of mechanisms would tend to equalize the degree of development of medicine’s capacities to prolong life and to control pain. To achieve this equalization, two simultaneous strategies are recommended: cutting back on overzealous prolongation of life (as Dan Callahan, for example, has long recommended<sup>2</sup>), and at the same time (as Hospice and others have been insisting<sup>3</sup>) accelerating the development of technologies, modes of delivery, and physician training for more effective methods of pain control. As life prolongation is held back a bit, pain control can catch up, and the current situation of discrepant development between the two can be alleviated. Thus calls for physician-assisted

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<sup>2</sup> See e.g. Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society* (New York, Simon and Schuster, 1987); Daniel Callahan, *What Kind of Life? The Limits of Medical Progress* (New York: Simon and Schuster, 1990); and Daniel Callahan, *The Troubled Dream of Life: Living with Mortality* (New York: Simon and Schuster, 1993).

<sup>3</sup> See especially the work of Kathleen Foley, “Pain, Physician-Assisted Suicide, and Euthanasia,” *Pain Forum* 4 (3) (1995) and other works.

suicide can be expected to become rarer and rarer, and as medicine's capacities for pain control are finally equalized with its capacities for life prolongation, finally to virtually disappear. Almost no one imagines that there will not still be a few difficult situations in which life is prolonged beyond the point at which pain can be effectively controlled, but these will be increasingly infrequent, it is assumed, and in general, as the disparity between our capacities for life prolongation and for pain control shrinks, interest in and need for physician-assisted suicide will decrease and all but disappear.

Fortunately, this view continues, the public debate over physician-assisted suicide now so intense will not have been a waste, since it has both warned against the potential cruelty of overzealous prolongation of life and at the same time stimulated greater attention to imperatives of pain control. The current debate serves as social pressure for bringing equalization of the disparity about. Yet as useful as this debate is, this view holds, it will soon subside and disappear; we're just currently caught in a turbulent – but fleeting – little maelstrom.

### 3 The Longer View

That's how things look now. But I think we can also see our current concern with physician-assisted suicide in a longer-term, historically informed view. Consider just three of the many profound changes that affect matters of how we die. First, there has been a shift, beginning in the middle of the last century, in the ways in which human beings characteristically die. Termed the "epidemiological transition,"<sup>4</sup> this change involves a shift away from death due to parasitic and infectious disease (ubiquitous among humans in all parts of the globe prior to about 1850) to death in later life of degenerative disease – especially cancer and heart disease, which together account for almost two thirds of deaths in the developed countries. This means dramatically extended lifespans and also deaths from diseases with characteristically extended downhill terminal courses. Second, there have been changes in religious attitudes about death: people are less likely to see death as divine punishment for sin, or to see suffering as a prerequisite for the afterlife, or to see suicide as a highly stigmatized and serious sin rather than the product of mental illness or depression. Third among the major shifts in cultural attitudes that affect the way we die is the increasing emphasis on the notion of individual rights of self-determination, reinforced in the latter part of this century by the civil rights movement's attention to individuals in

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<sup>4</sup> The term originates with A. R. Omran, "The Epidemiologic Transition: A Theory of the Epidemiology of Population Change," *Milbank Memorial Fund Quarterly* 49 (4) (1971): 509–538, and the theory is augmented in A. Jay Olshansky and A. Brian Ault, "The Fourth Stage of the Epidemiologic Transition: The Age of Delayed Degenerative Disease," in *Should Medical Care Be Rationed By Age?* ed. Timothy M. Smeeding et al. (Totowa, NJ: Rowman & Littlefield, 1987), pp. 11–43.

vulnerable groups: this shift has affected self-perceptions and attitudes towards the terminally ill, and patients, including dying patients, are now recognized to have a wide array of rights previously eclipsed by the paternalistic practices of medicine.

These three transitions, along with many other concomitant cultural changes, invite us to see our current concern with physician-assisted suicide in a quite different way – not just as a phenomenon resulting from the currently disparate development of life-prolonging and pain-controlling technologies, a temporary anomaly, but as a precursor, an early symptom of a much more substantial sea-change in attitudes about death. We might call this shift in attitudes a shift towards “directed dying,” or “self-directed dying,” in which the individual who is dying plays a far more prominent, directive role than in earlier eras in determining how and when his or her death shall occur. In this changed view, dying is no longer *something that happens to you* but *something you do*.

To be sure, this shift – if it is one – can be seen as already well under way. Taking its legally visible start with the California Natural Death Act, terminally ill patients have already gained dramatically enlarged rights of self-determination in matters of guiding and controlling their own deaths, including rights to refuse treatment, discontinue treatment, stipulate treatment to be withheld at a later date, designate decision makers, and to negotiate with their physicians, or have their surrogates do so, such matters as DNR orders, withholding and withdrawal of ventilators, surgical procedures, nutrition and hydration, the use of opioids, and even terminal sedation. Some patients also negotiate, or attempt to negotiate, physician-assisted suicide or physician-performed euthanasia with their physicians. In all of this, we already see the patient as playing a far more prominent role in determining the course of his or her dying process and in its character and timing, and far more willingness on the part of physicians, family members, the law, and other parties to respect the patient’s preferences and choices in these matters.

But this may be just the tip of a looming iceberg. For we may ask whether, much as we human beings have made dramatic gains in control over our own reproduction, particularly rapidly in very recent times (the birth control pill was introduced just 30 years ago), we human beings are beginning to make dramatic gains in control over our own dying, particularly rapidly in the last several decades. We cannot keep from dying altogether, of course. But by using directly caused death, as in physician-assisted suicide, it is possible to control many of dying’s features: its timing in the downhill course of a terminal disease, its place, the exact agents which cause it, its observers, and so on. Indeed, as Robert Kastenbaum has argued, because it makes it possible to control the time, place, manner and people present at one’s death, assisted suicide will become the *preferred* manner of dying.<sup>5</sup>

But this conjecture doesn’t yet show what could actually motivate such substantial social change, away from a culture which sees dying primarily as *something*

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<sup>5</sup> Robert Kastenbaum, “Suicide as the Preferred Way of Death,” in *Suicidology: Contemporary Developments*, ed. Edwin S. Shneidman (New York: Grune & Stratton, 1976), pp. 425–441.

*that happens to you*, to a culture which sees it as *something you do* – a deliberate, planned activity, one’s final and culminative activity. What might do this, I think, is a conceptual change, or, more exactly, a shift in decisional perspective in choice-making about pain, suffering, and other elements of dying. It is the kind of shift in decisional perspective that evolves on a society-wide scale as a populace gains understanding of and control over a matter, a shift in choicemaking perspective from a stance we might describe as immediately involved or “enmeshed”, to one that is distanced and reflective. (I’ll use two Latin names for these stances later.) This shift can occur for many features of human experience – it has already largely occurred in the developed world with respect to reproduction – but it has not yet occurred with respect to death and dying. It has not yet occurred – or rather, perhaps it has just begun.

Take a patient, an average man. This particular man is so average that he just happens to have contracted that disease which is the usual diagnosis (as we know from the Netherlands<sup>6</sup>) in cases of physician-assisted suicide – cancer – and he is also so average that this disease will kill him at just the average life-expectancy for males in the United States, 72.8 years. Furthermore, he is also so average that if he does turn to physician-assisted suicide, he will choose to forgo just about the same amount of life that, on average, Dutch patients receiving euthanasia or physician-assisted suicide do, less than 3.3 weeks.<sup>7</sup> He has been considering physician-assisted suicide since his illness was first diagnosed (since he is an average man, this was about 29.6 months ago), but now, as his condition deteriorates, he thinks more seriously about it. His motivation includes both preemptive elements, the desire to avoid some of the very worst things that terminal cancer might bring him, and reactive elements, the desire to relieve some of the symptoms and other suffering that he is already experiencing. *It’s bad enough now*, he tells his doctor, *and it will probably get worse*. He asks his doctor for the pills. He is perfectly aware of what he may miss – a number of weeks of continued life, the possibility of an unexpected cure, the chance, even if it is a longshot, of spontaneous regression or remission, and – not to be overlooked – the possibility that the worst is over, so to speak, and that the remainder of his downhill course in terminal cancer won’t be so bad. He is also well aware that even a bad agonal phase may nevertheless include moments of great intimacy and importance with his family or friends. But he makes what he sees as a rational choice, seeking to balance the risks and possible benefits of easy death now,

<sup>6</sup> Data on physician-assisted suicide and euthanasia in the Netherlands is provided by what is called the Remmelink Commission Report, Paul J. van der Maas, Johannes J. M. van Delden, and Loes Pijnenborg, “Euthanasia and Other Medical Decisions Concerning the End of Life,” published in full in English as a special issue of *Health Policy* 22 (1–2) (1992), and, with Caspar W. N. Looman, in summary in *The Lancet* 338 (September 14, 1991): 669–674; and the 5-year update in Paul J. van der Maas, 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* 335 (22) (1996): 1699–1705

<sup>7</sup> See Ezekiel J. Emanuel and Margaret P. Battin, “The Economics of Euthanasia: What are the Potential Cost Savings from Legalizing Physician-Assisted Suicide?” *New England Journal of Medicine* 339 (3) (July 16, 1998): 167–172.

versus a little more continuing life with a greater possibility of a hard death. He is making his choice *in medias res*, in the middle of things, as the physical, social, and emotional realities of terminal illness engulf him. He is enmeshed in his situation, caught in it, trapped between what seem like two bad alternatives – suffering, or suicide.

But, of course, he might have done his deciding about how his life shall end and whether to elect physician-assisted suicide in preference to the final stages of terminal illness from a quite different, more distanced perspective, a secular version of the view *sub specie aeternitatis*. This is not just an objective, depersonalized view – anybody’s view – but his own, distinctively personal view not confined to a specific timepoint.<sup>8</sup> Rather than assessing his prospects from the point of view he has at the time at which he would continue or discontinue his life – that point late in the course of his illness when things have already become “bad enough” and are likely to get worse – he might have done his deciding, albeit rather more hypothetically, from the perspective of a more generalized view of his life. From this alternative perspective, what he would have seen is the overall shape of his life, and it is with respect to this that he would have made his choices about how it shall end. Of course, he could not know in advance whether he will contract cancer, or succumb to heart disease, or be hit by a bus – though he does know that he will die sometime or other. Consequently, his choices are necessarily conditional in form, “if I get cancer, I’ll refuse aggressive treatment and use hospice care,” “if I get AIDS, I’ll ask for physician-assisted suicide,” “if I get Alzheimer’s, I’ll commit suicide on my own, since no physician besides Jack Kevorkian would help me,” and so on. Although conditional in form and predicated on circumstances that may not occur, these may be real choices nonetheless, and, particularly because they are reiterated and repeated over the course of a lifetime, have real motive force.

The difference, then, between these two views is substantial. In the first, our average man with an average terminal cancer, doing his deciding *in medias res*, is deciding whether or not to take the pills his physician has given him now. It is his last possible couple of weeks or a month (on average, 3.3 weeks) that he is deciding about. Even if continuing life threatens pain and other suffering, it is still all he has left, and while it may be difficult to live this life – all he has left – it may also be very difficult to relinquish it.

In contrast, if our average man were doing his deciding *sub specie aeternitatis*, from a distanced though still personal viewpoint not tied to a specific moment in his life, he would have been deciding all along between two different conceptions of his own demise, between two possible lives for himself. One of his possible lives would, on average, be 72.8 years long, the average lifespan for a male in the United States, with the possibility of substantial suffering at the end – on average, as the

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<sup>8</sup> The distinction I am drawing here between personal views *in medias res* and *sub specie aeternitatis* is thus not quite the same as that drawn by Thomas Nagel between subjective and objective views, though it has much in common with Nagel’s distinction in contexts concerning death. See Nagel, *The View from Nowhere* (New York and Oxford, Oxford University Press, 1986), especially Chapter XI, section 3, on death.

SUPPORT study finds, a 50% chance, if he is conscious, of moderate to severe pain at least 50% of the time during the last 3 days before his death. The other of his possible lives would be about 72.7 years long, foreshortened on average 3.3 weeks by physician-assisted suicide, but with a markedly reduced possibility of substantial suffering at the end. (This shortening of the lifespan is not age-based but time-to-death based, planned for, on average, 3.3 weeks before an unassisted death would have occurred; it occurs in this example at age 72.7 just because our man is so average.) This latter, shortened life also offers our man the opportunity to control the timing, the place, the manner, and so on of his death in the way he likes. Viewed *sub specie aeternitatis*, at any or many earlier points in one's life or from a vantage point standing outside life, so to speak, the difference between 72.8 and 72.7 seems negligible: these are both lives of average length not interrupted by grossly premature death. Why not choose the one in which, if he is conscious at all, the risk of agonal pain – as high as 50/50, according to the SUPPORT study – is far, far less great, and the possibility of conscious, culminative experience, surrounded by family members, trusted friends, and permitting final prayers and goodbyes, is far, far greater?

It may seem difficult to distinguish these two choices in practice. This is because we typically make our decisions about death and dying in *mediis rebus*, not *sub specie aeternitatis*, and our medical practices, our bioethics discussions, and our background culture strongly encourage this. The call for assisted dying, like other patient pleas, is seen as a reaction to the circumstances of dying, not a settled, longer term, preemptive preference.<sup>9</sup> True, some independently minded individuals consider these issues in a kind of background, hypothetical way throughout their lives, but this is certainly not the practical norm. We can only really understand this view as involving a substantial cultural shift from our current perspective.

But if this shift occurs, a slightly abbreviated lifespan in which there is dramatically reduced risk of pain and suffering will not only seem to be preferable to one which is negligibly longer but carries substantial risk of pain and suffering in its agonal phase, it will also be seen as rational and normal to plan for this abbreviated lifespan and to plan the means of bringing it about. The way to ensure it, of course, is to plan for direct termination of life. After all, one cannot count on being able to discontinue some life-prolonging treatment or other – refusing antibiotics, disconnecting a respirator – to hasten death and thus avoid what might be the worst weeks at the end. This most likely means planning for physician-assisted suicide. From this distanced perspective, a 72.7-year life with a virtually assured good end looks much, much better than a 72.8-year life that has an even chance of coming to a bad end. Arguably, it would be rational for any individual, except those for whom religious commitments or other scruples rule out suicide altogether, to plan to ensure this. But if it looks this way to one individual, it will look this way to many; and it is thus plausible to imagine that physician-assisted suicide would not be rare but rather a

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<sup>9</sup> See C. G. Prado, *The Last Choice: Preemptive Suicide in Advanced Age* (Westport, CT: Greenwood Press, 1990).

choice viewed as rational and preemptively prudent by many or most members of the culture. Thus it can come to be seen as a normal course of action, not a rarity or a “last resort.” To be sure, there are other ways of abbreviating a lifespan to avoid terminal suffering – withdrawing or withholding treatment, overusing of morphine or other pain-relieving drugs, discontinuing artificial nutrition and hydration, and terminal sedation – but these cannot be used unless the patient’s condition has already worsened and likely involves that pain or suffering the person might choose to avoid. Thus these other modalities function primarily reactively; it is assisted suicide that can function preemptively.

But, as soon as planning for a normal, slight abbreviation in the lifespan by means of assisted suicide becomes conceptually possible not just for our average man but for actual persons in general, it also becomes possible to imagine a wide range of context-specific cultural practices which might emerge surrounding physician-assisted suicide. After all, that a person understands and expects his lifespan to be one which will end in an assisted death a few weeks before he might otherwise have died, while he is still conscious, alert, and capable of deciding what location he wants it to take place in, what family members, caregivers, clergy, or others he wants to have present, what ceremonies, religious or symbolic, he wants conducted, etc., suggests that more general social practices would grow up around these possibilities. After all, our average man sees his life this way; but it is possible for him to do this partly because the others in his society see their lives this way as well. Attitudes about death are heavily socially conditioned, and so are the perspectives from which choicemaking about death is seen.

This is the precondition for the development of a whole range of social practices supporting such choices. These might include various kinds of practical supports, such as legal, insurance, and other policies which treat assisted dying as acceptable and normal; various sorts of cultural and religious practices which similarly treat assisted dying as acceptable and normal (for instance by developing rituals and rites concerning the forthcoming death); familial supports within the family, including family gatherings, preparing for the death, and sharing reminiscences and goodbyes; pre-death dispositions of wills and life insurance (we already recognize viaticums, pre-death payoffs of life insurance for terminally ill patients); and even such now-inconceivable practices as pre-death funerals, understood as ceremonies of leavetaking and farewell, expressions of both celebration of a life complete and grief at its loss. In turn, such social practices come to function as positive reasons for choosing a somewhat earlier, elective death – formerly and rudely called “physician-assisted suicide,” even when pain control is no longer the issue at all, and the new social pattern – so different from our current one – reinforces itself.

Furthermore, if the culture-wide view of choicemaking about death and dying were more fully held *sub specie aeternitatis* in this distanced, less enmeshed and less merely reactive way, in which earlier, elective death becomes the norm, we could also expect the more frequent practice of “setting a date,” as people who have contracted predictably terminal illnesses carry out the plans they had been developing all along for their own demises. Setting a date for one’s own death – presumably, a couple of weeks or so before the date it might naturally have been,

revisable of course in the light of any changes in the diagnosis or prognosis – would still be both preemptive and reactive in character, but far more preemptive than choices made *in mediis rebus*, where choices will be highly reactive to the then-current circumstances the patient finds himself or herself in. The timing of such choices might always be revised in consultation with the physician; but what would be culturally reinforced would be the general commitment to advance planning for one's own death as well as a commitment to assuming a comparatively autonomist, directive role in it. Self-directed dying would be the norm, though of course different people would direct their deaths in quite different ways.

If the profound changes affecting matters of how we die that are already underway – the epidemiological transition, shifting from parasitic and infectious disease deaths to deaths of predictably degenerative disease; the changes in religious conceptions of suicide so that it is not understood primarily as sin; and the steadily increasing attention to patients' and terminally ill patients' rights of self-determination, it is an open conjecture whether this is where we may be going. Are we in fact experiencing just a temporary aberration in our basic cultural patterns of death and dying, an aberration which is a function of the discrepant development of technologies for life prolongation and for pain control? Or are we seeing the first breaking waves of a sea-change from one perspective on death and dying to another, a far more autonomist and self-directive one?

Obviously, I can't say. But I can say that if this is what is happening, the assumption that physician-assisted suicide would or should be rare, an assumption still held by both sides in the current debate, will collapse. We would have no reason to assume that assisted dying should be rare, whatever the relationship between capacities for life prolongation and pain control. Of course, such a picture is very difficult to envision, since we do not think that way about death and dying now. But if we can at least see what is different about viewing personal choices about one's own death *sub specie aeternitatis* and in our current way, *in mediis res*, enmeshed in particular circumstances, we can understand why it might occur.

Would it be a good thing, or a bad thing? I can hardly answer that question here, but let me close with a story I heard somewhere in the Netherlands several years ago. I do not remember the exact source of the story nor the specific dates or names, and it is certainly not representative of current practice in Holland. But it was told to me as a true story, and it went something like this.

Two friends, old sailing buddies, are planning a sailing trip in the North Sea in the summer. It is late February now, and they are discussing possible dates.

"How about July 21?" says Willem. "The North Sea will be calm, the moon bright, and there's a music festival on the southern coast of Denmark we could visit."

"Sounds great," answers Joost. "I'd love to get to the music festival. But I can't be gone then; the 21st is the date of my father's death."

"Oh, I'm so sorry, Joost," Willem replies. "I knew your father was ill. Very ill, with cancer. But I didn't realize he had died."

"He hasn't," Joost replies. "That's the day he will be dying. He's picked a date and made up his mind, and we all want to be there with him."



Such a story seems just that, a story, a fiction, somehow horrifying and also somehow liberating, but in any case virtually inconceivable to us. But it was not told to me as a fiction, but as a true story. I've tried to explore the conceptual assumptions that might lie behind such a story, and to consider whether in the future such stories might become more and more the norm. I have not tried to say whether this would be good or bad, but only that this might well be where we are going. In fact, I think it would be good – just as I think increasing personal control over reproduction is good – but I haven't argued for that view here.

Cultural change is an ongoing, long-term process of evolution, one which it is often hard to discern from a particular point in time. We see evolution in the past; but we have little way to think about the future. I've tried to suggest that our current point of view about personal autonomy in death and dying is unduly limited; while we recognize that substantial change has already occurred, we fail to realize that change as great or greater may be coming in the future. Indeed, it could involve a full reversal of earlier cultural attitudes about one's own role in one's own death. Of course cultural change is not unidirectional, and there may be backward as well as forward motion; nor do the attitudes of all members of a culture evolve at the same rate at the same time. Factors like wars, plagues, famines, scientific discoveries, and technological advances have reversed or hastened cultural change in the past, and could of course do so in the future. Just the same, I think it is possible to discern motion beyond the current view that physician-assisted suicide should be rare, a desperation move when nothing else works, toward the view that one's own death at the conclusion of terminal illness may be self-directed, that individuals can and should have the psychological and social freedom to reflect in a longer term way about their own future choices when they embark on the dying process, perhaps making physician-assisted suicide an eventual part of their plans, as well as the practical and legal freedom to plan whatever family gatherings, ceremonies, and religious observances they might wish – not as a desperate last resort or reactive escape from bad circumstances, but as a preemptively prudent, significant, culminating experience. How long this process of cultural change might take, and what might interrupt it or hasten it, only time will tell.

# Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia

Timothy E. Quill, Bernard Lo, and Dan W. Brock

## 1 Palliative Care

Palliative Care is the standard of care when terminally ill patients find that the burdens of continued life-prolonging treatment outweigh the benefits.<sup>1</sup> To better relieve suffering near the end of life, physicians need to improve their skills in palliative care and to routinely discuss it earlier in the course of terminal illness. In addition, access to palliative care needs to be improved, particularly for those Americans who lack health insurance. However, even the highest-quality palliative care fails or becomes unacceptable for some patients, some of whom request help hastening death. Between 10% and 50% of patients in programs devoted to palliative care still report significant pain 1 week before death.<sup>2</sup> Furthermore, patients request a hastened death not simply because of unrelieved pain, but because of a wide variety of unrelieved physical symptoms in combination with loss of meaning, dignity, and independence.<sup>3</sup>

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<sup>1</sup> Foley KM. Pain, physician-assisted suicide, and euthanasia. *Pain Forum*. 1995; 4:163–178. Council on Scientific Affairs, American Medical Association. Good care of the dying patient. *JAMA*. 1996;275:474–478. Quill TE. *Death and Dignity: Making Choices and Taking Charge*. New York, NY: WW Norton & Co; 1993:1–255. American Board of Internal Medicine End of Life Patient Care Project Committee. *Caring for the Dying: Identification and Promotion of Physician Competency*. Philadelphia, PA: American Board of Internal Medicine; 1996.

<sup>2</sup> Foley KM. Pain, physician-assisted suicide, and euthanasia. *Pain Forum*. 1995; 4:163–178. Kasting GA. The nonnecessity of euthanasia. In: Humber JD, Almeder RF, Kasting GA, eds. *Physician-Assisted Death*. Totowa, NJ: Humana Press; 1993:25–43. Coyle N, Adelhardt J, Foley KM, Portenoy RK. Character of terminal illness in the advanced cancer patient. *Pain Symptom Manage*. 1990;5:83–93. Ingham J, Portenoy R. Symptom assessment. *Hematol Oncol Clin North Am*. 1996;10:21–39.

<sup>3</sup> Back AL, Wallace JI, Starks HE, Pearlman RA. Physician-assisted suicide and euthanasia in Washington State. *JAMA*. 1996;275:919–925. VanderMaas PJ, van Delden JJM, Pijnenborg L. *Euthanasia, et al. Medical Decisions Concerning the End of Life*. Amsterdam, the Netherlands: Elsevier; 1992.

How should physicians respond when competent, terminally ill patients whose suffering is not relieved by palliative care request help in hastening death? If the patient is receiving life-prolonging interventions, the physician should discontinue them, in accordance with the patient's wishes. Some patients may *voluntarily stop eating and drinking* (VSED). If the patient has unrelieved pain or other symptoms and accepts sedation, the physician may legally administer *terminal sedation* (TS). However, it is generally legally impermissible for physicians to participate in *physician-assisted suicide* (PAS) or *voluntary active euthanasia* (VAE) in response to such patient requests. The recent Supreme Court decisions that determined that there is no constitutional right to PAS placed great emphasis on the importance of relieving pain and suffering near the end of life.<sup>4</sup> The Court acknowledged the legal acceptability of providing pain relief, even to the point of hastening death if necessary, and left open the possibility that states might choose to legalize PAS under some circumstances.

In this article, we compare VSED, TS, PAS, and VAE as potential interventions of last resort for competent, terminally ill patients who are suffering intolerably in spite of intensive efforts to palliate and who desire a hastened death. Some clinicians and patients may find some of the differences between these practices to be ethically and psychologically critical, whereas others perceive the differences as inconsequential. We will define and compare the practices, examine underlying ethical justifications, and consider appropriate categories of safeguards for whichever practices our society eventually condones.

## 2 Definitions and Clinical Comparisons

With VSED, a patient who is otherwise physically capable of taking nourishment makes an active decision to discontinue all oral intake and then is gradually "allowed to die," primarily of dehydration or some intervening complication.<sup>5</sup> Depending on the patient's preexisting condition, the process will usually take 1–3 weeks or longer if the patient continues to take some fluids. Voluntarily stopping eating and drinking has several advantages. Many patients lose their appetites and stop eating and drinking in the final stages of many illnesses. Ethically and legally, the right of competent, informed patients to refuse life-prolonging interventions, including artificial hydration and nutrition, is firmly established, and voluntary cessation of "natural" eating and drinking could be considered an extension of that right. Because VSED requires considerable patient resolve, the voluntary nature of the action should be clear. Voluntarily stopping eating and drinking also protects patient privacy and independence, so much so that it potentially requires no participation by a physician.

<sup>4</sup> *Vacco v Quill*, 117 SCt 2293. (1997). *Washington v Glucksberg*, 117 SCt 2258. (1997).

<sup>5</sup> Bernat JL, Gert B, Mogielnicki RP. Patient refusal of hydration and nutrition. *Arch Intern Med*. 1993;153:2723–2727. Printz LA. Terminal dehydration, a compassionate treatment. *Arch Intern Med*. 1992;152:697–700. Eddy DM. A conversation with my mother. *JAMA*. 1994;272:179–181.

The main disadvantages of VSED are that it may last for weeks and may initially increase suffering because the patient may experience thirst and hunger. Subtle coercion to proceed with the process may occur if patients are not regularly offered the opportunity to eat and drink, yet such offers may be viewed as undermining the patient's resolve. Some patients, family members, physicians, or nurses may find the notion of "dehydrating" or "starving" a patient to death to be morally repugnant. For patients whose current suffering is severe and unrelievable, the process would be unacceptable without sedation and analgesia. If physicians are not involved, palliation of symptoms may be inadequate, the decision to forgo eating and drinking may not be informed, and cases of treatable depression may be missed. Patients are likely to lose mental clarity toward the end of this process, which may undermine their sense of personal integrity or raise questions about whether the action remains voluntary.

Although several articles,<sup>6</sup> including a moving personal narrative,<sup>7</sup> have proposed VSED as an alternative to other forms of hastened death, there are no data about how frequently such decisions are made or how acceptable they are to patients, families, physicians, or nurses.

With TS, the suffering patient is sedated to unconsciousness, usually through ongoing administration of barbiturates or benzodiazepines. The patient then dies of dehydration, starvation, or some other intervening complication, as all life-sustaining interventions are withheld.<sup>8</sup> Although death is inevitable, it usually does not take place for days or even weeks, depending on clinical circumstances. Because patients are deeply sedated during this terminal period, they are believed to be free of suffering.

It can be argued that death with TS is "foreseen" but not "intended" and that the sedation itself is not causing death.<sup>9</sup> The sedation is intended to relieve suffering, a long-standing and uncontroversial aim of medicine, and the subsequent withholding of life-sustaining therapy has wide legal and ethical acceptance. Thus, TS probably requires no change in the law. The recent Supreme Court decision gave strong

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<sup>6</sup> Bernat JL, Gert B, Mogielnicki RP. Patient refusal of hydration and nutrition. *Arch Intern Med.* 1993;153:2723–2727. Printz LA. Terminal dehydration, a compassionate treatment. *Arch Intern Med.* 1992;152:697–700.

<sup>7</sup> Eddy DM. A conversation with my mother. *JAMA.* 1994;272:179–181.

<sup>8</sup> Cherney NI, Portenoy RK. Sedation in the management of refractory symptoms: guidelines for evaluation and treatment. *J Palliat Care.* 1994;10:31–38. Troug RD, Berde DB, Mitchell C, Grier HE. Barbiturates in the care of the terminally ill. *N Engl J Med.* 1991;327:1678–1681. Enck RE. *The Medical Care of Terminally Ill Patients.* Baltimore, MD: Johns Hopkins University Press; 1994. Saunders C, Sykes N. *The Management of Terminal Malignant Disease.* 3rd ed. London, England: Hodder Headline Group; 1993:1–305.

<sup>9</sup> Cherney NI, Portenoy RK. Sedation in the management of refractory symptoms: guidelines for evaluation and treatment. *J Palliat Care.* 1994;10:31–38. Troug RD, Berde DB, Mitchell C, Grier HE. Barbiturates in the care of the terminally ill. *N Engl J Med.* 1991;327:1678–1681. Enck RE. *The Medical Care of Terminally Ill Patients.* Baltimore, MD: Johns Hopkins University Press; 1994. Saunders C, Sykes N. *The Management of Terminal Malignant Disease.* 3rd ed. London, England: Hodder Headline Group; 1993:1–305.

support to TS, saying that pain in terminally ill patients should be treated, even to the point of rendering the patient unconscious or hastening death.<sup>10</sup> Terminal sedation is already openly practiced by some palliative care and hospice groups in cases of unrelieved suffering, with a reported frequency from 0% to 44% of cases.<sup>11</sup>

Terminal sedation has other practical advantages. It can be carried out in patients with severe physical limitations. The time delay between initiation of TS and death permits second-guessing and reassessment by the health care team and the family. Because the health care team must administer medications and monitor effects, physicians can ensure that the patient's decision is informed and voluntary before beginning TS. In addition, many proponents believe that it is appropriate to use TS in patients who lack decision-making capacity but appear to be suffering intolerably, provided that the patient's suffering is extreme and otherwise unrelievable, and the surrogate or family agrees.

Nonetheless, TS remains controversial<sup>12</sup> and has many of the same risks associated with VAE and PAS. Like VAE, the final actors are the clinicians, not the patient. Terminal sedation could therefore be carried out without explicit discussions with alert patients who appear to be suffering intolerably or even against their wishes. Some competent, terminally ill patients reject TS. They believe that their dignity would be violated if they had to be unconscious for a prolonged time before they die, or that their families would suffer unnecessarily while waiting for them to die. Patients who wish to die in their own homes may not be able to arrange TS because it probably requires admission to a health care facility. There is some controversy in the anesthesia literature about whether heavily sedated persons are actually free of suffering or simply unable to report or remember it.<sup>13</sup> In some clinical situations,

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<sup>10</sup> *Vacco v Quill*, 117 S Ct 2293 (1997). *Washington v Glucksberg*. 117 S Ct 2258 (1997).

<sup>11</sup> Foley KM. Pain, physician-assisted suicide, and euthanasia. *Pain Forum*. 1995; 4:163–178. Coyle N, Adelhardt J, Foley KM, Portenoy RK. Character of terminal illness in the advanced cancer patient. *J Pain Symptom Manage*. 1990;5:83–93. Ingham J, Portenoy R. Symptom assessment. *Hematol Oncol Clin North Am*. 1996;10:21–39. Cherney NI, Portenoy RK. Sedation in the management of refractory symptoms: guidelines for evaluation and treatment. *J Palliat Care*. 1994;10:31–38. Troug RD, Berde DB, Mitchell C, Grier HE. Barbiturates in the care of the terminally ill. *N Engl J Med*. 1991;327:1678–1681. Enck RE. *The Medical Care of Terminally Ill Patients*. Baltimore, MD: Johns Hopkins University Press; 1994. Saunders C, Sykes N. *The Management of Terminal Malignant Disease*. 3rd ed. London, England: Hodder Headline Group; 1993:1–305. Byock IR. Consciously walking the fine line: thoughts on a hospice response to assisted suicide and euthanasia. *J Palliat Care*. 1993;9:25–28. Ventafridda B, Ripamonti C, DeConno F, et al. Symptom prevalence and control during cancer patients' last days of life. *J Palliat Care*. 1990;6:7–11.

<sup>12</sup> Brody H. Causing, intending, and assisting death. *J Clin Ethics*. 1993;4:112–117. Billings JA. Slow euthanasia. *J Palliat Care*. 1996;12:21–30. Orentlicher D. The Supreme Court and physician-assisted suicide: rejecting assisted suicide but embracing euthanasia. *N Engl J Med*. 1997;337:1236–1239.

<sup>13</sup> Moerman N, Bonke B, Oosting J. Awareness and recall during general anesthesia: facts and feelings. *Anesthesiology*. 1993;79:454–464. Utting JE. Awareness: clinical aspects; consciousness, awareness, and pain. In: Rosen M, Linn JN. *General Anesthesia*. London, England: Butterworths; 1987:171–179. Evans JM. Patient's experience of awareness during general anesthesia;

TS cannot relieve the patient's symptoms, as when a patient is bleeding uncontrollably from an eroding lesion or a refractory coagulation disorder, cannot swallow secretions because of widespread oropharyngeal cancer, or has refractory diarrhea from the acquired immunodeficiency syndrome (AIDS). Although such patients are probably not conscious of their condition once sedated, their death is unlikely to be dignified or remembered as peaceful by their families. Finally, and perhaps most critically, there may be confusion about the physician's ethical responsibility for contributing to the patient's death.<sup>14</sup>

With PAS, the physician provides the means, usually a prescription of a large dose of barbiturates, by which a patient can end his or her life.<sup>15</sup> Although the physician is morally responsible for this assistance, the patient has to carry out the final act. Physician-assisted suicide has several advantages. For some patients, access to a lethal dose of medication may give them the freedom and reassurance to continue living, knowing they can escape if and when they choose.<sup>16</sup> Because patients have to ingest the drug by their own hand, their action is likely to be voluntary. Physicians report being more comfortable with PAS than VAE,<sup>17</sup> presumably because their participation is indirect.

Opponents of PAS believe that it violates traditional moral and professional prohibitions against intentionally contributing to a patient's death. Physician-assisted suicide also has several practical disadvantages. Self-administration does not guarantee competence or voluntariness. The patient may have impaired judgment at the time of the request or the act or may be influenced by external pressures. Physician-assisted suicide is limited to patients who are physically capable of taking the medication themselves. It is not always effective,<sup>18</sup> so families may be faced with a patient who is vomiting, aspirating, or cognitively impaired, but not dying. Patients brought to the emergency department after ineffective attempts are likely to receive unwanted life-prolonging treatment. Requiring physicians to be present

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consciousness, awareness and pain. In: Rosen M, Linn JN. *General Anesthesia*. London, England: Butterworths; 1987:184–192.

<sup>14</sup> Brody H. Causing, intending, and assisting death. *J Clin Ethics*. 1993;4:112–117. Billings JA. Slow euthanasia. *J Palliat Care*. 1996;12:21–30.

<sup>15</sup> Foley KM. Pain, physician-assisted suicide, and euthanasia. *Pain Forum*. 1995; 4:163–178. Quill TE. *Death and Dignity: Making Choices and Taking Charge*. New York, NY: WW Norton & Co; 1993:1–255. Brock DW. Voluntary active euthanasia. *Hastings Cent Rep*. 1992;22:10–22.

<sup>16</sup> Quill TE. Death and dignity. *N Engl J Med*. 1991;324:691–694. Rollin B. *Last Wish*. New York, NY: Warner Books; 1985.

<sup>17</sup> Cohen JS, Fihn SD, Boyko EJ, et al. Attitudes toward assisted suicide and euthanasia among physicians in Washington State. *N Engl J Med*. 1994;331:89–94. Bachman JG, Alchser KH, Koukas DJ, et al. Attitudes of Michigan physicians and the public toward legalizing physician-assisted suicide and voluntary euthanasia. *N Engl J Med*. 1996;334:303–309. Duberstein PR, Conwell Y, Cox C, et al. Attitudes toward self-determined death. *J Am Geriatr Soc*. 1995;43:395–400.

<sup>18</sup> Preston TA, Mero R. Observations concerning terminally-ill patients who choose suicide. *J Pharm Care Pain Symptom Control*. 1996;1:183–192. Admiraal PV. Toepassing van euthanatica (the use of euthanatics). *Ned Tijdschr Geneesk*. 1995;139:265–268.

when patients ingest the medication could coerce an ambivalent patient to proceed, yet their absence may leave families to respond to medical complications alone.

Physician-assisted suicide is illegal in most states, but no physicians have ever been successfully prosecuted for their participation.<sup>19</sup> Several studies have documented a secret practice of PAS in the United States. In Washington State, 12% of physicians responding to a survey had received genuine requests for PAS within the year studied.<sup>20</sup> Twenty-four percent of requests were acceded to, and over half of those patients died as a result. An Oregon study showed similar results.<sup>21</sup> Physician-assisted suicide is usually conducted covertly, without consultation, guidelines, or documentation. Public controversy about legalizing PAS continues in the United States. After narrow defeats of referenda in the states of Washington and California, an Oregon referendum was passed in 1994 that legalized PAS, subject to certain safeguards.<sup>22</sup> After a series of legal challenges, the Oregon legislature required that the referendum be resubmitted to the electorate this November before implementation, and it was repassed this November by a margin of 60%–40%. The US Supreme Court ruled that laws in the states of Washington and New York prohibiting PAS were not unconstitutional, but the Court simultaneously encouraged public discussion and state experimentation through the legislative and referendum processes.<sup>23</sup>

With VAE, the physician not only provides the means, but is the final actor by administering a lethal injection at the patient's request.<sup>24</sup> As practiced in the Netherlands, the patient is sedated to unconsciousness and then given a lethal injection of a muscle-paralyzing agent like curare. For patients who are prepared to die because their suffering is intolerable, VAE has the advantages of being quick and effective. Patients need not have manual dexterity, the ability to swallow, or an intact gastrointestinal system. Voluntary active euthanasia also requires active and direct physician participation. Physicians can ensure the patient's competence and voluntariness at the time of the act, support the family, and respond to complications. The directness of the act makes the physician's moral responsibility clear.

<sup>19</sup> Quill TE. *Death and Dignity: Making Choices and Taking Charge*. New York, NY: WW Norton & Co; 1993:1–255.

<sup>20</sup> Back AL, Wallace JI, Starks HE, Pearlman RA. Physician-assisted suicide and euthanasia in Washington State. *JAMA*. 1996;275:919–925.

<sup>21</sup> Lee MA, Nelson HD, Tilden VP, Ganzini L, Schmidt TA, Tolle SW. Legalizing assisted suicide: views of physicians in Oregon. *N Engl J Med*. 1996;334:310–315.

<sup>22</sup> Alpers A, Lo B. Physician-assisted suicide in Oregon: a bold experiment. *JAMA*. 1995;274:483–487.

<sup>23</sup> *Vacco v Quill*, 117 SCt 2293 (1997). *Washington v Glucksberg*. 117 SCt 2258 (1997). Alpers A, Lo B. Physician-assisted suicide in Oregon: a bold experiment. *JAMA*. 1995;274:483–487. *Compassion in Dying v Washington*. No. 94-35534, 1966 WL 94848 (9th Cir, Mar 6, 1996).

<sup>24</sup> Foley KM. Pain, physician-assisted suicide, and euthanasia. *Pain Forum*. 1995; 4:163–178. Quill TE. *Death and Dignity: Making Choices and Taking Charge*. New York, NY: WW Norton & Co; 1993:1–255. Utting JE. Awareness: clinical aspects; consciousness, awareness, and pain. In: Rosen M, Linn JN. *General Anesthesia*. London, England: Butterworths; 1987:171–179.

On the other hand, VAE explicitly and directly conflicts with traditional medical prohibitions against intentionally causing death.<sup>25</sup> Although intended to relieve suffering, VAE achieves this goal by causing death. Furthermore, VAE could be conducted without explicit patient consent.<sup>26</sup> If abused, VAE could then be used on patients who appear to be suffering severely or posing extreme burdens to physician, family, or society, but have lost the mental capacity to make informed decisions.

The Netherlands is the only country where VAE and PAS are openly practiced, regulated, and studied, although the practices remain technically illegal. According to the Rummelink reports,<sup>27</sup> VAE accounts for 1.8%–2.4% of all deaths, and PAS, another 0.2%–0.4%. In 0.7%–0.8% of deaths, active euthanasia was performed on patients who had lost the capacity to consent, raising concern about whether guidelines restricting VAE to competent patients can be enforced in practice.<sup>28</sup>

United States laws prohibiting VAE, however, are stricter than those governing PAS and more likely to be prosecuted. Physicians are also more reluctant to participate in VAE even if it were legalized.<sup>29</sup> Even less is known about the secret practice of VAE than of PAS in the United States. The recent Washington State study showed that 4% of physicians had received a genuine request for VAE within the year studied, and 24% of those responded by administering a lethal injection.<sup>30</sup> Voluntary active euthanasia was recently legalized in a province of Australia, but this legalization was subsequently reversed by the legislature.<sup>31</sup>

<sup>25</sup> Gaylin W, Kass LR, Pellegrino ED, Siegler M. Doctors must not kill. *JAMA*. 1988;259:2139–2140.

<sup>26</sup> Teno J, Lynn J. Voluntary active euthanasia: the individual case and public policy. *J Am Geriatr Soc*. 1991;39:827–830. Kamisar Y. Against assisted suicide—even a very limited form. *Univ Detroit Mercy Law Rev*. 1995;72:735–769.

<sup>27</sup> vanderMaas PJ, van Delden JJM, Pijnenborg L. *Euthanasia*, et al. *Medical Decisions Concerning the End of Life*. Amsterdam, the Netherlands: Elsevier; 1992. vanderMaas PJ, vanderWal G, Haverkate I, et al. Euthanasia, physician-assisted suicide and other medical practices involving the end of life in the Netherlands, 1990–1995. *N Engl J Med*. 1996;335:1699–1705. van der Wal G, van der Maas PJ, Bosma JM, et al. Evaluation of the notification procedure for physician-assisted death in the Netherlands. *N Engl J Med*. 1996;335:1706–1711.

<sup>28</sup> Hendin H. Seduced by death. *Issues Law Med*. 1994;10:123–168.

<sup>29</sup> Cohen JS, Fihn SD, Boyko EJ, et al. Attitudes toward assisted suicide and euthanasia among physicians in Washington State. *N Engl J Med*. 1994;331:89–94. Bachman JG, Alchser KH, Koukas DJ, et al. Attitudes of Michigan physicians and the public toward legalizing physician-assisted suicide and voluntary euthanasia. *N Engl J Med*. 1996;334:303–309.

<sup>30</sup> Back AL, Wallace JI, Starks HE, Pearlman RA. Physician-assisted suicide and euthanasia in Washington State. *JAMA*. 1996;275:919–925.

<sup>31</sup> Ryan CJ, Kaye M. Euthanasia in Australia: the Northern Territory rights of the terminally ill act. *N Engl J Med*. 1996;334:326–328.



### 3 Ethical Comparisons Between the Practices

Many normative ethical analyses use the doctrine of double effect and the distinction between active and passive assistance to distinguish between currently permissible acts that may hasten death (forgoing life-sustaining treatment and high-dose pain medications) and those that are impermissible (PAS and VAE).<sup>32</sup> Both TS and VSED have been argued to be ethically preferable alternatives to PAS and VAE on the basis of similar arguments.<sup>33</sup> In this section, we will critically examine these analyses. We also discuss the issues of voluntariness, proportionality, and conflict of duties, which may ultimately be more central to the ethical evaluation of these options. We suggest that there are more problems with the doctrine of double effect and the active/passive distinction than are ordinarily acknowledged and that TS and VSED are more complex and less easily distinguished ethically from PAS and VAE than proponents seem to realize. Our discussion in this section will be restricted to the potential ethical permissibility of these actions and not the public policy implications.

#### 3.1 Doctrine of Double Effect

When evaluating an action, the doctrine of double effect distinguishes between effects that a person intends (both the end sought and the means taken to the end) and consequences that are foreseen but unintended.<sup>34</sup> As long as the physician's intentions are good, it is permissible to perform actions with foreseeable consequences that it would be wrong to intend. In this view, intentionally causing death is morally impermissible, even if desired by a competent patient whose suffering could not

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<sup>32</sup> Foley KM. Pain, physician-assisted suicide, and euthanasia. *Pain Forum*. 1995; 4:163–178. Council on Scientific Affairs, American Medical Association. Good care of the dying patient. *JAMA*. 1996;275:474–478. American Board of Internal Medicine End of Life Patient Care Project Committee. *Caring for the Dying: Identification and Promotion of Physician Competency*. Philadelphia, PA: American Board of Internal Medicine; 1996. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical and Legal Issues in Treatment Decisions*. Washington, DC: US Government Printing Office; 1982. The Hastings Center Report. *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*. Briarcliff Manor, NY: Hastings Center; 1987.

<sup>33</sup> Bernat JL, Gert B, Mogielnicki RP. Patient refusal of hydration and nutrition. *Arch Intern Med*. 1993;153:2723–2727. Printz LA. Terminal dehydration, a compassionate treatment. *Arch Intern Med*. 1992;152:697–700. Troug RD, Berde DB, Mitchell C, Grier HE. Barbiturates in the care of the terminally ill. *N Engl J Med*. 1991;327:1678–1681. Byock IR. Consciously walking the fine line: thoughts on a hospice response to assisted suicide and euthanasia. *J Palliat Care*. 1993;9: 25–28.

<sup>34</sup> Brody H. Causing, intending, and assisting death. *J Clin Ethics*. 1993;4:112–117. Billings JA. Slow euthanasia. *J Palliat Care*. 1996;12:21–30. Marquis DB. Four versions of the double effect. *J Med Philos*. 1991;16:515–544. Kamm F. The doctrine of double effect. *J Med Philos*. 1991;16:571–585.

otherwise be relieved. But if death comes unintentionally as the consequence of an otherwise well-intentioned intervention, even if foreseen with a high probability, the physician's action can be morally acceptable. The unintended but foreseen bad effect must also be proportional to the intended good effects.

The doctrine of double effect has been important in justifying the use of sufficient pain medications to relieve suffering near the end of life.<sup>35</sup> When high-dose opioids are used to treat pain, neither the patient nor the physician intends to accelerate death, but they accept the risk of unintentionally hastening death in order to relieve the pain. The doctrine of double effect has also been used to distinguish TS from PAS and VAE.<sup>36</sup> Relief of suffering is intended in all 3 options, but death is argued to be intended with PAS and VAE but is merely foreseen with TS. Yet to us it seems implausible to claim that death is unintended when a patient who wants to die is sedated to the point of coma, and intravenous fluids and artificial nutrition are withheld, making death certain.<sup>37</sup> Although the overarching intention of the sedation is to relieve the patient's suffering, the additional step of withholding fluids and nutrition is not needed to relieve pain, but is typically taken to hasten the patient's wished-for death. In contrast, when patients are similarly sedated to treat conditions like status epilepticus, therapies such as fluids and mechanical ventilation are continued with the goal of prolonging life.

According to the doctrine of double effect, intentionally taking life is always morally impermissible, whereas doing so foreseeably but unintentionally can be permissible when it produces a proportionate good. As applied to end-of-life medical decision making, the intentions of the physician are given more moral weight than the wishes and circumstances of the patient. An alternative view is that it is morally wrong to take the life of a person who wants to live, whether doing so intentionally or foreseeably. In this view, what can make TS morally permissible is

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<sup>35</sup> Foley KM. Pain, physician-assisted suicide, and euthanasia. *Pain Forum*. 1995; 4:163–178. Council on Scientific Affairs, American Medical Association. Good care of the dying patient. *JAMA*. 1996;275:474–478. American Board of Internal Medicine End of Life Patient Care Project Committee. *Caring for the Dying: Identification and Promotion of Physician Competency*. Philadelphia, PA: American Board of Internal Medicine; 1996. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical and Legal Issues in Treatment Decisions*. Washington, DC: US Government Printing Office; 1982. The Hastings Center Report. *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*. Briarcliff Manor, NY: Hastings Center; 1987.

<sup>36</sup> Cherney NI, Portenoy RK. Sedation in the management of refractory symptoms: guidelines for evaluation and treatment. *J Palliat Care*. 1994;10:31–38. Troug RD, Berde DB, Mitchell C, Grier HE. Barbiturates in the care of the terminally ill. *N Engl J Med*. 1991;327:1678–1681. Saunders C, Sykes N. *The Management of Terminal Malignant Disease*. 3rd ed. London, England: Hodder Headline Group; 1993:1–305. Byock IR. Consciously walking the fine line: thoughts on a hospice response to assisted suicide and euthanasia. *J Palliat Care*. 1993;9:25–28.

<sup>37</sup> Brody H. Causing, intending, and assisting death. *J Clin Ethics*. 1993;4:112–117. Billings JA. Slow euthanasia. *J Palliat Care*. 1996;12:21–30. Quill TE. The ambiguity of clinical intentions. *N Engl J Med*. 1993;329:1039–1040.

that the patient gives informed consent to it, not that the physician only foresees but does not intend the patient's inevitable death.

The issue of intention is particularly complicated because the determination of what is intended by the patient or physician is often difficult to verify and because practices that are universally accepted may involve the intention to hasten death in some cases.<sup>38</sup> Death is not always intended or sought when competent patients forgo life support; sometimes patients simply do not want to continue a particular treatment, but hope nevertheless that they can live without it. But some patients find their circumstances intolerable, even with the best of care, and refuse further life support with the intent of bringing about their death. There is broad agreement that physicians must respect such refusals, even when the patient's intention is to die.<sup>39</sup> However, such practices are highly problematic when analyzed according to the doctrine of double effect.

### ***3.2 The Active/Passive Distinction***

According to many normative ethical analyses, active measures that hasten death are unacceptable, whereas passive or indirect measures that achieve the same ends would be permitted.<sup>40</sup> However, how the active/passive distinction applies to these 4

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<sup>38</sup> Brody H. Causing, intending, and assisting death. *J Clin Ethics*. 1993;4:112–117. Alpers A, Lo B. Does it make clinical sense to equate terminally ill patients who require life-sustaining interventions with those who do not? *JAMA*. 1997;277:1705–1708.

<sup>39</sup> Foley KM. Pain, physician-assisted suicide, and euthanasia. *Pain Forum*. 1995; 4:163–178. Council on Scientific Affairs, American Medical Association. Good care of the dying patient. *JAMA*. 1996;275:474–478. Quill TE. *Death and Dignity: Making Choices and Taking Charge*. New York, NY: WW Norton & Co; 1993:1–255. American Board of Internal Medicine End of Life Patient Care Project Committee. *Caring for the Dying: Identification and Promotion of Physician Competency*. Philadelphia, PA: American Board of Internal Medicine; 1996. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical and Legal Issues in Treatment Decisions*. Washington, DC: US Government Printing Office; 1982. The Hastings Center Report. *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*. Briarcliff Manor, NY: Hastings Center; 1987. Alpers A, Lo B. Does it make clinical sense to equate terminally ill patients who require life-sustaining interventions with those who do not? *JAMA*. 1997;277:1705–1708.

<sup>40</sup> Foley KM. Pain, physician-assisted suicide, and euthanasia. *Pain Forum*. 1995; 4:163–178. Council on Scientific Affairs, American Medical Association. Good care of the dying patient. *JAMA*. 1996;275:474–478. American Board of Internal Medicine End of Life Patient Care Project Committee. *Caring for the Dying: Identification and Promotion of Physician Competency*. Philadelphia, PA: American Board of Internal Medicine; 1996. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical and Legal Issues in Treatment Decisions*. Washington, DC: US Government Printing Office; 1982. The Hastings Center Report. *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*. Briarcliff Manor, NY: Hastings Center; 1987. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 3rd ed. New York, NY: Oxford University Press; 1994.

practices remains controversial.<sup>41</sup> Voluntary active euthanasia is active assistance in dying, because the physician's actions directly cause the patient's death. Stopping life-sustaining therapies is typically considered passive assistance in dying, and the patient is said to die of the underlying disease no matter how proximate the physician's action and the patient's death. Physicians, however, sometimes experience stopping life-sustaining interventions as very active.<sup>42</sup> For example, there is nothing psychologically or physically passive about taking someone off a mechanical ventilator who is incapable of breathing on his or her own. Voluntarily stopping eating and drinking is argued to be a variant of stopping life-sustaining therapy, and the patient is said to die of the underlying disease.<sup>43</sup> However, the notion that VSED is passively "letting nature take its course" is unpersuasive, because patients with no underlying disease would also die if they stopped eating and drinking. Death is more a result of the patient's will and resolve than an inevitable consequence of his disease. Furthermore, even if the physician's role in hastening death is generally passive or indirect, most would argue that it is desirable to have physicians involved to ensure the patient is fully informed and to actively palliate symptoms.

Both PAS and TS are challenging to evaluate according to the active/passive distinction. Physician-assisted suicide is active in that the physician provides the means whereby the patient may take his or her life and thereby contributes to a new and different cause of death than the patient's disease. However, the physician's role in PAS is passive or indirect because the patient administers the lethal medication. The psychological and temporal distance between the prescribing and the act may also make PAS seem indirect and thereby more acceptable to physicians than VAE.<sup>44</sup> These ambiguities may allow the physician to characterize his or her actions as passive or indirect.<sup>45</sup>

Terminal sedation is passive because the administration of sedation does not directly cause the patient's death and because the withholding of artificial feedings and fluids is commonly considered passively allowing the patient to die.<sup>46</sup> However,

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<sup>41</sup> Brody H. Causing, intending, and assisting death. *J Clin Ethics*. 1993;4:112–117. Brock DW. Voluntary active euthanasia. *Hastings Cent Rep*. 1992;22:10–22.

<sup>42</sup> Edwards MJ, Tolle SW. Disconnecting a ventilator at the request of a patient who knows he will die. *Ann Intern Med*. 1992;117:254–256.

<sup>43</sup> Bernat JL, Gert B, Mogielnicki RP. Patient refusal of hydration and nutrition. *Arch Intern Med*. 1993;153:2723–2727. Printz LA. Terminal dehydration, a compassionate treatment. *Arch Intern Med*. 1992;152:697–700.

<sup>44</sup> Cohen JS, Fihn SD, Boyko EJ, et al. Attitudes toward assisted suicide and euthanasia among physicians in Washington State. *N Engl J Med*. 1994;331:89–94. Bachman JG, Alchser KH, Koukas DJ, et al. Attitudes of Michigan physicians and the public toward legalizing physician-assisted suicide and voluntary euthanasia. *N Engl J Med*. 1996;334:303–309. Duberstein PR, Conwell Y, Cox C, et al. Attitudes toward self-determined death. *J Am Geriatr Soc*. 1995;43:395–400.

<sup>45</sup> Brody H. Causing, intending, and assisting death. *J Clin Ethics*. 1993;4:112–117. Quill TE. The ambiguity of clinical intentions. *N Engl J Med*. 1993;329:1039–1040.

<sup>46</sup> Cherney NI, Portenoy RK. Sedation in the management of refractory symptoms: guidelines for evaluation and treatment. *J Palliat Care*. 1994;10:31–38. Troug RD, Berde DB, Mitchell C, Grier HE. Barbiturates in the care of the terminally ill. *N Engl J Med*. 1991;327:1678–1681. Byock IR.

some physicians and nurses may consider it very active to sedate to unconsciousness someone who is seeking death and then to withhold life-prolonging interventions. Furthermore, the notion that TS is merely “letting nature take its course” is problematic, because often the patient dies of dehydration from the withholding of fluids, not of the underlying disease.

The application and the moral importance of both the active/passive distinction and the doctrine of double effect are notoriously controversial and should not serve as the primary basis of determining the morality of these practices.

### 3.3 *Voluntariness*

We suggest that the patient’s wishes and competent consent are more ethically important than whether the acts are categorized as active or passive or whether death is intended or unintended by the physician.<sup>47</sup> With competent patients, none of these acts would be morally permissible without the patient’s voluntary and informed consent. Any of these actions would violate a competent patient’s autonomy and would be both immoral and illegal if the patient did not understand that death was the inevitable consequence of the action or if the decision was coerced or contrary to the patient’s wishes. The ethical principle of autonomy focuses on patients’ rights to make important decisions about their lives, including what happens to their bodies, and may support genuinely autonomous forms of these acts.<sup>48</sup>

However, because most of these acts require cooperation from physicians and, in the case of TS, the health care team, the autonomy of participating medical professionals also warrants consideration. Because TS, VSED, PAS, and VAE are not part of usual medical practice and they all result in a hastened death, clinicians should have the right to determine the nature and extent of their own participation. All physicians should respect patients’ decisions to forgo life-sustaining treatment, including artificial hydration and nutrition, and provide standard palliative care, including skillful pain and symptom management. If society permits some or all of these practices (currently TS and VSED are openly tolerated), physicians who choose not to participate because of personal moral considerations should at a minimum discuss all available alternatives in the spirit of informed consent and respect for patient autonomy. Physicians are free to express their own objections to these practices as part of the informing process, to propose alternative approaches, and to

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Consciously walking the fine line: thoughts on a hospice response to assisted suicide and euthanasia. *J Palliat Care*. 1993;9:25–28.

<sup>47</sup> Orentlicher D. The legalization of physician-assisted suicide. *N Engl J Med*. 1996;335:663–667. Drickamer MA, Lee MA, Ganzini L. Practical issues in physician-assisted suicide. *Ann Intern Med*. 1997;126:146–151. Angell M. The Supreme Court and physician-assisted suicide: the ultimate right. *N Engl J Med*. 1997;336:50–53.

<sup>48</sup> Brock DW. Voluntary active euthanasia. *Hastings Cent Rep*. 1992;22:10–22. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 3rd ed. New York, NY: Oxford University Press; 1994.

transfer care to another physician if the patient continues to request actions to hasten death that they find unacceptable.

### ***3.4 Proportionality***

The principles of beneficence and nonmaleficence obligate the physician to act in the patient's best interests and to avoid causing net harm.<sup>49</sup> The concept of proportionality requires that the risk of causing harm must bear a direct relationship to the danger and immediacy of the patient's clinical situation and the expected benefit of the intervention.<sup>50</sup> The greater the patient's suffering, the greater risk the physician can take of potentially contributing to the patient's death, so long as the patient understands and accepts that risk. For a patient with lung cancer who is anxious and short of breath, the risk of small doses of morphine or anxiolytics is warranted. At a later time, if the patient is near death and gasping for air, more aggressive sedation is warranted, even in doses that may well cause respiratory depression. Although proportionality is an important element of the doctrine of double effect, proportionality can be applied independently of this doctrine. Sometimes a patient's suffering cannot be relieved despite optimal palliative care, and continuing to live causes torment that can end only with death.<sup>51</sup> Such extreme circumstances sometimes warrant extraordinary medical actions, and the forms of hastening death under consideration in this article may satisfy the requirement of proportionality. The requirement of proportionality, which all health care interventions should meet, does not support any principled ethical distinction between these 4 options.

### ***3.5 Conflict of Duties***

Unrelievable, intolerable suffering by patients at the end of life may create for physicians an explicit conflict between their ethical and professional duty to relieve suffering and their understanding of their ethical and professional duty not to use at least some means of deliberately hastening death.<sup>52</sup> Physicians who believe they should respond to such suffering by acceding to the patient's request for a hastened death may find themselves caught between their duty to the patient as a caregiver

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<sup>49</sup> Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 3rd ed. New York, NY: Oxford University Press; 1994.

<sup>50</sup> Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 3rd ed. New York, NY: Oxford University Press; 1994. de Wachter MAM. Active euthanasia in the Netherlands. *JAMA*. 1989;262:3316–3319.

<sup>51</sup> Quill TE, Brody RV. 'You promised me I wouldn't die like this': a bad death as a medical emergency. *Arch Intern Med*. 1995;155:1250–1254.

<sup>52</sup> de Wachter MAM. Active euthanasia in the Netherlands. *JAMA*. 1989;262:3316–3319. Welie JVM. The medical exception: physicians, euthanasia and the Dutch criminal law. *J Med Philos*. 1992;17:419–437.

and their duty to obey the law as a citizen.<sup>53</sup> Solutions often can be found in the intensive application of palliative care, or within the currently legitimized options of forgoing life supports, VSED, or TS. Situations in which VSED or TS may not be adequate include terminally ill patients with uncontrolled bleeding, obstruction from nasopharyngeal cancer, and refractory AIDS diarrhea or patients who believe that spending their last days iatrogenically sedated would be meaningless, frightening, or degrading. Clearly the physician has a moral obligation not to abandon patients with refractory suffering,<sup>54</sup> hence, those physicians who could not provide some or all of these options because of moral or legal reservations should be required to search assiduously with the patient for mutually acceptable solutions.

## 4 Safeguards

In the United States, health care is undergoing radical reform driven more by market forces than by commitments to quality of care,<sup>55</sup> and 42 million persons are currently uninsured. Capitated reimbursement could provide financial incentives to encourage terminally ill patients to hasten their deaths. Physicians' participation in hastening death by any of these methods can be justified only as a last resort when standard palliative measures are ineffective or unacceptable to the patient.

Safeguards to protect vulnerable patients from the risk of error, abuse, or coercion must be constructed for any of these practices that are ultimately accepted. These risks, which have been extensively cited in the debates about PAS and VAE,<sup>56</sup> also exist for TS and VSED. Both TS and VSED could be carried out without ensuring that optimal palliative care has been provided. This risk may be particularly great if VSED is carried out without physician involvement. In TS, physicians who unreflectively believe that death is unintended or that it is not their explicit purpose may fail to acknowledge the inevitable consequences of their action or their responsibility.

The typical safeguards proposed for regulating VAE and PAS<sup>57</sup> are intended to allow physicians to respond to unrelieved suffering, while ensuring that adequate

<sup>53</sup> Quill TE, Brody RV. 'You promised me I wouldn't die like this': a bad death as a medical emergency. *Arch Intern Med.* 1995;155:1250–1254.

<sup>54</sup> Quill TE, Cassel CK. Nonabandonment: a central obligation for physicians. *Ann Intern Med.* 1995;122:368–374.

<sup>55</sup> Emanuel EJ, Brett AS. Managed competition and the patient–physician relationship. *N Engl J Med.* 1993;329:879–882. Morrison RS, Meier DE. Managed care at the end of life. *Trends Health Care Law Ethics.* 1995;10:91–96.

<sup>56</sup> Gaylin W, Kass LR, Pellegrino ED, Siegler M. Doctors must not kill. *JAMA.* 1988;259:2139–2140. Teno J, Lynn J. Voluntary active euthanasia: the individual case and public policy. *J Am Geriatr Soc.* 1991;39:827–830. Kamisar Y. Against assisted suicide—even a very limited form. *Univ Detroit Mercy Law Rev.* 1995;72:735–769.

<sup>57</sup> Quill TE, Cassel CK, Meier DE. Care of the hopelessly ill: proposed criteria for physician-assisted suicide. *N Engl J Med.* 1992;327:1380–1384. Brody H. Assisted death. *N Engl J Med.* 1992;327:1384–1388. Miller FG, Quill TE, Brody H, et al. Regulating physician-assisted death. *N Engl J Med.* 1994;331:119–123. Baron CH, Bergstresser C, Brock DW, et al. Statute: a model state act to authorize and regulate physician-assisted suicide. *Harvard J Legislation.* 1996;33:1–34.

palliative measures have been attempted and that patient decisions are autonomous. These safeguards need to balance respect for patient privacy with the need to adequately oversee these interventions. Similar professional safeguards should be considered for TS and VSED, even if these practices are already sanctioned by the law. The challenge of safeguards is to be flexible enough to be responsive to individual patient dilemmas and rigorous enough to protect vulnerable persons.

Categories of safeguards include the following:

1. Palliative care ineffective: Excellent palliative care must be available, yet insufficient to relieve intolerable suffering for a particular patient.
2. Informed consent: Patients must be fully informed about and capable of understanding their condition and treatment alternatives (and their risks and benefits). Requests for a hastened death must be patient initiated, free of undue influence, and enduring. Waiting periods must be flexible, depending on the nearness of inevitable death and the severity of immediate suffering.
3. Diagnostic and prognostic clarity: Patients must have a clearly diagnosed disease with known lethality. The prognosis must be understood, including the degree of uncertainty about outcomes (i.e., how long the patient might live).
4. Independent second opinion: A consultant with expertise in palliative care should review the case. Specialists should also review any questions about the patient's diagnosis or prognosis. A psychiatrist should consult if there is uncertainty about treatable depression or about the patient's mental capacity.
5. Documentation and review: Explicit processes for documentation, reporting, and review should be in place to ensure accountability.

The restriction of any of these methods to the terminally ill involves a trade-off. Some patients who suffer greatly from incurable, but not terminal, illnesses and who are unresponsive to palliative measures will be denied access to a hastened death and forced to continue suffering against their will. Other patients whose request for a hastened death is denied will avoid a premature death because their suffering can subsequently be relieved with more intensive palliative care. Some methods (e.g., PAS, VAE, TS) might be restricted to the terminally ill because of current inequities of access, concerns about errors and abuse, and lack of experience with the process. Others (e.g., VSED) might be allowed for those who are incurably ill, but not imminently dying, if they meet all other criteria, because of the inherent waiting period, the great resolve that they require, and the opportunity for reconsideration. If any methods are extended to the incurably, but not terminally, ill, safeguards should be more stringent, including substantial waiting periods and mandatory assessment by psychiatrists and specialists, because the risk and consequences of error are increased.

We believe that clinical, ethical, and policy differences and similarities among these 4 practices need to be debated openly, both publicly and within the medical profession. Some may worry that a discussion of the similarities between VSED and TS on the one hand and PAS and VAE on the other may undermine the desired



goal of optimal relief of suffering at the end of life.<sup>58</sup> Others may worry that a critical analysis of the principle of double effect or the active/passive distinction as applied to VSED and TS may undermine efforts to improve pain relief or to ensure that patient's or surrogate's decisions to forgo unwanted life-sustaining therapy are respected.<sup>59</sup> However, hidden, ambiguous practices, inconsistent justifications, and failure to acknowledge the risks of accepted practices may also undermine the quality of terminal care and put patients at unwarranted risk.

Allowing a hastened death only in the context of access to good palliative care puts it in its proper perspective as a small but important facet of comprehensive care for all dying patients.<sup>60</sup> Currently, TS and VSED are probably legal and are widely accepted by hospice and palliative care physicians. However, they may not be readily available because some physicians may continue to have moral objections and legal fears about these options. Physician-assisted suicide is illegal in most states, but may be difficult, if not impossible, to successfully prosecute if it is carried out at the request of an informed patient. Voluntary active euthanasia is illegal and more likely to be aggressively prosecuted if uncovered. In the United States, there is an underground, erratically available practice of PAS and even VAE that is quietly condoned.

Explicit public policies about which of these 4 practices are permissible and under what circumstances could have important benefits. Those who fear a bad death would face the end of life knowing that their physicians could respond openly if their worst fears materialize. For most, reassurance will be all that is needed, because good palliative care is generally effective. Explicit guidelines for the practices that are deemed permissible can also encourage clinicians to explore why a patient requests hastening of death, to search for palliative care alternatives, and to respond to those whose suffering is greatest.<sup>61</sup>

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<sup>58</sup> Teno J, Lynn J. Voluntary active euthanasia: the individual case and public policy. *J Am Geriatr Soc.* 1991;39:827–830. Kamisar Y. Against assisted suicide—even a very limited form. *Univ Detroit Mercy Law Rev.* 1995;72:735–769.

<sup>59</sup> Mount B, Flanders EM. Morphine drips, terminal sedation, and slow euthanasia: definitions and facts, not anecdotes. *J Palliat Care.* 1996;12:31–37.

<sup>60</sup> Foley KM. Pain, physician-assisted suicide, and euthanasia. *Pain Forum.* 1995; 4:163–178. Council on Scientific Affairs, American Medical Association. Good care of the dying patient. *JAMA.* 1996;275:474–478. Quill TE. *Death and Dignity: Making Choices and Taking Charge.* New York, NY: WW Norton & Co; 1993:1–255. American Board of Internal Medicine End of Life Patient Care Project Committee. *Caring for the Dying: Identification and Promotion of Physician Competency.* Philadelphia, PA: American Board of Internal Medicine; 1996.

<sup>61</sup> Quill TE, Brody RV. 'You promised me I wouldn't die like this': a bad death as a medical emergency. *Arch Intern Med.* 1995;155:1250–1254. Quill TE, Cassel CK. Nonabandonment: a central obligation for physicians. *Ann Intern Med.* 1995;122:368–374. Lee MA, Tolle SW. Oregon's assisted-suicide vote: the silver lining. *Ann Intern Med.* 1996;124:267–269. Block SD, Billings A. Patient requests to hasten death: evaluation and management in terminal care. *Arch Intern Med.* 1994;154:2039–2047. Quill TE. Doctor, I want to die: will you help me? *JAMA.* 1993;270:870–873.

**Part II**  
**Physician-Assisted Suicide – An**  
**International Perspective**

# Physician-Assisted Suicide in Oregon

Linda Ganzini and Edgar Dahl

## 1 The Death with Dignity Act and Its History

On November 4, 1997, Oregon implemented the *Death with Dignity Act* making it the first jurisdiction in the United States of America to legalize physician-assisted suicide. The Act allows mentally competent, terminally ill patients who are over 18 years of age and residents of the state of Oregon to obtain a lethal dosage of medication to end their own life. Patients eligible for the Act must make one written and two oral requests over 15 days. The prescribing physician and a consulting physician must concur with the diagnosis and prognosis. If either doctor believes the patient's judgement is impaired because of a mental disorder, the patient must be referred for a mental health evaluation. The prescribing physician is required to inform the patient of potential alternatives to physician-assisted suicide, such as comfort care, hospice care, and pain management. The *Death with Dignity Act* explicitly prohibits active euthanasia, where a doctor directly administers a lethal medication to end a patient's life. Doctors and patients who adhere to the requirements of the law are protected from criminal prosecution, and the choice of assisted suicide cannot affect the status of a patient's health or life insurance policy. Physicians are under no obligation to participate in the *Death with Dignity Act*.

Between 1997 and 2006, 292 individuals died under the provisions of the *Death with Dignity Act*. In 1998, 16 Oregonians used physician-assisted suicide, followed by 27 in 1999, 27 in 2000, 21 in 2001, 38 in 2002, 42 in 2003, 37 in 2004, 38 in 2005, and 46 in 2006.<sup>1</sup> Physician-assisted suicide accounts for 1 in 1,000 deaths among Oregonians. Interestingly, about 36 percent of patients who have obtained a lethal dose of barbiturates from a doctor never used it, suggesting that some were reassured by having the prescription they could control the timing and manner of their deaths. As Timothy E. Quill recently put it: "Perhaps the knowledge that they

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<sup>1</sup> Department of Human Services, *Seventh Annual Report on Oregon's Death with Dignity Act*. Office of Disease Prevention and Epidemiology, Portland, Oregon 2005.

could end their life if they so desired makes them feel less trapped – and therefore freer to keep going.”<sup>2</sup>

The history of the *Death with Dignity Act* has been circuitous. Oregonians originally passed this statewide, voter-initiated ballot measure by a slim margin of 51–49 percent on November 8, 1994. Implementation of the Act was delayed, however, when Judge Michael Hogan of the U.S. District Court issued a legal injunction prohibiting enactment. After multiple legal proceedings, including a petition that was denied by the United States Supreme Court, the Ninth Circuit Court of Appeals lifted the injunction on October 27, 1997. The same year the Oregon legislature placed the law back on the general election ballot, unchanged, for a second time. Oregon voters chose to retain the *Death with Dignity Act*, this time by a margin of 60–40 percent.<sup>3</sup>

On November 6, 2001, U.S. Attorney General John Ashcroft reinterpreted the Controlled Substances Act as prohibiting physicians from prescribing barbiturates with the intent to hasten their patient’s death. On April 17, 2002, Judge Robert Jones of the U.S. District Court for Oregon issued a restraining order preventing implementation of the reinterpretation. In September 2002, Ashcroft appealed this decision to the U.S. Court of Appeals for the Ninth Circuit, but on May 26, 2004, his appeal was denied. On July 12, 2004, Ashcroft’s Justice Department appealed the Ninth Circuit’s decision. The Court refused this petition for a hearing on August 11, 2004. On November 9, 2004, Ashcroft filed a petition with the United States Supreme Court. On February 22, 2005, the Supreme Court granted the Department of Justice’s request for a hearing. A ruling is expected by July 2006.<sup>4</sup> If the Department of Justice eventually prevails, the physicians who prescribed barbituratesto cause death would run a substantial risk of losing their Drug Enforcement Agency licenses despite the fact that physician-assisted suicide would remain legally permissible under Oregon’s *Death with Dignity Act*. Barbiturates are considered to be the only reliable method of ensuring a peaceful death.

The political debate about the Oregon *Death with Dignity Act* included a series of speculations about why patients might choose physician-assisted suicide and the attitudes of health care providers about this practice. Opponents prophesied that the patients most likely to avail themselves of physician-assisted suicide would be the poor, the ill-educated, and the uninsured who are without access to adequate hospice care.<sup>5</sup> Others suggested that physicians would be less likely to agree to participate in assisted suicide if they had greater knowledge, skills, and levels of

<sup>2</sup> Timothy E. Quill, *The Million Dollar Question*. New England Journal of Medicine 352: 1632, 2005.

<sup>3</sup> Department of Human Resources, *Oregon’s Death with Dignity Act: The First Year’s Experience*. Center for Disease Prevention and Epidemiology. Portland, Oregon 1999.

<sup>4</sup> Susan Okie, *Physician-Assisted Suicide – Oregon and Beyond*. New England Journal of Medicine 352: 1627–1630, 2005.

<sup>5</sup> Wesley J. Smith, *Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder*. Spence, New York 2003.

comfort in caring for dying patients.<sup>6</sup> In the absence of reliable data, however, most of what was asserted about the risks of legalizing physician-assisted suicide was largely conjecture. Seven years of experience with Oregon's *Death with Dignity Act* and empirical data from the Oregon Department of Human Services and other sources present an opportunity to begin to test these hypotheses.

## 2 Some Empirical Findings

Are patients choosing physician-assisted suicide socially disadvantaged? The Oregon experience suggests that this is not the case. The overwhelming majority of patients seeking physician-assisted suicide are financially well off, highly-educated and have health insurance. For example, of the 292 patients who have availed themselves of physician-assisted suicide between 1998 and 2006, 41 percent had a Bachelor or higher academic degree, 22 percent had some college education, and 28 percent had a high school diploma. Only 9 percent did not attend high school. Thus, Oregonians with a Bachelor degree or higher degree are 8 times more likely to use physician-assisted suicide than those without high school education. Similarly, 62 percent of patients using the *Death with Dignity Act* had private insurance and 36 percent had government-funded insurance, such as Medicare or Medicaid. Moreover, only 2 percent of physicians reported that a patient in their care who died by physician-assisted suicide chose it because of financial concerns.<sup>7</sup> Hospice nurses and social workers concur that financial concerns and poor social support are rarely important reasons for these requests.<sup>8</sup>

Do patients availing themselves of physician-assisted suicide lack access to palliative care? According to the Department of Human Services, 86 percent of patients using the *Death with Dignity Act* are enrolled in home hospice care, which is the most comprehensive form of end-of-life-care available. Physicians reported that virtually all patients who request assisted suicide are offered hospice care. Contrary to wide-spread concerns, legalization of physician-assisted suicide has not impeded, but has been actually associated with improved palliative care. Both proponents and opponents of the *Death with Dignity Act* agree that it underscored the need to improve care of the dying in Oregon. Many physicians who responded to a survey conducted in 2001 reported they had made efforts to improve their ability to care for terminally ill patients, were more likely to refer these patients to hospice, and believed that hospice is more accessible since legalization of physician-assisted suicide.<sup>9</sup>

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<sup>6</sup> Ann Alpers and Bernard Lo, *Physician-Assisted Suicide in Oregon: A Bold Experiment*. Journal of the American Medical Association 274: 483–487, 1995.

<sup>7</sup> Department of Human Services, *Seventh Annual Report on Oregon's Death with Dignity Act*. 2005.

<sup>8</sup> Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide*. New England Journal of Medicine 347: 582–588, 2002.

<sup>9</sup> Linda Ganzini et al., *Oregon Physicians' Attitudes About Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act*. Journal of the American Medical Association 285: 2363–2369, 2001.

Do patients opting for physician-assisted suicide fear being a burden to others? The most frequently reported reasons for choosing physician-assisted suicide are “loss of autonomy” (87 percent), “loss of dignity” (80 percent), and “loss of the ability to enjoy the activities that make life worth living” (84 percent). Concerns about being a “burden to family, friends or caregivers” are moderately important: 36 percent of patients perceived themselves as a burden to others. Physicians may be less likely to grant physician-assisted suicide requests for patients who express this as a major concern. Physicians reported that among patients who requested assisted suicide, 10 percent who viewed themselves as a burden received a lethal prescription compared to 47 percent who did not view themselves as a burden.<sup>10</sup> Hospice nurses reported that only 11 percent of family members of patients who received lethal prescriptions were more burdened by caring for their ill relative than other families of hospice patients, whereas 31 percent were less burdened.<sup>11</sup> Concerns about being a burden to their families appear to reflect patient’s own perceptions of the dying process as being without value rather than attitudes communicated to them by others. We will return to this issue shortly when we have a closer look at the characteristics of patients seeking assisted suicide under the *Death with Dignity Act*.

Are patients requesting physician-assisted suicide depressed? As is widely known, suicide is often associated with depression. In retrospective reviews of suicides, researchers report that in approximately 80 percent of completed suicides by cancer patients the decedent was depressed.<sup>12</sup> In the decade following a suicide attempt, only 10–14 percent of patients complete suicide, suggesting that for most suicidal persons the desire to die is not permanent.<sup>13</sup> Oregon physicians report that about 20 percent of requests for assisted suicide came from depressed patients, but no depressed patient received a lethal prescription.<sup>14</sup> Given that the overall prevalence of depression among terminally ill patients is between 10 and 25 percent, depression may not increase the attributable risk for actually requesting physician-assisted suicide. Oregon hospice social workers, who have experience in recognizing depression in terminally ill patients, report that among patients who received lethal prescriptions, depression was one of the least important reasons for their request.<sup>15</sup>

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<sup>10</sup> Linda Ganzini et al., *Physician’s Experiences with the Oregon Death with Dignity Act*. New England Journal of Medicine 342: 557–563, 2000.

<sup>11</sup> Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide*.

<sup>12</sup> Markus M. Henriksson et al., *Mental Disorders in Cancer Patients*. Journal of Affective Disorders 36: 11–20, 1995.

<sup>13</sup> Rene F. Diekstra, *An International Perspective on Epidemiology and Prevalence of Suicide*. In: Susan J. Blumenthal and David J. Kupfer (eds.) *Suicide Over the Life Cycle: Risk Factors, Assessment, and Treatment of Suicidal Persons*. American Psychiatric Press, Washington, D.C. 1990, 533–570.

<sup>14</sup> Linda Ganzini et al., *Physicians’ Experiences with the Oregon Death with Dignity Act*.

<sup>15</sup> Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance with Suicide*.

However, studies of patients actually in the process of requesting physician-assisted suicide are needed to clarify the relationship of this act and depression.

There are striking differences between studies inside and outside of Oregon in the role of depression in interest in physician-assisted suicide. Although the reasons for the differences are not quite clear, a likely explanation stems from differences in the populations studied. Studies conducted outside of Oregon have found that more than 10 percent of surveyed terminally ill patients express an *interest* in assisted suicide.<sup>16</sup> However, only 1 percent of Oregonians who die each year make an *explicit* request for assisted suicide, and only 0.1 percent die by assisted suicide. That is, only one in one hundred terminally ill patients who might endorse interest in assisted suicide on a questionnaire would, were it legal, die by assisted suicide. As we will point out shortly, Oregon physicians describe patients who actively pursue assisted suicide as focussed, determined, and stubborn individuals who are uncompromising in their approach to obtaining a lethal prescription. It is possible that even though depression may increase a patient's interest in assisted suicide, the apathy associated with depression makes it difficult to convince others of the sincerity of the request. Despite this, surveillance for depression, which is a potentially treatable condition, remains an important intervention maximizing quality of life and potentially reversing requests.

What do patients requesting physician-assisted suicide have in common? As already noted, the majority of patients using the *Death with Dignity Act* are highly-educated. Thus, it does not come as a surprise that doctors who have been approached with requests for a lethal prescription describe these patients as "outspoken", "articulate", and "forthright". Other adjectives used to describe these patients included "interesting", "memorable", "amazing", "passionate", and "likeable", but also "crusty", "reclusive", "demanding", or even "patriarchs", "queen bees", and "solitary odd ducks" whose views did not always mesh with the philosophy of hospice. However, if there was one single characteristic all these patients shared, it was their desire "to be in control". They dreaded the thought of being dependent on others. Physicians perceived that for these individuals the dying process presented too much risk of becoming dependent through pain, mental deterioration, living in a nursing home, becoming emotional, or losing the ability to talk, walk, or control bowels and bladder. Typical comments from physicians about these patients included: "She said she didn't want anyone washing her butt"; "He was a tough, macho, in control-of-himself-and-everything-else-kind of fellow"; or "She was a control person saying, 'I am in charge here. I want to be in control of my destiny. I don't want to go out as incontinent, in pain, crying, you know, tearful person. I want to go out with some dignity.'" "One patient who worried that dying of her disease would be undignified was quoted by her doctor as saying: "I want to do it on my own terms. I want to choose the place and time. I want my friends to be there. And

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<sup>16</sup> Ezekiel J. Emanuel et al., *Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers*. Journal of the American Medical Association 285: 734-735, 2001.

I don't want to linger and dwindle and rot in front of myself."<sup>17</sup> Physicians also commented about these patients' clear distaste at burdening others with their care even when family members professed to take pleasure and find meaning in caring for the patient.

When approaching a doctor about a lethal prescription, these patients' requests for assisted suicide reflected their determined nature. Physicians described them as "adamant", "forceful", and "persistent". One doctor stated they are not the kind of patient who come into your office and say, "Tell me what to do." Rather, they are saying: "I want to make one thing perfectly clear. I need a doc who is going to give me a lethal prescription because I want to be in charge." One patient even went so far as to request euthanasia by saying: "I want you to administer a lethal injection. . . , well, . . . when I'm done hunting." Apparently, he wanted to live through one more season of deer-hunting.

### 3 Attitudes to PAS Among Families, Physicians, and Other Groups

Are patients seeking physician-assisted suicide supported by their families? Doctors reported that when family members were available, there was a wide variety of views regarding the patient's request for a lethal prescription. Some family members were supportive and understanding. Some were uncertain. Other family members opposed assisted suicide initially, but became convinced by the patient that this was the correct course. One physician recounted a patient's request: "When he asked me, he caught his wife by surprise . . . He just said, 'I'm gonna, I want to take advantage of the assisted, of the *Death with Dignity Act*.' And his wife was in the room with him and she turned around and said, 'What are you talking about?' And she, they got into a little discussion right there. 'Don't you think I have something to contribute to this conversation?' and 'We've been married almost 50 years' and 'I think I should have something to say here.' And they actually called back and she called the next day and said, 'We've had a good talk about it and I think he's right and I support him.' She just said, 'This is what he wants and I think it is best for him.' "

Others continued in their opposition to physician-assisted suicide, but acknowledged that it was the patient's right. They struggled with the idea, were slow to accept it, and were anxious about the process. For example, one physician noted about a daughter: "She struggled a lot. Her husband was the family member who was the most opposed, still is. None of these family members wanted this to happen but they also wanted to support their Mom and they knew that she was just really solid about this. So that was her point of view, was that 'I'm going to do what my Mom wants me to do for her.' "

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<sup>17</sup> Linda Ganzini et al., *Oregon Physicians' Perception of Patients Who Request Assisted Suicide and Their Families*. *Journal of Palliative Medicine* 6: 381–390, 2003.



Even when family members disagreed strongly, they tried to accept the idea. One doctor told of a meeting with a wife: “And basically I spent an hour with her as I heard her describe in exquisite detail how mad she was at him. And how mad the family was at him. And how they disagreed with this decision. And how they did not like what was happening at all. But ultimately it had been his choice, and although they did not like it, they were trying hard to accept it. They were very, very mad at him because they thought it was selfish of him. And they were mad at him because they liked him.”

How do physicians feel about requests for assisted suicide? Although many doctors express willingness to help a terminally ill patient, they differ considerably in their views on physician-assisted suicide. For some, it is a clinical option of last resort, to be seriously considered only after other treatment and palliative efforts have been exhausted. For example, one physician said: “To me this law is a last gasp. It’s the last thing you do when nothing else is going to make it better.” Others consider physician-assisted suicide to be a patient’s right: “I have a strong personal belief that, like divorce and abortion, it’s a painful step that persons are entitled to make for themselves.” However, even if supportive of the general concept of assisted suicide, many physicians feel ambivalent about getting personally involved. Some are concerned that their involvement might affect their reputation: “One of the things I have sort of been anxious about is sort of becoming the assisted suicide doctor.” Others feel that their competence and ability to provide optimal care is called into question: “It’s almost as if your treatments and attempts to make the patient comfortable have been a complete failure if they’re going to ask for that.” And yet others feel obligated not to abandon their patients: “I think I would just feel really uncomfortable if I couldn’t help.”<sup>18</sup>

Regardless of whether they prescribed a lethal dosage of medication or not, most physicians do not express regrets about their decisions. Beliefs that their actions were the “right thing to do” usually override any feelings of discomfort. For example, one physician said: “This seemed right to me... this seemed as right as it could get.” Even when they feel they have made appropriate choices, however, many physicians are not sure how they will respond to requests in the future: “I find I can’t turn off my feelings at work as easily... because it does go against what I wanted to do as a physician. Doesn’t mean it’s the wrong thing to do. I still think it’s the right thing to do. But it’s going to be hard to do that emotionally.” Despite discomforts, physicians often report that their involvement had a positive effect on them. Requests for assisted suicide frequently facilitated discussion of important issues. Such discussions were considered a valuable patient-centered activity, a hallmark of good end-of-life care. Many physicians feel that they have become better doctors. They feel more comfortable in discussing end-of-life options, and are more proactive in bringing up end-of-life issues.

What do psychologists think of the *Death with Dignity Act*? Eighty-five percent of Oregon psychologists support physician-assisted suicide for competent, termi-

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<sup>18</sup> Steven K. Dobscha et al., *Oregon Physicians’ Responses to Requests for Assisted Suicide: A Qualitative Study*. *Journal of Palliative Care* 7: 451–471, 2004.

nally ill patients. Eighty-two percent indicated that they would consider obtaining a physician's assistance to end their own lives under some circumstances. Only 3 percent feel that a request for assisted suicide is evidence of a mental disorder. Sixty-seven percent believe the legal safeguards of the *Death with Dignity Act* to be adequate. However, 28 percent call for an additional mandatory mental health evaluation. Sixty-two percent would be willing to provide a psychological assessment to the referring physician and then take no further action. Twenty-eight percent say they would also support the patient in obtaining a lethal medication from his or her primary physician. Only 20 percent feel that participating in an assisted suicide would constitute a threat to their professional ethics.<sup>19</sup>

Have there been any complications in physician-assisted suicide? Of the 208 patients, 194 did not experience difficulties with ingesting their lethal medication. In 10 cases, patients are reported to have vomited one third to one half of the barbiturate after ingestion. However, in all cases but one, patients became unconscious and remained so until they died. The median time from ingestion to death was 25 minutes, although 17 patients survived for more than 4 hours, 1 of them surviving for 31 hours and another one for 48 hours. There have been no cases where emergency medical services needed to be called.<sup>20</sup> However, on January 30, 2005, David E. Prueitt, a patient suffering from lung cancer, reportedly swallowed 10 g of secobarbital powder mixed with water, applesauce, cinnamon, and a small amount of a sweet-tasting laxative, but did not die. Instead, he woke from a coma nearly three days later and lived for another two weeks. His wife recalled that when he woke up on February 2, he asked "What the hell happened? Why am I not dead?" He survived for 13 more days, coherent and alert, before dying of his cancer. The Oregon Board of Pharmacy is currently investigating the case. It could be that the laxative might have interfered with absorption of the barbiturate.<sup>21</sup>

Given that the available evidence does not bear out the widely voiced concerns that the most vulnerable members of our society, such as the poor and the disabled, will be pressured into choosing death, the number of Americans supporting similar legislation as in Oregon seems to be steadily growing. According to a TIME poll conducted in March 2005, "52 percent of Americans surveyed said that they agree with the Oregon law, vs. 41 percent who did not."<sup>22</sup> A survey conducted by HARRIS Interactive in April 2005 found even stronger support for legalizing physician-assisted suicide. Asked whether they would favor or oppose a law similar to Oregon's *Death with Dignity Act*, 32 percent were opposed and 67 percent were

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<sup>19</sup> Darien S. Fenn and Linda Ganzini, *Attitudes of Oregon Psychologists Toward Physician-Assisted Suicide and the Oregon Death with Dignity Act*. *Professional Psychology: Research and Practice* 30: 235–244, 1999.

<sup>20</sup> Department of Human Services, *Seventh Annual Report on Oregon's Death with Dignity Act*.

<sup>21</sup> Don Colburn, *Why Am I Not Dead?* Salt Lake Tribune, March 12, 2005.

<sup>22</sup> Margot Roosevelt, *Choosing Their Time*. TIME Magazine of April 4, 2005.

in favor.<sup>23</sup> In California, where a bill modeled after the *Death with Dignity Act* is currently on its way to the state legislature,<sup>24</sup> a FIELD poll conducted in April 2005 “showed 70 percent of residents agreeing that ‘incurably ill patients have the right to ask for and get life-ending medication’. More than two thirds said they would want their doctor to help them die if they were expected to live less than six months.”<sup>25</sup> Whether California with its more diverse population and its less inclusive palliative care program will be able to replicate Oregon’s reassuring experience with physician-assisted suicide remains to be seen. It might very well be that it is not so much the legal safeguards, but the social safety net that prevents abuses in end-of-life care from happening.

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<sup>23</sup> HARRIS Interactive, *Majorities of U.S. Adults Favor Euthanasia and Physician-Assisted Suicide by More than Two-to-One*. HARRIS Interactive Press Release, April 27, 2005.

<sup>24</sup> Susan Okie, *Physician-Assisted Suicide – Oregon and Beyond*.

<sup>25</sup> Roosevelt, *Choosing Their Time*.

# Physician-Assisted Suicide in the Netherlands and Belgium

John Griffiths

## 1 Euthanasia and Physician-Assisted Suicide in Dutch and Belgian Law

I will show that euthanasia and physician-assisted suicide (PAS) are treated practically identically in Dutch and Belgian law. And I will raise the question whether this is desirable and if not, what should be done about it.

It is important to begin by noting that the difference between the two may not always be very big. Take for example the ‘suicide machines’ that Nitsche and Kevorkian are said to have designed. A doctor attaches a patient intravenously to an apparatus containing a deadly drug. We can certainly wonder whether under such circumstances it makes any difference for our moral evaluation or for the demands of effective legal regulation whether the patient turns the apparatus on by typing instructions into a pre-programmed computer or by asking the doctor to open a valve.

For present purposes I assume two archetypical scenarios (which, I suspect, in fact represent most cases in actual practice). In the case of what we call ‘euthanasia’ the doctor injects the patient with a deadly drug. In the case of ‘PAS’ the doctor gives the drug to the patient who swallows it. My question is whether it is desirable that the law should be indifferent between these two scenarios.

Two limitations on what I shall have to say should be noted. (1) There are patients who are not capable of performing even the simplest last act required for suicide. I do not know how many of these there are in current euthanasia practice in the Netherlands and Belgium. For these patients, PAS is not an available choice, and they are therefore not covered in what I shall say. (2) I shall deal only with that form of euthanasia and PAS that is legal in the Netherlands and Belgium, namely when it is done by a doctor. The possibility of assisted suicide by non-doctors raises a range of specific problems that I will not dealing with here.

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## 2 Current Law in the Netherlands and Belgium

Article 293 of the Dutch Criminal Code forbids euthanasia (and thereby makes it a less serious offence than what it otherwise would be, namely murder). Article 294 forbids PAS (which otherwise would not be an offence at all). Euthanasia is a more serious offence than PAS, with a maximum punishment of 12 years as against 3 for PAS.

In the Dutch legalization discussion there has seldom been any distinction made between euthanasia and PAS: most participants who refer to 'euthanasia' mean to include PAS as well.<sup>1</sup> In the case law that brought about the legalization of both there was no suggestion that there is any difference in legality or in the required 'rules of careful practice' that a doctor must abide by. The State Commission proposed in 1985 to legalize them on the same footing. Reports of the Royal Dutch Medical Association (KNMG) until recently made no distinction between the two. The successive legislative proposals and the law enacted in 2001 treat the two in the same way.<sup>2</sup> The observation of Leenen – until his recent death the most prominent Dutch expert in medical law – reflects the Dutch debate very nicely. Despite the fact, he said, that two different articles of the Criminal Code are involved, PAS 'performed by a doctor in a situation of serious physical or mental suffering . . . is in essence the same as euthanasia.' 'There is,' he continued, 'no reason to distinguish between the two.'<sup>3</sup>

Nevertheless, in one specific situation the two are in practice distinguished, although the fact that this is being done is not mentioned. When the patient's suffering is of non-somatic origin, lawyers, judges, politicians, psychiatrists and other participants in the legal and policy discussion uniformly assume that if a doctor can be involved at all, then of course this will take the form of PAS.<sup>4</sup> From the fact that whereas in other contexts the term 'euthanasia' is used to refer to both indifferently, in this case the term 'PAS' is specifically and consistently used, we can infer, I think, that in the case of non-somatic suffering Dutch law in principle only permits PAS.

In the last few years there have been sporadic signs of change in the Dutch tendency not to distinguish between euthanasia and PAS.<sup>5</sup> Once in a while a doctor writes an article in a newspaper or elsewhere arguing that in general a patient who wants to die earlier than he otherwise would have done, should take the moral responsibility for the final act himself. The Medical Association, in its most recent

<sup>1</sup> See Griffiths, J., A. Bood and H. Weyers, *Euthanasia and Law in the Netherlands*. Amsterdam: Amsterdam University Press 1998, 111 ff.

<sup>2</sup> See Griffiths, Bood & Weyers (Fn 1) for the successive legislative proposals and Weyers H. A. M., *Euthanasie: het proces van rechtsverandering*. Amsterdam: Amsterdam University Press 2004 for the history of legal change. The new law is the Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding, Stb. 2001, 194, in effect as from 1 April 2002.

<sup>3</sup> Leenen, H. J. J., *Handboek gezondheidsrecht. Deel I: Rechten van mensen in de gezondheidszorg* (3rd ed). Alphen a/d Rijn: Samsom H. D. Tjeenk Willink 1994, 296.

<sup>4</sup> See Griffiths, Bood & Weyers (Fn 1), 141.

<sup>5</sup> See Griffiths, Bood & Weyers (Fn 1), 112–113.

policy statement on euthanasia, suggests that where possible PAS should be preferred. So far, however, there has been no indication in the case law or other legal sources that lawyers are inclined to impose any such requirement.

What about Belgium? Until recently, Belgian law contained nothing more on the subject than an unqualified prohibition of murder (with no lesser offence of euthanasia). PAS was not prohibited at all as far as the Criminal Code was concerned, but the Medical-ethical Code did forbid it for doctors on pain of temporary or permanent suspension from practice.<sup>6</sup> According to Adams some Belgian legal scholars suggested that a doctor who performed PAS might be prosecuted for some other crime (such as failure to assist a person in danger of death). Nevertheless, the situation was one of *de facto* decriminalization: until the public debate on legalization of euthanasia got started, a doctor had apparently never been prosecuted either for euthanasia or for PAS.

The new Belgian law<sup>7</sup> regulates only 'euthanasia'. It is defined in the same way as in the Netherlands: 'intentional termination of another person's life at his request.' It appears from the text of the law that 'psychiatric patients' are not excluded. A doctor who performs 'euthanasia' does not commit an offence if he complies with rules of careful practice very similar to the Dutch rules.

The Belgian law says nothing about PAS. In light of the considerable confusion on the matter that marked the debates in the Belgian Senate (different speakers referring to totally different things when using the term 'PAS'), it is unclear whether the statutory term 'euthanasia' includes PAS or not. However that may be, it is in any case certain that there are no different indications or rules of careful practice for PAS than those that apply to euthanasia. If there is a difference between the two, it would appear to be that whereas the statute legalizes euthanasia, PAS, to the extent it ever was prohibited, still is. There is in any case no question of a legally preferred position for PAS.

### 3 The Exceptional Position of the Netherlands and Belgium

Just about everywhere in the world where there is any discussion at all of the possibility that a doctor might be permitted, under narrowly specified circumstances, to end the life of a patient at his request, what the proponents have in mind is PAS and not euthanasia. Outside Belgium and the Netherlands, euthanasia is rarely even considered.

In the 'common-law' countries suicide was traditionally a serious criminal offence. In the course of the last century decriminalization took place everywhere. In the statutes by which this was accomplished, a new offence of assisting suicide

<sup>6</sup> Adams, M., "Euthanasia: the process of legal change in Belgium. Reflections on the parliamentary debate", in: A. Klijn, M. Otlowski and M. Trappenburg, ed., *Regulating Physician-Negotiated Death*. Den Haag: Elsevier 2001, 29–31.

<sup>7</sup> For the text of the law see Kamer van Volksvertegenwoordigers, doc. 50 1488/001.

was almost always created. In practically the whole common-law world, the public debate concerns the question whether this relatively new offence should be repealed, or at least limited in its application to doctors.<sup>8</sup>

In countries with continental legal systems, suicide has not been an offence for some two centuries (since the Napoleonic codifications). In principle, assistance with a legal act is also legal. In Switzerland there is an institutionalized practice of PAS by laymen (medical ethics being thought to make assistance by a doctor impossible). In some countries (France and until recently, at least, Germany<sup>9</sup>) the requirement of helping a person in danger is thought to stand in the way of assistance with suicide.

The Netherlands is thus exceptional in two respects. It deviates from the other countries in the continental tradition in that the legislator – in the second half of the 19th century – added a specific prohibition of assistance with suicide to the Criminal Code. And it deviates from the rest of the world in the predominant position that euthanasia occupies in the public debates and in legal development. Belgium, as a result of its new law and despite the uncertainties concerning the legal status of PAS, has come in these respects to resemble the Netherlands.

#### 4 The Place of PAS in Medical End-of-Life Practice

How deviant the Dutch and Belgian situation is becomes even clearer if we look not only at the law but also at medical practice. From the very beginning, Dutch doctors have practiced euthanasia far more frequently than PAS. As far as we can tell, the same applies to their Belgian colleagues.

In the 3 years for which we have reliable national statistics, the picture for the Netherlands is as follows:<sup>10</sup>

Euthanasia and PAS, Netherlands, 1990, 1995 and 2001 (percentages of all deaths)			
	1990	1995	2002
Euthanasia	1.8%	2.4%	2.5%
PAS	0.3%	0.3%	0.2%

<sup>8</sup> Cf. Otlowski, M., *Voluntary Euthanasia and the Common Law* (2nd ed). Oxford: Oxford University Press 2000.

<sup>9</sup> See the contributions of Birnbacher and Wolfslast in this volume.

<sup>10</sup> Source: Griffiths, Bood & Weyers (Fn 1), 210; G. van der Wal, and P. van der Maas, *Euthanasie en andere medische beslissingen rond het levenseinde*. Den Haag: Sdu Uitgeverij 1996. A study among ALS-patients gives a similar picture (Veldink, J. H. et al., “Euthanasie and physician-assisted suicide among patients with Amyotrophic Lateral Sclerosis in the Netherlands”, *New England Journal of Medicine* 346 (2002), 1638–1644). One study suggests that among AIDS patients the frequency of assistance with suicide may be rather greater: about half (Bindels, P. J. E. and A. Krol, “Euthanasia and physician-assisted suicide in homosexual men with AIDS”, *The Lancet* 347 (1996), 499–505).

In 2001, of every 12 cases of termination of life by a doctor on request only 1 was PAS. The imbalance had become rather more pronounced since 1990, when it was 7–1. Similar data are available for Belgium (Flanders) for the year 1998.<sup>11</sup>

The annual reports of the Dutch Regional Assessment Committees cover cases that the responsible doctor officially reported (currently about half of all cases). For 1998 through 2001 these reports give the following distribution over euthanasia and PAS:<sup>12</sup>

Euthanasia and PAS, Netherlands, 1998–2001 (percentages of all reported cases)				
	Euthanasia	PAS	combination	All reported cases
1998	91%	8%	1%	349
Nov/Dec				
1999	90%	9%	1%	2216
2000	88%	10%	2%	2123
2001	89%	9%	2%	2054
2002	89%	10%	1%	1882

As in the national data covering both reported and unreported cases, it appears from the data on reported cases that the share of PAS in all medical termination of life on request is about 10%.<sup>13</sup> There is no indication of any movement in the direction of a greater role for PAS. It is interesting to note that the Assessment Committees give no indication in their annual reports that they are concerned about this situation.

These data say a lot, but not everything. To be scrupulous in interpreting them we would have to limit ourselves to cases in which the patient could have performed the final act himself, for it is only in these cases that there is a real choice. As far as I am aware, such data do not exist. If we make the rather crude assumption that patients with less than a week to live are generally not able to perform the final act, whereas if remaining life is longer than that they generally are, then in 1990 there were 920 and in 1995 1,280 cases of euthanasia in which PAS was an available alternative.<sup>14</sup> That is two to three times the number of cases in which PAS in fact occurred.

<sup>11</sup> See Deliëns, L. et al., “End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey.” *The Lancet* 356 (2000), 1806–1811, 1808.

<sup>12</sup> Source: Regionale Toetsingscommissies Euthanasie 2000–2002.

<sup>13</sup> Comparison of the data from the national studies (all cases) with those of the Assessment Committees (reported cases) shows that the ratio of PAS to euthanasia apparently is not correlated with the frequency with which doctors report.

<sup>14</sup> See Griffiths, Bood & Weyers (Fn 1), 224–225.



## 5 How Can the Preference of Dutch and Belgian Doctors for Euthanasia be Explained?

We do not know why it is that Dutch and Belgian doctors so overwhelmingly prefer euthanasia to PAS, the question never having been seriously addressed in research. There are, however, some suggestive hints in the Dutch literature.

One possibility, of course, is that it is not doctors but their patients who choose for euthanasia. However, a doctor who has a preference for PAS could offer only PAS as an option to a patient, or he could try to convince the patient that it is the better choice, or he could simply refuse to perform euthanasia. In short, the ultimate choice lies with the doctor.

It has been suggested that at the beginning of the process of legal change in the Netherlands many doctors associated suicide with psychiatric disorder. Since in the view of doctors patients' requests for termination of life have nothing to do with any such disorder, they preferred that form of termination of life free from any such association.<sup>15</sup> This may be a plausible explanation for the early years but it does not explain why the share of PAS is still so low and in fact declining.

In the early years of euthanasia practice Dutch doctors were supported in their preference for euthanasia by influential organizations.<sup>16</sup> It was not until 1984 that the Medical Association recognized PAS as a legitimate alternative for euthanasia. Proponents of legal euthanasia, such as the Dutch Association for Voluntary Euthanasia, apparently sought in the early years to avoid any association with psychiatric disorders. But if the position of such organizations was an important influence on doctors, the fact that the organizations concerned long since changed their position should have been reflected in a change in medical practice. *Quod non*.

Another possible explanation for the preference of Dutch doctors for euthanasia is the fact that from the beginning legalization in the Netherlands was seen as a matter of the empowerment of doctors and not, as in the United States for example, in terms of the rights of patients. Perhaps doctors find it natural, once they have taken a decision that is conceived of as uniquely theirs, that they should carry it out themselves.

There may also be reasons of a more practical nature. Euthanasia can be performed with drugs that act very quickly, so that the dying process is over within a few minutes and the duty of the doctor to be present the whole time is less burdensome. The dying process is also more within the doctor's control. On the other hand, one must not forget that in the early years, when current practice achieved institutionalized form, the drug of choice for euthanasia was morphine, whose working is slow and notoriously unpredictable. Any difference between euthanasia and PAS in this respect cannot have been great. Such practical considerations therefore offer no explanation for the emergence of Dutch doctors' preference for euthanasia, at most for its resistance to change.

<sup>15</sup> Cf. KNMG, "Standpunt inzake euthanasie", *Medisch Contact* (1984), 990–1002.

<sup>16</sup> See Weyers (Fn 1), 136–137, 178 n. 83; cf. Griffiths, Bood & Weyers (Fn 1), 57–58.

The risks that outside the Netherlands are often associated with PAS might also offer an explanation for the preference for euthanasia. But when proper drugs are used, these risks are in fact small.<sup>17</sup> Furthermore, they are principally relevant in the case of PAS outside the presence of the doctor, something that in the Netherlands is permitted, if at all, only in exceptional circumstances. These supposed risks, too, seem not to explain doctors' preference for euthanasia.

In short: it remains a mystery why Dutch (and apparently also Belgian) doctors exhibit such a consistent, long-term, and apparently growing preference for euthanasia over PAS.

## 6 Considerations that Would Support a Different Choice

Whatever the reasons may be that explain the preference of doctors for euthanasia, these would not seem nearly comparable in weight to the reasons that point in the other direction: that PAS should be the 'normal' procedure and euthanasia the exception. Let me mention some of them:

- (1) Legalization of euthanasia deviates more strongly from the law in other countries and arouses stronger emotional and ethical objections than legalization of PAS. Even if one does not share the objections, there is something to be said for a 'healthy respect for the opinion of mankind', at least when one does not have to offer up any basic principle. To the extent law and practice were to move in the direction of PAS, international opposition would probably lose much of its fervor.
- (2) In the case of PAS the patient bears the moral responsibility for actually carrying out his wish. A number of Dutch doctors have pointed out that in the case of a patient who could have done the fatal act himself euthanasia involves a shift of responsibility to the doctor.<sup>18</sup> Whether it is the patient who prefers to pass the moral buck, or the doctor who prefers to keep everything in his own hands, the shift of responsibility is in itself undesirable and imposes a far greater psychological burden on the doctor than in the case of PAS.
- (3) When the patient takes responsibility for carrying out his decision, the seriousness and autonomy of his wish to die are better guaranteed than when all he has to do is ask.

<sup>17</sup> See Horikx, A. and P. Admiraal, Toepassing van euthanatica; ervaringen van artsen bij 227 patiënten, 1998–2000. *Nederlands Tijdschrift voor Geneeskunde* 52 (2000), 2497–2500. Oregon Health Division 1999–2002, *Annual Reports on Oregon's Death with Dignity Act*. Portland: Department of Human Services.

<sup>18</sup> See Arentz, D. H., "Hulp bij zelfdoding", *Medisch Contact* 56 (2001), 217–219. Zwaveling, J. H., "Euthanasie legt te zware last bij de arts", *NRC Handelsblad*, 25 November 1994. Cf. Griffiths, Bood & Weyers (Fn 1), 112 n. 78. According to Van der Wal and Van der Maas (Fn 10), 173 and Benjaminsen M., *Bij het einde. Een onderzoek naar terminale zorg en euthanasieproblematiek in Utrecht*. Utrecht: Afdeling Bestuursinformatie, Gemeente Utrecht 1988, many doctors say they share this view. Such a general attitude apparently has little influence on their behavior.

- (4) A number of writers have observed (and a recent decision of the Dutch Supreme Court in the *Brongersma* case seems to support them in this) that the involvement of a doctor in termination of life is only justifiable when there is a ‘medical’ basis for the involvement.<sup>19</sup> To the extent the patient’s wish to die is not directly related to his ‘medical’ situation but has a more ‘existential’ character, the force of the doctor’s ‘medical’ legitimation becomes weaker and the degree of his involvement should also be more limited. According to Van Delden<sup>20</sup> the experience of the Regional Assessment Committees shows,

that cases of active termination of life in which the patient’s choice plays a central role and the medical element a more modest one, more often lead to PAS than to euthanasia. Apparently doctors want their modest role in the decision-making to be reflected in a modest role in carrying out the decision.

- (5) Although from the beginning of the process of legal development toward legalization both the courts and the Medical Association resolutely rejected the ‘terminal phase’ as a requirement for legal euthanasia,<sup>21</sup> the idea continues to play a low-visibility role just under the surface of legal and political discussion. Reluctant supporters of legal euthanasia are often particularly troubled when it concerns someone who is not already in the process of dying. And almost everyone feels intuitively that the amount of shortening of life has some relevance in assessing a case of euthanasia.<sup>22</sup> There have been suggestions, for example, that some of the rules of careful practice should perhaps be rather stricter when life expectancy is considerable. The new Belgian law does so explicitly: in the case of a patient who is not ‘expected to die within a short time’ a second consultation is required with a psychiatrist or a specialist in the patient’s particular disorder and at least a month must expire between the patient’s written request and its execution.

The idea that to the extent that remaining life is considerable, euthanasia is more problematic, has for reasons similar to those noted under point (4) less persuasive force in the case of PAS. In short, the greater the shortening of life, the more PAS is the appropriate choice.

- (6) It appears that it regularly happens in practice that a patient whose doctor has agreed to participate in PAS decides at the last minute not to take the lethal drugs the doctor has supplied. This may be a confirmation of point (3): the patient’s wish for death was not as authentic as it appeared. But it may also indicate – and some thoughtful doctors are of this view – that what the patient

<sup>19</sup> *Brongersma* (24-12-2002, case nr. 00797/02). Compare Trappenburg, M., “De nieuwe wetsvoorstellen abortus en euthanasie. Wille we dit nu echt?”, *Socialisme & Democratie* 2000/1: 3–9; Blijham, G. H., *Ondraaglijk lijden: over standaarden en afgrenzingen*. Lecture Vrije Universiteit 2002 (to be published in a collection of essays edited by G. Kingsma).

<sup>20</sup> Delden, H. van, *Het juiste moment voor euthanasie. Een medisch-ethische beschouwing over de relatie tussen euthanasie en tijd*. in M. Adams, J. Griffiths and G. den Hartogh, ed., *Euthanasie. Nieuwe Knelpunten in een voortgezette discussie*. Kampen: Kok. 2003, 117–132.

<sup>21</sup> See Weyers (Fn 1), 96, 147.

<sup>22</sup> See Griffiths, Bood & Weyers (Fn 1), 103–104, 295.

really sought was control over the situation surrounding his death.<sup>23</sup> Once given that power of control the patient recovered the will to continue struggling for life.

This effect may be even stronger in a jurisdiction such as Oregon where – unlike the Netherlands – the doctor is not required to be present when the patient takes the lethal drugs. In Oregon about a quarter of all PAS patients ultimately make no use of the drugs prescribed.<sup>24</sup> It is precisely for this reason that objections can be raised against the Dutch requirement that the doctor be present: this is thought to make it more difficult for the patient to change his mind at the last minute, thereby reducing one of the advantages of PAS over euthanasia.<sup>25</sup>

- (7) The transparency of medical behavior and the effectiveness of the control regime are undermined by the presence of a ‘gray zone’ between euthanasia and pain relief. It appears from the Dutch data that a significant part of what is actually euthanasia is – consciously or unconsciously – regarded by the doctor as pain relief and reported as a ‘natural death’, so that the controls applicable to euthanasia do not operate.<sup>26</sup> There is no room for such (self-) deception in the case of PAS.<sup>27</sup>

<sup>23</sup> See Griffiths, Bood & Weyers (Fn 1), 113–114.

<sup>24</sup> See Oregon Health Division 1999–2002 (Fn 17). The first annual report concerning practice under the ‘Death with Dignity Act’ (1999: 31) indicates that 6 of the 29 persons who were prescribed a lethal drug later decided not to use it. Subsequent annual reports do not give this information in so many words; one has to extrapolate from the number of persons still alive at the end of the year.

<sup>25</sup> See Griffiths, Bood & Weyers (Fn 1), 106, 113, 149; Nederlandse Vereniging voor Psychiatrie, *Hulp bij zelfdoding door patiënten met een psychiatrische stoornis. Richtlijnen voor de psychiater*. Utrecht: NVP.1998, 25. Nevertheless, the Regional Assessment Committees apparently want to sharpen the norm of presence. In their 1999 report they opine “that it is preferable that the physician be in the immediate vicinity of the patient.” (p. 15) In 2000 their position has hardened: “Even when the patient himself takes the lethal medicine the doctor must be present during the whole process. He must not leave the patient along with the euthanatica.” (p. 24) The text is essentially the same in 2001, with the addition of the explanation that “It occasionally happens that the patient vomits up the drugs and active intervention by the doctor is required.” (pp. 23–24). No sources are given that support these unqualified statements of the rule. Of course there are important arguments in favor of presence, but the Committees are apparently unaware of the fact that the practice they require is not necessarily best in all circumstances.

For similar reasons, one can question the advice of the Royal Dutch Association of Pharmacists that in cases of PAS an intravenous needle should always be inserted a day in advance in case the suicide is unsuccessful and the doctor has at the last minute to administer a euthanaticum (cited with apparent approval by the Royal Dutch Medical association, KNMG (Royal Dutch Medical Association) Duidelijkheid voorbereidende handeling euthanasie). *KNMG Nieuws*, archief 2002, June/July 2002, <http://www.knmg.nl>.

<sup>26</sup> See Griffiths, Bood & Weyers (Fn 1), 255–256, 271–272

<sup>27</sup> It might be objected here that it is precisely the greater possibility to report the death of the patient as a ‘natural’ one, thereby eluding the control system, that consciously or unconsciously leads doctors to choose euthanasia. There may well be some truth to this idea, but perhaps not quite as much as one might think at first. The choice between PAS and euthanasia will seldom depend only on a doctor’s anticipation of his willingness to report accurately. To the extent the other reasons for preferring PAS can in some way be met, the resulting increased effectiveness of the control system will be a desirable side-effect.

We can conclude from considerations such as these that there are substantial reasons for preferring doctors to choose PAS whenever that is possible. I am not aware of any counter-argument.

## 7 A Modest Proposal

There are a number of ways that the law could make PAS a more attractive alternative for euthanasia. The simplest, in the Netherlands, would be simply to repeal the prohibition of assistance with suicide in article 294 of the Criminal Code. In Belgium the confusing status of assistance with suicide would require a slightly more complicated legislative act to the same effect. In such a case, the involvement of a doctor would, as in Switzerland, not be required. Although there are some attractive arguments for this solution, I am on balance not persuaded that it would be wise.

One could decriminalize PAS but only when performed by a doctor. For reasons having to do with the past history of the development of euthanasia law in the Netherlands, in the course of which the so-called ‘medical exception’ was resolutely rejected (in my view unwisely),<sup>28</sup> I would not be particularly enthusiastic about such a partial resurrection. In my opinion, if the ‘medical exception’ is to be recognized it would be completely wrong to exclude euthanasia. And if euthanasia were included we would not have solved the problem of making PAS the preferred course of action.

I therefore propose to depart from the existing legal framework for euthanasia and PAS in the Netherlands (and I assume that in Belgium PAS will one way or another be included in the statutory legalization of euthanasia).

In such a situation, the simplest and best way to make PAS more attractive whenever it is a real alternative is to add the following to the rules of careful practice (which are enforced by the Regional Assessment Committees and in Medical Disciplinary Law):

In principle the doctor offers the patient PAS. If the patient is not able to carry it out, or if for any other legitimate reason it is the more appropriate course of action, the doctor may perform euthanasia instead. In the latter case, the doctor’s report includes an explanation for the choice of euthanasia.

From everything we know about how doctors react to the various requirements of the reporting procedure, I am convinced that such a rule of careful practice – to which due publicity would be given and which would be included on the reporting form – would give just the sort of gentle but effective push in the right direction that seems to be needed.

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<sup>28</sup> See Griffiths, Bood & Weyers (Fn 1), 98; Griffiths, J. “Wat is de medische exceptie?”, *Medisch Contact* 54 (1999), 656–659.

# Physician-Assisted Suicide and the German Criminal Law

Gabriele Wolfslast

## 1 The Legal Situation De Lege Lata

Euthanasia is not regulated by law in Germany. § 216 of the German Criminal Code (*Strafgesetzbuch, StGB*) only expressly prohibits homicide with the victim's consent.<sup>1</sup> It follows unconditionally from this that active euthanasia where one person takes a direct and intentional step to kill another person, who is terminally ill, with such person's consent, will be punishable as a crime.<sup>2</sup> On the other hand, so called "indirect" euthanasia where the death of a terminally ill person is the unintentional but inevitable side-effect of palliative therapy is regarded both by the German courts and legal writers as justifiable homicide;<sup>3</sup> passive euthanasia, e.g. the refusal of the commencement or the continuation of life-sustaining or life-prolonging therapy is allowed under in many respects quite well-defined conditions.<sup>4</sup>

Neither are suicide and complicity in suicide regulated by law. The reason why complicity in suicide (incitement as well as assisting) goes unpunished is essentially technical. Since committing suicide is itself not a criminal act, inciting or aiding suicide cannot be regarded as criminal acts.<sup>5</sup> The view that clearly prevails among legal writers is that the elements that constitute the offence of homicide in §§ 211 et

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<sup>1</sup> § 216 StGB: *Ist jemand durch das ausdrückliche und ernstliche Verlangen des Getöteten zur Tötung bestimmt worden, so ist auf Freiheitsstrafe von sechs Monaten bis zu fünf Jahren zu erkennen.*

<sup>2</sup> V. e.g. Jähncke in: Leipziger Kommentar zum Strafgesetzbuch, 11. Aufl., Vor § 211, Rn. 12.

<sup>3</sup> BGHSt 42, 301, 305; BGH NStZ 2001, 324, 325 f.; Schreiber, NStZ 1986, 337, 340 ff.

<sup>4</sup> V. e.g. Principles of the German Medical Association concerning Terminal Medical Care, DÄBl. Jg 101 Heft 19, 7.5.2004, A 1298–1299; cf. also Kurt W. Schmidt, in: *Journal of Medicine and Philosophie* 2000 vol. 25, No. 2, pp. 254–258.

<sup>5</sup> V. e.g. BGHSt 32, 367, 371; BGH NStZ 2001, 324, 325; SK-StGB-Horn, § 212, Rn. 4; Tröndle/Fischer, *Strafgesetzbuch, Kommentar*, 52. Aufl. 2004, Vor § 211, Rn. 10 with further references; Merkel, *Teilnahme am Suizid, Tötung auf Verlangen, Euthanasie*, in: Heggelmann/Merkel, *Zur Debatte über Euthanasie*, 1991, pp. 71 ff., 75; the punishability of assisted suicide contrary to the principles of accessoriness assumes Bringewat, *ZStW* 87 (1975), 623 ff., 648; Horn in *Systematischer Kommentar zum Strafgesetzbuch (SK StGB)*, Band II, 6. Aufl. 2002, § 212 Rn. 7.

seq. of the German Criminal Code only make the killing of *another* person a crime.<sup>6</sup> German criminal theory adopts the view that incitement to commit a crime and acting as an accessory to a crime are only punishable if the underlying act is itself punishable. In other words, a person cannot act as an accomplice (*Teilnehmer*) before or after the fact, if the underlying offence itself is not punishable by law. This is an irrefutable presumption and is known as the “accessoriness of complicity” (*Akzes-sorietät der Teilnahme*). In this context, the motives of a person who incites another person to commit suicide, or who assists in its commission, are irrelevant. Unlike the position under Austrian criminal law and in part under Swiss criminal law,<sup>7</sup> even assisting in an act of suicide for egoistical and selfish reasons is not criminally punishable<sup>8</sup> because German criminal law does not recognize assisting in an act of suicide as a separate and independent offence. Another more substantive reason for not making a person who assists an act of suicide criminally liable is the principle of free will, understood as a specifically legal principle (*Freiverantwortlichkeit*).<sup>9</sup> According to this principle, the objective attribution of the suicide victim’s death to the acts of a third party is precluded unless the third party is in control of the situation to a greater extent than the suicidal person.<sup>10</sup>

This means that, as a rule, it is correct to say that assisting an act of suicide is not a criminal offence in Germany. The crucial question is, however, when an act should be regarded merely as assisting suicide and thus be exempt from punishment, and when it should be regarded as punishable homicide. This question makes matters more complicated than it seems at first sight. The only way to distinguish these two situations is by criteria based on the principle of free will.<sup>11</sup>

1. Suicide occurs if the person who wishes to die freely decides on his own fate up to the end, i.e. acts of his own free will<sup>12</sup> and is in control of the situation (*Tatherrschaft*).<sup>13</sup> These are the necessary factual and legal elements.<sup>14</sup>

<sup>6</sup> V. e.g. BGHSt 2, 150, 152; 32, 367, 371; LK-Jähncke (fn. 2), Vor § 211, Rn. 21; Neumann, in: NK-StGB, Vor § 211, Rn. 36 ff.; Roxin, NStZ 1984, 71; Roxin in Festschrift für Dreher, 1977, pp. 331 ff., 336 ff.; different Schmidhäuser, Festschrift für Welzel, 1974, pp. 801 ff., 812 ff.

<sup>7</sup> For the Swiss Criminal Law v. Riklin, Die strafrechtliche Regelung der Sterbehilfe, in: Adrian Holderegger (Hrsg.), Das medizinisch assistierte Sterben, 2. Aufl. 2000, pp. 322 ff.

<sup>8</sup> Under Art. 115 of the Swiss Criminal Law accomplicity in suicide is liable to punishment if carried out by selfish motives.

<sup>9</sup> Neumann, JA 1987, 244, 248 f.; Witteck, KritV 2003, 163, 169 f.; Witteck, Das Posting in Suizidforen im Internet – ein Fall für das (deutsche) Strafrecht? In: Wolfslast/Schmidt, Suizid und Suizidversuche als Herausforderung im klinischen Alltag – Medizinische, ethische und rechtliche Aspekte, Beck 2005; Schneider, MüKo-StGB (2003), Vor § 211 ff., Rn. 37 with further references; Engländer, Jura 2004, 233, 235.

<sup>10</sup> Same as fn. 9 and: Kutzer, NStZ 1994, 110, 112; BGH NStZ 2001, 324, 327.

<sup>11</sup> V. e.g. z.B. Neumann, JA 1987.

<sup>12</sup> V. e.g. MünchKommStGB-Schneider, Vor §§ 211, Rn. 37.

<sup>13</sup> For example Kühl in Lackner/Kühl, Strafgesetzbuch, Kommentar, 25. Aufl. 2004, § 216 Rn. 3; further literature and precedents also in Engländer, Jura 2004, 233, 236 (fn. 20).

<sup>14</sup> For this see Merkel in Merkel/Hegselmann (like fn. 5), p. 71, pp. 75 ff (80 f.)

Therefore, a physician will in principle not be guilty of homicide if he hands over a lethal substance to a suicidal person who takes it of his own free will. (The physician may nonetheless be guilty of an offence under the Drugs Act (*Betäubungsmittelgesetz*) and/or be subject to disciplinary proceedings for breaching his code of professional ethics). Similarly, a spouse will in principle not be criminally liable if he or she buys and gives a rope to a suicidal spouse who then uses it of his or her own free will.<sup>15</sup> In these cases, the death of the person wanting to die is not attributed to the third party. The central condition is that, ultimately, death is based on the free decision of the suicidal person, and that responsibility for his death lies only with him. Only he is considered responsible for the consequences of his actions.<sup>16</sup>

2. In other cases, what appears as suicide is not classified as suicide by the law. In these cases, at least according to prevailing jurisdiction, the participation of a third person changes from complicity (not punishable) to homicide (punishable) and the role of the third person switches from merely being an innocent helper to a perpetrator criminally liable for homicide. These cases include the following:
  - the suicidal person’s decision to commit suicide is not an act of his own free will or an act for which he is fully responsible (*freiverantwortliche* or *eigenverantwortliche Entscheidung*)
  - the suicidal person “puts himself into the hands of or subjects himself to the authority of another person because he wants to be killed by him”<sup>17</sup> so that the other person was in control of the situation (*Tatherrschaft*)
  - the control of the situation shifts from the suicidal person to the other person, who originally acted only as a helper.<sup>18</sup>

Let me elaborate on these points:

(a) The question of free will: Whenever a doctor or another person hands over a lethal drug to an incompetent patient, the doctor is considered to perpetrate an offence. The act is regarded as an act of using an innocent agent and not just one of assisting a suicide (indirect perpetration, *mittelbare Täterschaft*). This will be the case even if it is the patient who takes the lethal drug so that he has de facto control of the situation.<sup>19</sup>

The legal criteria for a free decision<sup>20</sup> are regarded by legal commentators as the main criterion for determining whether physician-assisted suicide (PAS) is

<sup>15</sup> Cf. Geilen, JZ 1974, 153; Roxin in Festschrift für Dreher, pp. 347 f.; LK-Jähncke, Vor § 211, Rn. 24.

<sup>16</sup> BGHSt 32, 262; BGH NSStZ 2001, 324, 327 with further literature and precedents; Engländer, Jura 2004, pp. 236 with further references in fn. 20.

<sup>17</sup> “Gisela”-case, BGHSt 19, 135 ff.

<sup>18</sup> To further constellations that are of no importance for the problem of PAS, especially incitement of suicide by deception, s. BGHSt 32, 38 (“Sirius”-case) and from literature e.g. Engländer, Jura 2004, 235; SK-StGB-Horn, § 212, Rn. 10; Neumann JA 1987, 244 ff.

<sup>19</sup> OLG München NJW 1987, 2941 f.

<sup>20</sup> For this v esp. Neumann, JA 1987, pp. 249.



punishable or not.<sup>21</sup> If the suicidal person was not acting of his own free will, then the third person cannot be left unpunished on the basis that he merely assisted the suicide. Instead he will be criminally liable for homicide on the basis of indirect perpetration.<sup>22</sup> The issue of how free will should be defined is, however, highly controversial.<sup>23</sup> So far, there is a consensus only that a person who is under the age of 14 cannot be considered to be acting of his own free will (§ 19 of the German Criminal Code) nor can a person who suffers from one of the mental diseases listed in § 20 of the German Criminal Code and who is thus incapable of understanding the nature of his acts or of acting according to this understanding.<sup>24</sup> In addition, a person who acts in a state of emergency is considered not to be acting on his own free will (§ 35 of the German Criminal Code).<sup>25</sup> Nevertheless, there is dispute as to when persons who are criminally responsible for their actions in the above sense can still be regarded as not acting of their own free will. Some legal writers assume the existence of free will only where the decision to commit suicide is an expression of a free and serious request to die within the scope of § 216 of the German Criminal Code.<sup>26</sup> Others apply the standard that has been developed to deal with the question of when a patient's consent to treatment is effective, i.e. these legal writers focus on the question of whether the person who wants to die is able to grasp and evaluate the meaning and consequences of his decision.<sup>27</sup> Whether this can only be assumed where the person has deliberately weighed the considerations involved (*Bilanzsuizid*) (which would mean that approximately 95% of all suicides do not fall

<sup>21</sup> V. e.g. Schönke/Schröder/Eser, Strafgesetzbuch, Kommentar, 26. Aufl. 2001, Vor §§ 211 ff., Rn. 37; LK-Jähncke, Vor § 211, Rn. 25.

<sup>22</sup> Schönke/Schröder/Eser (fn. 21), Rn. 37 with reference to Arzt/Weber; if the perpetrator was mistaken on the suicidal person's free will he possibly will be sentenced for homicide through negligence, s. MünchKommStGB-Schneider (fn. 12), Vor §§ 211 ff., Rn. 64; Schönke/Schröder/Eser (fn. 21), Vor § 3 211 ff., Rn. 40; NK/Neumann (fn. 6), Vor § 211, Rn. 85; Arzt/Weber, Strafrecht BT, § 3, Rn. 31.

<sup>23</sup> For example OLG München, NJW 1987, 2940 ff., 2942; LK-Jähncke (fn. 2), Vor § 211, Rn. 26 with further references; SK-Horn, § 212, Rn. 13; MünchKommStGB-Schneider (fn. 12), Vor §§ 211 ff., Rn. 37 ff.

<sup>24</sup> But it is quite doubtful why a patient, suffering from an endogenous or exogenous psychosis should not be able at all to judge his situation realistically, so that his decision for suicide can be assessed as free; in this sense probably also MünchKommStGB-Schneider (fn. 12), Vor §§ 211 ff., Rn. 44.

<sup>25</sup> LK-Jähncke (fn. 2), Vor § 211, Rn. 26 m.w.N.; SK-StGB-Horn (fn. 5), § 212, Rn. 13; MünchKommStGB-Schneider (fn. 12), Vor § 211, Rn. 38 ff., Rn. 43 ff.; Witteck, Das Posting in Suizidforen im Internet ... (fn. 9).

<sup>26</sup> V. Schreiber, NStZ 1986, 337, 343; MünchKommStGB-Schneider (fn. 12), Vor §§ 211 ff., Rn. 40 with further references.

<sup>27</sup> LK-Jähncke, Vor 211, Rn. 26 with further references in fn. 201, 202; AE-Sterbehilfe, comment II. 1.-6 zu § 215 (pp. 29 ff.); MünchKommStGB-Schneider, Vor §§ 211 ff., Rn. 39 with further references.

into this category<sup>28</sup>) can be left open. Another group of legal writers points out that acting on one's own free will is not a social skill or an empirical ability of the victim, but a normative responsibility.<sup>29</sup>

In contrast to legal theory, the criterion of free will is only given a minor role in actual jurisdiction.<sup>30</sup> There has not, so far, emerged a uniform system for evaluating these questions.<sup>31</sup> Thus, in the "Hackethal" case<sup>32</sup> the Higher Regional Court of Munich (*Oberlandesgericht München*) found that the deceased was acting of her own free will in spite of depression caused by severe pain. The case concerned a 69-year old woman with incurable cancer (a Basaliom spread out to the brain and causing serious disfigurements) who had been suffering from excruciating pain for seven years. She was given cyanide by her physician (Professor Hackethal) and drank it. In a similar case, the Federal Supreme Court of Justice (*Bundesgerichtshof*) had no doubt about the free will of a woman with multiple sclerosis (who had herself worked before as a physician) who took Sodium-Pento-Barbital after she had obtained it from a Swiss member of "Exit".

(b) The criterion of being in control of the situation (*Tatherrschaft*): Whether or not a person has perpetrated an offence (*Täterschaft*) essentially depends on whether the person was in control of the situation. However, being in control of the situation is not synonymous with carrying out an offence personally, or the other way round: the fact that a person carried out an offence personally does not mean that he is in control of the situation and is therefore the perpetrator. Even self-inflicted death can be classified as killing by a third party. Thus, suicide can be assessed as homicide committed indirectly whenever the third party is in charge of events due to the fact that the suicide victim is in a state of agitation or mistaken in his beliefs and only the third party is aware of all the relevant circumstances.<sup>33</sup> Examples of this occur when a third party deliberately talks a hypochondriac into believing that he is suffering from an incurable illness which will lead to a painful death, although the third party knows this not to be true or when a third party gives a sick person an injection supposedly containing a required medication, but in fact containing poison which the sick person then administers to himself.<sup>34</sup>

<sup>28</sup> For example LK-Jähncke, Vor § 211, Rn. 27 ff., 29; cf. also Reimer, Zum Verständnis des Suizids: Freiheit oder Krankheit? in Wolfslast/Schmidt (Hrsg.), Suizid und Suizidversuch, München 2005, pp. 27 ff.

<sup>29</sup> Neumann, JA 1987, 249.

<sup>30</sup> V. Engländer, Jura 2004, 237 (fn. 29) with reference to Roxin, Strafrecht AT II, 2003, § 25, Rn. 63.

<sup>31</sup> Schneider in MünchKommStGB, Vor §§ 211 ff., Rn. 37 notices an "occasionally remarkable superficiality" in this "central problem" *bemerken*.

<sup>32</sup> BGHSt 46, 279 ff.

<sup>33</sup> V. Engländer, Jura 2004, 237 (fn. 29) with references to Roxin, AT II, § 25, Rn. 63.

<sup>34</sup> For example Engländer, Jura 2004, 235; ausführlich Roxin, Strafrecht AT II, 2003, § 25 Rn. 61 ff., Rn. 70 ff. (72); LK-Jähncke, Vor § 211, Rn. 25.

The view adopted by jurisdictions is that what is crucial for the distinction between unpunishable assistance in an act of suicide and homicide with the victim's consent is who is de facto in control of the course of events. The relevant leading case is a 1963 Federal Supreme Court of Justice decision.<sup>35</sup> In this case, a 16-year old woman and her boyfriend who was older had decided that they wanted to die together. The young woman was the instigator. Several attempts at suicide failed. Eventually, fumes were discharged into the car by the boyfriend running a hose from the exhaust pipe into the car and pressing the accelerator while the young woman waited on the front passenger seat. She had closed the door on the front passenger side of the car herself. The young woman died whereas the boyfriend was rescued. He was sentenced for committing homicide with the victim's consent. The Federal Supreme Court found that his actions did not amount to unpunishable complicity in suicide because he had actually been in charge of the events which led to the young woman's death.

In the "Hackethal" case, too, the key issue was who had the *Tatherrschaft*, i.e. was in control of the situation. As the patient had drunk the cyanide herself, the Higher Regional Court of Munich held – in disagreement with the prosecutor – that she had committed suicide and that it was not a case of homicide with the victim's consent. The court found that it was the patient who had taken the initiative since she had repeatedly called the doctor to remind him of his promise to help her. It attached great significance to the fact that the patient had drunk the poison herself.<sup>36</sup> Therefore, the court was correct in its decision that procuring the cyanide and handing it over to her was assessed as unpunishable complicity in suicide.

(c) Finally, central to the legal evaluation of PAS is the possibility that assisted suicide, which is not punishable, can turn into (punishable) perpetration of an offence through *omission*. In this connection, the jurisdiction of the Federal Supreme Court has developed the highly controversial<sup>37</sup> "transfer of control" concept (*Wechsel der Tatherrschaft*). The starting point for this concept is that "according to general principles a person will be guilty of homicide by omission if upon finding another person unconscious and in a helpless situation he fails to provide him with whatever help is necessary and reasonable to save his life, whenever he has obligations as a 'guarantor' for the life of that other person, as, for example, the person's spouse or personal physician".<sup>38</sup> The above assessment is expressly not

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<sup>35</sup> BGSt 19, 135.

<sup>36</sup> OLG München NJW 1987, 2940 ff., 2942; with critical comments to this ruling Kutzer, St 1994, 110, 112, who misses the thought if this was not a case of shared control of the situation. He wants to consider this even then, when, as it was the case here, the victim of the suicide carried out the immediate act of killing and the third person – here the physician – violated his "guarantor's duties" for the victim's life. "At least in such a case" the meaning of § 216 – to protect the victim – was higher evaluated than the principle of not punishing assisting suicide.

<sup>37</sup> V. e.g. LK-Jähneke (fn. 2), Vor § 211, Rn. 24; MünchKommStGB-Schneider (fn. 12), Vor §§ 211 ff., Rn. 68 with further references in fn. 206, Rn. 73 with further references, Rn. 74 with further references.

<sup>38</sup> BGHSt 32, 367, 373.

changed by the fact that “the person who has become unable to act and unable to form his own intentions deliberately put himself in a position of needing help”.<sup>39</sup> In plain language that means: a physician is permitted to procure a lethal substance and give it to a patient who in using it exercises his own free will. However, if the physician remains with the patient who has taken the substance himself until the patient becomes unconscious or if he later checks on him and finds him unconscious, according to the jurisdiction of the Federal Supreme Court the physician is obliged in principle to try to save the patient’s life (he will only be exempt from a duty to act if it is virtually impossible to save the patient either because the substance takes effect quickly or because too much time has elapsed prior to the physician’s arrival<sup>40</sup>). If the physician fails to intervene and the person wishing to commit suicide dies, the physician will be guilty of homicide by omission, and not only for failure to render assistance according to § 323c StGB. Because he as the patient’s doctor is under a special obligation to him and is expected to avert any risks to his patient’s life.<sup>41</sup> This change from assisted suicide in relation to a person acting of his own free will (not punishable) to perpetration of an offence through omission (punishable) is explained as follows: Due to his condition the unconscious person no longer has the option of changing his mind about wanting to die. Only the third party is capable of influencing the course of events. It is up to him to decide whether the victim is rescued or not. According to this view, control of the situation (*Tatherrschaft*) is transferred from the victim to the physician present (or other “guarantor”<sup>42</sup>) as soon as the victim loses consciousness: “After loss of consciousness, death can still take hours to occur. During this phase, the suicide victim is no longer in control of the situation. Instead, the ‘guarantor’ is in control and if he accepts the victim’s wish to die and does not intervene in the course of the suicide victim’s last remaining hours he becomes the perpetrator”.<sup>43</sup> In the opinion of the Federal Supreme Court, the fact that the decision to die was reached freely does not make any difference since it alleges that the latest findings from research into suicide indicate “that a desire to commit suicide which was originally very strong often disappears after the attempt at suicide”.<sup>44</sup> Thus, the exemption from punishment granted to assistance in an act

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<sup>39</sup> Ibid.

<sup>40</sup> For example, BGH NStZ 2001, 324, 327; OLG München, NJW 1987, 2940 ff.

<sup>41</sup> Cf. also e.g. MünchKommStGB-Schneider (fn. 12), Vor §§ 211 ff., Rn. 68, giving as example another, often cited hypothetical case (the wife is allowed to give her husband who is weary for life the rope, but who then, when he falls unconscious, is obliged to cut the rope immediately).

<sup>42</sup> “Transfer of control” is only assumed for the “guarantor” but not for the “everybody-person” who is obliged to give the needed aid to a helpless person, v. BGHSt 32, 367, 375.

<sup>43</sup> Literally: “In diesem Stadium des sich . . . oft über viele Stunden hinziehenden Sterbens hat dann nicht mehr der Selbstmörder, sondern nur noch der Garant die Tatherrschaft und, wenn er die Abhängigkeit des weiteren Verlaufs ausschließlich von seiner Entscheidung in seine Vorstellung aufgenommen hat, auch den Täterwillen”, BGHSt 32, 367, 374.

<sup>44</sup> BGHSt 32, 367, 376.

of suicide is made nil by the “transfer of control” concept.<sup>45</sup> This concept implies an obligation to act, whose breach is punishable, even if the “guarantor” by not acting fulfils the wishes of his patient.<sup>46</sup>

In practice, however, the “transfer of control” concept is not universally relevant. Whether a physician is actually held guilty will also depend on other facts of the case. A physician will not be expected to intervene if he can assume that he will not be able to save the suicide victim’s life or that his intervention would only result in the prolongation of “lost life” with the help of machines.<sup>47</sup> Moreover the concept is only applied to suicidal patients and not to “normal” patients.<sup>48</sup> A “normal patient” is a discerning patient who wants to let nature run its course.<sup>49</sup> According to established jurisdiction, such a person is permitted to exercise his right to self-determination and to refuse the continuation or commencement of medical treatment even when to do so is “unreasonable” and would pose a threat to his life or be lethal.<sup>50</sup> For example, a cancer patient who has refused to be operated upon and has rejected radiation treatment and chemotherapy as well as other life-sustaining treatment cannot be subjected to dialysis treatment against his will, not even after loss of consciousness. In contrast to this, the death wish of a suicidal person is not respected; suicide is regarded as unethical and something that should be condemned.<sup>51</sup> It is an act whose success – surely in view of the victim’s neediness – should be prevented.

## 2 The Question of the Punishability of Failure to Render Assistance in an Emergency (Unterlassene Hilfeleistung)

A final way of evading the impunity of assisting suicide is to have recourse to the general duty to provide assistance in an emergency contained in § 323c of the German Criminal Code.<sup>52</sup> Whilst the prevailing view among legal writers is that there

<sup>45</sup> For critical comments v. e.g. MünchKommStGB-Schneider (fn. 12), Vor §§ 211 ff., Rn. 68 with numerous further references, who talks of results that seem to be not only doctrinaire but absurd.

<sup>46</sup> Cf. Eser in Auer/Menzel/Eser, Zwischen Heilauftrag und Sterbehilfe, 1977.

<sup>47</sup> For example in the “Wittig”-case, BGHSt 32, 367.

<sup>48</sup> Cf. for this distinction BGHSt 32, 367, 378; Kutzer, MDR 1985, 710, 712; Kutzer, Die derzeitige Rechtsprechung auf dem Prüfstand: Kann die Unterscheidung von Normalpatient und Suizidpatient Bestand haben? in: Wolfslast/Schmidt, Suizid und Suizidversuche als Herausforderung im klinischen Alltag – Medizinische, ethische und rechtliche Aspekte, Beck 2005; opposing e.g. MünchKommStGB-Schneider (fn. 12), Vor § 211, Rn. 75; Eser, MedR 1985, 6 ff.; Grop, NSZ 1985, 97 ff.

<sup>49</sup> Kutzer, MDR 1985, 710, 712 f.

<sup>50</sup> BGHSt 11, 111, 113 f.; the application of these principles to cases of suicides based on a free will is approved by OLG München NJW 1987, 2943.

<sup>51</sup> V. e.g. BGHSt 46 pp. 279, 284; BGHSt 32, 367, 371 with references to the jurisdiction of the Bundesgerichtshof and *Reichsgericht*.

<sup>52</sup> § 323c StGB goes: *Unterlassene Hilfeleistung. Wer bei Unglücksfällen oder gemeiner Gefahr oder Not nicht Hilfe leistet, obwohl dies erforderlich und ihm den Umständen nach zuzumuten,*

is no duty to provide assistance where suicide is an act of free will because this would run contrary to the value judgment contained in the legislature's decision not to punish active assisted suicide,<sup>53</sup> jurisdictions take every (attempted) suicide – even in relation to a person acting of his own free will – to be an accident as defined in § 323c of the German Criminal Code. In the courts' opinion, the duty to intervene arises as soon as the suicidal person puts himself in danger and not only when the person has lost consciousness, given that the other elements of the offence are fulfilled.<sup>54</sup> Accordingly, criminal liability pursuant to § 323c has been assumed in several cases where perpetration of a homicide was excluded because the accused was not in control of the situation.<sup>55</sup> Criminal liability has been ruled out in particular in those cases where the requirements of the necessity for<sup>56</sup> or the reasonableness of the assistance were missing.

### 3 Conclusion

On account of its incalculability, the current legal situation is acceptable neither to physicians nor to patients. A human being's right to self-determination should also be respected when he has ended his life; a physician should neither be entitled nor expected to undermine such a decision if it was made freely.<sup>57</sup> The physician's duty as a "guarantor" should be restricted by the decision of a "suicidal patient" whose decision to die is made just as freely as that of a "normal patient". Only when it becomes apparent that the suicidal person has changed his mind (and rescue is possible) should a third party be subject to a duty to act whose breach is punishable.<sup>58</sup> However, this will be relevant to physician-assisted suicide only in very few cases. Furthermore, it would be desirable if at least physician-assisted suicide was regulated by statute, even if a reform of suicide assistance in general seem unrealistic in Germany.<sup>59</sup>

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*insbesondere ohne erhebliche eigene Gefahr und ohne Verletzung anderer wichtiger Pflichten möglich ist, wird mit Freiheitsstrafe bis zu einem Jahr oder mit Geldstrafe bestraft.*

<sup>53</sup> MünchKommStGB-Schneider (fn. 12), Vor §§ 211 ff., Rn. 84.; v. also SK-StGB-Rudolphi, § 323c, Rn. 1.

<sup>54</sup> V. MünchKommStGB-Schneider (fn. 12), Vor § 3 211 ff., Rn. 82, BGHSt 32, 367, 375.

<sup>55</sup> For the development of jurisdiction v. Gropp, NSTz 1985, 97 ff., 99, 100; Schönke/Schröder/Eser (fn. 21), Vor §§ 211 ff., Rn. 42 f.; MünchKommStGB-Schneider (fn. 12), Vor §§ 211 ff., Rn. 82, all with further references.

<sup>56</sup> So did the OLG München in the "Hackethal"-case, v. NW 1985, 2945.

<sup>57</sup> V. for this also Schönke/Schröder/Eser (fn. 21), Vor §§ 211 ff., Rn. 41 with numerous references to the literature.

<sup>58</sup> So, correctly, MünchKommStGB-Schneider (fn. 12), Vor §§ 211 ff., Rn. 77; Schönke/Schröder/Eser (fn. 21), Vor § 3 211 ff., Rn. 41, 44.

<sup>59</sup> For the question of legal regulation of euthanasia v. Koch, Der medizinisch assistierte Tod, in: Adrian Holderegger (Hrsg.), Das medizinisch assistierte Sterben, 2. Aufl. 2000, p. 292 ff.; Wolfslast, Rechtliche Neuordnung der Tötung auf Verlangen? In: Festschrift für Hans-Ludwig Schreiber, 2003, p. 913 ff.

# Physician-Assisted Death An Australian Perspective

Alan Rothschild

## 1 Introduction

In recent years medical science has found and increasingly continues to find ways of maintaining biological life beyond its formerly natural limit due to new forms of life sustaining medical treatment and technologies.<sup>1</sup> Australia, as other countries around the world, has struggled to come to grips with issues at the end-of-life such as the emerging autonomy of the individual, which in turn raises questions concerning physician-assisted death.<sup>2</sup>

These issues were made very public in Australia when in March 1995, seven Victorian<sup>3</sup> doctors who admitted having helped patients to die wrote an open letter to the then Premier, Jeff Kennett, which was published in *The Age*, calling for legislative reform at end of life.<sup>4</sup> Despite the admissions by the authors as to their

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<sup>1</sup> Although obviously not only as a result of new and improved medical science, life expectancies at birth in Australia have risen from 47 years for males and 50 years for females in 1875 to 74 years for males and 79 years for females in 1990, with a particular mortality decline since 1970: Taylor R., Lewis M., & Powles J., "The Australian mortality decline: all-cause mortality 1788–1990", *Australian and New Zealand Journal of Public Health*, Vol. 22 (1998), 27–36, at 29–30. In Victoria, life expectancy at birth for the period 1997–2001 was 77.4 years for a male and 82.7 years for a female: "Life expectancy at birth: Victoria 1997–2001", Victorian Government of Human Services, <http://www.health.vic.gov.au/healthstatus/le.htm> (accessed 24 February 2005).

<sup>2</sup> The term physician-assisted death ("PAD") in this paper means both physician-assisted suicide, wherein a doctor gives a patient the means or otherwise assists the patient to kill themselves, but it is the patient who commits the final act; and active voluntary euthanasia wherein the competent, informed patient asks the doctor to directly end his or her life.

<sup>3</sup> The States of Australia include Victoria, New South Wales, Queensland, South Australia and Western Australia. There are also the Territories of Australian Capital Territory, Northern Territory and Norfolk Island.

<sup>4</sup> "It cannot be right to tolerate this totally unsatisfactory situation, where it is a matter of chance whether patients will receive the treatment which they so desperately seek and where it must be only a matter of time before some doctor is prosecuted by the State for following the dictates of his conscience."

involvement in illegal practices, an investigation by the police did not lead to charges being brought,<sup>5</sup> nor was there any professional disciplinary action undertaken.<sup>6</sup> This was in spite of surveys both in Australia and overseas which indicate that physician-assisted death (PAD) is a not uncommon practice.<sup>7</sup> While there may not yet have been prosecutions in Australia, overseas there have been, as evidenced by cases in both England and the United States.<sup>8</sup>

Australia does not overtly give patients the legal right to PAD, but through the State and Territorial jurisdictions which have responsibility for this area of the law, it does have laws that facilitate a patient's wishes, including an ability to have life supporting medical treatment withheld or withdrawn. But these laws vary between the jurisdictions and may provide only limited guidance and protection for doctors and their patients in what is an area of the law which needs a comprehensive revision. As will be seen, what can be done regarding medical treatment is often dependent on which State or Territory the patient is in.

## 2 Rights of the Terminally Ill Act 1995 (NT) and Reform

The Northern Territory, with a size of 1.35 million km<sup>2</sup>, is about the size of France, Spain and Italy combined. It is sparsely populated, with its population of approximately 200,000 representing only about 1% of Australia's 20 million residents. But the twenty five members of its single house Legislative Assembly passed a law never before approved by any government in any country. When on 25 May 1995 the *Rights of the Terminally Ill Act 1995* (NT) ("RTIA") was passed, the Northern Territory became the first jurisdiction in the world to legislate for PAD. It became operational on 1 July 1996 and on 22 September 1996, cancer sufferer Bob Dent was the first person to utilise the RTIA.

The RTIA was legislation for an explicit class of person, that of the terminally ill, informed, and competent persons who wished to make a fundamental life altering decision. It attempted to answer the concerns of the opponents of PAD, implementing safeguards to protect the mentally ill and the vulnerable who may make decisions through impulse, coercion or depression, provided penalties for those who wished to take advantage of the RTIA for their own purpose, ensured there would be no liability on doctors either ethically or legally who followed the RTIA's provisions, and gave transparency by providing for reporting.

The four persons who made use of the RTIA all died in a similar manner, by a mechanism developed by pro-reform campaigner Dr. Philip Nitschke called the

<sup>5</sup> *The Age* 10 August 1995, at 3.

<sup>6</sup> *Id.* 21 June 1995, at 3.

<sup>7</sup> One of these surveys is detailed later in this paper.

<sup>8</sup> *R. v Moor (David)* (Unreported, May 11, 1999) (Crown Ct); *R. v Cox* (1992) 12 BMLR 38; *Barber v Superior Court of the State of California* (1983) 147 Cal. App.3d 1006; Palmer, "Dr. Adams on Trial for Murder", *R. v Adams* (1957) *Criminal Law Reports*. 365.



“Deliverance Machine”. This was a laptop computer attached to a syringe driver which was inserted into the patient’s arm. After the patient answered a series of questions on the computer, a lethal drug was released and the patient died. As it was the patient who in effect self-administered the drug, it was physician-assisted suicide rather than euthanasia.

The Act caused a furore nationally and internationally. John Keown asserted it is a long and complex Act,<sup>9</sup> describing it also as “both vague and lax.”<sup>10</sup> While it is not the purpose of this paper to defend point by point the RTIA, it is submitted that any Act, on any subject, can be criticised on its detail. It can never be assumed that an Act will cover all scenarios to which that Act relates. If such legislation could be written, would there ever be a need for judicial interpretation?

Other commentators suggest the RTIA was a commendable piece of legislation for any reform of the law,<sup>11</sup> being the first legislation in the world to specifically address the issues of PAD.<sup>12</sup> For the 9 months the RTIA was in operation, there was no evidence to show that there was any exploitation of the weak or vulnerable or abuse of the Act’s provisions. During those 9 months, only 4 people made use of the RTIA.

As in Oregon, where physician-assisted suicide but not euthanasia was also introduced solely by legislation,<sup>13</sup> only a very limited number of patients utilised its provisions, indicating that it worked only for whom it was intended.<sup>14</sup> By allowing for both euthanasia and physician-assisted suicide the RTIA did not have the potential for confusion as Oregon which specifically prohibits the ending of a patient’s life “... by lethal injection, mercy killing, or active euthanasia.”<sup>15</sup> While it states what the doctor may not do, it does not give the doctor direction as to the extent of assistance the doctor may give the patient. The question of when does physician-assisted suicide become euthanasia is largely unanswered. Would a self-administered lethal intravenous infusion contravene the Act? Although administered by the patient, the

<sup>9</sup> Keown J., *Euthanasia, Ethics, and Public Policy, An Argument Against Legalisation* (Cambridge University Press, 2002) at 153.

<sup>10</sup> Id. at 158. It is of interest that Keown in attempting to prove his argument as to the inherent dangers of PAD states that Oregon’s *Death With Dignity Act* is even more lax and vague than either the RTIA or the Dutch guidelines: id. at 171. This is in spite of the detailed annual reports put out by the Oregon Department of Human Services indicating that the Act is working but only for whom it is intended.

<sup>11</sup> When discussing the Oregon *Death With Dignity Act* and where it could be improved, Cohen-Almagor R. & Hartman M., in their article, “The Oregon Death With Dignity Act: Review and Proposals for Improvement”, *Journal of Legislation*, Vol. 27 (2001), 269–298, frequently cited with approval the provisions of the RTIA.

<sup>12</sup> The Oregon *Death With Dignity Act*, the Netherlands *Termination of Life on Request (and Assisted Suicide) Review Procedures Act* and Belgium’s *Act Concerning Euthanasia*, all came into being after the Australian Act.

<sup>13</sup> *Death With Dignity Act*. See the annual reports compiled each year by the Oregon Department of Human Services.

<sup>14</sup> Only four persons died by utilising the Act.

<sup>15</sup> S. 3.14.

setting up would need the attending doctor's expertise. If the patient needs help in pushing the plunger, is this assisted suicide or euthanasia?

Opponents of PAD called for the repeal of the RTIA, and while various attempts in the Northern Territory Legislative Assembly to amend or repeal the RTIA were made, they were not successful. There was also an application before the Northern Territory Supreme Court.<sup>16</sup> The allegations failed and an appeal was lodged with the High Court of Australia but was not heard as the Federal government stepped in and used their power under s. 122 of the Australian Constitution to override the RTIA,<sup>17</sup> an action that could not have been taken if the Northern Territory was a State. Section 122 allows the Federal Government to override Territory law by enacting its own law and is not applicable to the States.

The RTIA was controversial legislation, and Federal politicians preferred to distance themselves from the moral issues the RTIA invoked. Going against national opinion polls,<sup>18</sup> Member of Parliament Kevin Andrews introduced the *Euthanasia Laws Bill* into the House of Representatives as a private member's bill. It was passed 88 votes to 35 in the House of Representatives and 38 votes to 34 in the Senate, in a conscience vote rather than a party vote, to become law.<sup>19</sup> It removed from the Territories<sup>20</sup> the power to enact laws which permitted intentional killing being euthanasia or assisting a suicide.<sup>21</sup> The *Euthanasia Laws Act 1997* (Cth) specifically names the RTIA and overrides it. Kevin Andrews stated that its principles reflected the state of the law throughout Australia with the notable exception of the Northern Territory. These principles rejected the intentional killing of the terminally ill.

The Australian Federal Government continues to actively work against reform, having introduced into Parliament the *Crimes Legislation Amendment Telecommunications Offences and Other Measures Bill 2004*. This Bill, which was delayed by the October 2004 Federal election, was recently re-introduced into Federal Parliament. Justice Minister Chris Ellinson was quoted as saying that the changes

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<sup>16</sup> *Wake and Gondarra v Northern Territory and Asche* (1996) 5 NTLR 170. It was claimed that no valid assent had been given to the legislation and that the Northern Territory did not have the legislative competence to introduce the RTIA.

<sup>17</sup> *Euthanasia Laws Act 1997* (Cth).

<sup>18</sup> For a summary of Morgan polls and News poll, see Senate Legal and Constitutional Legislation Committee *Consideration of Legislation Referred to the Committee, Euthanasia Laws Bill 1997*, at 81–83. Opinions since then have not changed. A Morgan poll in June 2002 showed a decisive 73% of respondents in favour of euthanasia. Victoria's largest selling newspaper, the *Herald Sun*, in its own survey, found that 71% of respondents favoured euthanasia: "Issues Survey", 20 January 2005, at 4.

<sup>19</sup> Although the leaders of the two main parties, John Howard, Liberal, and Kim Beazley Labour, both stated publicly that they were for the Bill, arguably putting overt pressure on their colleagues to follow their lead.

<sup>20</sup> Northern Territory, Australian Capital Territory and Norfolk Island. Territories have only limited self-government when compared to the States, whose rights are more extensive.

<sup>21</sup> It does allow the Territories to enact laws relating to the withholding and withdrawal of medical treatment; palliative care; an appointment of an agent to make medical decisions on a patient's behalf; and withdrawal of the prohibition on attempted suicide.

introduced under the Bill, including curbing the use of the internet, text messages and telephone to teach people how to end their lives, would “protect vulnerable individuals from people who use the internet with destructive intent to counsel or incite others to kill themselves.”<sup>22</sup> The Bill is considered by pro-PAD groups as a direct assault against them, with Dr. Philip Nitschke,<sup>23</sup> director of pro reform group *Exit International*, reported as saying that every supporter of voluntary euthanasia in Australia would be at risk under such severe and draconian legislation.<sup>24</sup>

The parliaments of the various States of Australia have been scenes of activity in relation to the pro-reform movement, despite the antipathy of the major parties and their members. There have been Bills introduced into the parliament of every Australian State and the Northern Territory, with the exception of Victoria and Tasmania by independents or members of minor parties, proposing a reform of the law at end of life.<sup>25</sup> There is one Bill currently before a State parliament, that being the private member’s Bill of Dr. Bob Such titled *Dignity in Dying Bill 2005* in the House of Assembly, South Australia.<sup>26</sup> The Bill allows a competent adult person who is “hopelessly ill”<sup>27</sup> “to obtain appropriate and humane medical assistance to hasten death”.

### 3 Australian Legislation and Guidelines

A number of Australian States and Territories have each enacted legislation which although not uniform, in general follow overseas common law allowing persons to

<sup>22</sup> Schubert M., *The Age*, March 9, 2005, at 12.

<sup>23</sup> Vocal and articulate advocate for end of life reform, Dr. Philip Nitschke is the public face of the campaign to change the law at end of life in Australia. He came to national prominence when he supervised all four physician-assisted deaths under the RTIA. He has remained well-known in the end of life debate notably by continuing agitation for reform such as burning a copy of the *Euthanasia Laws Act 1997* (Clth) outside of Federal Parliament after learning of its successful passage through the Senate and as Director of the pro-reform organization, *EXIT International*. Like the American reformer Dr. Jack Kervorkian, because of his pro-reform views and tendency to polarise the issues, he has been called Australia’s “Dr. Death”.

<sup>24</sup> *Deliverance*, Vol. 2, Issue 1 (April–June 2004) (*Final Exit Australia*, Winnellie NT) at 3. As a consequence of the proposed law, Dr. Nitschke has been reported as saying that he is considering moving to New Zealand to continue his activities there: Meylan G., *Stuff*, 1 May 2005, <http://www.stuff.co.nz/stuff/0,2106,3265701a11,00.html> (accessed 6 May 2005).

<sup>25</sup> Without necessarily being exhaustive, *Dignity in Dying Bill*, South Australia; *Rights of the Terminally Ill Bill*, then *Voluntary Euthanasia Trial (Referendum) Bill*, New South Wales; *Voluntary Euthanasia Bill*, Western Australia, *Care of Terminally Ill Patients Bill*, Queensland: Willmott L. & White B., “Private thoughts of public representatives: Assisted death, voluntary euthanasia and politicians”, *Journal of Law and Medicine*, Vol. 11 (2003), 77–92, at 79–81.

<sup>26</sup> This is the third time Dr. Such had introduced the same Bill. Previously in 2001 and 2003: *Hansard* 16 February 2005.

<sup>27</sup> As defined in the Bill, a “hopelessly ill” person has an injury or illness that will result or has resulted in serious mental impairment or permanent deprivation of consciousness; or that illness or injury seriously and irreversibly impairs the person’s quality of life so that life has become intolerable to that person and there is no realistic chance of clinical improvement.

control in varying degrees the medical treatment to which they may be subjected to and which in turn will protect the treating doctor from allegations of PAD.

In Victoria, under the *Medical Treatment Act 1988* (Vic.) (MTAV), a refusal of treatment certificate<sup>28</sup> may be executed where a patient of sound mind who has attained the age of 18 years,<sup>29</sup> may refuse medical treatment (the definition of which does not include palliative care) generally or of a particular kind for a condition which must be current.<sup>30</sup> The decision is to be informed and made voluntarily and without compulsion.<sup>31</sup> The condition necessarily being current the certificate cannot be in the form of an advance directive. With the condition being current, the certificate will not cover future conditions and a decision would need to be made pursuant to the common law. The rationale is that the patient may not have intended the advance directive to cover the situation that has arisen, or that the patient may have changed his or her mind as to treatment.

The MTAV specifically protects medical practitioners or persons acting under their direction from professional misconduct, liability in civil proceedings or guilty of an offence, when acting in good faith and reliance on a refusal of treatment certificate refuses to perform or continue medical treatment.<sup>32</sup> If the medical practitioner performs or continues medical treatment in the knowledge of a refusal of treatment certificate, they commit the offence of medical trespass.<sup>33</sup>

There is therefore some statutory guidance for patients and their practitioners in relation to medical treatment. But, there may be need for statutory interpretation if a zealous prosecutor is of the opinion that there has been a contravention of a provision of the *Crimes Act 1958* (Vic.) such as s. 6B wherein it is an offence to aid and abet a suicide, and decides to prosecute on the basis that the withholding or withdrawal of medical treatment aids and abets a suicide.<sup>34</sup> To add confusion, this may be read in conjunction with the preamble to the MTAV which states that it is desirable “to give protection to medical practitioners who act in good faith in accordance with the patient’s express wishes” and its related s. 9(1). The MTAV also states that it does not affect or limit the operation of any other law,<sup>35</sup> potentially

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<sup>28</sup> Which is to be witnessed by a medical practitioner and another person: s. 5(1) and which may be in writing, oral or any other way a person can communicate: s. 5(3)

<sup>29</sup> S. 5(1).

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> S. 9(1)

<sup>33</sup> S. 6.

<sup>34</sup> The legislature has indicated the seriousness of deterring the aiding and abetting of suicide by the provision of s. 463B of the *Crimes Act 1958* (Vic.) wherein reasonable force may be used to prevent a suicide, or any act which it is reasonably believed will amount to suicide. It is suggested that this provision and more so s. 6B have the potential to be the subject of conflict with the MTAV. For example, a patient properly executes a refusal of treatment certificate with the stated intent of dying. Will the doctor who complies with the certificate have aided the patient in a suicide? Should the doctor have ensured medical treatment is continued?

<sup>35</sup> S. 4.

bringing the common law in areas such as palliative care and double effect into the equation.

In the Australian Capital Territory, the *Medical Treatment Act 1994* (ACT) (MTAA) is similar to the MTAV.<sup>36</sup> The patient, while of sound mind can give a power of attorney to be exercised if they later become incapacitated,<sup>37</sup> and the grantee of the power has been sufficiently informed as to the patient's illness may make medical decisions on the patient's behalf.<sup>38</sup> If medical treatment is withheld or withdrawn, the health professional or person acting on their behalf, incurs no liability for professional misconduct, shall be guilty of any offence, or liable in civil proceedings.<sup>39</sup> While not mentioning the double effect doctrine explicitly, a patient has the right to receive adequate pain relief consistent with their level of pain and suffering.<sup>40</sup>

In South Australia, the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) (CMTPCA) deals with wider ranging medical issues than those described in the MTAV and MTAA, allowing persons over the age of 16 years to make an informed decision whether or not to undergo medical treatment;<sup>41</sup> and persons over the age of 18 to make anticipatory decisions regarding medical treatment.<sup>42</sup> Anticipatory decisions may be made if the person is either in the final phase of a terminal illness, in a persistent vegetative state, or is incapable of making a decision regarding medical treatment when the question of administering treatment arises.<sup>43</sup> Under these circumstances, the CMTPCA allows a form of advance directive, there being a commitment to follow an anticipatory direction where it is a consent to, or refusal of treatment, as long as there is no reason to believe the person has revoked or intended to revoke the direction.<sup>44</sup>

The CMTPCA recognises the common law doctrine of double effect, wherein the hastening of a patient's death due to the administration of palliative medication with the intention of relieving pain and distress, while foreseen, is not criminal.<sup>45</sup> The patient must be in the terminal stage of a terminal illness, the treatment given with the requisite standard of care, and in good faith and without negligence. While the Act does not extend the doctrine of double effect as we understand it from overseas law, it codifies the doctrine, recognizes its validity and sets parameters. It is the only Act specifically relating to medical treatment in Australia which does so. PAD under the

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<sup>36</sup> S. 11.

<sup>37</sup> S. 13.

<sup>38</sup> S. 16.

<sup>39</sup> S. 22.

<sup>40</sup> S. 23.

<sup>41</sup> S. 3(a).

<sup>42</sup> S. 3(b).

<sup>43</sup> S. 7(1).

<sup>44</sup> S. 7(3)(b).

<sup>45</sup> S. 17(1).

CMTPCA is specifically prohibited.<sup>46</sup> The CMTPCA protects medical practitioners and those acting under their supervision from civil and criminal liability for acts and omissions done or made with the patient's consent.<sup>47</sup>

The Northern Territory has the limited *Natural Death Act 1988* (NT). There is a restricted form of advance directive where a person over the age of 18 years and of sound mind who is suffering from a terminal illness<sup>48</sup> may stipulate that he or she does not desire to be subjected to "extraordinary measures".<sup>49</sup> It is the duty of the medical practitioner to act in accordance with the patient's direction.<sup>50</sup>

Queensland does not have specific legislation but provisions within three Acts relate to this area of the law. The *Guardianship and Administration Act 2000* (Qld) has an assumption that an adult has capacity for a matter,<sup>51</sup> acknowledging that it is a fundamental right for a person to be able to make decisions even if others disagree.<sup>52</sup> The *Powers of Attorney Act 1998* (Qld) allows for an advance health directive, for future health care and an attorney appointed under an advance health directive, where directions for future health care are inadequate.<sup>53</sup> The attorney pursuant to an advance health directive may, consent to life-sustaining measures being withheld or withdrawn.<sup>54</sup> There is specific provision that nothing in the *Powers of Attorney Act 1998* (Qld) allows, authorises, justifies, or excuses killing a person; or affects the Queensland *Criminal Code*.<sup>55</sup> The *Criminal Code 1899* provides that there is no criminal sanction where even if an incidental effect of providing palliative care is to hasten the other person's death, although nothing in the Act authorises, justifies or excuses, an act done or omission made with intent to kill another person; or aiding another person to kill himself or herself.<sup>56</sup>

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<sup>46</sup> S. 18.

<sup>47</sup> S. 16.

<sup>48</sup> Defined as illness, injury or degeneration of mental and physical faculties that as a result death would be imminent if extraordinary measures were not undertaken and from which there is no prospect of a recovery, temporary or permanent, even if extraordinary measures were taken: s. 3.

<sup>49</sup> Defined as medical or surgical measures that either prolong or are intended to prolong life, by supplanting or maintaining the operation of bodily functions that are temporarily or permanently incapable of functioning independently: s. 3.

<sup>50</sup> S. 4(3).

<sup>51</sup> Schedule 1. No. 1.

<sup>52</sup> S. 5.

<sup>53</sup> S. 35.

<sup>54</sup> S. 35(2). Pursuant to s. 110, an application may be made to the court for a declaration, order, direction, recommendation or advice about something in, or related to, this Act. Applicant may include (a) the principal; (b) a member of the principal's family; (c) an attorney; (d) the adult guardian or public trustee; (e) if the document is an advance health directive or the application involves power for a health matter – the adult guardian or a health provider of the principal; (f) an interested person.

<sup>55</sup> S. 37.

<sup>56</sup> S. 282A.

The New South Wales Department of Health has issued guidelines titled *End-of-Life Care and Decision-Making – Guidelines* (“Guidelines”).<sup>57</sup> While not law, they would be influential in determining the legality or otherwise of medical treatment in the areas they pertain to. The Guidelines core purpose is stated thus “Ideally, patients are able to determine their own decisions for end-of-life care.”<sup>58</sup> And “they have a right to receive or refuse life prolonging treatment,”<sup>59</sup> even where that decision may have serious consequences including death.<sup>60</sup> The Guidelines note that when the primary goal of preserving life in medicine is not sustainable, the “withholding or withdrawal of life-sustaining medical interventions may be permissible in the best interests of the dying patient.”<sup>61</sup>

## 4 The Doctrine of Double Effect

Providing medical care with the intent of alleviating or palliating the suffering of the patient which may as a secondary effect hasten the patient’s death is probably legal in Australia<sup>62</sup> and is commonly known as the doctrine of double effect.<sup>63</sup> That is, there are two effects of such care, the primary effect being the intended effect of alleviating pain and the secondary effect, being the unintended although foreseen effect of causing death.<sup>64</sup> It was noted by the Senate Legal and Constitutional

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<sup>57</sup> March 2005.

<sup>58</sup> At 1.

<sup>59</sup> At 2.

<sup>60</sup> At 4.2.

<sup>61</sup> *Id.* at 2 & 4.4.

<sup>62</sup> There having been no judicial determination and no specific legislation in Australia, apart from South Australia where there is statutory recognition of the doctrine under s. 17 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA); and in Queensland, s. 282A *Criminal Code 1899* (Qld).

<sup>63</sup> Although opponents of end of life reform suggest that the term “doctrine of double effect” could be construed as “double think” and it would be better if it were given a bland term such as “unintended bad side-effects”: Keown J., *Euthanasia, Ethics and Public Policy, An Argument Against Legalisation* (Cambridge University Press, 2002) at 20. It is suggested that this is just an exercise in semantics.

<sup>64</sup> Although the doctrine is accepted by most commentators without question, it is disputed by some who argue that “Today, guidelines for the appropriate administration of opioids based on scientific principles have been formulated and if properly adhered to, should increase the person’s well being without hastening death”: Dr. Danuta Mendelson, *Health Care, Crime and Regulatory Control*, Smith R. ed. (Hawkins Press 1998), 149–166, at 150. Dr Mendelson then suggests “The focus should be . . . on the appropriateness of treatment for the individual patient.” at 153. If this is done, “Properly administered medical therapy will effectively control the patient’s physical discomfort and minimize his or her dependence without hastening death.” at 151; see also Ashby M., “The fallacies of death causation in palliative care”, 166 *Medical Journal of Australia* (1997), 176; Ashby M., “Hard Cases, Causation and Care of the Dying”, 3 *Journal of Law and Medicine* (1995), 152; and Foley K., “Controversies in Cancer Pain: Medical Perspectives”, *Cancer*, 63 (1989), 2257–2265; the Royal College of Physicians in the UK state that “correctly used, morphine and

Legislation Committee<sup>65</sup> in their consideration of the *Euthanasia Laws Bill 1996* that the Federal Attorney – General’s Department was unsure if the doctrine of double effect was applicable in Australia.

It is uncertain whether the rule as stated is part of the law in all common law jurisdictions in Australia . . . [and a] degree of further uncertainty exists as to the Code jurisdictions . . . The Department said if the rule were to be adopted here, “which seems probable as to general principle, if uncertain as to reasoning or detail” many uncertainties would nonetheless remain on matters of significant detail.<sup>66</sup>

The doctrine has become established law in the United States and Canada.<sup>67</sup> Justice Sopinka writing for the majority in the Canadian case of *Rodriguez* stated that the distinction between the lawful and unlawful was intent. If the intent is to ease pain it is palliative care, but if the intent is to cause death, it is assisting a suicide. While in fact the distinction may be hard to draw, in law it is clear.<sup>68</sup> The United States Supreme Court has found that a prohibition on assisting a suicide does not obstruct the provision of adequate palliative care by the medical profession, particularly if the patient is in great pain, even to the point of causing unconsciousness and hastening death, that is, terminal sedation.<sup>69</sup>

In the English jurisdiction, Devlin J. (later Lord Devlin) noted that if the restoration of health could not be achieved, a doctor was entitled to all that was necessary and proper to relieve pain and suffering, even if this may incidentally shorten life.<sup>70</sup> It is a fine line for doctors to tread in relation to treatment and intention to cause death. In *R v Nedrick* it was held that

If the jury are satisfied that at the material time the defendant recognised that death or serious harm would be virtually certain . . . to result from his voluntary act, then that is a fact from which they may find it easy to infer that he intended to kill or do serious harm, even though he may not have had any desire to achieve that result.<sup>71</sup>

Without any decided authority, Australia, as a common law jurisdiction would in all probability follow English, Canadian, and United States authority,<sup>72</sup> and

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other opioid analgesics are very safe, and so allow doctors to relieve pain and ensure a comfortable death without shortening life.”: Royal College of Physicians, *Principles of Pain Control in Palliative Care for Adults* (London, RCP, 2000).

<sup>65</sup> *Consideration of Legislation Referred to the Committee, Euthanasia Laws Bill 1996*.

<sup>66</sup> *Id.* at 29.

<sup>67</sup> *Washington v Glucksberg* (1997) 117 S. Ct. 2258; *Rodriguez v Attorney General of British Columbia* (1993) 3 S.C.R. 519.

<sup>68</sup> *Rodriguez v Attorney General of British Columbia* (1993) 3 S.C.R. 519, at 607. The relevant facts being a woman with a terminal illness wanting assistance to suicide at a time of her choosing.

<sup>69</sup> *State of Washington et al. v Glucksberg et al.* (1997) 117 S. Ct. 2258. at 2303 per O’Conner J.

<sup>70</sup> *R v Bodkin Adams* (1957) Crim LR 365, at 375.

<sup>71</sup> (1986) 3 All ER 1, at 3–4.

<sup>72</sup> *Airedale NHS Trust v Bland* (1993) AC 789; *Pretty v Director of Public Prosecutions* (2001) UKHL 61; *Rodriguez v British Columbia (Attorney General)* (1993) 3 SCR 519; *R v Latimer* (2001) 1 SCR 3; *Vacco Attorney General of New York v Quill* (1997), 117 S. Ct. 2293; *Washington v Glucksberg* (1997) 117 S. Ct. 2258.



conclude that there is no criminal liability, there being “lawful justification and excuse” and allow the doctrine of double effect.<sup>73</sup> There is anecdotal evidence that it is common medical practice in the field of palliative care to give terminally ill patients with high levels of pain sufficient medication to relieve that pain with the foresight that it may also hasten that patient’s death.<sup>74</sup> If such a practice was made illegal or at least uncertain, it would place both the patient and his or her treating doctor in an untenable position. For the doctor, he or she would need to practice with one eye on the criminal law even more so than currently, and the other on what was appropriate treatment for their patient, which could not be conducive to good medical care. For the patient, their treatment may be compromised more than it is now due to concerns as to the legality of the care given.

Dr. Roger Hunt, formally Chairman of the South Australian Association for Hospice and Palliative Care, notes that there are similarities between palliative care and PAD.<sup>75</sup> First, the motive in both is that of compassion. Both attempt to ease suffering in a way acceptable to the person suffering. Second, the death of the patient may result as a secondary effect of administering pain killing drugs. When such drugs are given with the knowledge that there will be such a secondary effect and the treatment is intentionally administered, then to say that there was only the intent to relieve pain is fallacious. It may be equated to PAD for death is the direct result of the palliative treatment by the increasing dosage of the pain relieving medication.

## 5 Ethics and the Australian Medical Association

The Australian Medical Association (AMA), has condemned PAD,<sup>76</sup> but is at the same time confusing in putting its position to its members. Recognising the complexities of issues at the end-of-life the AMA states that it “encourages open and frank discussion of death and dying within the profession and the wider community.”<sup>77</sup> Does this mean alternatives to its current position are needed? Or at least

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<sup>73</sup> Compare the uncertainty of the common law in Australia with the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) which has codified the doctrine and given statutory guidelines. The Parliament of Victoria Social Development Committee in its *Inquiry into Options for Dying with Dignity, Second and Final Report* (April 1987) made the point from a moral perspective “it is morally acceptable to administer pain-killing medication with the intention of relieving pain and suffering, even though the medication may shorten life.” at 89.

<sup>74</sup> The author spoke to pharmacists practicing in suburban Melbourne, who fill prescriptions for drugs such as morphine to terminally ill patients. They believe overprescribing for therapeutic use only is an accepted practice.

<sup>75</sup> Hunt R., “Palliative Care”, at 125, Kuhse H. ed., *Willing to Listen, Wanting to die* (Penguin Books, Ringwood, 1994).

<sup>76</sup> “The AMA believes that doctors should not be involved in interventions that have as their primary goal the ending of a person’s life.” “Care of Severely and Terminally Ill Patients”, *AMA Position Statement 1997* at point 1.1. See also point 1.5.

<sup>77</sup> Id. at point 1.4.

that alternatives should be canvassed? Similarly, the AMA has stated that a patient's autonomy regarding the management of their position should be respected,<sup>78</sup> and "death should be allowed to occur with dignity and comfort when death is inevitable and when treatment which might prolong life appears futile."<sup>79</sup> The AMA, for a terminal illness at least, while being explicit about PAD being unethical then states that death for a terminally ill person may be in their best interests and that it should occur with "dignity", a term often used by proponents of PAD. It is suggested that this makes the AMA's stance confusing.<sup>80</sup>

In the AMA *Code of Ethics*, under the heading "The Dying Patient" there is the statement, "Remember the obligation to preserve life, but, where death is deemed to be imminent and where curative or life prolonging treatment appears to be futile, try to ensure that death occurs with dignity and comfort."<sup>81</sup> This statement is in two parts. First, there is a primary obligation by the medical profession to preserve life. This is consistent with medical associations worldwide. Second, where death is close and the patient can neither be cured or life prolonging treatment is pointless, it is ethically correct to "... try to ensure that death occurs with dignity and comfort." What does this mean? It is suggested that it may be interpreted as a tacit acknowledgement that in such a circumstance, for a patient with a terminal condition for which there is no cure and further treatment is futile, PAD does occur so that death may occur with "dignity and comfort".

In the AMA's position statement on the *Care of Severely and Terminally Ill Patients*, the preamble states that "The AMA believes that doctors should not be involved in interventions that have as their primary goal the ending of a person's life."<sup>82</sup> However, the preamble then goes on to describe the "wide divergence of views on euthanasia and physician-assisted suicide in Australian society ... many complex factors, including differing degrees of involvement in palliative medicine, contribute to the views, and difficulties experienced by doctors."<sup>83</sup> Opponents of PAD would probably say that the AMA's position is an endorsement of palliative care and if pain was being treated, foreseen life shortening palliative care. But, it is suggested that the AMA seems to be having an each way bet. It seems to be

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<sup>78</sup> Id. at point 1.6.

<sup>79</sup> Id. at point 1.7.

<sup>80</sup> The AMA is seemingly not alone in its confusion, as evidenced by the *New York State Board for Professional Medical Conduct*, August 16, 1991, which, ruling on the published admission of Dr. Timothy Quill that he had supplied the drugs and inter alia gave counselling as to the quantity needed to end life, allowing a terminally ill patient to end her life, determined that he could not "know with certainty" that the patient would take the drugs to end her life, at 2. Cited in *When Death is Sought-Assisted Suicide and Euthanasia in the Medical Context* "New York State Task Force on Life & the Law" at 66. This shows the convoluted manner in which professional bodies will interpret existing ethics to deal with such end of life scenarios.

<sup>81</sup> Point 1.4 a.

<sup>82</sup> Point 1.1.

<sup>83</sup> Point 1.2.

perplexed as to what is ethically correct. The situation for the medical profession from an ethical perspective seems to be confusing or at the least, fluid.

## 6 Medical Practice

In Australia several different surveys taken both nationally and in individual States have shown that a sizeable proportion of the medical profession is involved in illegitimate practices such as PAD. Doctors are more intimately involved in end-of-life decision making than any other group and should be afforded proper protection by greater legal (and ethical) clarity.

It has been argued by opponents of reform that PAD is not common and that there is little hard evidence that it is at all frequent.<sup>84</sup> The surveys undertaken of the medical profession in Australia seem to rebut this argument.<sup>85</sup> While the same statistics may at times be utilised to argue for opposing sides of the debate, the bottom line is that these statistics do show that PAD is occurring. Although they do not necessarily survey exactly the same areas of practice, desired practice or opinion and subsequently cannot be compared in great detail, they do give an empirical analysis in differing modes of the attitudes of the profession. One study, *End-of-Life Decisions in Australian Medical Practice*<sup>86</sup> in particular will be analysed.

This study is of interest as it was conducted between May and July 1996 when the Northern Territory's *Rights of the Terminally Ill Act 1995* (NT) was operative. At this time, apart from the Northern Territory, the only jurisdiction where PAD was tolerated was the Netherlands, which in 1990,<sup>87</sup> and again in 1995,<sup>88</sup> conducted surveys in relation to PAD and other end of life medical practices. Doctors' practices in the

<sup>84</sup> Keown J. *Euthanasia, Ethics and Public Policy, An Argument Against Legalisation* (Cambridge University Press, 2002) at 61.

<sup>85</sup> Kuhse H. & Singer P., "Doctors practices and attitudes regarding voluntary euthanasia", *Medical Journal of Australia*, Vol. 148 (June 1988), 623–627; Baume P. & O'Malley E., "Euthanasia: attitudes and practices of medical practitioners", *The Medical Journal of Australia*, Vol. 161 (July 1994), 137–144; Stevens C. & Hassan R., "Management of death dying and euthanasia: attitudes and practices of medical practitioners in South Australia." *Journal of Medical Ethics*, Vol 20 (March 1994), 41–46; Waddell C. et al., "Treatment decision-making at end of life: a survey of Australian doctors' attitudes towards patients' wishes and euthanasia", *The Medical Journal of Australia*, Vol. 165 (November 1996), 540–544; Kuhse H. et al., "End-of-life decisions in Australian medical practice", *Medical Journal of Australia*, Vol. 166 (February 1997), 191–196; Douglas C. et al., "The intention to hasten death: a survey of attitudes and practices of surgeons in Australia", *Medical Journal of Australia*, Vol. 175 (Nov. 2001), 511–515.

<sup>86</sup> Kuhse H. et al., "End-of-life decisions in Australian medical practice", *Medical Journal of Australia*, Vol. 166 (February 1997), 191–196.

<sup>87</sup> van der Mass P.J., van Deldren J.J.M., Pijnenborg L., "Euthanasia and other medical decisions concerning the end of life", *Lancet*, Vol. 338 (1991), 669–674.

<sup>88</sup> van der Maas P.J., 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 (1996), 1699–1705.

study were separated into four categories: euthanasia (including physician-assisted suicide); ending of life without the patient's explicit request (non-voluntary euthanasia); alleviation of pain and symptoms with opioids in large enough doses so that there was a probable life shortening effect; and decision not to treat (withholding or withdrawal of treatment). The authors of this study used a similar questionnaire to the Dutch with some essential differences,<sup>89</sup> to ascertain the number of deaths in Australia which involve medical end of life decisions and compared these figures with the Dutch figures.<sup>90</sup>

The survey commenced with 3,000 randomly selected doctors,<sup>91</sup> particularly from disciplines where there would be the possibility of making an end of life decision. The response rate was 1918 (64%) which was lessened to the 1,361 doctors who had attended a death in the previous year. Eight hundred doctors had taken steps which were intended to or foreseen to hasten death.

The authors estimated 1.8% of all Australian deaths were the result of euthanasia (1.7%) or physician-assisted suicide (0.1%).<sup>92</sup> Compared to the Netherlands figures for euthanasia of 1.7% in 1990 and 2.4% in 1995, and 0.2% in both 1990 and 1995 for physician-assisted suicide. In 30.9% of deaths the administration of opioids with or without the intent to hasten death were involved in an Australian end-of-life decision. In the Netherlands this was 18.8% in 1990 and 9.1% in 1995. These are remarkable figures considering that such acts are specifically criminal acts in Australia,<sup>93</sup> whereas at the time, they were tolerated if not legal in the Netherlands. The authors made the observation that if euthanasia could be classified as all cases in which death is "intentionally accelerated by a doctor", 30% of all Australian deaths would be in this manner compared to 16.6% for the 1995 Netherlands survey.<sup>94</sup>

The authors concluded that practice of PAD in Australia has not been stopped by the prohibition of the intentional termination of life, whether by act or omission.<sup>95</sup>

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<sup>89</sup> Mainly because the Australian study needed anonymous responses, as some questions regarding end of life issues were based on illegal practices in all of Australia apart from the Northern Territory. While the questionnaire was similar, there were no face to face interviews as in the Dutch studies.

<sup>90</sup> It has been suggested that the methodology used in this survey was confusing and should be viewed with caution: Somerville M.A., "Death talk: debating euthanasia and physician-assisted suicide in Australia", *Medical Journal of Australia*, Vol. 178 (August 2003), 171–174.

<sup>91</sup> From a list of 27,000 that had been extracted from the Australian Medical Masterfile Database (Australasian Medical Publishing Company, Sydney).

<sup>92</sup> *Id.*

<sup>93</sup> Apart from the limited circumstances then allowed under the *Rights of the Terminally Ill Act 1995* (NT).

<sup>94</sup> *Id.*

<sup>95</sup> Kuhse H. et al., "End-of-life decisions in Australian medical practice", *Medical Journal of Australia*, Vol. 166 (February 1997), 191–196, at 196.

## 7 Conclusion

Medicine is a science that today would be incomprehensible to Hippocrates when he penned his oath so many years ago. Traditional medical ethics, as well as medical law, are lagging behind the progression of both medical science and patient autonomy, when they should be ahead or at least abreast of medical practice so that the medical profession has standards it can follow rather than improvise. Medical professional bodies which set ethical standards, condone “passive” euthanasia or the withholding or withdrawal of medical treatment with the foresight that the patient will die, using the rationale that it was the disease not the arguable omission that killed the patient.

But the law also needs clarification. It would appear that the members of the Australian Federal Parliament, if not afraid of dealing with moral issues, were at least naïve or politically weak by their passing of the *Euthanasia Laws Act 1997* (Cth). Without any attempt to replace the system the RTIA implemented with another, they have failed to acknowledge that current law does not adequately address end-of-life issues and that PAD is already being practiced covertly and without adequate regulation. It is these issues and covert practices the RTIA within its own jurisdiction, at least in part, attempted to address.

Prospects of reform in Australia appear to be diminishing. At the last Federal election, a member of the *Family First* Party was elected to the Australian Federal Parliament’s Upper House, the Senate. The party, with its conservative policies has strongly opposed the legalisation of PAD, citing protection of the weak and vulnerable, and the unethical prospect of a doctor killing a patient.<sup>96</sup>

The Prime Minister, Mr. Howard, was recently reported as saying that “The Liberal Party does not have a party policy on euthanasia, it falls into that small category of issues where we allow a free vote. I certainly don’t intend to impose my view on anybody else...”<sup>97</sup> However, in the conscious vote for the *Euthanasia Laws Bill*, as Prime Minister he very publicly made it known that he would be voting for the Bill. Kevin Andrews who introduced the Bill has also had a steady rise up the government ranks and is now a senior government minister. While the government is circumspect, under the present leadership there appears to be little if any prospect of reform.

What is the current law in Australia? PAD is commonly recognised as being criminal while other acts or omissions at end-of-life are legal. Is this distinction readily discernable and is it reasonable? The medical profession is able to practice so as to commit an act with the potential intent of their patient’s death but are able to escape criminal liability if acting with lawful justification or excuse. That these acts or omissions by a doctor are legitimate forms of conduct, merely confirms that under the criminal law there is a particular defence peculiar to the medical profession. Otherwise, they would under general criminal principles be culpable of criminal

<sup>96</sup> [http://www.familyfirst.org.au/ffimages/File/Euthanasia%20Petition%20Web\(1\).pdf](http://www.familyfirst.org.au/ffimages/File/Euthanasia%20Petition%20Web(1).pdf) (accessed 11 May 2005).

<sup>97</sup> AAP <http://www.news.com.au/story/0,10117,15171079-421,00.html> (accessed 11 May 2005).

homicide. It is a defence not available to the public nor to the families or friends of loved ones.

In Australia, as in other common law countries, with the prohibition on intentional “mercy killing”, it remains a moot point if the legal introduction of PAD will be the start of the “slippery slope” towards an expansion of PAD to non-voluntary and then involuntary killing. But it is a basic argument for maintenance of the status quo. Manne believes

... once we agree to the principle of doctors performing voluntary euthanasia by what effort of societal will, on what rock of ethical principle, can we resist its extension to ever new categories of sufferers? There is no such will: no such fixed and reliable principle.<sup>98</sup>

On the other hand, there is sufficient evidence to assert that PAD, though currently illegal, is obtainable. The problem is mainly to access a doctor willing to participate in such an activity. Thus, declaring PAD illegal does not solve the problem. On the contrary, it implies that there is no regulation against mistake, incompetence or abuse.<sup>99</sup>

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<sup>98</sup> “The Slippery Slope is a Life and Death Argument”, *The Age*, 14 June 1995, at 18.

<sup>99</sup> The author would like to thank Professor Bernadette McSherry for her comments and assistance on an earlier draft of this paper.

# Assisted Dying: The View from the United Kingdom

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## 1 Introduction

Unlike some of its European neighbours, the law governing decisions at the end of life in the United Kingdom has not been subject to the vital, ongoing debates which have resulted in law reform in countries like the Netherlands and Belgium. Although there have been two major reports on assisted dying in the last 11 years, the law remains essentially static. However, this may yet change, following the House of Lords Select Committee Report on the Assisted Dying for the Terminally Ill Bill.<sup>1</sup> Although it is probably unlikely that law reform is on the cards, the recommendation from the Select Committee that an early opportunity to debate this topic should be found may at least permit the issue of assisted dying to reach the Parliamentary agenda.

At present, deliberate acts of euthanasia would be dealt with by the law of murder or manslaughter (culpable homicide in Scotland), while the provision of the wherewithal to commit suicide (often referred to as assisted suicide or physician assisted suicide) is criminalised by common law in Scotland and by the terms of the Suicide Act 1961 in England and Wales.<sup>2</sup> Prosecution of such cases is, however, relatively rare as is conviction, and, in what might be seen as a tacit critique of current law, sentences are generally light, even – interestingly – when the act is carried out by a non-healthcare professional.<sup>3</sup>

Where doctors are involved, convictions are unlikely, although not impossible. For example, in the case of *R v Carr*,<sup>4</sup> a doctor charged with attempted murder was acquitted after injecting a massive dose of phenobarbitone into a terminally ill

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<sup>1</sup> *Select Committee on the Assisted Dying for the Terminally Ill Bill*, HL Paper 86-I (April 2005).

<sup>2</sup> S. 2(1)

<sup>3</sup> See, for example, the cases of Brian Blackburn (<http://news.bbc.co.uk/1/hi/england/4174155> accessed 9 May 2005) and Brady ‘The Glasgow Herald’, 15 October 1996.

<sup>4</sup> (unreported) 1986

patient. In 1999, a Dr Moor admitted bringing about the death of some of his patients by giving them massive doses of painkillers. He was charged with, but acquitted of, murder.<sup>5</sup> Even when a conviction has been secured, such as in the case of *R v Cox*,<sup>6</sup> the sentence is generally light; in this case no custodial sentence was imposed and the doctor was admonished by the General Medical Council. Nonetheless, as the court said, '[i]f he injected her with potassium chloride with the primary purpose of killing her, of hastening her death, he is guilty of the offence charged.'<sup>7</sup>

The capacity of modern medicine to maintain life – irrespective of quality – has likely increased the incidence of people seeking a way out when pain and/or suffering become too great, or when loss of dignity becomes intolerable. Even although more attention has recently been paid to the provision of palliative care services, and much pain can be controlled, some people remain reluctant to experience the final indignities of their progress towards death; preferring the death itself. That they are currently unable to avoid these indignities has been described by Ronald Dworkin as 'a devastating, odious form of tyranny.'<sup>8</sup>

## 2 Is Assisted Dying Always Unlawful?

Not everyone, however, is forced to continue an unwanted life. Where a person has life-sustaining treatment which can be rejected, then they are permitted to choose to die. That the law respects patient autonomy over any concept of the sanctity of life was recently restated in the case of *Ms B*.<sup>9</sup> In this case, and against the judgement of her doctors, a competent woman was permitted to demand removal of the ventilator which was keeping her alive. Indeed, the doctors' failure to accede to her wishes in this respect motivated the court to impose a small fine – a most unusual event in cases involving clinical matters.

At present in the UK, a competent person who is physically or psychologically incapable of committing suicide (which is not a crime) cannot – unlike those who have life-sustaining treatment they can refuse – be provided with the means to end their experienced suffering; they cannot choose death. Strangely, this group of competent patients is probably the only group where decisions about achieving death with assistance are not legally permissible. In the case of disabled neonates, courts have routinely permitted the withholding of life-sustaining treatment, based on the decisions of third parties that their life is of insufficient quality.<sup>10</sup> Most recently, the High Court in England upheld the decision of a lower court that baby Charlotte

<sup>5</sup> Dyer, C., 'British GP cleared of murder charge' (1999) 318 *BMJ* 1306.

<sup>6</sup> (1992) 12 *BMLR* 38

<sup>7</sup> At p. 39.

<sup>8</sup> Dworkin, R., *Life's Dominion*, London, Harper Collins, 1993, at p. 217.

<sup>9</sup> *Ms B v An NHS Hospital Trust*, 65 *BMLR* 149 (2002).

<sup>10</sup> For an excellent discussion of these cases, see Mason, J.K., McCall Smith, R.A. and Laurie, G.T., *Law and Medical Ethics* (6th ed.), London, Butterworths, 2002, particularly chapter 16.



Wyatt should not be resuscitated should this be necessary to save her life. Although her parents maintain that Charlotte's condition is improving, her doctors believe that she is capable only of experiencing pain.<sup>11</sup> Indeed, in one case, even although it seemed possible that future treatment might be able to save the life of a child, a life of reasonable quality, the objections of the parents to the treatment prevailed.<sup>12</sup> This case is unusual, in that the trend has been to endorse medical opinion, which in this case was 'unanimous in believing that the chances of a successful transplant were good...'.<sup>13</sup> What these cases taken together show, arguably, is that UK courts are willing on occasion to see death, if not as a preferred option, at least as a legitimate one.<sup>14</sup>

Equally, in cases where the person is in a permanent vegetative state, decisions have held that treatment which could keep them alive for many years can be withdrawn. Perhaps the paradigmatic case in the UK was that of *Airedale NHS Trust v Bland*.<sup>15</sup> In this case, the House of Lords used a variety of devices to reach the conclusion that it was permissible to remove life-sustaining nutrition and hydration from a young man who was the victim of a crush injury in a disaster at a football stadium. The case is too well known to require extensive discussion, but suffice it to say that by and large the judges in the House of Lords reached the same conclusion from different approaches. For example, for some of Their Lordships, the critical question was whether or not assisted nutrition and hydration was medical treatment. For others, withdrawal of assisted nutrition and hydration was actually legally required, because to continue it without consent was effectively to assault the young man. Still others alluded to the distinction between acts and omissions. Although there are a number of counts on which it could be said that the judgement is flawed, it was recently endorsed in the case of *NHS Trust A v M, NHS Trust B v H*,<sup>16</sup> which further concluded that removal of nutrition and hydration did not breach the human rights of the patients concerned.<sup>17</sup> Indeed, removal of nutrition and hydration has even been legally endorsed in cases where patients did not satisfy the criteria for permanent vegetative state<sup>18</sup> laid down by the Royal College of Physicians.<sup>19</sup>

Again, it would appear, the clinical evaluation that life has no quality and/or should not be maintained is accepted by UK courts, even in the face of their

<sup>11</sup> <http://news.bbc.co.uk> accessed on 21 April 2005

<sup>12</sup> *Re T (a minor)(wardship: medical treatment)* (1996) 35 BMLR 63.

<sup>13</sup> Mason et al., at p. 486.

<sup>14</sup> For further discussion of this point, see McLean, S.A.M. and Elliston, S., 'Death, Decision Making and the Law', *Juridical Review* 2004, Part 3, 265–293.

<sup>15</sup> 12 BMLR 64 (1993).

<sup>16</sup> 58 BMLR 87 (2001).

<sup>17</sup> Although, as will be seen *infra*, this judgement in part at least has recently been doubted.

<sup>18</sup> Cases such as *Re D* 38 BMLR 1 (1997); *Re H* (adult: incompetent) 38 BMLR 11 (1997)

<sup>19</sup> 'The Permanent Vegetative State – Review by a Working Group Convened by the Royal College of Physicians and Endorsed by the Conference of Medical Royal Colleges and their Faculties of the United Kingdom' (1996) 30 *J R Coll Physicians Lond* 119.

purported endorsement of the sanctity of life and in the absence of a judgement by the patient concerned.

Moreover, competent patients can effectively make prospective decisions, which will be respected providing that their request was competently made and is applicable in the circumstances, even although they will be incompetent at the time their decision is given effect to.<sup>20</sup> These advance statements are respected as they are viewed as equivalent to a contemporaneous refusal of treatment which, as we have seen, is legally endorsed.

However, the lawfulness of choices for death has been proclaimed only where the cause of death can be categorised as an act rather than an omission. As there is no general legal duty to rescue, it is argued that although we are culpable for our acts we have no such liability for our omissions to act. In general this is true. However, it is also the case that, where there is an existing duty of care, the person owing that duty is technically as culpable for his/her omissions as for his/her acts. Thus, when a doctor is involved, for example, it is insufficient merely to declare something to be an omission as they clearly have a duty of care, which is assumed as soon as the professional relationship with the patient is formed. At least in theory, then, an omission to act could be culpable. However, the courts have also inquired further into this conclusion, and have asked whether or not it could be said that the doctor has a duty to provide (even life-sustaining) treatment.

In the *Bland* case, this question was primarily resolved by conceptualising the nature and extent of the doctors' duty in this respect as definable by what doctors themselves believed to be good medical practice. By categorising – in this case – assisted nutrition and hydration as medical treatment, the question as to whether or not it could be withdrawn became a matter for medical judgement. Quite apart from the question of whether or not it is appropriate to categorise life-sustaining provision of nutrition and hydration, or ventilation, as medical treatment, there remains the issue as to whether or not the alleged distinction between act and omission in these circumstances can or should be maintained.

The point is that, no matter whether the behaviour in question involves willed physical movement (an act), or the failure to continue treatment (an omission), its purpose and intention are to all intents and purposes on all fours. Although health-care professionals might argue that in removing or omitting treatment they do not intend death but merely foresee it, the foreseeability of the eventual death is – in layman's terms at least – virtually indistinguishable from intending that outcome. Indeed, this has recently been held to be the legal position in the criminal law.<sup>21</sup> So, the dubious distinction between acts and omissions seems to have been legally narrowed, if not removed, in general criminal law.

For those at the end of life, the significance of this is that when a currently lawful decision is taken to remove or withhold treatment the patient in fact is being

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<sup>20</sup> *C (adult: refusal of treatment)* 15 BMLR 77 (1994); *AK (medical treatment: consent)* 58 BMLR 151 (2001)

<sup>21</sup> *R v Woollin* [1994] 1 AC 82

assisted to die (whether or not they have requested this). Given this, there should be no distinction drawn between a death brought about by act and one brought about by omission. It can be concluded, therefore, that the apparent prohibition in UK law on assisting dying is partial, and the law is warped by the pretence that the two situations are different. Otlowski seems to agree, saying that ‘... the distinction between active and passive euthanasia and the underlying acts/omissions doctrine is most problematic and unsatisfactory... the distinction is of debatable moral and philosophical significance.’<sup>22</sup> Despite the apparent logic of this argument, it has yet to commend itself to UK legislators.

However, although likely to be appealed, a novel (to the UK at least) approach to treatment at the end of life emerged from the recent case of *R (Burke) v General Medical Council*.<sup>23</sup> In this case, Mr Justice Munby held that Article 3 of the European Convention on Human Rights (the right not to be subjected to inhuman or degrading treatment) could be engaged when it was proposed to withdraw or withhold assisted nutrition and hydration. For Munby, treatment could be degrading if it was perceived to be so by those close to the patient concerned, even if s/he was unable to experience it as such. This judgement flies in the face of the earlier case of *NHS Trust A v M, NHS Trust B v H*,<sup>24</sup> and – if this part of the judgement is not overturned on appeal – seems likely to have significant repercussions in the management of patients in a permanent vegetative state.

### 3 The House of Lords Select Committee on Medical Ethics 1994<sup>25</sup>

Before evaluating the recent House of Lords report on the Assisted Dying for the Terminally Ill Bill, it is interesting to consider the only other substantive Parliamentary report in this area. Noting that individuals are increasingly demanding respect for their autonomous decisions, and that this includes medical decisions,<sup>26</sup> the House of Lords Select Committee on Medical Ethics nonetheless drew the line at the right to exercise autonomy in certain decisions. This conclusion was substantially based on respect for the sanctity of human life:

Belief in the special worth of human life is at the heart of civilised society. It is the most fundamental value on which all others are based, and is the foundation of both law and medical practice. The intentional taking of human life is therefore the offence which society condemns most strongly.<sup>27</sup>

<sup>22</sup> Otlowski, M.F.A., *Voluntary Euthanasia and the Common Law*. Oxford, Clarendon press, 1997, at p. 12

<sup>23</sup> 79 BMLR 126 (2004)

<sup>24</sup> 58 BMLR 87 (2001)

<sup>25</sup> *Report of the Select Committee on Medical Ethics*, HL Paper 21-1, 1994

<sup>26</sup> p. 7, para 4

<sup>27</sup> p. 13, para 34

Further, the Report concluded that the prohibition of intentional killing

... is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia.<sup>28</sup>

And despite the argument that there is no relevant distinction between rejecting medical treatment and choosing death with assistance, the report concluded that '[t]he right to refuse medical treatment is far removed from the right to request assistance in dying.'<sup>29</sup> Considerable weight was placed on society's interest in the way in which autonomy is exercised and its effect on society:

... dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interests of society as a whole.<sup>30</sup>

Of course, it could be said, this argument about dying must apply to all deaths. That is, it is not *how* the death is brought about that matters, rather the *fact* of the death is what affects others. Yet, as we have seen, courts already allow certain deaths to be lawful; why, it must be asked, are they too not regarded as being the subject of the 'interests' of others? In any event, as Beauchamp and Childress point out, the rightness or wrongness of the action depends:

... on the merit of the justification underlying the action, not on the type of action it is. Neither killing nor letting die, therefore, is *per se* wrongful, and in this regard they are to be distinguished from murder, which is *per se* wrongful. Both killing and letting die are *prima facie* wrong, but can be justified under some circumstances.<sup>31</sup>

Interestingly, recently published research on the effect of death on relatives suggests that '[t]he family and friends of the patients who died by euthanasia had less traumatic symptoms than the group whose relatives died through natural causes.'<sup>32</sup>

Since the 1994 Select Committee Report was published, there have been a number of significant developments which affect the climate and context in which current law must now be considered. The first is the passing into UK law, by the Human Rights Act 1998, of the European Convention on Human Rights. The second was the case of *Pretty v United Kingdom*,<sup>33</sup> in which the implications of the Human Rights Act were carefully scrutinised. Both can usefully be considered together. It was anticipated by many that the incorporation of the Convention would see both a rise in litigation based on human rights and more respect for individual claims to have specific rights.

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<sup>28</sup> p. 48, para 237

<sup>29</sup> p. 48, para 236

<sup>30</sup> p. 48, para 237

<sup>31</sup> Beauchamp, T.L. and Childress, J.S., *Principles of Biomedical Ethics*, 4th ed., Oxford University Press 1994, at p. 225

<sup>32</sup> 'Euthanasia grief less severe', <http://news.bbc.co.uk> accessed on 14/94/05

<sup>33</sup> 66 BMLR 147 (2002)

In the domestic courts of England, Diane Pretty challenged the refusal of the Director of Public Prosecutions to guarantee immunity from prosecution to her husband should he assist her to die.<sup>34</sup> Mrs Pretty was in the final stages of motor neurone disease and wished to avoid the inevitably distressing and unpleasant death which results from that condition.

Having been unsuccessful in the domestic courts, she sought judgement from the European Court of Human Rights, basing her argument on a number of Articles of the Convention. First, she sought to argue that her Article 2 right (the right to life) was engaged. It was argued that the purpose of this Article was to protect individuals from the unlawful actions of third parties, but that it should also be interpreted as encapsulating freedom of choice. In her submission:

While most people want to live, some want to die, and the article protects both rights. The right to die is not the antithesis of the right to life but the corollary of it, and the state has a positive obligation to protect both.<sup>35</sup>

Mrs Pretty challenged the terms of the Suicide Act 1961, which in S 2(1) makes assisted suicide a crime in England and Wales as breaching her right to choose assistance in dying. However, the Court of Human Rights was unconvinced, saying:

It is not enough for Mrs Pretty to show that the United Kingdom would not be acting inconsistently with the Convention if it were to permit assisted suicide; she must go further and establish that the United Kingdom is in breach of the Convention by failing to permit it or would be in breach of the Convention if it did not permit it. Such a contention is in my opinion untenable. . .<sup>36</sup>

Mrs Pretty also sought to distinguish assisted suicide from euthanasia, but the Court held that ‘there is in logic no justification for drawing a line at this point.’<sup>37</sup>

The case then turned to Article 3 of the Convention. It was argued that

(1) Member states have an absolute and unqualified obligation not to inflict the proscribed treatment and also to take positive action to prevent the subjection of individuals to such treatment. . . .(2) Suffering attributable to the progression of a disease may amount to such treatment if the state can prevent or ameliorate such suffering and does not do so. . . .(3) In denying Mrs Pretty the opportunity to bring her suffering to an end the United Kingdom. . . .will subject her to the proscribed treatment. . . .(4) since. . . .is open to the United Kingdom under the Convention to refrain from prohibiting assisted suicide, the Director [of Public Prosecutions] can give the undertaking sought without breaking the United Kingdom’s obligations under the Convention. (5) If the Director may not give the undertaking, s 2 of the 1961 Act is incompatible with the Convention.<sup>38</sup>

However, the court held that the United Kingdom could not be said to be under an obligation ‘to ensure that a competent, terminally ill, person who wishes but is

<sup>34</sup> *R (on the application of Pretty) v DPP* [2002] 1 All ER 1

<sup>35</sup> *Pretty v UK*, supra cit, at p. 155

<sup>36</sup> At p. 159.

<sup>37</sup> At p. 156.

<sup>38</sup> At pp. 159–160.

unable to take his or her own life should be entitled to seek the assistance of another without that other being exposed to the risk of prosecution.’<sup>39</sup>

Attention then focussed on Article 8 of the Convention (the right to private and family life). The Court concluded in this case that even if Article 8 could be said to be engaged, the derogation possible under Article 8 (2) could be satisfied by the current legal prohibition of assisted suicide. As the Court said:

Article 8 protects the physical, moral and psychological integrity of the individual, including rights over the individual’s own body, but there is nothing to suggest that it confers a right to decide when or how to die.<sup>40</sup>

Mrs Pretty then sought to derive support for her argument from Article 9 – freedom of thought, conscience and religion. Generally, it must be said, freedom of religion is respected and claims based on this fundamental right are taken seriously. However, although Mrs Pretty was free to express her strongly held views on assisted dying, Article 9 did not entail ‘a requirement that her husband should be absolved from the consequences of conduct which, although it would be consistent with her belief, is proscribed by the criminal law.’<sup>41</sup> As in the domestic courts, Mrs Pretty’s arguments at the European Court of Human Rights were unsuccessful and, sadly, she eventually died the death she had feared.

#### **4 The Assisted Dying for the Terminally Ill Bill and the Select Committee Report<sup>42</sup>**

Despite current prohibitions in the UK, it is clear that patients continue to seek assistance in dying. Considerable evidence exists to suggest that people are indeed asking doctors for help, and that – despite the legal prohibition – some doctors are willing to assist their patients to die.<sup>43</sup> Moreover, in recent years, there have been reports of patients from the United Kingdom travelling to Switzerland to take advantage of the services of the right to die society DIGNITAS.<sup>44</sup> Equally, such opinion poll evidence as exists tends to suggest that the public (and even some healthcare professionals) are in favour of a change in the law.<sup>45</sup>

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<sup>39</sup> At p. 162.

<sup>40</sup> At p. 163.

<sup>41</sup> At p. 169

<sup>42</sup> *House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill*, HL Paper 86-I, 2005

<sup>43</sup> See, for example, McLean, S.A.M. and Britton, A., *Sometimes a Small Victory*, Institute of Law and Ethics in Medicine, University of Glasgow, 1996

<sup>44</sup> For a brief discussion, see ‘Swiss group “helped 22 Brits die”’, <http://news.bbc.co.uk> accessed on 14 April 2005; see also ‘Woman dies in assisted suicide’, <http://news.bbc.co.uk> accessed 9 May 2005

<sup>45</sup> Although it must be noted that the Select Committee’s own evidence suggested that existing evidence should be viewed with some scepticism.

It is against this backdrop that Lord Joffe introduced the Assisted Dying for the Terminally Ill Bill in the House of Lords in 2004. Based in large part on the Oregon legislation, the Bill is very tightly drafted to ensure that the availability of assisted suicide or euthanasia is closely constrained. Although not going as far as proponents of legalisation might have wanted, the Bill commanded the support of most of the pro-euthanasia lobby, which recognised it as a pragmatic compromise. The Bill

... provides for a competent and terminally-ill person who has reached the age of majority and who is suffering unbearably to request either assisted suicide or voluntary euthanasia. . . .the Bill provides for the requesting patient to sign a written declaration of intent and, if this has not been revoked within 14 days of the date on which the request was first made, to receive either the means to take his or her own life or, if the patient is physically unable to do that, to have his or her life ended through voluntary euthanasia.<sup>46</sup>

The Bill would permit a qualifying individual – that is someone ‘who has made a declaration in accordance with this Act that is for the time being in force, to die.’<sup>47</sup>

The ‘attending physician’, defined as the doctor with primary responsibility for the patient,<sup>48</sup> must be satisfied that the patient is competent, has requested to die, is terminally ill and suffering unbearably, and must have notified the patient of the diagnosis, prognosis, the process of assisted dying and alternatives, including palliation and hospice care.<sup>49</sup> The declaration must be witnessed by 2 people, one of whom is a qualified solicitor.<sup>50</sup>

Before assisting a person to die, the physician must inform the patient that s/he can revoke the declaration, ensure that the patient’s wish for assisted death remains in place and specifically ask whether or not the patient wishes to revoke the declaration.<sup>51</sup> A conscientious objection facility for doctors is contained in s 7 of the Bill.

The Select Committee was established following a decision in March 2004 to examine the Bill and report on its content.<sup>52</sup> It had the power to ‘decide whether the bill should proceed or not; and, if it is to proceed, the committee may amend the bill.’<sup>53</sup> The report, therefore, was not intended as a final judgement on legalisation; rather, it was to decide on the fate of this particular Bill, which shortage of parliamentary time meant would never become law. In establishing the Select Committee, the House of Lords ensured that the debate would not fall foul of time constraints; whatever its conclusions, at least consideration of the Bill’s underlying principles would be undertaken.

<sup>46</sup> *House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill*, HL Paper 86-I, 2005, At p. 15.

<sup>47</sup> S. 1 (1)

<sup>48</sup> S. 1 (2)

<sup>49</sup> S. 2

<sup>50</sup> S. 4

<sup>51</sup> S. 5

<sup>52</sup> Select Committee Report, p. 9, para 1.

<sup>53</sup> *Id.*

Lord Joffe's Bill is based fundamentally on the value to be attached to autonomy or self-determination; a principle now widely accepted as dominant in medical practice and medical ethics. Indeed, courts have expressly said that where there is a conflict between respect for autonomy and the sanctity of life, the former should prevail.<sup>54</sup> Thus, the sanctity of life principle respected by UK courts is what might be called a secular rather than a religious one.<sup>55</sup> Nonetheless, the House of Lords Committee was prepared to see self-determination as a concept which was susceptible of limitation, in that 'there must be some limits set, in the interests of the wider community, to what a patient can require his or her doctor to do. There is not consensus, however, on where those limits should be.'<sup>56</sup> Arguably, these limitations are, however, already defined by the cases which have already been considered: that is, people are already allowed to choose death (on my argument with assistance) because we respect their right to make autonomous choices independently of the views of others.

However, whatever I may claim for the extent of autonomy, it is clear that for the Select Committee a balance needs to be struck between the rights claimed by those who seek assistance in dying and others. In a statement which imports caution rather than clarity, the Select Committee talks of the need to use a 'cost-benefit analysis',<sup>57</sup> arguing that '[t]here is clearly a need to balance the interests of terminally-ill people who wish for assistance to end their lives against those of patients who do not.'<sup>58</sup> This, however, is an arguable proposition, as it is unclear why – unless they endorse the slippery slope argument – the two sets of interests require juxtapositioning at all. There is no evident logic in the assumption that permitting one group of people to exercise their own choice will necessarily affect those who do not wish to make that choice. Indeed, Dworkin has described slippery slope arguments as 'very weak' and as only 'disguises for deeper convictions that actually move most opponents of euthanasia.'<sup>59</sup>

Nonetheless, it seems that the slippery slope argument did carry some weight with the Committee. Describing it in terms of a 'paradigm shift' argument, their language is essentially equivalent to the slippery slope:

The essence of the concern here is that, if assisted suicide and voluntary euthanasia should be legalised and if implementation of the law were to be carried out within the health care system, these procedures will of necessity become a therapeutic option; that over time there will be drift from regarding the death of a patient as an unavoidable necessity to regarding it as a morally acceptable form of therapy; and that pressure will grow as a result for euthanasia to be applied more widely – for example, to incompetent people or to minors – as a morally acceptable form of medical therapy which is considered to be in the patient's best interests.<sup>60</sup>

<sup>54</sup> See, for example, Lord Donaldson in the case of *Re T (adult: refusal of treatment)* [1992] 4 All ER 649.

<sup>55</sup> For further discussion, see McLean and Elliston, *Death, Decision Making and the Law*.

<sup>56</sup> p. 26, para 62

<sup>57</sup> p. 27, para 67

<sup>58</sup> *Id.*

<sup>59</sup> Dworkin, R., 'When is it right to die?' *New York Times*, 5 May 1994

<sup>60</sup> p. 40, para 102



Consideration was also paid to the difference between acts and omissions which has formed a central plank of the current legal position, and – quite specifically – to its evaluation in light of the views of healthcare professionals:

We recognise that, from the patient’s point of view, refusing life-prolonging treatment may appear little different from seeking assisted suicide or euthanasia. But we recognise also that there is a clear difference between the two situations from the point of view of the physician, mainly because the intention in the former case is not to bring about the death of the patient, whereas that is indisputably the intent in the case of assisted suicide . . . there is consensus among us that, in the last analysis, the acceptability or otherwise of the Bill is a matter for society as a whole. Having said that, we recognise also the crucial role which doctors would have to play in the implementation of the Bill, were it to become law, and that the views of the medical and nursing professions must be considered very seriously.<sup>61</sup>

Interestingly, this emphasis on the views of the professionals reflects the concerns of the deliberations of the Select Committee in 1994, which said:

Some people may consider that our conclusions overall give too much weight to the role of accepted medical practice, and that we advocate leaving too much responsibility in the hands of doctors and other members of the health-care team. They may argue that doctors and their colleagues are no better qualified than any other group of people to take ethical decisions about life and death which ultimately have a bearing not only on individual patients but on society as a whole. But no other group of people is better qualified to do so . . . By virtue of their vocation, training and professional integrity they may be expected to act with rectitude and compassion.<sup>62</sup>

Further, the recent Select Committee report said:

It might perhaps be argued that the case of withholding or withdrawing treatment is more open to question because the patient’s consent to such action is not required if the treatment is deemed futile or burdensome. But here too most of the medical practitioners whom we questioned saw a clear difference between withholding or discontinuing life-prolonging treatment considered to be futile – and often burdensome to the patient – and taking action specifically to end his or her life.<sup>63</sup>

Two things need to be said about this substantial concern for the views of healthcare professionals. First, that although the recent Select Committee regards the decision on legalisation as being one for the public, both Select Committees placed what could be argued to be unreasonable or unjustified emphasis on the attitudes of healthcare professionals. While nobody can seriously doubt that their views should be taken into account, the question of the legalisation or not of assisted dying is neither a matter of medical ethics nor the sole domain of doctors and nurses. Although the 2005 Select Committee does not argue that their views should predominate, the traditional respect in which doctors in particular are held may – inadvertently or not – lead to an over-emphasis on their preference for categorising acts and omissions as different from each other, and serve to maintain the fiction that a difference between foresight and intention can be established. In any event, in the *Bland*

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<sup>61</sup> p. 27, para 64

<sup>62</sup> p. 56, para 272

<sup>63</sup> At p. 23

judgement, Lord Mustill expressed his distaste for using the acts and omissions distinction, saying:

The acute unease which I feel about adopting this way through the legal and ethical maze is I believe due in an important part to the sensation that however much the terminologies may differ, the ethical status of the two courses of action is for all relevant purposes indistinguishable. By dismissing this appeal I fear that your Lordships' House may only emphasise the distortions of a legal structure which is already both morally and intellectually misshapen.<sup>64</sup>

Additionally, Otlowski has said that '... the distinction between active and passive euthanasia and the underlying acts/omissions doctrine is most problematic and unsatisfactory ... the distinction is of debatable moral and philosophical significance.'<sup>65</sup> Despite concern about the actual applicability of this doctrine, however, it seems that it carried considerable weight with both Select Committees.

Second, it is increasingly unclear just what the views of healthcare professionals are. Although the Select Committee received evidence from the Association of Palliative Medicine that of the 84% of its members who responded to a survey, 72% indicated that they would not participate in 'a process of patient assessment which formed part of an application for assisted suicide or voluntary euthanasia. . . .',<sup>66</sup> this is by no means representative of increasing evidence that healthcare professionals are less clear than previously as to their approach to legalisation. Indeed, given the nature of the specialists involved in this survey, it might have been surprising had the conclusion been any different, but this group cannot be taken as representative of healthcare professionals as a whole. Indeed, although not endorsing law reform the Royal College of Physicians and the Royal College of General Practitioners adopted a neutral position; a significant deviation from the outright hostility to law reform which could confidently have been anticipated in the past. Thus, even if considerable emphasis is to be placed on the views of healthcare professionals, it is unclear that this would result in denial of the rights of patients to make a choice for assisted death.

Perhaps more serious criticism of the Bill comes from the evidence of experts as to its precise terms. S.1 of the Bill, for example, indicates that assisted dying should be available on request for those who suffer from a terminal illness. 'Terminal illness' is said to be an illness 'which in the opinion of the consulting physician is inevitably progressive, the effects of which cannot be reversed by treatment (although treatment may be successful in relieving symptoms temporarily) and which will be likely to result in the patient's death within a few months at most. . . .'<sup>67</sup> In Lord Joffe's Bill, the nature and likely duration of the illness is central to the right to obtain assistance in dying. However, as the Select Committee notes, '[t]he evidence which we have taken from medical practitioners suggests that the prognosis of a

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<sup>64</sup> At p. 132

<sup>65</sup> Otlowski, M.F.A., *Voluntary Euthanasia and the Common Law*, Clarendon Press, Oxford, 1997 p. 12.

<sup>66</sup> p. 44, para 116

<sup>67</sup> S. 1(2)

terminal illness is far from being an exact science.’<sup>68</sup> Additionally, ‘[i]t is, we were told, even more difficult to forecast the course of degenerative disease (such as motor neurone disease, multiple sclerosis, heart disease or emphysema) than of malignant conditions such as cancer.’<sup>69</sup> The Select Committee, therefore, proposed that any new Bill introduced to Parliament should include a definition of terminal illness that is ‘based on the realities of clinical practice and is sufficiently precise in terms of the exception to the general law which it is proposing in order to ensure proper protection for those who may make use of it.’<sup>70</sup>

Concern was also expressed about another qualifying condition; that is the need for the patient to be competent to make such a decision. Whereas doctors seem relatively unconcerned about taking responsibility for adjudicating on competence in other situations:<sup>71</sup>

There was a general consensus among our expert witnesses on one point – that the attending and consulting physicians who are envisaged as being effectively the ‘gatekeepers’ in regard to applications for assisted dying could not be expected to spot impairment of judgement in all cases.<sup>72</sup>

On this question, the Select Committee recommended that any future Bill should consider including ‘a requirement for any applicant for assistance with suicide or voluntary euthanasia to be given a psychiatric assessment.’<sup>73</sup> These two concerns are not without merit, but it should be noted that they go to the practicalities and language of legislative change rather than to the underlying principles which might inform it. Indeed, evidence suggests that neither of these have proved insurmountable objections to the law apparently working in other jurisdictions.

The Select Committee also turned its attention to the need to demonstrate ‘unbearable suffering’. ‘This’, according to the Select Committee, ‘is undoubtedly the most difficult of the qualifying conditions to define.’<sup>74</sup> Although the difference may be subtle – perhaps meaningless – the Committee suggests that it may be preferable to consider using words such as ‘unbelievable’ or ‘intractable’ instead of ‘unbearable’.<sup>75</sup>

As we have seen, the Bill as it currently stands requires that information about – amongst other alternatives – palliative care is provided to the patient. The Select Committee placed considerable emphasis on the availability of alternatives to assisted dying, and were particularly concerned that there should be a real possibility of having access to palliative care, rather than information as to its availability simply amounting to empty rhetoric which would accompany the limited availability

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<sup>68</sup> p. 44, para 118

<sup>69</sup> p. 45, para 120

<sup>70</sup> p. 85, para 251

<sup>71</sup> For example, in respect of young people.

<sup>72</sup> p. 47, para 126

<sup>73</sup> p. 86, para 254

<sup>74</sup> p. 86, para 255

<sup>75</sup> p. 87, para 256

of such services. The conclusion, therefore, was that ‘If...a future bill is to be able to claim with credibility that it is offering assistance with suicide or voluntary euthanasia as complementary rather than as an alternative to palliative care, it may need to find a way of resolving this dilemma’.<sup>76</sup>

The Committee also considered the possibility of imposing a waiting period before a declaration can be acted on,<sup>77</sup> and proposed that the conscientious objection clause should be extended to all members of the healthcare team that would be involved, including pharmacists.<sup>78</sup>

Finally, it should be noted that Lord Joffe’s Bill seeks to legalise both assisted suicide and voluntary euthanasia. Fears of possible widespread use of these proposed rights form part of the platform of those who oppose legalisation. Experience elsewhere has unsurprisingly shown that the number of people receiving assisted dying will vary according to what is permissible. Thus:

In Oregon, in 2003 [where only assisted suicide is legalised], one in 714 deaths resulted from assisted suicide. In The Netherlands [where voluntary euthanasia is also allowed] in the same year one in 38 of those who died did so via either assisted suicide or voluntary euthanasia, mainly the latter (the figure is 1 in 32 if cases of euthanasia without explicit request are included).<sup>79</sup>

As the Select Committee said:

It seems clear...that the demand for assisted suicide or voluntary euthanasia, if measured in terms of the numbers of applicants, will vary according to what the law permits.<sup>80</sup>

However, no matter how sensible this conclusion seems at first sight, it also ignores the level of assisted dying (whether by euthanasia or assisted suicide) that occurs in countries where theoretically both are illegal. In other words, the law may contribute to the numbers of those dying with assistance, but it will not prevent it occurring even where it is prohibited. However, the Select Committee recommends that if a subsequent Bill is brought before Parliament, it should ‘distinguish clearly between assisted suicide and voluntary euthanasia and thereby give the House the opportunity to address these two courses of action separately, as the considerations involved in each are very different.’<sup>81</sup>

Other concerns about the terms of the Joffe Bill outlined in the Select Committee Report revolved around the evidence offered by research which seems to suggest that a majority of people in the UK would support legalisation. For the Committee:

Parliament must obviously weigh public opinion very carefully in an issue of this nature. But we suggest that, as with other controversial issues...it must also assess to what

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<sup>76</sup> p. 88, para 258

<sup>77</sup> p. 88, para 259

<sup>78</sup> p. 89, para 262

<sup>79</sup> p. 49, para 131

<sup>80</sup> p. 49, para 132

<sup>81</sup> p. 84, para 246

extent opinion research based on answers to questions placed with little surrounding context represents a sound basis for changing the law.<sup>82</sup>

This comment is a reflection of the conclusions of a review of past research commissioned by the Select Committee from Market Research Services (MRS), which concluded that ‘virtually all the surveys which had been carried out... were quantitative rather than qualitative.’<sup>83</sup> Thus, in the MRS’s view, these results may be considered as ‘one-dimensional’.<sup>84</sup> Arguably, however, whether or not quantitative research is in fact as limited as they suggest must be moot.

## 5 Conclusion

The debate on Lord Joffe’s Bill is undoubtedly to be welcomed, as is the balanced – some might even say rather bland – report from the Select Committee. It is speculative, but scarcely surprising, that the Committee was deeply divided on the merits of legalisation, yet it was clearly unprepared to block genuine, intelligent debate on the subject. Indeed, perhaps the most significant of the Committee’s recommendations is that ‘we consider that the appropriate course for us to take is to present a balanced account of the evidence we have received; to recommend that an early opportunity should be sought for our report to be debated by the House...’<sup>85</sup>

However, it can also be said that the recent Report takes us very little further than did its predecessor. Each restates, without profound analysis, the value of the sanctity of life, and each gives considerable weight to the concerns of healthcare professionals rather than those individuals who seek assistance in their dying. In particular, inadequate attention is paid to the legal inequalities – some might say iniquities – which permit assisted dying in a range of circumstances at present, while at the same time denying it when a competent request for assistance is made.

However, it must also be said that Lord Joffe’s Bill itself represented a compromise; one which in part facilitated the critiques levelled at it by the Select Committee. That is, in seeking to ensure that *some* progress in this area was made, the Bill tried to cover every eventuality, and to circumscribe what may be done, so much so that many of the criticisms or proposals of the Select Committee are in fact targeted at the *constraints* rather than the *permissions* contained in the Bill.

In the UK, division over this issue is more than likely. Moreover, few politicians have been prepared to raise their heads above the parapet and declare their support for legalisation of assisted suicide and/or voluntary euthanasia. Only the Liberal Democrat party (in England and Wales) has been prepared to make a commitment to legalisation in their manifesto, and a Liberal Democrat Member of the Scottish

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<sup>82</sup> p. 82, para 240

<sup>83</sup> p. 75, para 217

<sup>84</sup> Id .

<sup>85</sup> p. 81, para 235

parliament is reportedly intending to introduce a Bill to the Scottish Parliament in the near future.

In all, the exercise conducted by the Select Committee was interesting, but makes little progress. However, what it does achieve is to give its imprimatur to a Parliamentary debate on the future on this most sensitive and contentious of areas.

**Part III**  
**Physician-Assisted Suicide – Narratives**  
**from Professional and Personal Experience**

# Physician-Assisted Suicide: A Doctor's Perspective

Pieter Admiraal

In order to explain how I became involved with physician-assisted suicide and euthanasia in the Netherlands, I shall first tell you about my professional life as an anaesthesiologist in the Reinier de Graaf Hospital in Delft.

More than 40 years ago, I realised that even anaesthesiologists had hardly any knowledge about pain treatment. In those days morphine-like drugs were only used by us in cases of severe postoperative pain and, as we know now, mostly in insufficient low doses and with far too long intervals. The administration of morphine to cancer patients was restricted by doctors but in daily practice seldom done. There were three main reasons for that practice:

1. Patients in those days did not know that they had cancer. A good doctor would not tell a patient what the diagnosis was because cancer was almost incurable at that time and the diagnosis was like a death sentence. Furthermore the doctor thought that the patient could not cope with the truth.  
For the same reason it was not told to a patient that morphine had to be used because that confirmed the diagnosis of cancer, leaving the patient without any hope.
2. Everyone was convinced that the use of morphine, even during a very short period of time, made a patient dependent on and addicted to morphine. This was due to the fact that every patient who was treated with an insufficient dose of morphine, which was prescribed only once a day as a drink or as a powder, was unsatisfied about the result and consequently asked for more, and that was seen as an addiction!
3. Administration of morphine via injection was only used in the very last stage when the patient was suffering unbearably.

As a result, a lot of these exhausted patients died after such an injection which was in fact the reason that most patients and doctors feared the use of morphine and viewed it as a form of euthanasia.

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In the early 1960s, a new type of anaesthesia was introduced in Europe: neuroleptanalgesia, using high doses of a tranquilliser and a new very potent morphine-like drug. For that reason anaesthesiologists learned a lot about the pharmacology of morphine and morphine-like drugs and how to use these in a better way for pain treatment.

The next, very important, step in those years was the introduction of new morphine-like drugs which could be taken orally. Now, efficient pain treatment was also possible for outpatients: they could take their painkiller at prescribed times making them independent from their family doctor, who otherwise had to visit them at home to administer the morphine. And so, instead of getting one injection a day, patients could take their medication up to several times a day.

By the way, even back then I wondered about the fact that doctors tended to prescribe their medications "3 times a day". It was common practice, both in the hospital and at home, that medications were at 8 at 12 and at 18 o'clock: in other words, the time when patients ate their meals. The interval between these times is respectively 4, 6 and 14 hours! No wonder those patients with severe pain woke up in the middle of the night. It took me a lot of time to arrange that medications are prescribed today at fixed hours: 8, 15 and 23 o'clock.

A few anaesthesiologists in our country became specialised in pain treatment. They realised that morphine or morphine-like drugs are best used in a later stage for cancer patients, they realised that addiction is non-existing among cancer patients and they also realised, together with other doctors involved in palliative care, that a patient has the right to know his diagnosis. It is regrettable, but I have to state that even today in several civilised countries, including Germany and the USA, morphine is still not accepted by doctors as the best drug to stop pain in cancer patients.

During those years, I was more frequently consulted to treat the pain of the cancer patients in our hospital in Delft, and within short time we decided to organise palliative care. In 1968, we visited Cecily Saunders in the St. Christopher's Hospice in London. She was one of the first to promote a good pain treatment as an important part of palliative care. All her terminally ill patients were in the same department and they witnessed the dying of other patients. We, in Delft, made other choices: we integrated palliative care in different departments of our hospital. As soon as necessary, a dying patient got his own separate room with an extra bed for their partner and other facilities for family to stay in the hospital, day and night.

We realised from the beginning that the best way to care for a cancer patient, with all his specific physical and psychological problems, is by a team of nurses, doctors and clergymen. Within a short time we realised also that it is impossible to stop suffering in all cases or to make unbearable suffering bearable, despite all our efforts. It is extremely difficult for a dedicated team, to speak about that fact to accept it and not to deny it as others still do.

After long emotional discussions, we came to the conclusion that euthanasia could be the last dignified act of terminal care. In other words: no euthanasia without palliative care and no palliative care without the possibility of euthanasia.

Our first act of euthanasia took place in 1969 after we decided that euthanasia only could be done if all members of the team in our hospital agreed. Our primary thoughts about doing palliative care and euthanasia were:

- respect for the humanity of life and death,
- respect for the self-determination and the self-responsibility of the patient towards life and death,
- respect for the conscience of every caregiver,
- respect for the law.

Our central concerns were

- that good information was given by doctors and nurses and a good recording of this information,
- the best nursing care, or as Florence Nightingale once said: “Nurse the sick one, not the sickness”,
- the best possible treatment of pain and anxiety, leaving intact spiritual consciousness,
- to refrain from futile prolonging of life or experimental treatment, including the decision made with the patient, if possible, not to resuscitate,
- to support the family and to offer them adequate privacy, and to facilitate the possibility of dying at home.

The open debate about euthanasia in our country started after the first court case in 1972 and I was very involved in advocating the possibility of physician-assisted suicide and euthanasia.

In 1980 I published, as the first in medical history, “Justifiable Euthanasia”, a guideline about the use of drugs for euthanasia. This brochure was sent by the Dutch Voluntary Euthanasia Society to all doctors and pharmacists in our country. Our Royal Dutch Medical Association agreed with the possibility of euthanasia under strict conditions in 1985.

In 1986, after having become a member of the Euthanasia Committee of our Health Council to advise our Ministry of Health, I became member of a working party of the Royal Dutch Association for the Advancement of Pharmacy to publish official guidelines for doctors and pharmacists how to use and to prepare euthanatic drugs. The official definition of “euthanasia” in the Netherlands was published in 1985 in a Report of the Dutch Government Commission on Euthanasia: “a deliberate termination of an individual’s life at that individual’s request, by another”. This means in today’s practice the active and deliberate termination of a patient’s life on that patient’s request, by a doctor. Euthanasia was legalised in 2002. Under current law in the Netherlands, the law only accepts euthanasia by a physician if the suffering of a patient is unbearable and cannot be stopped in any other way.

What is suffering and what makes suffering unbearable? Suffering is specific to each human being. Only someone who is conscious and capable of deliberate retrospective and prospective contemplation can suffer. So, the person who suffers

compares, weighs and evaluates life in the past and in the future. He knows that death within a short time is certain, he knows that he has to go his way alone and that nobody can stop the dying process. Suffering is strictly individual and determined by the psychological tensions and inner recourses of the individual in enduring his condition.

However, the suffering of others is largely outside our comprehension and difficult to judge. We have to try to understand the suffering of another based upon our close observations and leaving aside our own emotions as far as possible. It takes many years of experience with palliative care to be as fair as possible in our judgement. In any event, we must seriously ask ourselves from where comes the authority to judge the suffering of another to be bearable when that individual tells us that it is not?

Hearing young doctors of hospices say that they can stop all suffering always astonishes me. And not only young doctors. Let me quote Dame Cicely Saunders, mother of the hospice movement and leading example for most hospices today. In 1988 she said about spiritual pain: "Sometimes unrealistic fears can be explained and eased, but a good deal of suffering has to be lived through. The very pain itself may lead to resolution or a new vision as it came to Job", and, further, that "our vision is of God's sharing with us all in the deeper way still with all the solidarity of His sacrificial and forgiving love and the strength of His powerlessness". It was not the first time in my life that I realised that you could be almighty and powerless at the same time. The words of Saunders reflect the Christian view of herself and others about life, death and suffering. These people believe, and want to accept, that God preordains all their suffering: He can give life and He can take life.

To request euthanasia is, on this view, a blasphemy, and we have to respect that view. But, at the same time, we are aware of the fact that there are millions of terminally ill patients in the world today, including Christians, with a totally different view. And no one in the world can make a judgement on that view or about my own humanistic view about life and death.

Suffering can be the result of physical and psychological causes, which are closely related to each other. Physical causes are:

- A serious loss of physical strength, especially in the end-stage of cancer. It makes the patient no longer capable of any physical exertion and makes him totally dependent on nursing care day and night.
- The loss of physical strength leads to extreme fatigue, even without any physical effort at all.

Both these symptoms are common and experienced as exhausting, there is no therapy to stop these problems.

- Less common, but often experienced as serious problems are shortness of breath, sleeplessness, nausea, thirst, constipation, hiccupping, perspiration, itching, coughing, bedsores, etc.
- Incontinence of urine or faeces is experienced as humanly degrading.

- Our therapeutic action can cause serious side effects, last but not least: pain.

Is it not true that pain is an essential part of suffering? Yes, it is. Until recently pain was the most important cause of physical and psychological suffering in the Western World. Most patients base their image of this kind of pain on hearsay or accounts from others and this information gives reason enough for the fear of such pain and for the identification of cancer with a specific type of pain, the so-called “cancer pain”. Is this justified? In my opinion definitely not!

Of course there are important psychological differences between pain encountered in normal life and pain of a malignant origin. One of them is fear. Every moment you feel pain it reminds you that you have cancer, every time that pain becomes worse you have the fear that the cancer is growing and every time you feel pain in another part of your body you have fear of metastases.

This fear can make you anxious or even depressed. So, “cancer pain” stands for real pain combined with fear, anxiety, depression, sorrow, fatigue, etc.

It would be most desirable if doctors would speak about cancer and about pain as two separate elements. “Pain” related to fear, depression and sorrow should be recognised as a signal indicating shortcomings in meeting the patient’s needs. This “pain” can be treated with better human and emotional support and proper medication. “Real” pain can be the direct result of the growing tumour and its metastases or the indirect result of the disease or even of the therapy.

The intensity of this pain can vary from mild to agonising, but it can be treated like all other pain.

Today this is possible in several ways: the administration of non-narcotic analgesics in the early stages of the cancer and adequate administration of morphine-like drugs in combination with neuroleptics at a later stage.

In some cases one has to administer morphine-like drugs continuously to the spinal cord or to block the nervous input. In our country, this technique is practised by anaesthesiologists.

In some cases one may be compelled to administer morphine, neuroleptics, or sedatives on a continuous basis in such high doses that it has serious effects on the psychological functioning of the patient. Sometimes the patient will be kept unconscious prior to dying, the so-called “terminal sedation”. Some doctors and nurses believe that the use of high doses of morphine by itself is euthanasia. This is not correct. In this extreme situation, morphine even prolongs life.

By the way, opponents always said that if you stop the pain a patient would never ask for euthanasia. But now they know better.

Unfortunately, the above mentioned methods of controlling pain are not yet known or applicable all over the world and so the pain of millions of cancer patients in the Third World is rarely treated if at all.

Psychological causes are:

- Psychological suffering as a result of the described somatic problems can become a burden. Many problems last during an extended period of the illness and almost all of them get increasingly worse often up to the time of death.
- Anxieties. Almost every patient is plagued by anxiety in the course of his illness.

- The fear of pain has been discussed earlier.
- The anxiety about spiritual and physical deterioration and deformation.
- The anxiety to become totally dependent on others.
- The anxiety about dying itself and what may come after death is culturally and religiously determined. Furthermore this can range from the acceptance that there is nothing more after death or a vague anxiety about the unknown to a literally deadly fear of eternal punishment.

On the other hand, many persons die in the firm conviction of another, blessed life, united with those who went before.

**Grief.** Though we all realise that death is inescapable and part of life, the certainty of the approaching end of our lives makes us sorrowful. Especially in the beginning, it often happens that the patient, his family and his friends hide their grief from each other. Grief is then bottled up and becomes sorrow. It would be better to listen and to give each other the possibility to cry out one's feelings. Mutual understanding makes sorrow less serious. Grief can be unbearable when a patient is left alone. Grief becomes bitter when the patient asks the question of why it happens to him, who does not deserve it, and why it happens now at this point of his life. Such a grief can easily turn into feelings of rancour, revolt and aggression. There can also be grief about the grief about others or about the future of those left behind. Such grief makes the patient feel depressed. This all can lead to feelings of isolation and loneliness, especially when a patient at home has his own room with his family sleeping in another room. Nights can be very long, silent and dark under these circumstances. Even a mild pain is sufficient to keep him awake and to become a burden.

**Dignity of life.** Each person, and certainly patients with a terminal disease, has her or his own feelings about human dignity, influenced by society, culture or religion. In a civilised world we all try our best to protect and respect the dignity of others and we see this respect as being a natural human right. We regard it also as a right to consider for ourselves our own human dignity and expect others to respect that. As competent persons, we do not expect others to make decisions about our own dignity. There are many reasons for a patient to judge his life as inhumane and these reasons are strictly individual. What is acceptable for one person may be unacceptable for another person. And again we have to respect the view of the patient. We are only observers.

**The meaning of suffering.** Many patients, in fact, regard their suffering as meaningless. They cannot find any reason to continue to live in their own specific circumstances – not for themselves and not for others. In our country, even most Christians regard suffering as senseless.

**The longing to die.** Many patients who have arrived at the point of total acceptance and acquiescence in their fate may no longer attach any value to their life, their relatives and friends and their world. In other words, they reach a state of total detachment – something that is especially difficult for relatives and caregivers to understand and to accept. These patients long for an early, gentle death: death as a deliverer. They regard any hesitation from others in fulfilling their wishes to die as

unjustified and as a denial of their last wish. Family doctors and nurses are hesitant because they do not understand this detachment.

As far I know, I am the only one who writes and speaks about this longing for death, which is, in my opinion, a normal part of human life, a fact which one can overlook but not deny. The opponents of euthanasia say that every human being has only one wish: to survive and to live. So if a patient asks to end his life there can be only one explanation: she or he must be very depressed. And, indeed, these doctors prescribe anti-depressant drugs in high doses. But, in my opinion, these doctors are unobservant and seem to be more preoccupied with their own concerns than with serving the needs of their patients. To send a terminally ill patient to a psychiatrist is an insult.

**Last but not least.** Suffering may also include the essential human characteristics of hope, acquiescence and acceptance.

All this physical and psychological problems can make suffering unbearable for a patient. The best way to help patients in this situation is palliative care by nurses, doctors and clergymen.

What role should they play?

**The Nursing Staff.** In dealing with patients who may request euthanasia, they are in a key position, they are the most important figure in daily care. Behind curtains and unobserved they have the most direct emotional verbal contact. If the patient wants to discuss his condition, the nurse is around more than anyone else. Their information remains noncommittal, allowing the patient to question everything he may be afraid of, because their answer may be less threatening than from a doctor. A nurse can be the all-important liaison between patient and doctor. To do so, they must be able to take their time to listen; to encourage the patient to fully express his feelings; to provide a homelike environment for the patient and his family; not to give up on a patient and to allow a patient to die his own way.

**The Doctor.** He is the one whose help was sought by the patient and in whom the patient has put his trust. He has told the patient the truth about the diagnosis, the prognosis and about the possibilities we have for therapeutic or palliative treatment and the results of pain treatment. The basis must be a good relationship with the patient and his family. Only wearing a white coat does not make a doctor.

The most concise and telling definition of a physician is: "the doctor is not for the dying". Indeed, incredible as it may seem, the word "dying" does hardly fit into medical jargon. Even today, the aspects of dying are at no time seriously dealt with in medical teaching. More absurd still, even the psychology of the sick or dying person has hardly received much attention until now. This fact is far from surprising: the primary duty of a doctor is to preserve life and to fight death day and night. That seems to be in conformity with the Oath of Hippocrates. In fact, the very point of the view of Hippocrates was that it is the interest in the patient that is of supreme importance. And it is the terminal patient who expects the doctor to be available with the best of his knowledge and abilities and, when the worst comes to the worst, not to fail him by saying: "I cannot do anything for you anymore". A dying patient is begging for help along the final and often long leg of the road he will have to travel. Help in the face of death ought to be peaceful, mild and good

through euthanasia as the last final dignified act. In our country, the responsibility to do euthanasia lies completely with the doctor, after consultation with another independent doctor.

**The Clergyman.** In my opinion, a clergyman has to participate in attending a terminal patient and to contribute to the decision-making. They have to be fully informed about the patient's condition to be able to share the fears and hopes of the patient.

**The Family.** They can be seen as members of the team: Their spiritual input is unique and irreplaceable during the last weeks and days. The family suffers with the patient, and it is clear that, during the terminal phase, they ask themselves how much longer it will last and an eventual request for euthanasia from their side is understandable. However, their request will never play a role as long as the patient can ask for it.

Today, every person in the Netherlands has the indisputable right to self-determination and the right to judge his suffering as unbearable. In that case he has an indisputable right to ask for euthanasia. Doctors all over the world must have the authority to end suffering by euthanasia.

And doctors must have the indisputable right to refuse.

Why do patients in our country ask for euthanasia and what is the role of doctors confronted with these requests?

In 2003, Gerrit van der Wal et al. published "Medische besluitvorming aan het einde van het leven" (Medical End-of-life Decisions), a report about euthanasia and other medical decisions at the end of life during 2001–2002 in the Netherlands. The same had been done before in 1990–1991 and in 1995–1996. These investigations were made on the request of the Ministry of Justice and the Ministry of Health in co-operation with the Royal Dutch Medical Association. The Report has 272 pages, so I will only summarise the most important results.

We have a Population of 16 million, and 140.400 will die each year of which 4.720 (3.4%) die as a result of euthanasia; from these, about 80 % have cancer. The most important reasons mentioned by patients who ask for euthanasia are:

meaninglessness of suffering	65%
loss of human dignity	44%
fear to lose dignity in a short time	35%
extreme fatigue	43%
being totally dependent on others	33%
pain	29%

In my opinion, these figures confirm the importance of the physical and psychological reasons of suffering. Senselessness and loss of dignity are the most relevant reasons, pain is seldom the only reason to ask for euthanasia.

The results concerning terminal sedation are different. The percentage is 12%, almost 4 times that of euthanasia. The reasons here are:

pain	54%
restlessness	43%
shortness of breath	30%
anxiety	12%

From the Report it can be estimated that of all cancer patients about 10% die with euthanasia and that with about 20% of them pain will be a reason to end life or to use sedation.

Euthanasia is a word burdened with reminiscences and, because of the madness originating in the perfidious mind of Hitler and his criminal cronies, associated in people's minds with the senseless murder of innocent victims. It explains the fear of some that euthanasia will be applied to mentally disintegrated patients and others.

I can understand this fear, and so we have to define our aims and our thinking today in order to prevent any possibility of misuse in the future. The way we have legalised euthanasia in the Netherlands may be a good example for other countries. After all these years, it is in my honest opinion that every doctor has the duty to help his patients to die with dignity and that he has the right, after thorough deliberation, to do euthanasia at the request of a patient and in his interest, knowing of his responsibility to himself, the patient and the law.

To carry out euthanasia is an emotional and difficult decision. I have seen my patients as friends, and every time I was sad and satisfied after euthanasia: sad to lose a friend and satisfied that I could end the suffering of that friend.



# Physician-Assisted Suicide in Switzerland: A Personal Report

Elke M. Baezner-Sailer

## 1 Introduction

Until February 2004 there has not been much to report on the subject of physician-assisted suicide in Switzerland. Over the last 24 years, since the onset of the public debate over aid in dying, the Swiss Academy of Medical Sciences (SAMS) has constantly emphasized that neither active euthanasia nor assisted suicide are a proper part of medical practice.

However, in an anonymous survey carried out last year, Swiss doctors have admitted to having carried out voluntary active euthanasia in about 400 cases. According to unofficial computer projections there are many more patients in Swiss hospitals and nursing homes who have received medical aid in dying. Before I come to the most recent policy changes of the professional association of Swiss doctors, let me give you an account of the past practice of assisted suicide in Switzerland.

Switzerland is a country with only 7 million inhabitants, but 5 right-to-die societies. These are: EXIT Deutsche Schweiz, EXIT ADMD Suisse romande, Dignitas, Ex-International and SuizidHilfe. The membership figures for all the associations combined is about 62,000, of which 50,000 are members of EXIT Deutsche Schweiz. In what follows I will mainly refer to EXIT Deutsche Schweiz as I have been a member of its board for 17 years and president for a term of 4 years.

The annual number of deaths in Switzerland is about 64,000. In 2003, there were 181 cases of assisted suicide by members of the two EXIT associations. This figure is compromised by 131 members from EXIT Deutscher Schweiz and a further 50 from EXIT ADMD Suisse romande.

## 2 Assisted Suicide: Procedures

The sequence of events in an EXIT assisted suicide programme is briefly described, but under no circumstance is it considered or carried out with a light heart. Anyone asking for assistance in a suicide must be a member of EXIT and make the request

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in person. Only competent individuals of at least 18 years are accepted as members. In addition, they must have Swiss citizenship, be residing in Switzerland or at least have a second residency in Switzerland. Assisted suicide is only legally possible on Swiss soil.

Applicants for assisted suicide must demonstrably be suffering from a fatal illness, a severe disability deemed unacceptable or unbearable pain for which there are no prospect of relief.

If all of these requirements are met, an assisted suicide attendant will contact the applicant. This attendant will collect information on the medical history and the desire for suicide and try to create a basis of trust and confidence. On average, the contact between the applicant and the attendant stretches over a period of 2–4 months, but it has been known to take up to 1 or 2 years.

It must be ascertained that the person wishing to die is *compos mentis* and is capable of making his or her own decisions and that there is a long term and stable wish to die which is not influenced by a third party. It must also be clear that all treatment options have been exhausted.

For its practice of assisted suicide, EXIT uses a highly-dosed barbiturate that is only obtainable on a doctor's prescription. If the patient's doctor does not want to issue a prescription for a lethal dose of barbiturates (this is entirely up to the doctor), EXIT will turn to one of its own medical practitioners. If, after having consulted the patient's file, our medical practitioner comes to the conclusion that the applicant's desire for assisted suicide is voluntary and rational he will write out a prescription. If he is in doubt, the case will be brought before the ethics committee of EXIT.

The lethal dose of barbiturates are handed over by the pharmacist to the doctor, to EXIT or to the assisted suicide attendant, never directly to the applicant, and never "for supplies" in order to prevent abuse. The patient determines the day of death which can be postponed or cancelled at any given time.

Only when the applicant has signed a suicide declaration in front of the witnesses registered on file, does the assisted suicide attendant hand him the glass with 10–15 g of Sodium-Pento-Barbital dissolved in water (3–5 g of this barbiturate in pure form have a fatal effect<sup>1</sup>). Because of the risk of vomiting, applicants take an anti-emetic in pill or suppository form in advance. The patient falls into a deep coma within a few minutes exactly as under anaesthetic and without any signs of pain. Breathing ceases after 10, 20 or 30 minutes. In some cases it may take longer and death occurs only after several hours. Even in these cases, however, patients never regain consciousness. In addition to the assisted suicide attendant, there is always at least a second person present as a witness. This person can be a second attendant, a family member, a friend, or the patient's doctor. In fact, EXIT welcomes it if the next of kin or close family members are present at the hour of death. Whenever possible we try to avoid the family being unprepared or presented with a *fait accompli*. At the end of the day, however, all decisions rest solely with the patient.

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<sup>1</sup> Gutachten des Instituts für Rechtsmedizin, Universität Zürich-Irchel, Abt. Forensische Medizin, Zürich, 06.09.2000, p. 5.

According to a representative IPSO survey carried out across the entire Swiss population in 2000,<sup>2</sup> the following people were preferred as attendants: 90% wanted relations, families and friends; 22% wanted doctors; 11% preferred the attendance of a priest; and 11% wanted the presence of an assisted suicide attendant.

After the assisted-suicide attendant has determined that death has occurred, he or she calls the police, because Swiss law requires a police officer or public health officer to investigate every “non-natural” death to ensure that no crime has been committed.

All these procedures show the importance of an experienced suicide attendant. He or she stands by the dying person, monitors that their wishes are carried out, guards them against unforeseen incidents, offers emotional support to the family and assists the bereaved in dealing with the authorities.

Although our assisted suicide attendants are laymen or laywomen in the sense that they are not doctors, they do all possess the necessary human and professional experience required for their task. This has also been confirmed by an aptitude test developed specifically for EXIT by the Institute of Applied Psychology in Zurich which all suicide attendants have to undergo.

### 3 Voluntary Euthanasia Attendants

I will now move on to outlining a proposal for a new and practical way forward. At the beginning of life, we seek the help of a midwife who serves as a *birth attendant*. This is a qualified person with a solid training who is by no means in competition with the doctor, but rather an individual that complements the doctor. A gynaecologist is only consulted when there are complication during labor. Both professionals treat each other with respect and esteem.

Continuing in the analogy of the midwife (who, in French, are known as “la sage femme”, meaning the wise one or the one with knowledge), why should there not be a professional *death attendant*? This person could be either a man or a woman with a disposition akin to that of the midwife. At a time where ‘home births’ are becoming increasingly popular and doctors are not present anymore, dying at home or in the hospital could then be handled as naturally as the act of giving birth.

As a counterpart to the gynaecologist one could imagine a consultant with a qualification as a “thanatologist”. No doubt, at the outset the thanatologists would be exposed to the contempt of their colleagues, as were gerontologists 20 years ago, who have now become fully recognised specialists.

The course adopted by EXIT Deutsche Schweiz with its special training programme for assisted suicide attendants could serve as a model for these new professional areas and could thereby help to ease the relationship between right-to-die societies and the medical profession.

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<sup>2</sup> IPSO: Repräsentative Bevölkerungsbefragung: Sterbehilfe und Image EXIT. Dübendorf, 11. Oktober 2000.

## 4 The Legal Basis

Many people still believe that assisted suicides occur in a grey area. The truth is that EXIT's activities are based on existing Swiss law. They are based on Article 115 of the Swiss Penal Code which has been in force since 1942. Incidentally, it is almost identical with Article 102 of the old Swiss Penal Code dating back to 1898, which referred to an assisted suicide as an "act of friendship".

Art. 115 of today's Swiss Penal Code states: "Anyone, who out of selfish motives persuades someone into suicide or helps him/her in this process will be punished with a custodial sentence of up to 5 years imprisonment." In other words: if there is no selfish motive, assistance is not punishable. It is only logical that assisting an act is not punishable if the act itself is not punishable. The law does not specify which individuals or groups are allowed to give suicide assistance. It does not even limit its application to specific situations, such as the terminal phase of an illness.

Currently, politicians try to confine the activities of right-to-die societies to a more precisely and more restrictive defined legal framework through a statutory regulation. The new member of the *Bundesrat* Ch. Blocher decided to remove the subject of assisted suicide from the priority list of his Justice Department for the legislative period 2003–2007. This prompted Dr. Andreas Brunner, Attorney-General of the Canton of Zurich, to propose a cantonal law, or at least a decree, in the hope that it would have a snowball effect in the other cantons and would finally lead to a federal statutory regulation. He focussed on the following points:

- guidelines for the selection, training and control measures for assisted suicide attendants and doctors,
- measures to ensure the consistency of the wish to die,
- criteria to ascertain the competency of the person wishing to die, especially in cases of mentally ill patients,
- guidelines on the implementation of technical assistance measures in an assisted suicide programme such as perfusions or PEG shunts,
- restriction of assisted suicide to people resident in Switzerland or the canton of Zurich,
- sharing the costs incurred by the authorities through assisted-suicide organisations,
- obligation to testify by the assisted suicide attendant and his/her organisation in any judicial enquiry,
- inclusion of a second, independent doctor instead of one prescribing doctor,
- guidelines for cases in which a doctors issues a prescription for sodium-pentobarbital, and, above all,
- an authorisation and compulsory registration for all right-to-die societies.

To be sure, it is not the right to assist in a suicide that is being called into question. The point of the proposed measures is simply the prevention of abuse. Public prosecutor Brunner conferred unreserved praise on EXIT for its exemplary guidelines

and standards, especially as far as its selection, training and supervision of suicide attendants is concerned.

Political attention was, amongst others, aroused by what is now called “death tourism”. The term “death tourism” emerged as a consequence of the activities of Dignitas and the media attention that its president, Ludwig Minelli, deliberately provoked. The problem of “death tourism”, however, may soon be solved since the Zurich tax payers and authorities are no longer prepared to cover the procedural costs of CHF 3,000–5,000 per assisted suicide. While “death tourists” compensate Dignitas for its assistance, they do not compensate the city or the canton. According to the public prosecutor’s office, the accumulated costs for assisting foreigners in a suicide in the canton of Zurich amount to CHF 273,000 per annum! The best way to stop death tourism would be if countries such as Germany, France and the United Kingdom were to legalize or decriminalize physician-assisted suicide and enable their terminally ill patients to die in dignity in their home countries.

## 5 Advance Directives

EXIT has carried out pioneering work in respect to advance directives. In 1986 EXIT entrusted the renowned lawyer Dr. M. Keller to draw up a legal opinion on the question of the binding nature of advance directives. His result, which was revolutionary in 1986, seems almost self-evident from today’s point of view: “The advance directive is authorised. It is also binding for the addressees. The doctor may only deviate from it if he can prove that in fact it does not correspond to the current wishes of the patient. The patient can validly authorise a third person to ensure that his advance directive is observed”.<sup>3</sup> Although in 2000 only 6% of the Swiss population had filled out a advance directive, its usefulness is no longer in doubt and its binding legal nature is on the statute books in some cantons. In Denmark it has even been compulsory since 1987 prior to any hospital stay.<sup>4</sup>

Advance directives are designed for situations in which the patient can no longer express himself or herself or has lost consciousness, either through an accident or in the course of an illness. Advance directives protect a patient from undesirable life-prolonging medical treatment or demand their termination. They are a protection against what has become a senseless, excruciating prolongation of the death process. One may and indeed should, however, nominate a patient-representative who resolutely monitors compliance with the directives. This person, your “guardian angel”, if you will, has an important role in discussions with doctors and nursing staff, particularly when he or she is not part of the family and can refer to the long-standing existence of a document that has been renewed through annual signatures.

<sup>3</sup> Keller-Schwegler, Max: Rechtsgutachten über die Frage: Sind Patientenverfügungen in der Art des Textes, den EXIT seinen Mitgliedern vorschlägt, für jedermann, namentlich für Ärzte, Spitalärzte und das übrige Spitalpersonal, verbindlich? Zürich 1986.

<sup>4</sup> A Report from Denmark: Experiences and Attitudes Towards End-of-Life Decisions Amongst Danish Physicians. Dans: Bioethics ISSN 0269-9702, volume 10, number 3, 1996.

## 6 Patient Rights

Competent patients who are able to make their own decisions have a right to be informed about their medical treatment and a right to refuse life-prolonging measures. As EXIT members, they have the additional right to request assisted suicide.

How much physical and mental suffering we are willing to endure is entirely up to us. It depends on our character, our experiences, our medical care and our quality of life. There cannot be any general norm for the suffering that we “ought to tolerate”, and nobody is authorized to impose their personal values upon us. We are autonomous beings entitled to make our own decisions.

If we take the idea of autonomy seriously we must leave it to the judgement of competent patients to determine their willingness to endure suffering at the end of life. Especially the elderly, having lived a rich and full life, are the best judge of their desires.

What are the reasons behind the requests for assisted-suicide? According to our internal statistics, the most frequently expressed reasons are:

- advanced stages of cancer, often linked to a lung emphysema and metastases
- multiple sclerosis
- brain tumor
- muscular dystrophy
- amyotrophic lateral sclerosis
- Parkinson’s disease
- AIDS
- untreatable skeletal pains.

Today, most pain can be alleviated or reduced to a tolerable level. What cannot be treated is the physical and mental degeneration and its eroding effects on our self-image. Therefore, EXIT also assists the very old with irreparable multimorbidity, including blindness, loss of hearing, increasing arthrosis, paralysis, often all together – people who judge their quality of life as being intolerable and who see no point in continuing their existence.

In cases like these, it would be inhumane to insist that a competent patient has to go on living. If he does not want to live like this anymore, can no longer endure his suffering and has difficulties reconciling his mental state with his dignity, we have no choice but to accept it. Patients like this, however, do not necessarily have to ask for assisted suicide, for in the terminal phase, the majority of doctors are willing to help, in conformity with the law, by offering terminal sedation. As mentioned at the beginning, every year many more patients die this way in Swiss hospitals and nursing homes than the 400 patients officially stated. The problem, though, is that these patients too often die without having been asked to die this way. It is imperative that we introduce safeguards to protect patients from a non-voluntary death.

A word on the problem of the mentally ill: They have not been assisted by EXIT since the end of 1998 when the association initiated a self-imposed moratorium. We have, however, asked a commission composed of leading experts in the fields of psychiatry, medicine and law to draw up a report on the question of whether or

not some mentally ill patients are still capable of making a rational and autonomous choice when requesting assisted suicide.<sup>5</sup> Of course, the boundary between physical and mental illness is not always clear, and in each individual case it must be carefully examined whether the intention of committing suicide is conditional on the illness or not. In addition, one has to make sure that the wish to die is not simply a cry for help. But there are always exceptional cases in which the intention to commit suicide is to be respected as a rational decision and an autonomous choice.

## 7 Autonomy and the “Slippery Slope”

In the liberal states of Central Europe with their great diversity of philosophies of life and religious beliefs, more and more importance has been attached to the autonomy and self-ownership of the individual. Everyone, it is said, ought to be free to live his life and to end his life as he chooses so long as he does not harm others. However, freedom involves numerous new responsibilities that need to be learned and exercised. Self-determination must not be an invitation to selfishness.

The dangers of a “slippery slope” are always an important issue in debates over assisted suicide. It is not my intention to minimise these concerns, but let us recall how some of the most heinous crimes in the history of mankind have been made possible. Societies are sliding down a slippery slope when its population is kept in ignorance, fed misinformation or severely manipulated. The best protection against the risk of sliding down a slippery slope is therefore to educate people, to teach them to think for themselves and to question the blind faith in authorities. Sound ethical principles, firm boundaries, clear directives, transparency and strict criteria in the selection and training of the death attendants, be they doctors or non-doctors, provide reliable safeguards against any kind of abuse.

In Switzerland, as in most other Western nations, our right to personal freedom is viewed as a fundamental right. Nobody would deny a 20 year old woman the right to choose a profession, to marry or to have children, even if her choices are considered unreasonable, absurd or immoral, provided only that they do not violate the rights of others. But isn't an 80 year old woman who is tired of life similarly entitled to make her own decisions?

People in need of care, the elderly and terminally ill patients must not be degraded by being treated like children. Seventy per cent of the Swiss die in hospitals or nursing homes. But even home-care does not protect the individual from degrading situations. Some people detest their dependency which reaches into the most intimate sphere of their life that they would prefer a painless death to even the most loving care. Who would be so presumptuous as to decline their wish in good conscience?

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<sup>5</sup> Bosshard, Kiesewetter, Rippe, Schwarzenegger: Suizidbeihilfe bei Menschen mit psychischen Störungen. Unter besonderer Berücksichtigung der Urteilsfähigkeit. Expertenbericht zu Handen von EXIT-Deutsche Schweiz. Zürich 2004.

## 8 New Directives from the SAMW Ethics Commission

In my concluding remarks I would like to return to the new guidelines of the Swiss Academy of the Medical Sciences (SAMW).

In 2002, the final sentence of a press release published in the Swiss Medical Journal made people sit up and take notice. It read as follows: “Contrary to its previous position, the SAMW now assumes that assisting in a suicide under certain conditions may be a proper part of medical practice. . . . .”<sup>6</sup> In February 2004, the SAMW presented the draft for a revision of the guidelines on “Caring for Patients at the End of Life.”<sup>7</sup> The text presented for consultation – and this is totally new – recommends to respect the personal conscientious decision of a doctor to assist in a suicide. What is also new is what the President of the Central Ethics Commission, Prof. Michel Vallotton, formulated as follows: “It is undisputed that accompanying someone to his death is not reserved for doctors.” In other words, assisting the suicide of a seriously ill patient is now permissible *also* for doctors. Only voluntary active euthanasia is rejected on moral and legal grounds.

Respect for the autonomy of patients has finally led to a liberalisation in the practice of assisted suicide. Assisted suicide, even physician-assisted suicide, is no longer questioned, as it was 20 years ago when it was taboo – a provocation that unleashed a storm of indignation. Today, it is only a question of details, both in the draft legislation of the Zurich Public Prosecutor as well as in the SAMW Directives.

Active euthanasia, passive euthanasia, indirect euthanasia, terminal sedation, assisted suicide: All these activities refer to medical decisions at the end of life. As soon as a patient utters his wish to die, everyone is listening. But prior to this, at the start of the illness, in the course of the increasing aches and pains of old age, the multiple dependencies, at the outset of the social dying, the old and ill person all too often is made to hear and feel how expensive he is to the health care system, to the pension funds and to society in general, and how disturbing his request for attention is felt to be in the hyperactive everyday life of the family. For this reason not a few people are “pushed away” into a home.

I think that we should all make an effort to do justice to the elderly before it is too late for them, instead of considering the problem abstractly and making their plight anonymous in endless theoretical discussions. We should find our way back to a death culture consistent with human dignity.

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<sup>6</sup> Schweizer Ärztezeitung Nr. 1/2, 2002, S. 47.

<sup>7</sup> Schweizer Ärztezeitung Nr. 6, Februar 2004, S. 286 ff.



# The European Convention on Human Rights Protects the Right to Suicide

Ludwig A. Minelli

## 1 Diane Pretty vs. United Kingdom

In his book entitled “Is all this true?” the late Swiss legal scholar Manfred Kuhn wrote:

What has been forgotten to be said in the Universal Declaration of Human Rights and can't be found in any modern liberal constitution is the simple phrase: 'Everyone has the right to live and the right to die.'<sup>1</sup>

In its decision in the case of Diane Pretty vs. the United Kingdom of April 29, 2002, the European Court of Human Rights in Strasbourg said in paragraph 65:

The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity.<sup>2</sup>

The European Court's statement captures the very essence of the world-wide debate on aid in dying.

Most readers would have heard of Diane Pretty. She was plagued by a debilitating motor neurone disease. Even as her mind stayed sharp and focused, she knew that she would suffer from immobility, choking and gagging which would ultimately culminate in a death by suffocation. Given that she was unable to end her intolerable life without the help of a third party, she made a request to the authorities of the United Kingdom declaring, that should her husband assist her in committing suicide no criminal charges should be brought against him. Having had her request denied by the United Kingdom, Diane Pretty lodged an application at the European Court of Human Rights in Strasbourg. In paragraph 67 of its verdict, the Court stated:

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<sup>1</sup> Manfred Kuhn, *Ist das alles wahr?*, Oesch-Verlag Zürich 2002.

<sup>2</sup> Human Rights Law Journal, 2002, 194, 209.

The applicant in this case is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life. The Court is not prepared to exclude that this constitutes an interference with her right to respect for private life as guaranteed under Article 8, § 1 of the Convention.<sup>3</sup>

What exactly is the wording of the invoked Article 8 of the European Convention on Human Rights?

#### Article 8

- (1) Everyone has the right to respect for his private and family life, his home and his correspondence.
- (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.<sup>4</sup>

Let us now consider what the Court stated in paragraph 61 of its decision:

As the Court has had previous occasion to remark, the concept of “private life” is a broad term not susceptible to exhaustive definition. It covers the physical and psychological integrity of a person [. . .]. It can sometimes embrace aspects of an individual’s physical and social identity [. . .]. Elements such as, for example, gender identification; name and sexual orientation and sexual life fall within the personal sphere protected by Article 8 [. . .]. Article 8 also protects a right to personal development, and the right to establish and develop relationship with other human beings and the outside world [. . .]. Though no previous case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees.<sup>5</sup>

Taking into account what the Court has stated in Article 8 of the Convention, we have to conclude that the request by a person to end her own life is indeed a Human Right that is protected by Article 8.

But why did the Court not present it this way? The reason is quite simple: the European Court of Human Rights addresses only questions presented to them. In this instance, neither Diane Pretty nor the United Kingdom posed the question of a right to end one’s own life, thereby freeing the Court of any obligation to consider it. Addressing a question that has not been presented to a court is known as an “obiter dictum”. An obiter dictum can turn out to be quite dangerous as it may bind the court to a decision that has been made with insufficient information or lack of evidence. The European Court of Human Rights is the highest court in Europe and holds a reputation of being a Court that seldom makes any “obiter dicta”.

As we are not a court, we are at liberty to draw some conclusions from the case of Diane Pretty. Is there anything more private than one’s own death? Hardly. One’s

<sup>3</sup> <http://www.echr.coe.int/Convention/webConvenENG.pdf>

<sup>4</sup> Human Rights Law Journal, 2002, 194, 208.

<sup>5</sup> Decision in the case of NIEMITZ vs. Germany, December 16, 1992, § 30, Series A No. 251.

own death is a very private part of a person's life. Therefore, the decision of a person to end his or her life ought to be protected by Article 8 of the Convention.

Moreover, a look at Section 2 of Article 8 shows that there is no justification for state interference because this section does not entail anything that could possibly grant the state a right to intervene.

Thus, we arrive at the conclusion that the right to end one's own life is a human right protected by Article 8 of the European Convention on Human Rights.

By implication, this means that a human being is entitled to forego another human right enshrined in Article 2 of the Convention, namely the right to life. This point of view is broadly accepted in the commentaries to the Convention.<sup>6</sup>

## 2 Sanctity of Life

Let us return to paragraph 65 of the decision cited above. Here the Court speaks of the "sanctity of life", which recalls one other decision – not of the European Court, but that of the former European Commission on Human Rights.

On July 4, 1983, the European Commission rendered a decision in the case of *Mr. R. vs. the United Kingdom*. After being convicted of aiding the suicide of a third person and sentenced to 18 months of imprisonment, Mr. R. appealed to the European Commission. He complained that his conviction had interfered with his own right to private life, because he considered helping seriously ill people to die to be a part of his own private life.

The European Commission in Strasbourg rejected his complaint as unjustified. What were the reasons behind the Commission's rejection? Paragraph 13 of its decision reads as follows:

The Commission does not consider that the activity for which the applicant was convicted, namely aiding and abetting suicide, can be described as falling into the sphere of his private life . . . While it might be thought to touch directly on the private lives of those who sought to commit suicide, it does not follow that the applicant's right to privacy is involved. On the contrary, the Commission is of the opinion that the acts of aiding, abetting, counselling or procuring suicide are excluded from the concept of privacy by virtue of their trespass on the public interest of protecting life, as reflected in the criminal provisions of the 1961 Act.<sup>7</sup>

It is the concept of "the public interest of protecting life" that has led to the European Commission's decision, a notion which has also been invoked by the European Court of Human Rights when it referred to "the sanctity of life".

What does the principle "sanctify of life" really mean? Does it mean that we should protect human life at all costs? Does it mean that we should prevent people from dying even if they wish to do so?

<sup>6</sup> Lucius Wildhaber, in Heribert Golsong et al., *Internationaler Kommentar zur Europäischen Menschenrechtskonvention*, Köln etc., 1992, N 267–269 regarding Article 8 ECHR, with many citations.

<sup>7</sup> European Commission of Human Rights, *Decisions and Reports* 33, Strasbourg, October 1983, 270, 271.

I will address these questions at a later stage.

At this juncture, I would like to present some thoughts on the issue of suicide. In almost every country, suicide is considered to be a very private act of an individual, as well as somewhat of a taboo. Scientific research shows that people who consider taking their life rarely talk about it. The reasons appear to be twofold: first, talking about it violates the taboo, and second, it puts them at risk of being institutionalised – after all, being suicidal is considered to be a symptom of mental illness. In his article “Suicide Prevention and Primary Care”, Konrad Michel of the University of Berne writes:

In a seminar, a general practitioner from a rural practice related the following story. On a busy Saturday practice morning a 45-year-old teacher whom he had not seen for 2 years presents with a strained left ankle. The patient tells him that it happened a couple of days ago when he went for a walk in the forest. The general practitioner cannot find anything remarkable, and he discharges the patient with an ointment and an elastic bandage. Two hours later the patient’s wife calls to ask if her husband is still with him, as he has not returned yet. She calls again an hour later, reporting that her husband has been found dead in the forest. He had shot himself through the head.<sup>8</sup>

Obviously, the teacher had wanted to speak to his physician about his problems. But once in his surgery, his spirits sank. So there was no chance to prevent this suicide.

### 3 Suicide in Switzerland

Switzerland is a country with almost the highest suicide rate in the world. With a population of about 7.4 million people, we are counting every year about 1,350 people ending their lives by suicide. This gives a rate of 18.24 suicides per 100,000 capita. In an official answer to a question in parliament<sup>9</sup>, the Swiss Federal Government told the House that Switzerland has to consider that every year about 67,000 people attempt suicide. But the government had no details or recorded official statistics that would support this claim.

The Swiss Society for the European Convention on Human Rights (SGEMKO) has tried to ascertain the financial burden thrust upon Switzerland due to Suicide. A study was conducted by the renowned Swiss journalist Peter Holenstein and was subsequently published on September 11, 2003 in Berne.<sup>10</sup> It showed that the Swiss public economy has to bear expenses of about 1.8 billion Euro (2,400,000,000 Swiss Francs) per annum as a result of suicide and attempted suicide. These figures only pertain to the expenses for the Police, Justice and Public Health System. It does

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<sup>8</sup> See, as an example, Konrad Michel, in Keith Hawton and Kees van Heeringen (eds.), *The International Handbook of Suicide and Attempted Suicide*, Chichester etc., 2002, 661, 663.

<sup>9</sup> Simple question Andreas Gross of October 3, 2001, answer of the Swiss Federal Council of January, 9, 2002, matter No. 01.1105.

<sup>10</sup> Peter Holenstein, *Der Preis der Verzweiflung, Über die Kostenfolgen des Suizidgeschehens in der Schweiz*, Swiss Society for the European Convention on Human Rights, Forch, 2003.

not include the loss to the public economy that results from lost working years of individuals etc.

These data show that our society needs to have a new approach to tackle the issue of suicide. We have to do away with the taboo. We should finally speak up.

It needs to be stressed that we should not speak about particular suicides but about suicide in general. Ever since Goethe published his famous novel *Die Leiden des jungen Werther*, we are well aware that talking about particular cases of suicide may prompt others to commit “suicide by imitation”. Hence, we should speak about the social problem of suicide as well as about the difficulties people have in committing suicide today.

During the middle of the last century, suicide by an overdose of sleeping pills was the most common method to take one’s own life. Sleeping pills are designed from barbiturates. As is widely known, the American actress Marilyn Monroe died of an overdose of barbiturates.

Due to the growing popularity of using barbiturates to commit suicide, most Western countries have agreed to regulate access to psychotropic substances.<sup>11</sup> Nowadays, it is very difficult to obtain barbiturates. They are no longer to be found in sleeping pills. Even if barbiturates can still be found in some pharmaceutical products, it is highly unlikely that they will kill a person; more often than not, they harm a person – considerably and irreversibly.

Unfortunately, the general public is quite unaware of this. Most people still believe that an overdose of sleeping pills or Valium would result in death. Nothing could be further from the truth! There is evidence that an overdose of the sleeping pill LUMINAL<sup>®</sup>, which contains Phenobarbital, will not result in death but in coma – sometimes for as long as 3 months.

Another common method to commit suicide has similarly proved to be unsuccessful, namely that of staying in a closed garage with the car running and inhaling the gas fumes which result in suffocation. Exhaust gases today contain not nearly as much carbon monoxide as they did in the past. It is the carbon monoxide that takes the place of oxygen in the red blood cells therefore leading to unconsciousness and resulting in death by suffocation.

A lot of people still think that speeding and driving their car into a tree is going to kill them. Again, this is wrong. The construction of modern day motor vehicles with such safety features as the air bag will most likely save their lives. Most people trying to kill themselves this way will wind up in hospital suffering serious injuries.

Another common method used in the days gone by was that of sticking ones head in the oven and inhaling cooking gas. Unlike the past, today’s cooking gas is made of natural gas, which does not contain any carbon monoxide anymore. Instead of killing themselves, people using this method will simply endanger the lives of others, as there is a serious risk of an explosion.

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<sup>11</sup> <http://www.incb.org/e/conv/1971/cover.htm>

In order to launch a broad suicide prevention program, we need to be clear about the facts. We should inform the public about unsuccessful methods of suicide and make them aware of the risks associated with failed suicide attempts.

Apart from an information campaign, we should create opportunities for people to speak about their intention to commit suicide. It is crucial that people who contemplate taking their lives are taken seriously and not be judged for being suicidal. We should let them know that we are not opposed to their intention to kill themselves as long as their reasons for doing so are reasonable.

Taking suicidal individuals seriously and not trying to dissuade them is often the best way to change their minds. I myself have personally experienced such a case.

Having just left a psychiatric institution to which he was admitted for being suicidal, a 21 year old man from Germany took out his cell phone and dialled the number of DIGNITAS in Switzerland. He told me that he had completely failed his vocational training. Given that he had no scientific, cultural or social interests whatsoever, he thought that he would be better off dead.

I invited him to come to Switzerland so we could meet and talk more. Two months later whilst I was travelling from Augsburg to Munich my cell phone rang. It was the young man from Germany. He said "I am now in front of your house and would like to die immediately!" I informed him that since we did not have an appointment, I was away on business and would not be returning until noon the following day.

I picked up a lady in Munich who wished to die with the help of DIGNITAS. As scheduled, I arrived at home around noon and found the young man waiting for me. Together we visited a physician co-operating with DIGNITAS as he had informed me that he was prepared to provide a prescription for the lady from Munich.

At 8 p.m. that evening my phone rang and I was told that the lady from Munich had changed her mind and wished to return to Munich. Half an hour later, together with the young man, we were on our way to Munich. We arrived in Munich at a quarter past midnight and were back in Zurich by 4 a.m.

The following day the young man asked me over and over again how he could die quickly. He was relentless in his search for a quick and immediate death. I told him that no Swiss physician would write a prescription for him, given his motives for wanting to commit suicide. This answer was unacceptable to him and so he went on asking me how he could die quickly and immediately.

After several hours I felt I had to change my tactics. I told him if he really wants to die, he has three options. The first option would be hanging himself. In order to do so, however, he needs to know what rope to choose and how to tie a knot. Moreover, he would have to use a beam or tree strong enough to hold his weight even when falling. I advised him that he should also make certain that the place of hanging is remote enough to prevent him from being discovered too early. If found too early, he may not die but suffer severe brain damage.

Option number two would be to get a prescription for sleeping pills and to head for the Swiss Alps. "Take the sleeping pills, drink half a bottle of whisky and lay yourself to sleep on a glacier. If things go well, you will die without any pain. If things go wrong, however, you may simply lose your arms and legs."

The third and final option is: stop eating and you will be dead in a few weeks.

Neither the first nor the second option appealed to him. However, the third option was to his liking. "OK", he said, "I will die by starvation!" All his problems seemed to have been resolved and he cheered up instantly. I asked him if he had a swimsuit with him and suggested that we go to a bathing resort twenty miles from my house. We passed a very pleasant evening bathing in the warm water, which was followed by a trip to a nearby "Mövenpick-Restaurant", where he commenced his starvation. When we finally arrived home it was midnight and the sky above us was a cascade of brilliant starlight. It inspired me to get my 20-centimeter-telescope and set it up in my garden. I showed him Jupiter with his four Galileo moons and Saturn with its ring. He had never seen the planets before and almost instantaneously took to an interest in astronomy. We went back inside my house and browsed through some astronomy books in my library.

The following day I found him a psychologist in Germany. In his eagerness to see the psychologist, he confused his appointment and arrived a week early.

The young man returned to his colleagues with whom he shared an apartment and his girlfriend who he had kept in touch with via SMS to reassure her and his family of his well-being. All these people accepted him kindly and were nice to him, including his employer, who had been informed by telex that he was in Switzerland in order to receive help after a panic attack.

In the end the young man consulted his psychologist several times, continued working for his employer, finished his vocational training and is still together with his girlfriend. I am happy to report that I met him recently and that he is indeed doing well and in good spirits.

To be open to a person's genuine feelings of committing suicide and to strive to urge that person to go on living is often a decisive action in preventing a suicide. Imagine that you are standing in front of a heated steam boiler and the pressure just keeps on rising. By being open to a discussion about a risk-free and painless suicide we achieve two things: first we take away the fire and then the pressure. Only after taking away the pressure, we have a chance of helping a person towards life.

We regularly encounter similar experiences with members of DIGNITAS. Very often, they urge us to quicken the process of an assisted suicide. We let them know that we are seeking a physician willing to write a prescription for a lethal dose of barbiturates. As soon as they know that we have obtained a prescription, 80 per cent of our members never call us again. Knowing that there is a way out grants them a sense of calm.

Thus, if we wish to reduce the number of suicides and attempted suicides we should lift the barriers and offer a risk and pain free method of assisted suicide. I would suggest that the best method would be to provide a person with Pentobarbital of Sodium under the control of competent and experienced staff. It is my view that the staff assisting in a suicide should not be doctors or nurses, but rather persons with a wide experience of life and a good and firm character.

As already pointed out, an international treaty regulates the trafficking of psychotropic substances such as barbiturates. This treaty requires countries to ensure that barbiturates are only made available to a person with an original prescription

from a physician. Switzerland has implemented this rule in its law regulating narcotics. To my knowledge, in Germany physicians are not permitted to prescribe a lethal dose of barbiturates; and Pentobarbital of Sodium is only used by Veterinarians.

In the view of the European Court's statement "[. . .] that the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective",<sup>12</sup> we should interpret the Convention as granting everyone a legal right to obtain a lethal dose of Pentobarbital of Sodium provided they qualify for assisted suicide.

The problem of suicide shares some resemblance with the problem of abortion. Just as the liberal "pro choice" policy has helped to decrease the number of abortions, so a liberal "pro choice" policy will help to decrease the number of suicides. Thus, we should respect that people have the freedom to make their own choices.

Granting people the right to make their own choices does not only spare unnecessary suffering to the terminally ill people themselves, but also to third parties like the locomotive driver having to watch people throwing themselves in front of his train or the 13 year old boy who on his morning paper round discovers the body of someone who has hung himself. Imagine living with such traumatic images and horrendous experiences.

The Swiss model, which permits a doctor to write a prescription and allows any person to assist in a suicide seems to me to be optimal. I deplore that people residing in the United Kingdom or Germany have to travel to Switzerland in order to hasten their death, and I would be deeply grateful if these and other countries were to introduce a similar practice of assisted suicide.

## 4 Utopia

Let me finish with a quotation describing how, in a utopian state, the problem of dying in dignity could be solved:

I have already told you with what care they look after their sick, so that nothing is left undone that can contribute either to their ease or health: and for those who are taken with fixed and incurable diseases, they use all possible ways to cherish them, and to make their lives as comfortable as possible. They visit them often, and take great pains to make their time pass off easily: but when any is taken with a torturing and lingering pain, so that there is no hope, either of recovery or ease, the priests and magistrates come and exhort them, that since they are now unable to go on with the business of life, are become a burden to themselves and to all about them, and they have really outlived themselves, they should no longer nourish such a rooted distemper, but choose rather to die, since they cannot live but in much misery: being assured, that if they thus deliver themselves from torture, or are willing that others should do it, they shall be happy after death. Since by their acting thus, they lose none of the pleasures but only the troubles of life, they think they behave not only reasonably, but in a manner consistent with religion and piety; because they follow the advice given them by their priests, who are the expounders of the will of God. Such as

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<sup>12</sup> In the case *ARTICO vs. Italy*, Mai 13, 1980, Series A No. 37.



are wrought on by these persuasions, either starve themselves of their own accord, or take opium, and by that means die without pain. But no man is forced on this way of ending his life; and if they cannot be persuaded to it, this does not induce them to fail in their attendance and care of them; but as they believe that a voluntary death, when it is chosen upon such an authority, is very honourable.

The author of this text is the Lord Chancellor of His Majesty, King Henry VIII of England, Thomas More. He wrote this text in 1517 in his famous “Utopia”. Saint Thomas More was appointed by Pope John Paul VI on October 31, 2000, as the patron of statesmen and politicians.

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