EUTHANASIA

and Physician-Assisted Suicide

A major debate is currently taking place in the United Kingdom which directly challenges the sanctity of human life. This folder presents basic information about this crucial issue.

1. EUTHANASIA

Euthanasia is the deliberate act of putting an end to a patient's life. Physician Assisted Suicide is the death of a patient as a direct consequence of help by a doctor.

Most dictionary definitions present *'to kill'* as *'to put to death'* or *'to cause death'*. Whatever the intentions claimed for Euthanasia or Physician Assisted Suicide, this is nothing less than killing a patient. For this reason Euthanasia is illegal in this country and in most countries worldwide.

2. TERMS USED

All definitions of euthanasia agree that euthanasia means shortening the patient's life usually based on the belief that the patient would be better off dead.

Euthanasia is the active, intentional termination of a patient's life by a doctor who thinks that death is of benefit to the patient[1].
Voluntary euthanasia is euthanasia at the request (or at least with the consent) of the patient.
Involuntary euthanasia is euthanasia carried out against the wishes of a competent person.
Non-voluntary euthanasia is euthanasia carried out on incompetent patients such as babies or patients with dementia.
Active euthanasia is the intentional taking of a patient's life by a doctor who thinks that death is of benefit to the patient.
Passive euthanasia is the intentional termination of a patient's life by omission, for example by withdrawing treatment.
Physician-assisted suicide – is where a doctor helps the patient to take his or her own life.

The European Association for Palliative Care in a recent statement[2] emphasises that **medicalised killing of a patient either without consent (non-voluntary euthanasia) or against their consent (involuntary euthanasia) should not be called euthanasia at all, since this constitutes murder**. The Association also questions the distinction between 'active' and 'passive' euthanasia, stating that **euthanasia is an active decision by definition. The term 'passive euthanasia' should be abandoned**.[3] The Association therefore recommends using the terms euthanasia and physician-assisted suicide only.

3. CONFUSION

The debate about euthanasia is riddled with confusion. Much of this originates from the imprecise use of the words employed in the discussion. For example, some think that euthanasia may mean withdrawing life-prolonging treatment at the patient's request because it has become too burdensome for the patient. It is possible that some people surveyed by opinion polls who state that they are in favour of euthanasia may actually mean that they are in favour of being allowed to refuse burdensome treatment. However, it is perfectly possible to refuse medical treatment without the drastic step of legalising euthanasia.

4. THE ARGUMENTS

Despite all the medical advances, there are still patients who die in pain and distress and that steps should be taken to achieve a 'good death'. It is suggested that this could be accomplished by doctors administering a lethal injection (euthanasia) or the patient being helped by the doctor to die (physician-assisted suicide).

It is claimed that euthanasia is about the 'right to die'. However, euthanasia is not about the 'right to die', it is about giving doctors the 'right to kill' their patients.

The ethical question remains – **can it ever be right to kill, even with the intention to relieve suffering?** The law of most countries – including the UK – is clear on this. To kill a patient, even with the intent to relieve suffering, is considered murder or manslaughter. Currently, only the Netherlands and Belgium have formally legalised euthanasia and/or physician-assisted suicide. Physician-assisted suicide was legalised in Oregon, USA, in 1997.

A further question regarding euthanasia needs to be asked: If euthanasia became legal, **would patients be killed who had not requested to die?** The experience of the Netherlands in legalising euthanasia points to the fact that euthanasia, once legalised, cannot be effectively controlled. Voluntary euthanasia inexorably leads to involuntary euthanasia.

Euthanasia, initially intended for certain groups such as patients with terminal diseases will soon be performed on other groups of patients including the elderly, incapacitated patients, patients suffering with emotional distress, the disabled, and even children and newborn babies with disabilities who cannot ask for euthanasia.

There is clear evidence from the Netherlands that voluntary euthanasia leads to involuntary and non-voluntary euthanasia with at least **one thousand patients including children being killed every year without their expressed consent and/or against their will**. **This constitutes murder.** The Dutch experience is discussed in detail in paragraph 13.

5. THE SANCTITY OF LIFE

Human life has an intrinsic value. The Judaeo-Christian tradition holds that man is created in the image of God and therefore human life has an intrinsic dignity. This tradition underlies the **moral and legal principle of the sanctity or inviolability of human life, that one should never intentionally kill an innocent human being**.[4]

From a non-religious point of view and avoiding the term 'sanctity' this principle would be based on the term 'inviolability'

of human life. The Hippocratic oath affirms this same principle, not to prescribe a deadly drug and not to give advice causing death nor to procure an abortion.[5] The Declaration of Geneva by the World Medical Association (1948) states: *'I will maintain the utmost respect for human life from its beginning'.*[6] The same principle is also enshrined in the European Convention on Human Rights**.** Article 2 states: '*Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally…'*[7]

The principle of sanctity or inviolability of life prohibits intentional killing but it does not require that life must be preserved at all cost, for example through invasive treatment, such as ventilation, against the wishes of a competent patient or where treatment would be futile, for example aggressive chemotherapy in advanced metastatic cancer. However, this principle prohibits the intentional shortening of a person's life.

The **difference to euthanasia remains that if one accepts the principle of sanctity or inviolability of life, that the *patient's life is always considered worthwhile*** - and this is not questioned - however the ***treatment may not always be considered worthwhile***. This **contrasts with the approach taken by proponents of euthanasia who state that the patient's life is not worthwhile and therefore should be terminated**. Proponents of euthanasia use the concept of 'quality of life' to assess whether the patients life is worth preserving.

Ultimately, if euthanasia became legalised, the decision whether to terminate or preserve a patients life will rest with the medical profession. Despite all the claims by proponents of euthanasia, this would dramatically increase the power doctors have over their patients and severely decrease patient autonomy. The German physician Christoph William Hufeland wrote in 1806: *'It is not up to [the doctor] whether life is happy or unhappy, worth while or not, and should he incorporate these perspectives into his trade the doctor could well become the most dangerous person in the state.'*[8]

6. PATIENT AUTONOMY

Despite all the talk about 'patient autonomy' or 'patient choice' by proponents of euthanasia, ultimately, one or more doctors would have to make a value judgment as to whether a patient's quality of life is such as to preserve or terminate his or her life, or whether the patient would be better off dead. It should be noted that it does not take a doctor to kill a person. We are convinced that the reasons why those propagating euthanasia wish doctors to be involved is the attempt to give euthanasia, the killing of patients, a degree of false respectability.

A patient who may be convinced that his or her life is not worth living and who wants euthanasia will not be able to force the doctor to perform euthanasia or help with physician-assisted suicide if the doctor disagrees. For example while the patient thinks he/she is suffering unbearably the doctor may disagree. In Holland, just under 40% of all the 9,700 requests for euthanasia made in 2001 were accepted by the doctor.[9]

In addition, more than one-third of requests for euthanasia in the Netherlands are rejected by doctors since the doctor was not convinced that the patient was suffering intolerably.[10] Conversely, if the doctor is convinced that the patient's life is not worth preserving, he or she may perform euthanasia even against or without the patient's consent, this happens in at least 1,000 cases per year in the Netherlands.

7. THE CHOICE OF DEATH – A HUMAN RIGHT?

In our individualistic western society, individual choices and 'rights' are elevated to a quasi-religious good that no-one is allowed to argue with. What proponents of such an approach forget is that individual choices are only beneficial and non-destructive to society if performed within a moral framework. What about the individual's 'right' to choose paedophilia or to abuse crack cocaine? These activities are illegal because they have an adverse effect upon society. If autonomy is considered the highest value, then moral pluralism ('I do what is right for me') and moral relativism ('I decide what is right or wrong') will follow with disastrous effects on the fabric of society.

Contrary to the perception of the individualistic self-centred approach, our choices, especially if they affect crucial issues of life or death – have profound impact on others, especially the person's relatives as the recent case of a British couple showed who died in Switzerland following an overdose of barbiturates. In April 2003, a 59 year old epileptic man and his 53 year old wife who suffered from diabetes and back problem went to the Swiss suicide organisation Dignitas and were given a lethal cocktail of drugs. Neither of them had a terminal disease. The relatives were not aware of their plans and were obviously very shocked.[11]
Most importantly we should ask: how autonomous is the wish of a patient to die?

8. THE EVIDENCE OF TERMINALLY ILL PATIENTS

Recent research carried out on patients with terminal illnesses questions the concept of patient autonomy in requesting euthanasia for two reasons:

A. The wish to die

The wish to die is more an expression of depression, pain or the concern of being a burden rather than a genuine wish to die.

Among terminally ill patients occasional wishes that death would come soon were common in nearly half of all patients but only 9% of these individuals acknowledged a serious desire to die. **The desire for death was strongest in those with severe pain and low family support but most significantly in those with severe depression**. Nearly **60% of those patients who expressed a desire to die were depressed whereas depression was found in only 8% of patients without such a desire**. The authors conclude: '***The desire for death in terminally ill patients is closely associated with clinical depression – a potentially treatable condition – and can also decrease over time. Informed debate about euthanasia should recognize the importance of psychiatric considerations, as well as the inherent transience of many patients' expressed desire to die'***.[12]

In a study of HIV-infected patients the strongest predictors of interest in physician-assisted suicide was depression, hopelessness or suicidal ideation and experience with terminal illness in a family member or friend. Other strong predictors were Caucasian race, infrequent or no attendance at religious services, and perceived low level of social supports. The authors conclude: ***Patients' interest in physician-assisted suicide appeared to be more a function of psychological distress and social factors than physical factors***.[13]

In a study of terminally ill patients those patients with substantial care needs were **more likely to feel being an economic burden to others. This group was more likely to consider euthanasia or physician-assisted suicide.**[14]

In Oregon, physician-assisted suicide (PAS) was legalised in 1997. A recent survey found that, **with the increasing acceptance of PAS, the percentage of patients who died through PAS because they felt a burden to others** (not necessarily the only reason, however) **increased from 12% in 1998 to 26% in 1999 and to 63% in 2000**.[15] When Oregon

legalised PAS, only a minority of patients requested PAS because they felt a burden to others. However, with the increasing acceptance of PAS, nearly two-thirds of those dying through PAS cite being a burden to family, friends or caregivers as one of the main reasons for requesting PAS. These figures cast serious doubt over the assertion that the 'wish to die' is a truly autonomous decision**.**

B. The will to live

There is a very significant fluctuation in the will to live and the request for euthanasia among many patients. Patients who initially request euthanasia are particularly likely to change their minds when effective medical interventions such as pain control or treatment with an antidepressant are initiated.

In a study of cancer patients the 'will-to-live' was measured twice daily throughout the hospital stay. If the changes in the will-to-live score were less than 10%, this suggested that will-to-live was stable. By contrast, the **average maximum changes in will-to-live score were substantial, ranging between 33% after 12 hours to 68% after 30 days**. The main predictors of the will-to-live were depression, anxiety, shortness of breath, and sense of well-being.[16]

AIDS patients were asked about their preferences for cardiac resuscitation. One-quarter of AIDS patients who initially desired cardiac resuscitation had changed their minds four months later. **One-third of AIDS patients who initially declined cardiac resuscitation stated on the second interview that they would accept it now**. Patients reporting changes in physical function, pain, or suicide ideation were more likely to modify their desires to be resuscitated. [17]

In a survey of terminally ill patients, a total of 60% supported euthanasia in a hypothetical situation, however only 10.6% reported seriously considering euthanasia or PAS for themselves. **Factors associated with being less likely to request euthanasia were feeling appreciated, factors associated with being more likely to request euthanasia were depression, significant care needs and pain**. At follow-up interview **two to six months later, half of all terminally ill patients who had considered euthanasia or PAS for themselves changed their minds**, while an almost equal number began considering these interventions.[18]

In Oregon, **nearly one in two patients who initially requested physician-assisted suicide changed their mind after initiation of treatment, such as pain control, prescription of antidepressant medication or a referral to a hospice**. However, among those patients, where no active symptom control was initiated, only 15% of those who initially requested physician-assisted suicide changed their mind. [19]

9. A VERY SLIPPERY SLOPE

For some people it may not be morally objectionable to allow certain types of life and death decision making. For example, termination of pregnancy for medical reasons or legalising terminations in order to stop back street abortions. But there is a slippery slope here. One morally 'acceptable' decision can subtly open the door to other morally objectionable ones, such as termination of pregnancy solely for matters of convenience. For example, there is a case report of a termination carried out on a women who wanted a fourth child, however her current pregnancy would have interfered with a skiing holiday.[20] The risk of the slippery slope was cited by the Archbishop of York, Dr John Habgood, who wrote in 1974:

'Legislation to permit euthanasia would in the long run bring about profound changes in social attitudes towards death, illness, old age and the role of the medical profession. The Abortion Act has shown what happens. What ever the rights and wrongs concerning the present practice of abortion, there is no doubt about two consequences of the 1967 [Abortion] Act:

(a) The safeguards and assurances given when the Bill was passed have to a considerable extent being ignored.

(b) Abortion has now become a live option for anybody who is pregnant…. Because abortion is now on the agenda, the climate of opinion in which such a pregnancy must be faced has radically altered.[21]

10. THE IMPLICATIONS

Similarly, if euthanasia became legal, anyone with a medical condition – not just a terminal one – may consider euthanasia as a 'treatment option'. Euthanasia then would become an acceptable treatment option for conditions such as depression, stress, loneliness, fear of impending disease or fear of decline, but also for disabled children or adults. Euthanasia would become part of the armamentarium of medical treatment alongside established medical treatments such as pain relief, antidepressant medication, radiotherapy and chemotherapy.

As abortion is now an option for any pregnant women, euthanasia will become a 'treatment' option for anyone who is ill or considers him/herself to be ill. Dr Karel Gunning, a leading Dutch opponent of euthanasia states: ***'Once you accept killing as a solution for a single problem, you will find tomorrow hundreds of problems for which killing can be seen as a solution.'***[22]

11. PHYSICIAN-ASSISTED SUICIDE (PAS)

While in active euthanasia the doctor terminates the patient's life, in physician assisted suicide he assists the patient to take his own life. This may mean supplying a 'suicide pill' or developing a 'suicide machine' which injects the patient with a lethal substance.

While some claim that PAS has to do with patient autonomy and his right to be in control – as opposed to active euthanasia, where the Doctor is in control – it is far from clear that there is a significant difference between the two. The supposed greater degree of patient autonomy is overstated, since the doctor would not agree to 'help' unless he thought that suicide would be in the patient's best interest. The practical difference may not be that much - what is the real difference between a patient taking a lethal medication into his mouth and swallowing it or the doctor placing the lethal medication into the patient's mouth and the patient swallowing it? In both cases, the patient has to swallow, therefore making the 'ultimate' decision to end his or her life.

In the Netherlands, no distinct moral difference is made between euthanasia and PAS. Dutch doctors are aware that they frequently need to intervene if PAS 'fails' and the patient needs to be killed by the doctor. **In nearly one in five cases in which PAS was originally planned, complications occurred such as that the patient did not die as soon as expected, awoke from coma or the doctor felt compelled to administer a lethal injection**.[23]

One has the impression, that those who want to legalise euthanasia are attempting to sway public opinion with proposals to legalise PAS which may be more acceptable to the public (I can kill myself when I want to) than euthanasia (the doctor is going to kill me). It also 'avoids' the historical problem of euthanasia being a 'solution' for life not worth living in Nazi Germany, where thousands of disabled adults and children were killed, superficially to end their suffering, in reality to reduce cost to society.

12. EUTHANASIA IN GERMANY IN THE 1930s & 1940s

No discussion on the issue of euthanasia is complete without considering the history of the euthanasia programme in Germany in the 1930s and 1940s. Between 1939 and 1945 German physicians participated in a euthanasia programme established to kill 'life not worthy of life'. At the end of the war, an estimated 270,000 victims - disabled people or people with mental illnesses, the elderly and 'idiots' - were selected by doctors and terminated. This included approximately 8,000 infants with birth defects or congenital diseases such as Down's syndrome, and children with disabilities. The programme was expanded to include people with medical conditions such as epilepsy, polio, schizophrenia, paralysis and Huntington's disease. The euthanasia programme demanded the co-operation of German doctors who decided who was to be killed.

The intellectual preparation for this was done through a 1920 publication by two German professors, a professor of Criminal Law, Karl Binding and a professor of Psychiatry, Alfred Hoche. Their book on euthanasia with the title *'permitting the destruction of life not worthy of life'* was the first publication endorsing euthanasia by two highly respected academics.[24] One of the authors had realised how much it cost the German state to maintain 'idiots' and how much capital is withdrawn from the nation for such an 'unproductive purpose'. Euthanasia therefore would save huge amounts of money for the state.

Proponents of euthanasia today argue that the experiences of Nazi Germany are irrelevant for the euthanasia debate. However, **the ideology behind the euthanasia programme in the 1930s and 1940s in Germany was to deny the sanctity of life and to judge whether a life is worth living on a utilitarian principle, which is the same approach used by those favouring euthanasia today**. Professor Michael Franzblau, professor of medicine at the University of California and a 'Nazi hunter' who lost 25 relatives in the holocaust, has researched the Nazi ideology behind euthanasia. He states: *'**It is frightening to consider that many of the arguments made today by euthanasia advocates, echo almost precisely the arguments made by Binding and Hoche, and after them, Hitler and the Nazis as they implemented the euthanasia programme**.'*[25]

13. THE DUTCH EXPERIENCE TODAY

A. Background

It is an irony of history, that the Dutch medical profession mounted very strong and effective opposition to the German occupiers, also resisting euthanasia required of them. However, only three decades later, Holland moved towards acceptance of euthanasia and recently became the first country in the world to legalise euthanasia.

In 1984 the Dutch Supreme Court ruled that doctors could lawfully perform euthanasia in certain circumstances. In subsequent court cases, and a government bill which legalised euthanasia, a number of conditions for euthanasia were laid down, for example that the request for euthanasia must come only from the patient, it must be entirely free and voluntary, the patient must experience intolerable – but not necessarily physical – suffering with no prospect of improvement, euthanasia must be the last resort and euthanasia must be performed by a physician who must have consulted with an independent colleague who has experience in this field. Euthanasia can be performed on children aged 12 – 15 with parental consent, children between 16 and 17 do not require parental consent for euthanasia. [26]

It is doubtful, however if this guidance is really followed. For example John Keown, a senior lecturer in Law and Ethics of Medicine at Cambridge interviewed a leading Dutch practitioner of euthanasia. **An imaginary case of an old man who requested euthanasia because he felt a nuisance to his relatives who wanted him dead so that they could enjoy his estate was presented to the Dutch doctor. The doctor – who has given lectures on euthanasia to the police – stated that he would not rule out euthanasia in such a case**.[26] Another supporter of euthanasia in the Netherlands, a professor of Health Law, Professor Gevers observed: '***It is impossible to delineate precisely the situations in which euthanasia should be allowed***.'[26]
The evidence shows that euthanasia, once legalised, cannot be effectively controlled. **Dutch doctors have gone from killing the terminally ill who asked for it, to killing the chronically ill who ask for it, to killing the depressed who had no physical illness who ask for it, to killing newborn babies because they have birth defects, even though, by definition, they cannot ask for it**.[27]

B. Data

In 1991, the first official report on the extent and nature of euthanasia practiced in the Netherlands was published by a commission chaired by the Attorney General of the Dutch Supreme Court, Professor Remmelink. The report concluded that voluntary active euthanasia occurred in about 1.8% of all deaths or about 2,300 cases in 1990[28]. There were almost 400 cases of physician-assisted suicide, some 0.3% of all deaths. Disturbingly, the report found that in a further **1,000 cases (0.8% of all deaths) physicians administered a drug with the explicit purpose of hastening the end of life without an explicit request by the patient**.

Palliative drugs were administered in such high doses that would almost certainly shorten the life of the patients in 22,500 cases or 17.5% of all deaths. In at least one-third of these cases, palliative drugs were administered 'partly with the purpose of shortening life' in 6,750 cases and in a further 1,350 cases 'with the explicit purpose of shortening life'.[29] In a further 4,000 cases, treatment was withdrawn or withheld with the explicit purpose of shortening the patient's life without the explicit request by the patient.

Analysing the data of this first Remmelink report, John Keown comes to the conclusion that out of a total of **129,000 deaths that occurred in the Netherlands in 1990, 9,050 deaths – over 7% of all deaths – occurred because doctors explicitly intended to shorten life. 5,450 of these deaths – over 4% of all deaths – occurred without the explicit consent of the patient. In essence, these deaths constitute murder.**

A second survey was carried out in 1995-1996[30]. Out of all the 135,500 deaths that occurred in the Netherlands in 1995 the survey estimates that still 0.7% or approximately 950 patients died through euthanasia without their explicit consent. Large doses of opioids that led to death were administered in nearly 20,000 patients which is equivalent to nearly 15% of all deaths.

In 2001, the last year for which official data is available, approximately 1000 deaths (0.7% of total) were due to patients killed against their wishes or without explicit consent.[31] 'Alleviation of symptoms' with possible life-shortening effects occurred in nearly one in five of all deaths, over 28,000 deaths in 2001.

The 1995 reports observes a 37% increase in the requests for euthanasia since 1990 and an increase in the cases of euthanasia performed. Over half of all Dutch doctors surveyed in 1995 stated that they had performed euthanasia at some time and over a quarter of Dutch doctors had performed it in the past 24 months. **23% of the doctors surveyed stated that they had ended a patient's life without his or her explicit request**.[30]

In the Netherlands over the past few years cases of euthanasia have risen and euthanasia has become more acceptable to doctors: The number of requests for euthanasia increased from 1,600 per year in the late 1970s to 4,000 in the mid-eighties. The numbers then increased further to about 5,000 per year in the 1990s.[32] The percentage of deaths due to euthanasia as issued on death certificates increased from 1.7% of all deaths in 1990 (nearly 2,200 deaths) to 2.4% in 1995 (over 3,200 deaths) and further to 2.6% in 2001 (over 3,600 deaths). At the same time, the proportion of Dutch doctors who would never perform euthanasia fell from 4% in 1990 to 3% in 1995 to 1% in 2001. [31]

Euthanasia however does not stop with adults in the Netherlands. **8% of all neonatal deaths in the Netherlands occurred following the administration of drugs with the explicit aim of hastening death**.[33] A drug was given to explicitly hasten death to neonates not dependent on life-sustaining treatment in 1% of all deaths. **Nearly half of all Dutch neonatologists and nearly one-third of Dutch General Practitioners said they had given drugs explicitly to end the life of a neonate or infant in the past.** [33]

C. Clinical problems

Frequently, unintended and very distressing complications occur when euthanasia and physician-assisted suicide (PAS) are carried out.[23]

For example in **18% of cases where a patient attempted physician-assisted suicide the doctor had to intervene and kill the patient**, therefore performing euthanasia. The reasons for this were that the patient awoke from coma, or had difficulty taking all the oral medication, vomited after taking the first medication or fell asleep before taking all the medication. Furthermore, in nearly half of the cases which started as PAS the patient did not die quickly enough and the doctor had to terminate the patient. **While it was planned for the patient to die within half an hour after taking the lethal drugs, 19% of patients took 45 minutes to seven days to die**. There were less problems observed in euthanasia as opposed to PAS but still 10% of patients took much longer to die, some up to seven days. **In both euthanasia and physician-assisted suicide a small number of patients awoke from coma and had to be terminated**.

D. Underreporting

It is very worrying that one in two cases of euthanasia performed in the Netherlands are not reported to the authorities. For example in 1995 only 41% of all 3,600 cases of euthanasia and PAS were reported. The most important reasons given by doctors for not reporting was the wish to avoid the inconvenience for the doctor and/or relative of an investigation, to avoid the risk of prosecution. 30% of doctors stated that they did not report because they had failed to observe the requirements and 12% because they considered euthanasia a private matter between doctor and patient.[34] In 2001, 54% **of doctors in the Netherlands fulfilled their legal requirement and reported the case(s) of euthanasia they were involved in.[35] The low levels of reporting makes monitoring and prevention of abuse of euthanasia impossible.**

Furthermore, **two thirds of Dutch General Practitioners have certified a patient's death as resulting from natural causes when in fact it was euthanasia or assisted suicide**.[36] The real numbers of euthanasia deaths in the Netherlands will be far higher than the reported cases.

E. Out of control

Dr Henk Jochemsen of the Lindeboom Institute for Medical Ethics in the Netherlands, and Dr John Keown, of the University of Cambridge showed that the supposedly strict safeguards established by the Royal Dutch Medical Association to control how and when euthanasia is performed are being widely ignored.[10] Using the official data from a survey of 405 Dutch doctors, published by the authors of the Remmelink Report, Keown and Jochemsen state: '***The reality is that a clear majority of cases of euthanasia, both with and without request, go unreported and unchecked. In the face of the undisputed fact that in a clear majority of cases there is not even an opportunity for official scrutiny, Dutch claims of effective regulation ring hollow.'*** Almost two-thirds of cases of euthanasia and assisted suicide in 1995 were not reported. Doctors who responded to the survey reported that 74% of patients said intolerable suffering with no prospect of improvement was the reason for requesting euthanasia. 56% of patients wanted to prevent loss of dignity and 47% wanted to die to prevent further suffering. '***It must surely be doubted whether either of these reasons, by itself, satisfies the requirement of unbearable human suffering, as set down in the safeguards,***' **the researchers said.** [10]

F. Fear of the Elderly

In a survey of older people carried out by a Dutch doctor, nearly 60% of those polled were afraid that their lives would be terminated against their will. Half of the elderly living in their own homes and over 90% of those living in nursing homes were opposed to euthanasia.[37]

The **Dutch Patients Association with a membership of 60,000 distributes a wallet card to protect members form being involuntarily euthanised**. The card instructs: 'no treatment be administered with the intention to terminate life.'[38]

Anecdotal evidence suggests that some **Dutch patients prefer to be admitted to German hospitals where euthanasia is not legal for fear of being killed in a Dutch hospital against their will**.[39]

G. Case studies

To fully understand the widespread abuse of the euthanasia regulations in the Netherlands it is useful to look at some concrete examples of what can happen when euthanasia becomes legal.

- In 1998, **Dutch GP Dr Sutorius helped former senator Edward Brongersma to die, even though he had no serious physical or mental illness. Mr Brongersma suffered from physical decline and struggled with his 'pointless and empty existence.'** Dr Sutorius, who had helped the 86-year old patient to die in the belief that the patient was suffering unbearably because of his obsession with his physical decline and hopeless existence, was found guilty of assisted suicide, but no punishment was imposed, because it was recognised that he had acted out of great concern for his patient.[40]
- A 65 year old woman, suffering from incurable cancer was discharged from hospital. Her GP discussed euthanasia with her. The patient objected to euthanasia on religious grounds. However, with progressing cancer, she became more ill and **considered herself a burden to her husband**. She requested euthanasia and died. The case is reported and the public prosecutor couldn't see anything wrong.[39]
- During the hearing on assisted suicide before the Constitution Subcommittee of the American House of Representatives, Dr. Herbert Hendin, a psychiatrist and president of the American Foundation for Suicide Prevention told the story of a **Dutch wife who no longer wanted to take care of her sick husband: 'She gave him a choice between euthanasia and admission to a home for the chronically ill. The man, afraid of being left to the mercy of strangers in an unfamiliar place, chose to be killed. The doctor, though aware of the coercion, ended the man's life.'** [41] (the following four case examples are taken from this Congressional hearing)

- In 1985, a **Dutch physician was convicted of killing several nursing home patients without their consent. He was sentenced to one year in prison, but his conviction was quashed** because police officers had unlawfully seized medical documents from the doctor. In the end, the doctor was awarded the equivalent of $150,000 by the court for "injury to his reputation."
- In 1994, the case of Dr. Chabot, a psychiatrist was brought before the Dutch Supreme Court. He assisted one of his patients, who was a fifty-year-old physically healthy woman, in suicide. She had two sons. One son, died by suicide at the age of 20. Her second son, died of cancer at the age of 20. She attempted suicide, but did not succeed. She had bought a cemetery plot for her sons, her former husband, and herself; her only wish was to die and lie between the two graves of her sons. **Mrs. B objected to both bereavement therapy and anti-depressant drugs, consequently Dr. Chabot administered no treatment but assisted her in suicide**. Dr. Chabot contends, "Intolerable psychological suffering is no different from intolerable physical suffering" Ultimately, the Court did find Dr. Chabot guilty because he did not arrange for an independent physician to examine Mrs. B in person, but it imposed no punishment.
- **An 89-year-old widow, who lived by herself, had suffered a stroke** six years previously, from which she had partially recuperated. **She had, become increasingly unable to care for herself. The doctor had suggested psychotherapy, which she declined**, and at one point the doctor tried her on anti-depressant medication. A neighbour helped the woman plead her case and suggested that if this doctor would not perform euthanasia, the neighbour would help the patient find another doctor who would. The doctor finally agreed and, a week later, euthanized the patient in her home (no one else was present). The **doctor then notified the son that his mother had passed away suddenly but did not tell him of the circumstances. The cause of death was listed as "cardiac arrest"; the public prosecutor was not notified**.
- **A 56-year-old man was brought into a hospital emergency room with massive internal injuries following a car accident**. A doctor was called to the emergency room. Because his family would soon arrive, he suggested that the matter end quickly: **The physician, acting unilaterally, gave an injection of potassium chloride.** He stated "A few minutes later, after the patient is dead, the nurse comes to ask, Is it over? I say yes, and [the nurse] comes to fix the body." The physician did not actually consider this a case of euthanasia but of bringing on "what would surely happen, but perhaps after some hours." **When the family arrived, they were told the patient had expired from his wounds shortly after being brought to the hospital.**
- A **25 year old woman in remission from anorexia nervosa asks for euthanasia since she fears the recurrence of her anorexia**. She is euthanised because the doctor treating her feels that she would not have a good quality of life.[42]
- A man was hospitalised with cancer and in great pain. **His son approached his father's doctor asking for him to be euthanised since the family wanted to bury the man before they went on holiday** (We remind ourselves of the above mentioned case of the pregnant women asking for termination since her pregnancy would have interfered with the skiing holiday). The doctor agrees and administers a high dose of pain medication. *To everyone's surprise the patient improves since he became pain-free.*[42]

H. Children

- A girl born prematurely, in the thirty-second week, recovered from an infection, but there was a **suspicion of intracranial bleeding. This was followed by accumulation of intracranial fluid**. The parents refused to allow the insertion of a drainage tube or shunt. On the thirtieth day after birth the **child was killed by the pediatrician with injections**. (This and the following two cases were reported by Dr Richard Fenigsen, Ph.D., a retired cardiologist from the Netherlands, quoted in the above mentioned Congressional hearing).[41]
- In 1989, the Dutch Supreme Court heard the case of a physician who gave a **lethal injection to a newborn baby with Down syndrome**. The child was born with an intestinal atresia, a relatively common and repairable problem. The Court decided that since the child would have experienced very serious suffering after surgery, - which is medically incorrect – the physician was not prosecuted.
- Danny had **spina bifida and hydrocephalus but was in fair general condition**. No drainage tube to relieve the hydrocephalus was inserted. Once he seemed to have **some abdominal pain, and another time he apparently felt not quite well for two consecutive days. This prompted the parents to ask for euthanasia.** With this purpose the child was admitted. One of the nurses opposed the decision, and on the next day she and her husband offered to adopt the child. The offer was rejected. In 1990, Danny, then aged three, was killed with an intravenous injection. The nurse was reprimanded because by involving her husband in the adoption offer she violated professional confidentiality.

With the widespread adoption of euthanasia one needs to be concerned about the repercussions for people with disabilities. **There seems to be little tolerance for disabled children and the parents who raise them**. In fact, Professor J. Stolk, a specialist in mental retardation at the Free University in Amsterdam, has documented cases where parents of disabled children are rebuked. For example, **parents have heard statements such as: "What? Is that child still alive?" "How can one love such a child?", "Nowadays such a being need not be born at all."** [41]

14. The Real Agenda

What is the real agenda behind the move to legalise physician-assisted suicide or euthanasia?
'Most assisted suicide advocates do not want to limit death doctor services to people who are terminally ill. The true agenda of the assisted suicide movement came into rare focus in October 1998, when the World Federation of Right to Die Societies - an organization consisting of the world's foremost euthanasia advocacy groups -- issued its 'Zurich Declaration'. The Declaration urged that people *'suffering severe and enduring distress [should be eligible] to receive medical help to die.'* Finally, **the actual goal of the assisted suicide movement is revealed: death on demand for anyone with more than a transitory wish to die**. [43]

In the end, assisted suicide would be less about 'choice' than about cutting the costs of health care. This is the conclusion of no less than Derek Humphry and pro-euthanasia attorney, Mary Clement, who in their book Freedom to Die, admit that **cost containment may become the ultimate raison d'être for physician assisted suicide, that is, killing as a financial benefit to society: *'There is no contradicting the fact that since the largest medical expenses are incurred in the final days and weeks of life, the hastened demise of people with only a short time to live would free resources for others*.'**[43]

***'I think very soon the right to die will become the duty to die'* Dame Dr Cecily Saunders, founder of the Hospice movement.**

15. WORLD-WIDE OPPOSTION TO EUTHANASIA

A. The British Medical Association (BMA)

'The BMA opposes the legalisation of euthanasia or physician-assisted suicide, regarding such measures as in tension with the fundamental role of doctors. The BMA maintains that, if doctors were authorised to carry out euthanasia or assisted suicide, however carefully circumscribed the situation, they would acquire an additional role alien to the traditional one of healer.

'The issue of physician assisted suicide is often portrayed as a question of "patient rights", "free choice" or "liberty of action". The BMA considers that this language of choice may belie the real pressures from family members or society in general which may be exerted if assisted suicide were legalised. If the law were changed to permit assisted suicide, the BMA would still not wish doctors to be involved because of the effect this would have on the public perception of the medical profession. We support the view expressed by the distinguished American lawyer, Alexander Capron on the subject of euthanasia and echoed by many of the BMA's own members: *"I never want to have to wonder whether the physician coming into my hospital room is wearing the white coat of the healer ... or the black hood of the executioner."*
(End of life decisions - views of the BMA; June 2000)

B. The American Medical Association

In the face of growing public and legal support for doctor assisted suicide, the American Medical Association has reaffirmed its adamant opposition to the practice. Members representing the various state and speciality medical societies stated that doctors should be healers and not killers. Those against doctor assisted suicide spoke of the potential damage to the profession and the inability to control the practice once the "genie is out of the bottle".
('US doctors reaffirm opposition to euthanasia.' British Medical Journal, 6th July 1996)

C. Association for Palliative Medicine; National Council for Hospice & Specialist Palliative Care Services:

'The passage of this bill in any form will change the face of medicine and a doctor's duty to care. It is a most serious and disturbing development in the authority of medicine. Euthanasia, once accepted, is uncontrollable for philosophical, logical and practical reasons rather than slippery slopes of moral laxity or idleness. Patients will certainly die without and against their wishes if any such legislation is introduced.'
(The Patient-Assisted Dying - Bill, Joint briefing paper by the Association for Palliative Medicine & the National Council for Hospice & Specialist Palliative Care Services. 2003)

D. Baroness Finlay of Llandaff, (Professor of Palliative Medicine):

'The Select Committee on Medical Ethics concluded, that adequate safeguards around euthanasia and its oral form – assisted suicide – could not be put in place. All the evidence emerging from Holland, Belgium, Oregon and Australia supports the fact that one cannot have adequate safeguards.'
(Baroness Llandaff, professor of palliative medicine and visiting professor at Groningen University in Holland. Debate House of Lords on the patient (assisted dying) bill on 6th June 2003)

E. Dr Karel Gunning, (a leading Dutch opponent of euthanasia) states:

'Once you accept killing as a solution for a single problem, you will find tomorrow hundreds of problems for which killing can be seen as a solution.'

(Quoted in Wesley J Smith. Forced exit. The slippery slope from assisted suicide to legalised murder. Spence Publishing, Dallas 2003. p 116.)

F. Dr. Herbert Hendin, (a Psychiatrist & President of the American Suicide Foundation) states:

'The Netherlands has moved from assisted suicide to euthanasia, from euthanasia for people who are terminally ill to euthanasia for those who are chronically ill, from euthanasia for physical illness to euthanasia for psychological distress, and from voluntary euthanasia to involuntary euthanasia (called "termination of the patient without explicit request")'.
(Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report to the House Judiciary Subcommittee on the Constitution; September 1996. Issues in Law & Medicine, Volume 14, Number 3, 1998; p 301-24.)

G. The Disability Rights Commission (DRC)

'The Disability Rights Commission underlined its concerns over proposals to change the law to make assisted suicide legal. The (patient assisted dying) bill would open the floodgates for people who are not just terminally ill but for those with long term physical illnesses to be helped to die. The safeguards included in the bill are simply not good enough to guard against many disabled people being included. There is simply no system of safeguards that can detect the hidden pressures and strains from relatives and carers that may drive a disabled person to seek an assisted suicide. Rather than ensuring the right to die, the bill would quickly translate into a duty to die for disabled people.'
(Press release by the Disability Rights Commission; 'Joffe assisted suicide bill would place 'duty to die' on disabled people' 6th June 2003)

H. The New York State Task Force on Life & the Law.

'Recent proposals to legalize assisted suicide and euthanasia in some states would transform the right to decide about medical treatment into a far broader right to control the timing and manner of death. After lengthy deliberations, the Task Force unanimously concluded that the dangers of such a dramatic change in public policy would far outweigh any possible benefits. In light of the pervasive failure of our health care system to treat pain and diagnose and treat depression, legalising assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care. In the course of their research, many Task Force members were particularly struck by the degree to which requests for suicide assistance by terminally ill patients are correlated with clinical depression or unmanaged pain, both of which can ordinarily be treated effectively with current medical techniques.

As a society, we can do far more to benefit these patients by improving pain relief and palliative care than by changing the law to make it easier to commit suicide or to obtain a lethal injection. Contrary to what many believe, the vast majority of individuals who are terminally ill or facing severe pain or disability are not suicidal.
(New York State Task Force on Life & the Law. When death is sought – assisted suicide and euthanasia in the medical context. Published on www.health.state.ny.us/nysdoh/consumer/patient/preface.htm)

16. CONCLUSION

Fundamental principles about the value of human life are at stake. The Christian belief in the sanctity of life is in danger of being rejected. The legalising of Euthanasia & Physician-Assisted Suicide would do immense harm to the ethical foundations of our culture.

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