EUTHANASIA, ETHICS AND PUBLIC POLICY

An Argument against Legalisation

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ABBREVIATIONS

A 2d	Atlantic Reporter, 2nd Series
AC	Appeal Cases
All ER	All England Law Reports
Am J Hosp Pall Care	*American Journal of Hospice and Palliative Care*
Am J Law Med	*American Journal of Law and Medicine*
Am J Psychiatry	*American Journal of Psychiatry*
Ann Intern Med	*Annals of Internal Medicine*
BMJ	*British Medical Journal*
BMLR	Butterworths Medico-Legal Reports
Cal Rptr	California Reporter
Camb LJ	*Cambridge Law Journal*
Camb Q Healthc Ethics	*Cambridge Quarterly of Healthcare Ethics*
Cath Med Q	*Catholic Medical Quarterly*
Cm	Command Paper
Cr App R	Criminal Appeal Reports
Crim LR	*Criminal Law Review*
DLR	Dominion Law Reports
Duq L Rev	*Duquesne Law Review*
EHRR	European Human Rights Reports
Fam LR	Family Law Reports
Fam Pract	*Family Practice*
Fitzpatrick	F. J. Fitzpatrick, *Ethics in Nursing Practice*
Gomez	Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands*
Gormally	Luke Gormally, *Euthanasia, Clinical Practice and the Law*
Griffiths	John Griffiths et al., *Euthanasia and Law in the Netherlands*

Guidance	BMA, *Withholding and Withdrawing Life-Prolonging Medical Treatment. Guidance for Decision Making*
Guidelines	KNMG, 'Guidelines for Euthanasia'
Hastings Cent Rep	*Hastings Center Report*
HC	House of Commons
Hendin	Herbert Hendin, *Seduced by Death: Doctors, Patients and Assisted Suicide*
HL	House of Lords
ILRM	Irish Law Reports Monthly
Issues Law Med	*Issues in Law & Medicine*
J Contemp Health Law Policy	*Journal of Contemporary Health Law and Policy*
J Med Ethics	*Journal of Medical Ethics*
J Med Philos	*Journal of Medicine and Philosophy*
J Pall Care	*Journal of Palliative Care*
J R Soc Health	*Journal of the Royal Society of Health*
J R Coll Physicians Lond	*Journal of the Royal College of Physicians of London*
Keown	J. Keown, *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*
L Ed	Lawyers' Edition, United States Supreme Court Reporter
L Med & Health Care	*Law, Medicine and Health Care*
Legal Stud	*Legal Studies*
Lloyd's Rep Med	Lloyd's Law Reports: Medical
Lords' Report	*Report of the Select Committee on Medical Ethics*
LQR	*Law Quarterly Review*
Med J Aust	*Medical Journal of Australia*
Med L Rev	*Medical Law Review*
Med Law	*Medicine and Law*
Minn L Rev	*Minnesota Law Review*
N Engl J Med	*New England Journal of Medicine*
New LJ	*New Law Journal*
NJ	Nederlandse Jurisprudentie
Outline	Ministry of Justice, *Outlines Report Commission Inquiry into Medical Practice with Regard to Euthanasia [sic]*

Parl. Deb.	Parliamentary Debates
QB	Queen's Bench (Law Reports)
QBD	Queen's Bench Division (Law Reports)
Report	*Medische beslissingen rond het levenseinde. Rapport van de Commissie onderzoek medische praktijk inzake euthanasie*
Singapore J Legal Stud	*Singapore Journal of Legal Studies*
Survey	*Medische beslissingen rond het levenseinde. Het onderzoek voor de Commissie Onderzoek Medische Praktijk inzake Euthanasie*
Survey 2	G. van der Wal and P. J. van der Maas, *Euthanasie en andere medische beslissingen rond het levenseinde. De praktijk en de meldingsprocedure*
Task Force	*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)
U Rich L Rev	*University of Richmond Law Review*
WLR	Weekly Law Reports

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'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.

was that Tony, like most (though not all)[8] patients in pvs, would never regain consciousness. Contrary to some newspaper reports, however, he was neither dead nor dying: his 'brain stem' (that part of the brain necessary for basic bodily functions such as breathing) was still functioning. Nor was he on a 'life-support' machine: he breathed naturally, without any assistance. He also digested normally. However, as he could not feed himself he was fed through a nasogastric tube, a tube threaded into his stomach via his nose. His excretory functions were assisted by a catheter and enemas. Infections were treated with antibiotics.

Tony's parents and his doctor wanted to stop the tube-feeding and antibiotics. His doctor sought the approval of the local coroner but the coroner replied that the doctor might be prosecuted for homicide. In order to obtain an authoritative legal ruling, the Airedale NHS Hospital Trust, which ran the hospital, applied to the High Court for a declaration that it would be lawful to stop the tube-feeding and antibiotics. The application was opposed by the Official Solicitor (an officer of the court who represents those, like Tony, who are incapable of representing themselves). He argued that stopping Tony's feeding would be murder or at least manslaughter: the doctor would be intentionally causing death just as if he severed the air-pipe of a deep-sea diver. Sir Stephen Brown, President of the Family Division of the High Court, disagreed, and granted the declaration. The Official Solicitor appealed to the Court of Appeal, but without success. A further appeal to the House of Lords was also dismissed.

Of the five Law Lords, a majority expressly agreed with the Official Solicitor's submission that the doctor's intention in stopping tube-feeding would be to kill Tony. Lord Browne-Wilkinson said: 'As to the element of intention . . . in my judgment there can be no real doubt that it is present in this case: *the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland*.'[9]

Why, then, did the Law Lords dismiss the appeal? Why would it not be homicide (murder or manslaughter) to deny Tony food and fluids? The Law Lords held that the doctor would not commit homicide because that offence normally requires an act not an omission. Stopping feeding and antibiotics would be an omission not an act. Lord Goff said that the doctor

[8] Another Hillsborough victim, Andrew Devine, emerged from pvs after five years and learned to communicate via a buzzer and to count (*The Times*, 27 March 1997). See p. 250 n. 55.

[9] *Airedale NHS Trust* v. *Bland* [1993] AC 789 at 881 (emphasis added).

would not be killing the patient but would simply be allowing the patient to die as a result of his pre-existing medical condition. Because, in short, there was no *active* termination of life, this was not a case of unlawful killing or 'euthanasia'. Lord Goff said:

> [T]he law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life, and those in which he decides, for example by administering a lethal drug, actively to bring his patient's life to an end. As I have already indicated, the former may be lawful.

He went on:

> But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be . . . So to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia – actively causing his death to avoid or end his suffering. Euthanasia is not lawful at common law.[10]

Tony's tube-feeding was stopped and he died some days later.

To those who limit 'euthanasia' to active intentional termination of life (definition (1) above), this was not a case of euthanasia. But on the wider definition of intentional termination of life by act or deliberate omission, it was. Is there any reason to prefer this wider definition? If what characterises euthanasia is an *intention* to kill, it surely makes no *moral* difference if the doctor carries out that intention by an omission rather than by an act. By analogy, if a father were to drown his baby by pushing her head under the bathwater, we would regard this as a clear case of intentional killing and condemn the father's conduct as murder. So too, surely, if the baby, while reaching for a plastic duck, accidentally hit her head on the side of the bath and slipped unconscious beneath the water, and her father deliberately failed to save her with the intention that she should drown. We would hardly excuse the father because he deliberately killed his baby by an omission rather than by an act. On the contrary, we would regard his behaviour in either case as morally equivalent because his *intention* in both cases was the same: that his baby should die. Similarly, in the medical context, there is surely no significant moral difference between a doctor intentionally killing a patient by,

[10] At 865.

say, choking the patient, and by deliberately failing to stop the patient from choking, when the doctor could easily do so, precisely so that the patient should die. Is it not objectionable to define the first as 'euthanasia' but not the second when, in both cases, the doctor's intention (that the patient die) and the result (that the patient dies) are precisely the same?[11]

The *Bland* case raises profound questions of ethics and law, issues which will be discussed in chapter 19. The purpose of mentioning it here is simply to illustrate that, on the second definition under consideration, it was indeed a case of 'euthanasia', albeit PE, euthanasia by deliberate omission. There are those who would adopt an even wider definition.

'Euthanasia' as intentional or foreseen life-shortening

Some, especially many advocates of VAE, tend to adopt an even wider definition which embraces not only the intentional termination of life by act or omission, but also acts and omissions which have the *foreseen* consequence of shortening life. It is common practice, in hospitals and hospices alike, for doctors to administer pain-killing drugs such as morphine to those at the end of life who might otherwise die in pain if not agony. As the patient's body develops an increasing tolerance to the dosage given, the dosage may well have to be increased to achieve the same palliative effect. It is widely believed that a side-effect of administering increasingly large doses is the depression of respiration and the consequent shortening of the patient's life (though experts in palliative care point out that, if properly administered, morphine actually tends to extend life by relaxing the patient).[12] If, however, the popular assumption that morphine shortens life *were* true, would the administration of morphine to ease pain at the end of life, a practice long established in medicine and widely condoned by medical and palliative care associations, constitute 'euthanasia'? On either of the above two definitions, the answer must be 'No' if the doctor's intention is only to alleviate the patient's pain and

[11] An added problem with limiting euthanasia to active life-shortening is that it requires a clear distinction to be made between acts and omissions. While the distinction can be black and white, it can also be a murky grey. For example, there is still some disagreement among scholars as to whether switching off a life-support machine should be categorised as an act or an omission.

[12] See e.g. Robert G. Twycross, 'Where There is Hope There is Life: A View from the Hospice' in Keown, 141, 162.

discomfort and not to terminate life. An intention to ease pain is not an intention to shorten life. But, on the third definition, this practice would constitute euthanasia because the acceleration of death is *foreseen* by the doctor.

Similarly, if a doctor withholds/withdraws a life-prolonging treatment, for example by switching off a ventilator, and foresees that the patient will die sooner than would otherwise be the case, is this euthanasia? Again, if the doctor's intention is not to shorten the patient's life but to remove a treatment because it has become too burdensome to the patient, the answer, on either of the first two definitions, is 'No'. An intention to remove a burdensome treatment is not an intention to end life. (It is doubly 'No' on the first definition if the withholding/withdrawal is categorised as an omission.) But on the third definition the answer is 'Yes', because the doctor *foresees* the shortening of the patient's life.

What can be said in favour of this third definition over the first two? Well, at first blush it might well seem that there is very little difference between an intended and a merely foreseen result. If you *know* your conduct is going to have a particular result, isn't this the same as *intending* it? And the *result* is exactly the same, whether it is merely foreseen or intended. However, on closer examination, intention is significantly different from mere foresight. That difference is the subject of the next chapter.

Conclusions

Much of the confusion which besets the contemporary euthanasia debate can be traced to an unfortunate imprecision in definition. Lack of clarity has hitherto helped to ensure that much of the debate has been frustrating and sterile. In an attempt to clarify the confusion, this chapter has distinguished between 'voluntary', 'non-voluntary' and 'involuntary' euthanasia; has set out the three ways in which the word 'euthanasia' is often used; and has foreshadowed the pivotal moral distinction between intended and merely foreseen life-shortening.

It has argued that, although the first definition of 'euthanasia' (the 'active, intentional termination of a patient's life on the ground that death is thought to be a benefit') is the most common, the second (which would also include the intentional termination of life by omission) has more to commend it. As will be argued in the next chapter, it also has more to commend it than the third definition which conflates intended life-shortening

with merely foreseen life-shortening. It may be optimistic to expect the emergence of common definitions, at least in the near future, not least as the different definitions reflect different underlying moral presuppositions whose resolution is a prerequisite to definitional consensus. Until such consensus is achieved participants should at least be open and clear about which definition they are employing and why.