# Euthanasia 1 part 1

## Definitions and Consequences

* The shell explodes! You see your comrade fall. He is in agony, and there is no possibility of survival. "Please put me out of my misery!" he begs. There is a gun in your hand—should you use it?

* Cancer is diagnosed. You see your patient declining. She is in agony, and the disease is quite incurable. "Please put me out of my misery!" she begs. There is a hypodermic in your bag—should you use it?

**Introduction**

Euthanasia is a complex and emotive issue. Like the related controversy surrounding abortion, it exposes our most fundamental convictions about the meaning and dignity of human life.

This is the first of two essays on the subject. It seeks to clarify the definition of euthanasia and point out some of the worrying possible consequences if the current UK law is relaxed, A second essay examines the biblical and theological issues pertaining to the whole question of suicide, assisted suicide, and euthanasia.

**The Need for Definition**

**1. Voluntary Euthanasia**

EXIT (formerly the Voluntary Euthanasia Society) has long campaigned for the decriminalisation of assisted suicide where it is performed in a "humanitarian spirit". Opinion surveys indicate they have substantial public support. The president of the Hemlock Society (the equivalent American organisation) published a book entitled *Final Exit* in 1991 which gave explicit advice on how to terminate one's own life painlessly and conveniently. It topped the *New York Times* bestseller list. In Holland, although still technically illegal, voluntary euthanasia has been practised for twenty years under a set of guidelines agreed by the medical profession, the public prosecution service and the judiciary.
In this country the matter was brought into the public eye in 1992 by the case of Dr. Nigel Cox. He was prosecuted for the attempted murder of Lilian Boyes, a patient of his suffering from severe rheumatoid arthritis. He had been her doctor for thirteen years and was a close and trusted friend. Her life-expectancy was very short, and she asked Cox to end it all for her. At first he refused, but when the pain-killing medication he bad prescribed failed, he administered a lethal injection of potassium chloride as a result of which she died within minutes. Potassium chloride has little analgesic effect. The injection was clearly intended to kill. The jury found him guilty by an 11:1 majority and he was given a twelve month suspended sentence. The General Medical Council issued a formal reprimand and required him to attend a course on palliative medicine; however, it refused to bar him from future medical practice. In fact he returned to work for his former employer at the Royal Hampshire Hospital in Winchester.

**2. Non-voluntary Euthanasia**

Obviously euthanasia can only be voluntary where the person concerned is conscious and competent to express consent. There are some situations where such voluntary consent is clearly impossible.

(i) The severely handicapped infant

The cases of "Baby Doe" in the USA and John Pearson in this country highlighted the dilemma which faces medical staff in neonatal intensive care wards. Both these infants suffered from Downs Syndrome. "Baby Doe" died as a result of a deliberate refusal to correct surgically an oesophageal obstruction. John Pearson died as a result of a deliberate overdose of dihydrocodeine. Dr. Leonard Arthur, who was responsible for the administration of the drug, was acquitted at Leicester Crown Court and once again treated leniently by his profession.

(ii) The seriously brain-damaged

The cases of Nancy Cruzan in the USA and Tony Bland in this country brought the tragic plight of p.v.s. victims to media attention. Persistent Vegetative State (p.v.s.) describes patients who have suffered profound damage to the cerebral cortex. Though the brain stem is still intact and basic body functions continue including respiration, there is usually no evidence of cognitive awareness. In the case of Tony Bland, a victim of the Hillsborough disaster, a High Court ruling in 1992 granted the Airedale General Hospital in West Yorkshire permission to cease tube-feeding him. He died on 3rd March 1993 after further hearings both at the Appeal Court and the House of Lords.

3. The "Living Will"

A major concern of those pressing for voluntary euthanasia to be legalised is that in cases of coma or dementia consent is not possible, even though the individual concerned might have wished to give consent had they known they would suffer such incapacity. A practice already established in the USA permits people to draw up an advance directive requesting doctors not to administer life-prolonging treatment should they become incapable at some future date of exercising their legal right to refuse treatment themselves. A similar provision permits the extension of a power of attorney so that health care decisions of this sort can be taken by an appointed proxy.

Should voluntary euthanasia be made legal, it would be a short additional step to give advance consent by means of some such living will, thus bridging the gap between voluntary and some forms of non-voluntary euthanasia.

**The Arguments in Favour**

***1. Compassion***

The analogy of a vet putting down a sick animal is often cited. If compassion for a dumb beast demands such action, should not compassion for a human being lead to similar "mercy killing"? The example from the battlefield with which this paper began makes clear that such arguments have considerable moral cogency and emotional appeal. It is arguable, of course, that in the case of severely comatose patients suffering is not experienced anyway. But in such cases their families are certainly placed in a most distressing situation. Relatives will often confess to an overwhelming sense of relief when their loved one at last dies. Would it not be an act of humanity to bring that relief sooner?

***2. Autonomy***

In recent years, EXIT has abandoned to a considerable extent the argument from compassion. Improvements in analgesia and the growth of the hospice movement have meant that few people die in pain or distress these days, and those that do probably do not need to do so. EXIT now defends its cause principally on the grounds of individual self-determination—the right to die. We have decriminalised suicide. We acknowledge the right of a

patient to refuse treatment. Ought we not to repent of an excessively paternalistic attitude towards voluntary euthanasia also? Why should human beings not decide when they want to die if they so wish? To force someone to die in a way they find undesirable is to usurp their human rights just as tyrannically as to take someone's life unjustly.

***3. Economics***

The current financial crisis in health care both in Britain and the USA is a consequence of medical progress. It is possible to sustain life so successfully now that health care is becoming a major economic burden which the state cannot allow to mushroom indefinitely. Some kind of cost-benefit analysis must be applied, and this inevitably requires that health care provisions be prioritised. Should scarce resources be invested in an elderly patient when a young person is dying for lack of a vital operation? Should AIDS patients be treated with expensive drugs when the same money could buy more kidney machines? And is it not an act of commendable unselfishness to opt for voluntary euthanasia when you know your treatment is a costly burden to others? Like Captain Oates, or even like Christ himself, such a death is surely a vicarious sacrifice?

**A response**

***1. Two Important Distinctions***

The water is often muddied by imprecise use of the word "euthanasia", It is obviously in the interests of the pro-euthanasia groups to interpret it as widely as possible in order to exploit the thin end of the wedge. We make first, therefore, two observations about what euthanasia is and is not.

**(i) Euthanasia is not involved where "death" has technically already occurred.**

The legal definition of death embraces both irreversible cessation of cardio-respiratory functions (the heart stops beating, the lungs stop breathing) and permanent failure of the brain stem (so called "brain death"). The addition of the latter category was demanded by the development of supportive technology which could sustain respiration and heartbeat artificially. Where brain stem function is demonstrated to be zero by EEG examination it is now generally agreed that death has in fact already occurred. Disconnecting a respirator in such circumstances is therefore not to be regarded as killing the person, but as ceasing to ventilate a corpse.

Some argue that p.v.s. victims should be included in this category of "brain dead". They suggest that it is the cessation of cognitive function due to loss of upper-brain cortical activity which marks a person's death, rather than the loss of more primitive body functions due to the failure of the brain stem. However, the BMA is justifiably cautious about any further widening of the definition of death. At present p.v.s. cannot be unambiguously confirmed by any clinical test. It is a diagnosis based solely on the failure of the patient to respond after many months of observation. Unfortunately it also cannot be reliably distinguished from a so-called "locked-in" state, where the patient is inwardly conscious but paralysed so totally that no expression of their inner life is evident. Advances in diagnostic technology may make it possible to categorise p.v.s. more precisely in future. But at present it seems clear we have no safe alternative but to treat p.v.s. patients as living human persons. Furthermore, there are additional reasons for Christians resisting any definition of humanness based only on the observation of cognitive function. These will be discussed in the second essay.

**(ii) Euthanasia is only involved where there is an intention to bring life to an end.**

Much has sometimes been made of the distinction between active and passive euthanasia. Active euthanasia demands some specific lethal intervention. Passive euthanasia simply allows death to occur by the discretionary

withholding of vital treatment. The lines of Arthur Clough are often quoted in support of the latter (although their original intention was rather more satirical).

*Thou shalt not kill,*
*But need'st not strive,*
Officiously, to keep alive.

("The Latest Decalogue" in Selected Poems, Penguin, 1991)

A number of writers have argued cogently, however, that this is not a helpful or valid way to express the distinction in view. There are medical sins of omission. Doctors and nurses have a duty of care towards their patients. They are responsible to use their skills for the relief of suffering and the preservation of life. To allow someone to die when you can prevent it would normally be an act of moral, professional and probably criminal negligence. There is no refuge from responsibility in "passivity" either in law or Christian ethics, as Jesus made plain in his parables of the Good Samaritan and the Sheep and Goats.

A more relevant criterion is that of *intentionality*. A doctor may withhold treatment if in his or her professional judgement the benefit the patient would receive from it is insufficient to make it worthwhile. The *purpose* in this omission is thus not to kill, but to avoid unnecessary further distress to a dying patient. Certain medical procedures are only appropriate in the case of acute illness, where a patient requires their support through a critical period leading to recovery. Respirators and cardiac resuscitation (for instance) are not appropriate to the care of the terminally ill.
Equally a doctor may administer a pain-killing drug, knowing that a side-effect is likely to be the depression of respiration and therefore an acceleration in the process of death, if in his or her professional judgement life expectancy is very short anyway and the relief of pain is therefore the highest priority.

Once again, the *intention* is not to kill the patient. Death is already present in the situation. The physician's task is to allow it to occur in a dignified and pain-free way.
Undoubtedly this distinction between "allowing to die" and "killing" is sometimes blurred and even difficult to defend in logic. Indeed, Sir Douglas Black of the Royal College of Physicians admitted as much at the trial of Dr. Leonard Arthur. A number of writers (including Richard Higginson in *Dilemmas: A Christian Approach to Moral Decision-Making*, and James Rachels in *The End of Life: Euthanasia and Morality*) argue that it would be more rational to label such an exercise of medical discretion as "permissible euthanasia". But this would sacrifice the pejorative overtone of the word "euthanasia" which many are anxious to retain. To identify "permissible euthanasia" may create a slippery slope whereby the so-called "best interests" of the patient are cited to justify acts of deliberate killing in which natural death is not imminent at all. Foresight and intention are quite different and to apply the word "euthanasia" to both invites a dangerous and unnecessary confusion.
Within English law, intention is already understood as necessary to a charge of murder. It is also well established that motive constitutes no defence to murder. Admittedly, there is the possibility of ambiguity in the definition of intention, and the law has not always been consistent in this respect. Nevertheless, it seems wise to try to limit the term "euthanasia" to cases where there is an intention to bring life to an end, and therefore as the law currently stands there is a *prima facie*charge of murder to answer.
The case of Tony Bland

The importance of intention in medical decision is especially relevant to p.v.s. victims. In many cases the only ongoing medical support these patients require is tube-feeding either through the nose or stomach. Should food and water supplied in this manner be regarded as an invasive medical treatment which is artificially keeping the

patient alive? Or is it ordinary care which we owe to anyone who is unable to help themselves, irrespective of their quality of life or life expectancy? If it is the latter, on what possible grounds can such care be denied?

This was a key issue in the Tony Bland court hearing. Lord Goff pointed out that the law at present permitted medical treatment to be stopped provided doctors were convinced it was not "in the best interests" of the patient for it to be continued. He argued that ceasing to tube-feed a p.v.s victim was an acceptable extension of this established principle.

However, it is by no means clear that the court's verdict on the matter is safe. The House of Lords in effect acknowledged its unease at its own decision by insisting that further cases of a similar kind should not be decided on the precedent they were setting, but must be brought to the courts also.

Sympathetic as we must be to the appallingly tragic situation of someone like Tony Bland, it is important to recognise that for the first time an act with the explicit intention of bringing about death where this was not already imminent was given legal sanction. Leonard Arthur and Nigel Cox were at least tried by a jury. But, in the absence of legislation to widen the definition of death (as discussed above), the courts acted in the Bland case in a way that fundamentally undermined the law of murder in this country. The point was well made in a letter by Dr. John Keown of Queen's College, Cambridge, to the Daily Telegraph on 1st December 1992.

**2. The Perils of Liberalising the Law**

There are at least five dangerous consequences of any relaxation of the law of murder in order to permit euthanasia:

***(i) The possibility of mistaken prognosis***

It is interesting to observe that many of those who favour euthanasia are also supporters of the abolition of capital punishment. They would argue perhaps that judges make mistakes and the innocent ones executed cannot be compensated. Well, doctors make mistakes too, and euthanasia is similarly irreversible. The safeguards against wrongful conviction on a capital crime are far more stringent than any that have been proposed to regulate euthanasia.

**(ii) The possibility of criminal abuse**

The point is effectively, if rather cynically made by an old rhyme.

*"They bumped old granny off you know, she only had a cold.*
*Her sufferings, they told the court, were dreadful to behold.*
*The judge was kind, besides he said, she's getting rather old.*
*So they left the court and went away to share old granny's gold."*
(quoted in John Searle, Kill or Care?)

Sick and elderly people are often very emotionally vulnerable and will sign anything their relatives put in front of them, and take any medicine their doctor prescribes for them. And it is not at all easy to devise a procedure that would permit euthanasia and not be open to such abuse.

***(iii) The difficulty of establishing valid consent***

It is well known that people in a state of depression often express suicidal thoughts, or even commit suicidal acts, which they later emphatically disown. Take this letter to The Times from Mrs Jean Haslam, 24th October 1980:

It is well established that many people pass through a depressed phase in the process of coming to terms with serious illness or bereavement. Any legislation to permit voluntary euthanasia would have to be proof against indications of consent generated by temporary morbidity of this kind.

The "living will" is even more vulnerable to criticism on this score, since people who are not depressed at all frequently change their minds.

***(iv) The end of the Hippocratic Oath?***

In any situation where knowledge is one-sided the possibility of some kind of exploitative rip-off is present. It is for this reason that respectable second-hand car dealers offer a warranty on their vehicles. It is the only way the customer can be assured that vital information is not being withheld that will make them regret their purchase in the future.

The asymmetry of information between a doctor and patient is vast. It is absolutely vital, therefore, if trust is to be sustained in the relationship, that the highest standards of professional ethics be displayed. In the past, the Hippocratic Oath has been the foundation of this trust. It affirms that a doctor shall do no harm to a patient, but use his or her knowledge only for the relief of suffering and the preservation of life.

> *"I will give no deadly medicine to anyone if asked, nor suggest such counsel'.*

To abandon this warranty on the nature of good medical practice, as euthanasia would certainly require, inevitably leads to the introduction of an element of suspicion into doctor-patient relationships. An elderly patient, for instance, might well begin to wonder if their doctor was in league with the family to do away with them.

And what about doctors who for reasons of conscience feel they cannot participate in euthanasia? It is becoming difficult for medical staff with conscientious objections to abortion to work in the field of gynaecology these days. Euthanasia would affect a far wider spectrum of medical practice. Would its introduction not lead to even greater limits on the professional careers of doctors and nurses who preferred to remain bound by the Hippocratic tradition?

***(v) The thin end of the wedge***

Without wishing to indulge in irresponsible scare-mongering, it is important to be realistic about where a permissive law on euthanasia would eventually lead us.

When David Steele's abortion law was passed in the late 1960s, it was argued this was simply a necessary remedy to the unacceptable incidence of backstreet abortions. There was no anticipation at all of the escalation in abortion statistics that would result. One suspects that many who voted for the bill later regretted at least in some measure the unquestioning support they gave it. There is every reason to fear that opening the door to euthanasia, even if only by a crack, will have similarly disastrous long-term consequences.

The experience of Holland is instructive in this respect. Though it is difficult to establish reliable figures, many estimate that between five and ten per cent of annual deaths in Holland involve euthanasia. More alarming still was the admission of the government-sponsored Remmelink Report in 1991 that there had been a thousand cases of non-voluntary euthanasia, which Dutch protocol does not permit officially at all. And several independent studies have found that the agreed procedures to prevent abuse and establish valid consent are frequently flouted in practice and that only a fraction of actual cases are officially notified. The story here would no doubt be similar within a very short space of time.

We must beware too of an excessively idealistic picture of the medical profession. There are doctors around like Jack Kevorkian, nicknamed "Doctor Death". He constructed a number of bizarre suicide machines, one of which he installed in the back of a Volkswagen van. These machines enabled clients to kill themselves with poison supplied indirectly by Kevorkian. At least nine people hired the machines before the Michigan legislature tightened the state law on assisted suicide to prevent their further use. Unscrupulous and downright insane doctors will exploit their professional status to make money or indulge their homicidal tendencies if euthanasia gives them the opportunity.

And we must not forget the effect a permissive attitude towards euthanasia had in pre-War Germany. Long before Hitler turned his attention to the Jews, there was a widescale campaign to exterminate the mentally and physically defective within the population. Led by the notorious Dr. Karl Brandt, the Nazi euthanasia programme put at least 275,000 people to death in its killing centres. They included schizophrenics, epileptics, and those suffering from disorders like Parkinsonism, multiple sclerosis, paraplegia and brain tumours. Brandt claimed at the Nuremburg trials:

Dr Leo Alexander, a psychiatrist who studied the matter extensively in the late 1940s, describes the process of moral attrition by which the German people were educated into accepting Brandt's callous attitude:

The gas chambers of the holocaust were at the end of a slippery slope which began with very rational and plausible arguments in the early 1930s about the expediency of eliminating socially useless people in the best interests both of themselves and of the state.

Western doctors were shocked to the core by the revelations of the Nuremberg trials. The BMA in 1947 issued a statement which it would do well to reprint in the light of the current controversy:

It is of course a mistake to think that we can legislate morality. But it is vital to realise that legislation can corrode morality. Law educates culture as well as reflecting it. Thus, what may begin as apparently minor and moderate amendments to the law can end as monstrous denials of human dignity.

Already the debate about euthanasia is showing evidence of broadening. From p.v.s. victims it is not far to advanced cases of Alzheimer's Disease; from mentally handicapped infants to mentally handicapped adults.

How will an elderly or chronically ill person begin to feel if euthanasia becomes a regular and socially accepted event? "I can't do anything useful for anybody. I'm just a drain on everybody's resources, a burden they would rather be without. I may as well sign that form the doctor mentioned last time he had to renew my prescription and saw how much the drugs cost!" The right to die will very quickly be perceived by those who find themselves dependent on others as a duty to die. Euthanasia is bound to have an insidious long-term effect on how we value people and how as human beings we value ourselves.

**3. A Challenge and an Opportunity**

The argument has not yet been won by the pro-euthanasia advocates. Both the BMA and the Royal College of Nursing are in opposition. This conservative stance is all the more interesting in view of the fact that there was much less professional resistance to the pro-abortion movement. Maybe there are enough senior doctors around who remember Karl Brandt and the Nazi experiment? Or maybe it is advances in analgesia and the immensely valued work of Dame Cicely Saunders and the hospice movement that has swung medical opinion. It is noteworthy that the hospice alternative is far less developed in Holland where medical opinion seems much more in favour of euthanasia. Whatever the reasons, there is a strong residuum of commitment to the spirit of the Hippocratic Oath within the medical profession in the UK. Christians will not be alone in resisting any liberalising move.

We must beware, however, of adopting a defensiveness on the issue which fails to engage responsibly with the very serious intellectual challenge with which developments in modern medicine confront us. These matters are not simple, and raise profound questions about just what is meant by the sanctity of life. In an important book entitled *Life's Dominion*, Prof. Ronald Dworkin, though speaking from a decidedly secularist viewpoint, identifies the universal conviction which human beings share concerning the value and significance of their own existence. He acknowledges that there is an essentially intuitive element in this conviction which can only be called in the broadest sense "religious". The belief that life is in some sense "sacred" and that the way we die therefore matters, is the reason that the issue of euthanasia is so emotive for all concerned, be they liberal or conservative in their opinions about it.

Christians have an opportunity in this renewed debate to articulate that innate belief in the sanctity of life and interpret it for modern men and women who under the assault of humanistic philosophy find themselves no longer able to rationalise it for themselves. When Paul sought to find an Achilles' heel in intellectual defences of rationalistic Athens, he homed in on their altar to "the unknown god": a conspicuous confession within Athenian culture that there was something of which they were dimly aware but which their philosophy could not handle. It may be that the sanctity of human life may prove to be such an "altar" for late twentieth century culture: a signpost to the God who has not left himself without witness in the consciences even of those who are wilfully and culpably ignorant of him.

T*his essay was first published by Cambridge Papers in September 1993.*