Introduction

Despite the major advances in medicine and palliative care witnessed by the last century, many patients, even in affluent Western nations, still die in pain and distress. Some entreat their doctors to put an end to their suffering either by killing them or by helping them to kill themselves. In almost every country in the world, a doctor who complies with such a request commits the offence of murder or assisted suicide and faces a lengthy term of imprisonment and professional disgrace.

Yet many people think it should be lawful for a doctor to end a suffering patient's life on request, either by administering a lethal injection or by assisting the patient to commit suicide.[1] Organisations campaigning for legal reform, such as the Hemlock Society in the USA or the Voluntary Euthanasia Society (VES) in the UK, are not proposing that a doctor should be allowed to kill[2] patients whenever

[1] Lord Goff, the former Senior Law Lord, has quoted a poll, conducted on behalf of the Voluntary Euthanasia Society in England, which contained the following proposition: 'Some people say that the law should allow adults to receive medical help to a peaceful death if they suffer from an incurable physical illness that is intolerable to them, provided they have previously requested such help in writing.' His Lordship pointed out that when this was first put to the public in the early 1960s, 50% of those approached agreed with it, but that in 1993 the figure had risen to 79% ('A Matter of Life and Death' (1995) 3 *Med L Rev* 1, 11). His Lordship also pointed out, however, that the proposition raised a number of fundamental questions which cannot be expressed in a simple question suitable for an opinion poll, and that the proposition was ambiguous. What, for example, did those polled understand by 'medical help'?

[2] Some advocates of VAE object to the use of the word 'kill' in this context. They argue that 'killing' is a word which, like 'rape', connotes a lack of consent, and that in discussions of VAE the word 'kill' is misleading and emotive. See Jean Davies, 'Raping and Making Love Are Different Concepts: So Are Killing and Voluntary Euthanasia' (1988) 14 *J Med Ethics* 148. A counter-argument is that the normal definition of 'rape' is sexual intercourse without consent, but that the normal definition of 'kill' is simply 'put to death; cause the death of, deprive of life' (*The New Shorter Oxford English Dictionary* (1993) I, 1487). One can, therefore, kill with or without consent. It makes perfect sense, for example, for a soldier to say, 'My wounded comrade on the battlefield asked me to put him out of his misery, and so I killed him.' And, although it

he[3] feels like it. Mindful of the obvious and gross abuses which might follow were doctors given a completely free hand, such organisations typically propose that doctors should be allowed to end life only if the patient is competent to make a decision, has been informed about alternatives such as palliative care, and has voluntarily asked for life to be ended or to be given the means to commit suicide. Nor do such organisations typically propose that the law should allow doctors to kill patients whenever the *patient* feels like it. The patient should not only have thought seriously about the options but must also be terminally ill or at least experiencing serious suffering. Further, reformers generally put forward some form of procedural safeguards in an attempt to ensure that VAE would only be available to patients whose request was truly voluntary and who were genuinely terminally ill or suffering gravely. Such proposals often include a requirement that the doctor consult an independent doctor beforehand, such as an expert in the illness from which the patient is suffering and/or an expert in palliative care, and they also provide for at least the possibility of official review, as by requiring the doctor, having performed VAE, to report the details of the case to some public authority such as a coroner.

The ethical question whether it can *ever* be right for a doctor to kill a patient, even one who is experiencing severe suffering and who asks for death, continues to generate debate. That important issue of fundamental moral principle has been explored in other books, including *Euthanasia Examined*.[4] Although *Euthanasia, Ethics and Public Policy* outlines these arguments, its focus is different. It asks: even if VAE and PAS were morally acceptable, *could they be effectively controlled?* In other words, if the law were relaxed to permit doctors to administer, or hand, a lethal drug to a patient who was suffering gravely and who freely asked for it, could it effectively limit VAE and PAS to such circumstances? Or would the practice slide down a slippery slope to ending the lives of those who did not really want to die; of those whose severe suffering could be alleviated by palliative care; and of those who were not suffering severely or even at all?

For, although the question of whether VAE and PAS can be justified in principle is important, the question about the likely *effects* of their decriminalisation – not least about whether they would propel society down the

is true that the word 'kill' carries potentially emotive overtones, these overtones simply reflect the inherent moral gravity of taking life.

[3] In this book 'he' means 'he or she' unless the contrary is apparent.

[4] *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (1995) (hereafter 'Keown'). See especially chapters 1–10.

slippery slope – is hardly less important. Indeed, in the worldwide debate as it is unfolding, it is this issue of the slippery slope which has taken centre-stage and which is proving decisive, as it did in the landmark decisions of the US Supreme Court in 1997. Justice Souter, for example, concluded: 'The case for the slippery slope is fairly made out here . . . because there is a plausible case that the right claimed would not be readily containable by reference to facts about the mind that are matters of difficult judgment, or by gatekeepers who are subject to temptation, noble or not.'[5]

However, his rejection of PAS seemed provisional rather than final. Having noted that the advocates of PAS sought to avoid the slope by proposing state regulation with teeth, he concluded that 'at least at this moment' there were reasons for caution in predicting the effectiveness of the teeth proposed. This judge, therefore, seemed open to the possibility of creating a constitutional right to PAS if the dangers of the slippery slope could be avoided.

In the light of the pivotal importance of the slippery slope argument in the current debate, it is essential to consider the experience of three jurisdictions which have taken the radical step of permitting VAE and/or PAS: the Netherlands, the Northern Territory of Australia, and the US state of Oregon. Although this book will consider all three, it will concentrate on the Netherlands because of that country's much longer, and more fully documented, experience of VAE and PAS.

In 1984, the Dutch Supreme Court decided that a doctor who performed VAE/PAS in certain circumstances acted lawfully. In tandem with that decision, the Royal Dutch Medical Association, the KNMG, issued guidelines for doctors. Since 1984, thousands of Dutch patients have been euthanised or assisted in suicide. In April 2001 a government bill which essentially gives statutory force to the guidelines, and which had already been passed by the lower house of the Dutch parliament, received the approval of the upper house.[6]

This book considers the lessons the Dutch experience has for other jurisdictions which may wish to contemplate relaxing their laws to accommodate VAE and/or PAS. In particular, the book will consider whether, as campaigners for VAE both inside and outside the Netherlands have claimed, the Dutch experience shows that it can be effectively controlled. It

[5] *Washington* v. *Glucksberg* 138 L Ed 2d 772 at 828–9 (1997).
[6] *The Daily Telegraph*, 29 November 2000; (2001) 322 *BMJ* 947. The provisions of the bill are discussed in chapter 8.

is appropriate that this book take stock of the Dutch experience. First, given that VAE has been officially tolerated and widely practised in the Netherlands for over fifteen years, a substantial body of empirical evidence and academic commentary[7] has emerged which invites a thorough overview. Secondly, the author is ideally placed to conduct such an overview, having been researching the Dutch experience since 1989. Thirdly, the Dutch experience has provoked wildly divergent interpretations. Such divergence can confuse not only the judicious but even the judicial reader. Justice Souter observed that there was a 'substantial dispute' about what the Dutch experience shows: 'The day may come', he said, 'when we can say with some assurance which side is right, but for now it is the substantiality of the factual disagreement, and the alternatives for resolving it, that matter. They are, for me, dispositive of the . . . claim [for a constitutional right to PAS] at this time.'[8] This book offers a path through the thicket of contradictory interpretations.

Having examined the experience of these three jurisdictions, the book proceeds to review the conclusions of expert bodies – committees, courts and medical associations – in three other jurisdictions – the USA, Canada and the UK – which have thoroughly evaluated the arguments for legalisation. Finally, the book will address an important but often overlooked aspect of the euthanasia debate. This is the issue of *passive* euthanasia (PE): the termination of patients' lives not by an act, but by withholding or withdrawing medical treatment or tube-feeding with intent to kill.

The book is divided into five parts. Part I defines (in chapters 1 and 3) some important terms, such as 'voluntary euthanasia' and 'physician-assisted suicide', and considers (in chapter 2) the moral and legal difference between intended and merely foreseen life-shortening.

Part II outlines (in chapters 4, 5 and 6) three main arguments for permitting VAE, and three counter-arguments. Chapter 7 introduces the slippery slope arguments.

Part III explores the Dutch experience. Chapter 8 outlines the guidelines for VAE. Chapter 9 summarises the empirical evidence generated by a major survey and chapter 10 the extent of non-compliance with the

[7] See Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (1991) (hereafter 'Gomez'); Herbert Hendin, *Seduced by Death: Doctors, Patients and Assisted Suicide* (1998) (hereafter 'Hendin'); John Griffiths et al., *Euthanasia and Law in the Netherlands* (1998) (hereafter 'Griffiths').

[8] *Washington* v. *Glucksberg* 138 L Ed 2d 772 at 829 (1997).

guidelines disclosed by that survey. Chapter 11 considers evidence of increasing condonation of *non*-voluntary euthanasia (euthanasia of those incapable of asking for it). Chapter 12 summarises the empirical evidence produced by a second major survey. Chapter 13 considers the reliability of Dutch reassurances about the extent to which they control VAE.

Part IV outlines the experience of two other jurisdictions which have relaxed their laws. In 1996, the Northern Territory in Australia decriminalised VAE and PAS, though its legislation was overturned in 1997 by the Australian Federal Parliament. Chapter 14 outlines the Territory's legislation and evidence about its operation during its abbreviated life. In 1994, voters in the US state of Oregon enacted by referendum a law allowing PAS. The law came into force in 1997. Chapter 15 sets out the legislation and reviews its ongoing operation.

In Part V chapters 16, 17 and 18 consider respectively the conclusions of expert committees, supreme courts and medical associations which have scrutinised the case for legalising VAE.

Part VI asks whether jurisdictions such as England, which still prohibit doctors from taking *active* measures to hasten death, nevertheless permit doctors to hasten death *by deliberate omission*, as by the withdrawal of tube-feeding from mentally incapacitated patients with intent to shorten life and, if so, whether the law is morally consistent. Chapter 19 examines the *Bland* case, in which the Law Lords declared lawful the withdrawal of tube-feeding from a patient in a 'persistent vegetative state'. Chapter 20 analyses controversial guidance issued by the British Medical Association in 1999 permitting doctors to withhold/withdraw tube-feeding from patients with other forms of severe mental incapacity, such as advanced Alzheimer's disease. Chapter 21 examines the debate generated by a private member's bill introduced in the House of Commons which sought to prohibit doctors from withholding or withdrawing treatment or tube-feeding if their intention in so doing was to kill the patient.

As the book went to press, a further significant development took place in England. Diane Pretty, a terminally ill woman, sought a judicial ruling than she enjoyed a right to assisted suicide under the European Convention on Human Rights. This important case is considered in the Afterword.

PART I

Definitions

The euthanasia debate is riddled with confusion and misunderstanding. Much of the confusion derives from a failure of participants in the debate to define their terms. Part I seeks to clarify the confusion by noting some of the differing definitions in the current debate, indicating the underlying moral distinctions they reflect, and assessing their relative merits.

1

'Voluntary euthanasia'

'Voluntary'

Campaigners for relaxation of the law typically stress that they are campaigning only for *V*AE – *voluntary* active euthanasia. VAE is generally understood to mean euthanasia at the request of the patient,[1] and this is how it will be used in this book. VAE can be contrasted with 'non-voluntary' active euthanasia (NVAE), that is, euthanasia performed on those who do not have the mental ability to request euthanasia (such as babies or adults with advanced dementia) or those who, though competent, are not given the opportunity to consent to it. Finally, euthanasia against the wishes of a competent patient is often referred to as 'involuntary' euthanasia (IVAE).

Some commentators lump together the last two categories and classify all euthanasia without request as 'involuntary'. Others (including the author) think that it is preferable to keep the two categories distinct, not least because it helps to avoid unnecessary confusion.

'Euthanasia'

Given the absence of any universally agreed definition of 'euthanasia' it is vital to be clear about how the word is being used in any particular context. The cost of not doing so is confusion. For example, if an opinion pollster asks people whether they support 'euthanasia', and the pollster understands the word to mean one thing (such as giving patients a lethal injection) while the people polled think it means another (such as withdrawing a life-prolonging treatment which the patient has asked to be withdrawn because it is too burdensome), the results of the poll will be worthless. Similarly, if two people are discussing whether 'euthanasia'

[1] Or at least with the consent of the patient. Euthanasia would still be voluntary even if the doctor (or someone else) suggested it to the patient and the patient agreed.

should be decriminalised and they understand the word to mean quite different things, their discussion is likely to be fruitless and frustrating.

'Euthanasia', a word derived from the Greek, simply means a 'gentle and easy death'.[2] Used in that wide sense, one hopes *everyone* is in favour of euthanasia: who wants to endure, or wants others to endure, a protracted and painful death? Obviously, however, campaigners for the decriminalisation of euthanasia are not using the word in this uncontroversial sense. They are not simply supporting the expansion of hospices and improvements in palliative care. They are, rather, arguing that doctors should in certain circumstances be allowed to ensure an easy death not just by killing the pain but by killing the patient. Given the variety of ways in which the word 'euthanasia' is used, rather than pretend that there is one universally accepted meaning, it seems sensible to set out the three different ways in which the word is often used, beginning with the narrowest.

All three definitions share certain features. They agree that euthanasia involves *decisions which have the effect of shortening life*. They also agree that it is limited to the *medical* context: 'euthanasia' involves patients' lives being shortened *by doctors*[3] and not, say, by relatives. Moreover, all three concur that characteristic of euthanasia is the belief that *death would benefit the patient, that the patient would be better off dead*, typically because the patient is suffering gravely from a terminal or incapacitating illness or because the patient's condition is thought to be an 'indignity'. Without this third feature, there would be nothing to distinguish euthanasia from cold-blooded murder for selfish motives.

In short, all three definitions concur that 'euthanasia' involves *doctors* making decisions *which have the effect of shortening a patient's life* and that these decisions are *based on the belief that the patient would be better off dead*. Beyond these points of agreement, there are, as we shall see, several major differences.

'Euthanasia' as the active, intentional termination of life

According to probably the most common definition, 'euthanasia' connotes the *active, intentional* termination of a patient's life by a doctor who thinks that death is a benefit to that patient. On this definition, euthanasia is not

[2] 'Euthanasia' in *The New Shorter Oxford English Dictionary* (1993) I, 862.
[3] Or, possibly, nurses acting under medical direction.

simply a doctor doing something which he *foresees* will shorten the patient's life, but doing something *intending* to shorten the patient's life. 'Intention' is used here in its ordinary sense of 'aim' or 'purpose'. Such a definition of 'euthanasia' was adopted by the House of Lords Select Committee on Medical Ethics, which was appointed in 1993 to examine euthanasia and related issues. Published in 1994, its report defined 'euthanasia' as: 'a deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering'.[4] The word 'intervention' connotes some act, rather than an omission, by which life is terminated. Similarly, the New York State Task Force on Life and the Law, which also reported in 1994, defined 'euthanasia' as: 'direct measures, such as a lethal injection, by one person to end another person's life for benevolent motives'.[5] In short, 'euthanasia' is often understood to be limited to the active, intentional termination of life, typically by lethal injection.

The criminal law in most jurisdictions, including the UK and the USA, regards active intentional killing by doctors as the same offence as active intentional killing by anyone else: murder. An example of a doctor falling foul of the law of murder is the prosecution in England in 1992 of Dr Nigel Cox. Dr Cox was a consultant rheumatologist in a National Health Service hospital. One of his elderly female patients, a Mrs Boyes, was dying from rheumatoid arthritis. She was in considerable pain, and pleaded with Dr Cox to end her life. He injected her with potassium chloride and she died minutes later. Surprisingly, he then recorded what he had done in the patient's notes. A nurse who read the notes reported the matter to her superior. The police investigated the matter, and the Crown Prosecution Service decided to take action.

Dr Cox was charged with attempted murder. The charge was attempted murder rather than murder because, according to the Crown Prosecution Service, it was not possible to prove that the potassium chloride had actually caused the victim's death because her corpse had been cremated. The judge directed the jury that it was common ground that potassium chloride has no curative properties and is not used to relieve pain; that injected into a vein it is lethal; that one ampoule would certainly kill,

[4] *Report of the Select Committee on Medical Ethics* (HL Paper 21-I of 1993–4) (hereafter 'Lords' Report') para. 20.
[5] *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (Report of the New York State Task Force on Life and the Law (1994)) (hereafter 'Task Force') x.

and that Dr Cox had injected two.[6] In view of the weight of evidence against him, it is not surprising that Dr Cox was convicted. He was, however, given only a suspended prison sentence. The General Medical Council, the medical profession's regulatory body, was also lenient. Although it censured his conduct, it did not erase his name from the medical register and merely required him to undergo a period of re-training.[7] This is just the sort of case that everyone easily recognises as a case of 'euthanasia' (or, at least, *attempted* euthanasia). In short, everyone agrees that 'euthanasia' includes *active, intentional termination of life*. There are some, however (including the author), who use 'euthanasia' in a wider sense.

'Euthanasia' as the intentional termination of life by act or by omission

On this wider definition, 'euthanasia' includes not only the intentional termination of a patient's life by an act such as a lethal injection but also the intentional termination of life by an omission. Consequently, a doctor who switches off a ventilator, or who withdraws a patient's tube-feeding, performs euthanasia *if the doctor's intention is to kill the patient.* Euthanasia by deliberate omission is often called 'passive euthanasia' (PE) to distinguish it from active euthanasia. A good example of PE is the case of Tony Bland.

Tony Bland was a victim of the disaster in 1989 at the Hillsborough football stadium in Sheffield, in which almost 100 spectators were crushed to death. Tony was caught in the crush. Although he survived, he lost consciousness, never to recover it. In hospital, Tony was eventually diagnosed as being in a 'persistent vegetative state' (pvs) in which it was believed he could neither see, hear nor feel. This condition is similar to a coma in that the patient is unconscious but different in that, whereas in coma the patient seems to be asleep, in pvs the patient has 'sleep/wake' cycles. The patient is not, however, thought to be aware, even when apparently awake, which is why pvs has been described as a state of 'chronic wakefulness without awareness'. The consensus among the medical experts who examined him

[6] *R.* v. *Cox* (1992) 12 BMLR 38 at 46.
[7] 'Decision of the Professional Conduct Committee in the Case of Dr Nigel Cox' *General Medical Council News Review* (*Supplement*), December 1992.