CHAPTER 1

Introduction

Various sorts of decisions made about end-of-life medical care are known to culminate in death. They range from the relatively uncontroversial, like the many decisions that are made (with or without the patient's consent) concerning the withdrawal or withholding of life-prolonging measures, sometimes in concert with the use of 'terminal sedation';[1] through decisions by patients to refuse artificial nutrition and hydration, kidney dialysis, vital organ transplants, donated blood and life-prolonging surgery; to the controversial, like physician-assisted suicide and voluntary euthanasia; and on to the very controversial, like non-voluntary euthanasia. Even though it will include some reflection about the less controversial modes of bringing about death, this book is chiefly about the more controversial forms of medically assisted death, namely, physician-assisted suicide, voluntary euthanasia, and non-voluntary euthanasia. My central thesis is that there is a strong case for legalising physician-assisted suicide and voluntary euthanasia but that it is neither justifiable nor necessary to do so for non-voluntary euthanasia.

Briefly, when a person (typically, a doctor) carries out an act of *euthanasia* she brings about the death of another person because she has good reason to believe *either* that the effects of illness or disability have made the latter's present existence so bad that he would be better off dead, *or* that, unless she intervenes, illness or disability will lead to such deterioration that a point will soon be reached where he would be better off dead. Though it is necessary to allow for 'mixed motives', the agent's belief that euthanasia will benefit the one whose death is brought about has to constitute a primary element in her motivation, because euthanasia

[1] The name given to the medical practice of administering drugs (usually benzodiazepines, or, benzodiazepines in combination with morphine) to relieve the suffering of a dying patient in the knowledge that they will have the further effect of sedating the patient during what remains of his life. A patient who is terminally sedated is denied nutrition and hydration. For an impressive discussion of some of the strategic inadequacies of terminal sedation see Orentlicher (1998).

is (in Philippa Foot's words) 'for the sake of the one who is to die'.[2] The same holds for instances of *physician-assisted suicide*, but this term is restricted to forms of assistance which stop short of the doctor 'bringing about the death' of the patient. Instead, the doctor provides the patient with the means to end his life and the latter must then decide when to use them.

Much of the book is concerned with medically assisted death at the request of the dying. I will be focusing mainly, but not exclusively, on *voluntary euthanasia*, that is, those instances of euthanasia in which a competent person makes a voluntary and enduring request to be helped to die, and *physician-assisted suicide*. In relation to the former, I will consider not only the direct means of ending life but also the use of indirect means (as in the withholding and withdrawing of medical and other treatment). I will not be considering the justifiability of suicide for those who are able to end their own lives without medical assistance, a category which includes at least some who choose to do so for reasons unconnected with the impact of illness or disability on the value their lives have for them.[3] Prior to Chapter 11, I will not consider *non-voluntary euthanasia* – where death is procured for a person who is neither competent, nor able, to request euthanasia, and for whom there is no proxy authorised to make a substituted judgment[4] – except when investigating the claim that legalising voluntary euthanasia will lead inexorably to non-voluntary euthanasia. Non-voluntary euthanasia will, however, be the sole focus of Chapter 11. *Involuntary euthanasia* – in which a competent person's life is brought to an end despite an explicit rejection of euthanasia – will receive no further comment beyond the following: no matter how honourable the perpetrator's motive in bringing about such a death, it constitutes homicide.

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Debate about the morality and legality of physician-assisted suicide and voluntary euthanasia has, for the most part, been serious only in the last hundred years. By way of contrast, debate about the morality and legality

[2] Foot (1977: 87).
[3] See Battin (1995) for a thorough consideration of the ethical issues raised by suicide.
[4] In a substituted judgment a proxy decision-maker chooses on behalf of a no longer competent patient in accordance with how the patient would have chosen were he still competent to do so. The status of substituted judgments varies between jurisdictions: for example, they are recognised for various purposes in the United States; under Australian law their use is confined to the management of property under guardianship; while British law prohibits their use.

of suicide has been occurring for far longer. With the well-known exception of the Hippocratic school,[5] the ancient Greeks and Romans did not consider life needed to be preserved at any cost and were, in consequence, tolerant of (rational) suicide in cases where no relief could be offered to the dying, or to avoid the humiliation of military defeat or execution, or to show loyalty to a dead husband or master.[6] Opposition to suicide based on Neoplatonic thinking subsequently became entrenched in Judaeo-Christian and Islamic thought and has held sway ever since, even if individual thinkers within these traditions have sometimes challenged the supposed immorality of suicide. For example, in the sixteenth century Thomas More envisaged a utopian community that would facilitate the death of those whose lives had become burdensome as a result of 'torturing and lingering pain'.[7] Some modern scholars have claimed that More's use of irony means that he cannot be taken as having endorsed assisted dying. According to their reading, Book II of *Utopia* ridicules it.[8] Others acknowledge its ironic temper but believe *Utopia* 'shows Christian humanism's most attractive face',[9] and expresses qualified admiration for many of the practices it describes. John Donne's defence of suicide in *Biothanatos* was more straightforward, but despite being prepared to countenance it in a narrow range of circumstances he was not willing to have the work (which was originally written *c.* 1606) published until after his death. It was eventually published in 1644. David Hume's essay 'On Suicide', which he never authorised for publication in his lifetime, received its first publication in a French translation in 1770. It was published under Hume's name in English in 1783 and constitutes a landmark in that it attacked the prevailing religious opposition to suicide and offered the first defence of it on grounds of personal autonomy.

[5] See, for example, Temkin (1991: 34, 252).

[6] The Greeks were more inclined to write about suicide in plays and mytho-poetry while maintaining a discreet silence about the practice in real life, but some philosophical support can be found in the writings of Cynics like Antisthenes and Diogenes. Plato's *Phaedo* 62b-c and Aristotle's *Nicomachean Ethics*, Book 5.11 are well-known sources for philosophical criticism of suicide. There was greater philosophical support for the practice among the Romans. See, for example, Seneca, *Epistulae* 70.4 and 70.14 and *De Ira* 3.15.4, along with Epictetus, *Discourses* 1.24–1.25. For a comprehensive treatment of Graeco-Roman thought on these matters see van Hooff (1990). For a comprehensive study of ancient Greek and Roman medical views see Nutton (2004).

[7] See More (1516: 187).

[8] A suggestion that is said to gain support from his having written *A Dialogue of Comfort: Against Tribulation*, in which he explicitly criticises assisted death, during his period of imprisonment prior to his execution. See More (1535).

[9] Kenny (1983: 102).

In the last hundred years there has been sporadic discussion and debate about the moral and legal propriety of assisting dying people (and some severely disabled people who, strictly, are not dying) to die, but it has only been in the past several decades that it has been widely and publicly discussed.[10] The increasing interest in medically assisted death can be attributed, at least in part, to the fact that, whereas in the past little could be done to prolong the lives of the seriously ill, nowadays, at least in the developed world, large numbers of people face the unwelcome prospect of dying at an advanced age after a prolonged period of suffering from a degenerative and terminal condition.[11] This has undoubtedly increased reflection within the medical and legal professions in various countries, as well as by philosophers and theologians, about the right of competent patients to refuse medical treatment when that is tantamount to choosing to die, and to request voluntary medical assistance with dying. A further significant stimulus has been a series of landmark court hearings, particularly in The Netherlands, the United States, Canada and the United Kingdom.

I will briefly elaborate on each of these points. First, I will highlight a few of the more important court cases to illustrate how legal views have evolved. There is space only to mention a few of the relevant cases but those I have selected reveal that assisted death is not just about the relief of pain, nor merely an issue for those who are terminally ill. Second, I will offer a snapshot of the legislative initiatives that have been taken in favour of assisted death.

One, perhaps the chief, stimulus for these initiatives has been the legal toleration, followed recently by the legalisation, in The Netherlands of certain instances of medically assisted death. In the early 1970s a Dutch doctor, Geertruida Postma, was charged with murder after she eventually acceded to her elderly mother's persistent requests to be helped to die. Dr Postma ended her mother's life by administering a lethal dose of morphine. She was convicted of murder but was given only a token suspended sentence along with a brief period of probation. The court's lenient sentence was widely approved by the Dutch.[12] In 1976 the Royal Dutch Medical Association issued a statement in favour of (voluntary) euthanasia[13] remaining a criminal offence, but

[10] There has also been debate outside the public domain. The most significant instance has been among sub-communities in Western countries afflicted with AIDS. See, for instance, Magnusson (2002).
[11] Cf. Battin (2003).
[12] For a clear account of the *Postma* case and its aftermath see Griffiths, *et al.* (1998).
[13] The Dutch use the term 'euthanasia' to signify what is elsewhere referred to as 'voluntary euthanasia'.

urging that doctors be permitted to administer drugs for the purpose of pain relief despite knowing they would be hastening death, and to withhold or withdraw life-prolonging treatment in cases they deemed medically futile. In 1984 the Supreme Court heard an appeal by Dr Schoonheim against the judgment of the Court of Appeals which, having set aside an earlier judgment of the District Court in Alkmaar, had found him guilty of 'taking the life of another person at that person's express and earnest request'.[14] Schoonheim had hastened the death of a ninety-five year old, bed-ridden patient (who, though she was not, strictly, terminally ill, had asked to be helped to die because she found her dependent state intolerable). The Court of Appeals imposed no penalty despite its finding of guilt. The Supreme Court rejected several of the grounds on which the defendant based his appeal but accepted his contention that he was entitled to rely on a defence of 'necessity', that is, that he *had* to break the law because he was faced with a conflict between his duty to alleviate suffering and his duty not to bring about a patient's death, but could only fulfil one of them.[15] It ruled that he exercised his medical judgment properly in concluding that his duty to alleviate suffering should take precedence over his duty not to bring about his patient's death, and so reversed the finding of guilt. The case led ultimately to an agreement being drawn up between the Royal Dutch Medical Association and the Ministry of Justice on a series of guidelines that medical practitioners were required to follow in order to avoid a prosecution similar to that in *Schoonheim*. Though the agreement was not codified by Parliament until 1994 it played a significant role in the legal toleration of voluntary euthanasia and physician-assisted suicide for the best part of two decades, including a period prior to the codification, and another beyond it leading up to the introduction of legislation in 2001.[16]

In the United States, debate about assisted death has also been stimulated by various court cases. In 1975 Karen Ann Quinlan became a *cause célèbre* when she collapsed after a party at which she had imbibed alcohol and other drugs. She was subsequently diagnosed as having entered a persistent

[14] For details in English of this and two later landmark cases in The Netherlands see Griffiths, *et al.* (1998: 321–351).

[15] The Court distinguished this sense of 'necessity' from another, viz., that of being under duress. The notion of having to act out of necessity has been cited as a defence by those charged with a criminal offence in several celebrated cases involving euthanasia.

[16] There is a helpful account of the factors leading up to the introduction of legislation in Griffiths *et al.* (1998) and, more briefly, in Cosic (2003: ch. 7).

vegetative state,[17] connected to a respirator, and provided with hydration and nutrition via a nasogastric tube. Her parents sought to have her artificial respiration discontinued and when the matter eventually reached the New Jersey Supreme Court it found in their favour.[18] Despite being taken off the respirator she remained in a persistent vegetative state for a further nine years until her death. In 1983 Nancy Cruzan was severely injured when she lost control of the car she was driving. She, too, entered a persistent vegetative state but was able to live without a respirator. When her bodily condition deteriorated over a period of several years her parents gave up hope of any recovery and petitioned the Missouri Supreme Court to have her artificial feeding and hydration stopped. This was a step beyond what had been sought in *Quinlan*. After the court refused the request the matter went to the United States Supreme Court which recognised the right of competent patients to refuse life-preserving treatment – even where this may lead to death from an underlying disease – but upheld the right of the State of Missouri to insist on clear evidence that Ms Cruzan would have exercised that right had she been in a position to do so.[19] In 1997 attention was again focused on the Supreme Court when it heard two test cases to do with the existence of a constitutionally protected right to die – *Washington et al. v. Glucksberg et al.*[20] and *Vacco et al. v. Quill et al.*[21] It reaffirmed the position it supported in *Cruzan*; ruled that it was legally permissible to make use of terminal sedation and to give palliative care to terminally ill patients even if this hastened death; but rejected the proposition that such patients have the right to control the manner and time of their death.

Around the same time as important cases like *Cruzan* were being fought out in the United States, there were similar issues being faced in the United

[17] For a taxonomy of vegetative and related states see Jennett (2002). According to it, someone is in a vegetative state when, in the immediate period after an acute brain insult, there is dissociation between arousal and awareness such that there are periods of wakeful eye opening but no evidence of a working mind. A continuing vegetative state is one that has lasted for more than four weeks. A persistent or, as it is sometimes called, a permanent vegetative state is one that, in light of agreed criteria, is considered irreversible. The key indicator is lack of awareness (or, more technically, cognitive function). A patient who is in a vegetative state will have first been in a coma, that is, in a state in which her eyes are continuously closed and she cannot be aroused to consciousness. A comatose patient who regains consciousness never enters a vegetative state.

[18] *In re Quinlan* [1976] 137 NJ S. Ct. 227, 348 A2d 801, modified and remanded, 70 NJ 10 355 A2d 647, 429 S. Ct. 922.

[19] *Cruzan v. Director, Missouri Department of Health* [1990] 497 U.S. 261, 110 S. Ct. 2841.

[20] [1997] 117 S. Ct. 2258.

[21] [1997] 117 S. Ct. 2293.

Kingdom. In an important case in 1993, *Airedale N.H.S. Trust v. Bland*,[22] a request by a doctor to withdraw artificial feeding was found to be lawful. The decision was made on the basis of Anthony Bland's *best interests* rather than on what, given the opportunity, he would have chosen. In the eyes of many commentators this introduced a significantly different position from that taken in the United States. Notwithstanding their commentary, the later case of *R v. Cox*[23] reaffirmed that causing death with the intention of relieving a patient's intolerable pain remains murder under current British law. Subsequent events have supported that conclusion while showing at the same time that juries are unwilling to convict doctors who help the terminally ill to die. In 1999 Dr David Moor was charged with murder after he gave diamorphine to his eighty-five year old patient, George Liddell, who was dying an agonising death from bowel cancer. Despite the prosecution's claim that his intention was to end Liddell's life via a lethal overdose of diamorphine, the jury acquitted him. More recently, in 2005, Dr Howard Martin was charged with murder on similar grounds to Moor (in his case in connection with the deaths of three of his patients). He, too, was acquitted by a jury.[24]

It has, however, not only been the findings of various courts that have shaped the debate. An English journalist, Derek Humphry,[25] had a significant impact on the public debate in the 1980s, first in the United Kingdom and subsequently in the United States. In the early 1990s, two medical

[22] [1993] 1 All ER 821. Anthony Bland was crushed in an incident at a football stadium in April, 1989 and suffered severe anoxic brain damage. He lapsed into a persistent vegetative state but his ventilation, nutrition and hydration were technologically sustained for some three and a half years before being removed in 1993 following the decision of the final court of appeal, the House of Lords.

[23] [1992] 12 BMLR 38. Dr Cox administered an injection of potassium chloride to relieve the intolerable rheumatic pain being suffered by his patient, Lillian Boyes. He was charged only with attempted murder (apparently because it was considered to be too difficult to establish conclusively that the injection caused Boyes' death). The key issue on which his conviction seems to have turned was the identification of his primary purpose, namely, whether it was to relieve Boyes' pain or to end her life. Cox received only a suspended sentence and was allowed to continue to practise medicine.

[24] The pattern was repeated in 2001 in Western Australia when a jury deliberated for only ten minutes before acquitting a urologist, Dr Daryl Stephens, of murdering a woman who had died after being given an intravenous injection of drugs which ended her intense suffering and her life. (The patient's brother and sister were also acquitted of the same charge.) Court decisions like these were no doubt among the factors that influenced Lord Joffe in 2005 to try to legislate for medically assisted death in the UK via the introduction to the House of Lords of his *Assisted Dying for the Terminally Ill Bill*. The Bill's progress in the House of Lords was blocked by opponents in May, 2006 so as to stymie debate, but Lord Joffe has pledged to reintroduce the Bill at a later date.

[25] His impact was achieved initially through the publication of Humphry and Wickett (1978), in which an account is given of how he assisted his wife, Jean, to commit suicide to foreshorten the ravages of cancer. Subsequently, he migrated to the United States where he founded an activist organisation, The Hemlock Society, to promote reform of laws prohibiting assisted death, and published his (1981) and (1996).

activists joined the public debate in the United States with similar effect. Jack Kevorkian[26] became notorious for openly admitting to lending medical assistance with dying to numbers of terminally ill and disabled patients, while Timothy Quill, a far more distinguished medical practitioner, outlined in a prestigious medical journal how he had prescribed a lethal dose of drugs to one of his adult patients (who was suffering from leukaemia) when she requested help to facilitate her suicide.[27]

Disability advocacy groups have also contributed importantly to the recent debates and in the process have shown that medically assisted death is not simply about the relief of the pain and suffering of the terminally ill. Among those who made submissions in the now famous cases of *Washington et al. v. Glucksberg et al.* and *Vacco et al. v. Quill et al.*, to which I referred a moment ago, were various disability advocacy groups. They opposed the idea of there being a right to control the manner and time of one's death, as disability advocacy groups had done previously in 1993 in a Canadian case *Rodriguez v. British Columbia (Attorney General)*.[28]

Sue Rodriguez was a forty-two year old sufferer from motor neurone disease (amyotrophic lateral sclerosis), who knew that her desire to be able to control the manner and time of her death would be compromised once she could no longer commit suicide without assistance. She petitioned the Supreme Court of British Columbia under the Canadian Charter of Rights and Freedoms for a court order to allow a qualified medical practitioner to provide her with physician-assisted suicide. Her argument was that the severely disabled were disadvantaged as compared with able-bodied people in not being able to exercise the right to control their own bodies. She was denied her request at trial, had her appeal rejected by the Court of Appeal, and, finally, lost a further appeal to the Supreme Court

[26] He was acquitted on three occasions, had a further trial declared a mistrial, and was eventually found guilty in 1999 of unlawfully killing a patient suffering from amyotrophic lateral sclerosis, a progressive neuro-degenerative disease (a form of motor neurone disease) that attacks nerve cells in the brain and spinal cord. The progressive degeneration of the motor neurones, which reach from the brain to the spinal cord and from there to the muscles throughout the body, leads to loss of voluntary muscle control and, eventually, total paralysis and death. The minds of sufferers remain unaffected. It is the most common of the group of diseases collectively known as motor neurone disease and is often known as 'Lou Gehrig's disease', after a famous baseballer who was one of the first to be diagnosed with it. Kevorkian openly broke the law to draw attention to the need for law reform so as to permit assistance with dying to be given to competent individuals who requested it. He publicised what he had done on a national television programme, was imprisoned, and will be eligible for release on parole in 2007.

[27] Quill (1991). [28] [1993] 107 D.L.R. (4th) 342.

of Canada (by a margin of 5–4). She was illegally assisted to die by a doctor within months of this last defeat.

In the years since, there have been several further high profile instances involving victims of motor neurone disease who have sought to be assisted to die. Thus, for example, in 2001 Diane Pretty, a forty-one year old suffering from motor neurone disease, petitioned the Director of Public Prosecutions (DPP) in England for an assurance that her husband would not be charged with the criminal offence of assisting a suicide if he helped her to die (which they intended he would do before her condition deteriorated to the point where she would die of suffocation).[29] The DPP rejected her request. The couple went, in turn, to the High Court, the House of Lords and the European Court of Human Rights,[30] but, despite expressions of sympathy from the presiding judges and law lords, each of their requests was turned down. Mrs Pretty died in a hospice a couple of weeks after the European Court published its decision. Her case contrasts starkly with that of another Briton, Ms B, who was also suffering from an irreversible neurological disease and likewise wanted to be assisted to die. Ms B had suffered bleeding into her spinal cord, leaving her paralysed and dependent on a ventilator. She asked to have the ventilator turned off but her medical team refused her request despite her being judged to be competent. Ms B challenged the legality of the decision and won.[31] She was placed in the care of a different medical team, permitted to have the ventilator withdrawn, and died within weeks. The handling of these two cases is directly relevant to an issue I will consider below in Chapter 6, namely, that of the supposed moral permissibility of letting die, and the supposed moral impermissibility of killing. For the moment, though, I simply draw attention to the way in which Ms B was able to fulfil her desire to end her life whereas Diane Pretty was not. The only relevant difference between their cases was that, unlike Mrs Pretty, Ms B was dependent on mechanical life-support (and thus could end her life by discontinuing her medical treatment).[32]

Finally, I draw attention to several recent instances from my own neck of the woods where individuals have felt compelled to take drastic action in order to highlight the inadequacies of the legal situation with medically assisted death. In Australia in 2002, in an instance that did not go before a court but did achieve notoriety, another sufferer from motor neurone

[29] *R (Pretty) v. Director of Public Prosecutions (Secretary of State for the Home Department Intervening)* [2001] 3 WLR 1598.
[30] *Pretty v. United Kingdom* [2002] ECHR (application no. 2346/02).
[31] *Re B (adult: refusal of medical treatment)* [2002] FD.
[32] For further discussion see Boyd (2002).

disease, Sandy Williamson, publicly declared her intention to suicide while she remained able, in order to draw attention to the need to legalise voluntary euthanasia and physician-assisted suicide for those in similar circumstances. Her attempt did not go entirely to plan and she was rendered comatose, but died in hospital a week later.

In 2004 in New Zealand, Lesley Martin, an experienced intensive care nurse, was sentenced to fifteen months in prison for the attempted murder of her mother in 1999. Martin wrote a book, *To Die Like a Dog* (New Plymouth: M-Press, 2002), in which she detailed how she had given a 60 mg dose of morphine to her mother after her mother had requested help to die. When her mother lingered, she used a pillow to end her life. Martin's mother had had surgery early in 1999 for rectal cancer. During the surgery a tumour on her liver was discovered. She elected not to have further surgery but instead to be cared for at home by her daughter. Martin was prosecuted on the evidence of her book even though she had previously informed the police about what had transpired and they had taken no action. Yet, also in 2004, just across the Tasman Sea in Tasmania, Australia, John Godfrey was given a suspended sentence of twelve months for assisting his eighty-eight year old mother to commit suicide. She had been an outspoken campaigner for law reform in relation to voluntary euthanasia and physician-assisted suicide.

Undoubtedly, it has not just been cases like those mentioned above that have contributed to the fomentation surrounding the issue of medically assisted death during the past few decades in Australasia, Europe, North America and elsewhere. The impact of the cases that have been before the courts has been significant, but the contributions to the wider public debate of medical and other activists, some of whom I have had occasion to mention, have also had an impact. Nonetheless, there has been no direct path from any of these factors to what has happened legislatively (except perhaps in The Netherlands). It should, therefore, help if I detail what the situation is as regards legislation in favour of assisted death (and, where there is no legislation, its legal toleration).

In Switzerland, assisted suicide (in general, not merely in the guise of physician-assisted suicide) has been legally tolerated for some decades. As already noted, for a period of about two decades, medically assisted death was legally tolerated in The Netherlands before legislation was enacted in 2001 to permit both voluntary euthanasia and physician-assisted suicide under strict medical guidelines. However, it is perhaps less well known that the Northern Territory of Australia was the first jurisdiction to *legislate* in favour of voluntary medically assisted death. The legislation was agreed to