

Mercy Death Risks Are Far Too Great

Nicholas Tonti-Filippini

In Western countries, there is a relentless effort by advocates of euthanasia to effect change to the law, either by proposing changes to the criminal law statutes or by seeking regulatory guidelines in relation to the enforcement of the criminal law so that “mercy-killing” in defined circumstances is not prosecuted. The latter was the route taken in the Netherlands, with guidelines issued by the Royal Medical Society that only relatively recently became established practice supported in statute law. The initial medical guidelines permitted assisted suicide for the terminally ill if

- The patient’s decision is voluntary, well-considered, and persistent.
- The patient has unbearable pain without hope of improvement.
- The decision is made by more than one doctor, and the doctor and patient agree that euthanasia is the only reasonable option.

However, in thirty years from this restricted beginning, the Netherlands moved from assisted suicide to euthanasia and, as Herbert Hendin puts it, “from euthanasia for terminally ill patients to euthanasia for those who are chronically ill, from euthanasia for physical illness to euthanasia for psychological distress, and from voluntary euthanasia to nonvoluntary and involuntary euthanasia”¹ or, as the Dutch prefer to call it, “termination of the patient without explicit request.”²

¹ [Herbert Hendin, *Seduced by Death: Doctors, Patients, and Assisted Suicide*, rev. ed. (New York: W. W. Norton, 1998), 135.]

² Hermina Dykxhoorn, “Euthanasia in the Netherlands,” <http://www.euthanasia.com/netherlands.html>.

A similar process has developed in the United Kingdom, with the Crown Prosecution Service issuing guidelines for assisted suicide, citing six public-interest factors for not prosecuting:

- The victim had reached a voluntary, clear, settled and informed decision to commit suicide.
- The suspect was wholly motivated by compassion.
- The actions of the suspect, although sufficient to come within the definition of the crime, were of only minor encouragement or assistance.
- The suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide.
- The actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide.
- The suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.³

Belgium and the US State of Oregon followed the more direct route of immediate statute change.⁴ On October 27, 1997, Oregon enacted the Death with Dignity Act, “which allows terminally ill Oregonians to end their lives through the voluntary self-administration of lethal medications expressly prescribed by a physician for that purpose.”⁵

In Switzerland, an old law has been interpreted to allow assisted suicide. Samia Hurst and Alex Mauron note that “article 115 of the Swiss penal code considers assisting suicide a crime if, and only if, the motive is selfish. It thus condones assisting suicide for altruistic reasons. In most cases the permissibility of altruistic-assisted suicide cannot be overridden by a duty to save life. Article 115 does not require the involvement of a physician nor that the patient be terminally ill. It only requires that the motive be unselfish.”⁶

³ Crown Prosecution Service, [“Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide,” CPS website, February 2010, updated October 2014, http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html].

⁴ [See “The Belgian Act on Euthanasia of May 28th 2002,” *Ethical Perspectives* 9.2–3 (June 2002): 182–188, an unofficial translation “provided by Dale Kidd under the supervision of Prof. Herman Nys, Centre for Biomedical Ethics and Law, Catholic University of Leuven (Belgium),” <http://www.ethical-perspectives.be/viewpic.php?TABLE=EP&ID=59>; and Oregon Death with Dignity Act, Oregon Revised Statutes §§ 127.800–127.995, enacted October 27, 1997, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/statute.pdf>].

⁵ [Oregon Health Authority, Death with Dignity Act webpage, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx>.]

⁶ Samia A. Hurst and Alex Mauron, “Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-physicians,” *BMJ* 326.7383 (February 1, 2003): 271–273, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1125125/>.

Apart from lawful killing, there are also some indications that a small proportion of health professionals are willing to take the law into their own hands even in circumstances in which it is unlawful.⁷ Where it is lawful, there are also indications that doctors will practice euthanasia outside the legal requirements.⁸

Personal Perspective

I write this article as a person whose protected status would likely be affected was the jurisdiction where I reside to change the law to permit euthanasia.

I am dealing with my own terminal illness (combination of renal failure, advanced ischaemic heart disease and rheumatoid auto-immune disease) and am dependent on haemodialysis and palliative care. I have undergone fifteen angioplasty procedures and the placement of eight stents to attempt to recover some blood flow after the failure of coronary bypass surgery. The last such procedure was unsuccessful, as the blocked artery could not be accessed. The rheumatoid disease causes chronic pleuropericarditis. I mention these matters only to establish that I am no stranger to suffering and disability, and am well aware of the limitations of palliative care. It is particularly difficult to control chronic pain, because the effectiveness of most forms of pain relief is of limited duration, given the development of therapeutic tolerance. I have reached the limits of what palliative care can offer.

I cannot speak for all people who suffer from illness and disability, but think I can speak more credibly about suffering, illness, and disability than those people who advocate for euthanasia with an ideological view of suffering and disability. Facing illness and disability takes courage, and we do not need those euthanasia advocates to tell us that we are so lacking dignity and have such a poor quality of life that our lives are not worth living.

Professionally, I have been involved in issues to do with the care of the terminally ill for many years, having been Australia's first hospital ethicist twenty-eight years ago, at St. Vincent's Hospital, Melbourne, where I was also director of bioethics for eight years. Since then I have been a consultant ethicist in private practice and have taught ethics in the medical faculties of the University of Melbourne and Monash University, before taking my current position at the John Paul II Institute. The Institute is associated with the Lateran University in Rome and is a registered Higher Education Provider in Australia, offering accredited specialist graduate courses in bioethics and in theological studies in marriage and family.

Also relevant is that recently I had the experience of chairing a National Health and Medical Research Council (NHMRC) working committee preparing guidelines

⁷ Peter Baume and Emma O'Malley, "Euthanasia: Attitudes and Practices of Medical Practitioners," *Medical Journal of Australia* 161.2 (July 18, 1994): 137, 140, 142–144; and Charles Wadell et al., "Treatment Decision-Making at the End of Life: A Survey of Australian Doctors' Attitudes towards Patients' Wishes and Euthanasia," *Medical Journal of Australia* 165.10 (November 18, 1996): 540.

⁸ Paul J. van der Maas et al., "Euthanasia and Other Medical Decisions concerning the End of Life," *Lancet* 338.8768 (September 14, 1991): 669–674.

for the care of people in an unresponsive state or a minimally responsive state, and received a large number of public submissions on that topic. The strength of submissions from people who care daily for Australia's most dependent and needy individuals was overwhelming, and I highly recommend that you read the public submissions on the NHMRC's website or at least the NHMRC *Ethical Guidelines for the Care of People in an Unresponsive State or a Minimally Responsive State*.⁹ Importantly, the guidelines provide a careful analysis of the way in which care decisions may be made so as to preserve respect for the dignity and worth of people who are profoundly disabled and to provide care for the families and others who care for people in a post-coma unresponsive state or minimally responsive state.

I have also had a long-term association with a home hospice service that serves the eastern area of Melbourne. I would like to record my own view that it would not benefit seriously ill people, particularly those who are terminally ill and suffering intractably, if the Euthanasia Laws Act was rescinded. The current legal situation, while not perfect, does provide a measure of protection against the terminally ill being regarded as a burden. As a chronically ill person, I know well what it is to feel that one is a burden to others, to both family and community, how isolating illness and disability can be, and how difficult it is to maintain hope in the circumstances of illness, disability and severe pain, especially chronic pain.

For several years, until I objected, I received from my health insurer a letter that tells me how much it costs the fund to maintain my health care. I dreaded receiving that letter and the psychological reasoning that would seem to have motivated it. The fear of being a burden is a major risk to the survival of those who are chronically ill. If euthanasia were lawful, that sense of burden would be greatly increased, for there would be even greater moral pressure to relinquish one's hold on a burdensome life. Seriously ill people do not need euthanasia. We need better palliative care services aimed at managing symptoms and maximising function, especially as we approach death. Rather than help to die, the cause of dignity would be more greatly helped if more was done to help people live more fully with the dying process.

Palliative Neglect

The proposal to make provision for a terminally person who is suffering to request, and a doctor to provide, assistance to die makes it less likely that adequate efforts will be made to make better provision for palliative care services. Legalised euthanasia would give those responsible for funding and providing palliative care a political "out" in that respect.

In many jurisdictions, too little is done to make adequate palliative care available to those who need it:

⁹ [National Health and Medical Research Council, *Ethical Guidelines for the Care of People in Post-coma Unresponsiveness (Vegetative State) or a Minimally Responsive State* (Canberra: Australian Government, 2008), <https://www.nhmrc.gov.au/health-ethics/ethical-issues/development-guidelines-care-people-post-coma-unresponsiveness>. The public submissions are no longer available online.]

- Current entry requirements for palliative care usually exclude people with chronic pain, and [care] is often limited to people who are in the last stage of cancer with a prognosis of less than eight weeks.
- Government pharmaceutical subsidies, where they exist, for the more effective forms of pain relief are often restricted to cancer patients.
- People living outside major cities often have little access to palliative care facilities.
- Few doctors are adequately trained to provide palliative care.
- Such palliative care services as exist are chronically underfunded and struggle to provide the complex range of services that are needed to assist a person to live with pain and disability.
- Most pain clinics are over-subscribed and have long waiting lists. For people who are left suffering, such waiting is unconscionable.

Medical research in this area indicates that the desire for euthanasia is not confined to physical or psychosocial concerns relating to advanced disease, but “incorporates hidden existential yearnings for connectedness, care and respect, understood within the context of the patients’ lived experience. Euthanasia requests cannot be taken at face value but require in-depth exploration of their covert meaning, in order to ensure that the patients’ needs are being addressed adequately.”¹⁰ In most jurisdictions what is needed is often not available, or not available in time. It is distressing to note that in the US State of Oregon in 2009, none of the patients who were lawfully killed at their own request were referred for formal psychiatric or psychological evaluation. It is also distressing to note that two thirds of people lawfully killed under euthanasia laws, in those jurisdictions that permit it, are women.¹¹

If euthanasia or assisted suicide were to become a legitimate option with a determined structure, as was the case in the Australian Northern Territory for a brief period and is now the case in Switzerland, Belgium, the Netherlands, and Oregon, then life for the chronically seriously ill would become contingent on maintaining a desire to continue in the face of being classified as a burden to others. Essentially, such legislation or guidelines involve setting up a category for people whose lives may be deliberately ended. Their protected status as a member of their communities depends on a contingency. Passage of such legislation would imply that our community considers that our continued survival depends on us not succumbing to the effects of pain and suffering, depends on us not losing hope.

Chronically ill people need the unequivocal protection of their lives. We need protection and encouragement from our community; we do not need this form of discrimination. Far from protecting the dignity of those who are seriously ill and

¹⁰ Yvonne Yi Wood Mak and Glyn Elwyn, “Voices of the Terminally Ill: Uncovering the Meaning of Desire for Euthanasia,” *Palliative Medicine* 19.4 (June 2005): 343.

¹¹ Susan M. Wolf, “Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia,” in *Feminism and Bioethics: Beyond Reproduction*, ed. Susan M. Wolf (New York: Oxford University Press, 1996), 291.

suffering, the Bill would undermine dignity by undermining our sense of individual worth as a person, no matter our suffering and disability.

It should be noted that of the seven deaths that happened under the terms of the Rights of the Terminally Act in the Northern Territory of Australia that permitted euthanasia, four cases did not actually meet the criteria.¹² The legislation was manifestly unsafe, and I would argue that legislation that permits euthanasia could never be made safe for those of us who have serious chronic illnesses, because the essence of such legislation is to make respect for our lives contingent upon the strength of our will to survive. Such legislation depends on each of us—who have a serious illness and are suffering—not losing hope. If euthanasia is lawful, then the question about whether our lives are overly burdensome will be in not only our minds but also the minds of those health professionals and those family members on whose support and encouragement we depend. The mere existence of the option will affect attitudes to our care and hence our own willingness to continue.

That desire to live is often tenuous in the face of suffering and in the face of the burden our illnesses impose on others, our families and the wider community. Politicians would gain nothing worthwhile for us by supporting the legalisation of deliberately ending the life of those who request death. Such requests warrant a response in solidarity from our community, a response that seeks to give us more support and better care rather than termination of both life and care.

Often these proposals contain safeguards, such as

- Requiring two doctors, including a specialist, to examine the person making the request
- Demanding that a psychiatrist be consulted if either doctor believes the person is not of sound mind or is acting under “undue influence.”
- Creating some kind of bureaucracy to register euthanasia and even having powers to intervene if a relevant medical practitioner believes a request for euthanasia should not be granted
- Providing strict restrictions on witnesses, jail terms for misleading statements, and a ban on for-profit centres and the promotion of voluntary euthanasia by insurance companies

However, there are usually many practical problems with such legislation, including these:

- The legislation is likely to have a very wide scope, affecting not just those who are imminently dying. The definition of “terminal illness” includes people who may be months or years away from their illness-causing death. As a person whose life depends on extraordinary care, including haemodialysis for four four-hour sessions each week, on that basis alone, I fit the description. I also

¹² David W. Kissane, Annette Street, and Philip Nitschke, “Seven Deaths in Darwin: Case Studies under the Rights of the Terminally Ill Act, Northern Territory, Australia,” *Lancet* 352.9134 (October 3, 1998): 1097–1102.

have severe angina throughout those sessions, caused by the haemodynamics of the treatment and my own compromised coronary flows, and I have many other episodes of pain throughout the day, including waking at night in pain. Whether that is a profound level of pain and distress depends on the support that I receive from those close to me as much as it depends on my own will. That euthanasia is not offered to me is important to that response. People who are ill and disabled need that support and encouragement and the knowledge that those around them value them.

- The legislation is often ideologically driven and has not been generated by a broad-based enquiry that has taken into account the interests of all citizens, and especially those with chronic or terminal illness. It is a narrow approach that excludes the provision of adequate care and support for those in need, and appears to be more a matter of ideology than a genuine attempt to respond to the range of matters that affect us.
- The legislation would expect the doctors involved to prescribe a drug not for legitimate purposes that define the medical vocation, such as the care of the patient or the treatment of illness, but as an intentional and active intervention to end the life of the patient. In that respect, the bill is not supported by the Australian Medical Association or any of the medical colleges. The American Medical Association also “strongly opposes any bill to legalise physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician’s role as healer.”¹³
- The legislation is not supported by organisations and institutions directly involved in aged care, the care of the dying or the care of those with chronic illness. Those involved in day-to-day care are generally not in favour of being given the capacity to end the lives of those they care for.
- The legislation would make protection of the lives of those who are chronically ill dependent on the strength of their will to continue. The fear of being a burden is a major risk to the survival of those who are chronically ill. If euthanasia were lawful, that sense of burden would be greatly increased, for there would be even greater moral pressure to relinquish one’s hold on a burdensome life and to remove that burden from the lives of others.
- The legislation usually uses a notion of unbearable pain. A major part of pain experience and our capacity to tolerate it is what is sometimes called “existential pain.” Pain of an existential nature arises usually from loneliness and a lack of sense of self-worth. The option for euthanasia provides an out for families and carers: the fact that the option exists would be likely to make someone who had a burdensome illness feel even less valued, and increase the likelihood that they would choose death over dying alone or being a burden to others. Serious illness and dying are times when a person needs the

¹³ Wood Mak and Elwyn, “Voices of the Terminally Ill.”

support of others so that others can share empathy with that person.¹⁴ The possibility of opting instead for a fatal prescription would cast a shadow over those relationships and would be likely to undermine the person's wish to be wanted and valued.

- Pain and suffering are complex, involving physical, psychological, emotional and spiritual elements. Palliative care seeks to address the needs of those who are suffering in a multi-disciplinary way that reflects the many elements involved. Crucial to good palliative care is the support of the patients socially, emotionally, and spiritually. It is not simply a matter of relieving physical pain. For those who continue to live with a burdensome illness, the option of euthanasia would undermine one of the essential elements of good pain relief, the notion that the person is supported, loved, and wanted.
- In places such as the United Kingdom, for instance, which have adopted very liberal policies on other social policies, such as reproductive technology, gay unions, and abortion, parliaments have strongly opposed euthanasia because euthanasia cannot be made safe for people who are seriously ill and thus vulnerable. It is worth noting that jurisdictions that legalised euthanasia, such as the Netherlands and Belgium, lacked the availability of the kind of palliative care services that had developed in the United Kingdom.
- Euthanasia law cannot be made safe. The Northern Territory briefly had similar law. As discussed above, several of those for whom the legislation was implemented did not in fact meet the criteria of the Act despite the safeguards.¹⁵ This is reflected also in the Dutch experience, where much larger numbers than were expected have been subject to the law, raising human rights concerns. (See United Nations concern below.)
- Euthanasia is contrary to the international human rights instruments. When the Human Rights Committee of the United Nations considered a euthanasia law enacted in the Netherlands to codify what had become euthanasia practice, the committee said that “where a State party seeks to relax legal protection with respect to an act deliberately intended to put an end to human life, the Committee believes that [the International Covenant on Civil and Political Rights] obliges it to apply the most rigorous scrutiny to determine whether the State party's obligations to ensure the right to life are being complied with (articles 2 and 6 of the Covenant).” The committee expressed the concerns that the new Act (in the Netherlands) contains “a number of conditions under which the physician is not punishable when he or she terminates the life of a person, inter alia at the ‘voluntary and well-considered request’ of the patient in a situation of ‘unbearable suffering’ offering ‘no prospect of improvement’ and ‘no other reasonable solution.’” The committee also expressed concern

¹⁴ Peter L. Hudson et al., [Desire for Hastened Death in Patients with Advanced Disease and the Evidence Base of Clinical Guidelines: A Systematic Review,” *Palliative Medicine* 20.7 (October 2006): 693–701.]

¹⁵ Kissane et al., “Seven Deaths in Darwin.” Note that one of the authors, Nitschke, was a major proponent of the Northern Territory legislation.

“lest such a system may fail to detect and prevent situations where undue pressure could lead to these criteria being circumvented.” The committee was also concerned that, “with the passage of time, such a practice may lead to routinization and insensitivity to the strict application of the requirements in a way not anticipated. The Committee learnt with unease that under the present legal system more than 2000 cases of euthanasia and assisted suicide (or a combination of both) were reported to the [Netherlands] review committee in the year 2000 and that the review committee came to a negative assessment only in three cases. The large numbers involved raise doubts whether the present system is only being used in extreme cases in which all the substantive conditions are scrupulously maintained.”¹⁶

People often make a distinction between *active euthanasia*, in which a fatal intervention such as a drug overdose is given in order to end the suffering by ending the life, and *passive euthanasia*, in which life-prolonging treatment is deliberately withdrawn in order to end the suffering by ending the person’s life.

The Catholic Church makes no such distinction, and has declared that “euthanasia in the strict sense is understood to be an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering. ‘Euthanasia’s terms of reference, therefore, are to be found in the intention of the will and in the methods used.’” The Church asserts that “euthanasia is a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person.”¹⁷

The Church, however, makes a distinction between passive euthanasia, or killing by omission, and withdrawing or withholding treatment that is futile (that is, it is ineffective) or overly burdensome:

Euthanasia must be distinguished from the decision to forgo so-called “aggressive medical treatment,” in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. In such situations, when death is clearly imminent and inevitable, one can in conscience “refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.” Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement. To forgo extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death.¹⁸

¹⁶ United Nations Human Rights Committee, Seventy-Second Session, *International Covenant on Civil and Political Rights: Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: Netherlands* (CCPR/CO/72/NET), August 27, 2001, 5(a) and (b).

¹⁷ John Paul II, *Evangelium vitae* (March 25, 1995), n. 65, quoting Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (May 5, 1980).

¹⁸ *Ibid.*

Simply expressed, therefore, euthanasia may be defined as deliberately bringing about death by active intervention (e.g., overdose) or by neglect of reasonable care (e.g., withholding non-burdensome treatments, such as nutrition and hydration or antibiotics) in order to end suffering by ending life.

Conclusion

Euthanasia law can never be made safe to protect the vulnerable, as experiences in other countries have proved.

Instead, more resources should be spent on palliative care services.

Euthanasia is not supported by those in the medical profession and others in the care of the aged, dying, and those with chronic pain.