Death talk: the case against euthanasia and physician-assisted suicide

Author(s)	Somerville, Margaret A.
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shown in Washington State by the vote on Initiative 119, A Voluntary Choice for Terminally Ill Persons: Death with Dignity. The polls, before voting on this initiative, indicated that it would succeed, yet it failed by a margin of 54 per cent to 46 per cent. Moreover, the results of polling 2,000 randomly chosen physicians about this initiative, 1,105 of whom responded, show comparable discrepancies and have been described as "mystifying."[72]

Of the physicians who answered, 75 per cent said they did not believe they should have the legal right to give a terminally ill patient a lethal injection. Fully 60 per cent said doctors should not be allowed to prescribe a lethal dose of medication to be self-administered by the patient. And 75 percent said they would not be willing to be personally involved in aiding a patient's death. Yet, in answer to the question, "Should the WSMA [Washington State Medical Association] support or oppose Initiative 119?" respondents were split down the middle, with 543 doctors saying the association should support the initiative, and 562 indicating the organization should oppose it.[73]

These results might contain three important warnings. First, our sense of responsibility for the outcomes of decisions might be diminished when that responsibility is shared with a group and exercised through group decision-making. Second, some physicians might make decisions concerning their own conduct according to their own personal morality, but they might not necessarily want to impose the same morality on others. Third, discrepancies of the type outlined above might show that we may need to talk about doing (or, possibly more accurately, the doing of) things that we ourselves would not do and do not want others to do. In other words, the discussion itself might have a purpose other than promoting the conduct (in this case, euthanasia) that forms its content.

The warnings have been sounded: what we say might not reflect what we are willing to do, and what we say might not be inherently consistent. Yet it remains true that most Western democracies have witnessed a groundswell of popular opinion in favour of euthanasia and its promotion as a choice that should be made available (or at least not prohibited). Why is this support occurring? Why now?

Modern Medical Technology

Some people attribute this perceived need for euthanasia as one more effect of modern medical technology. "Playing God" to sustain patients who would once certainly have been dead might have given us a sense of power over life as well as death. Once we use technology to prolong life, in short, there might be some correlative sense in which we believe that we are entitled to use it also to shorten life. Certainly, we do not need new technology to kill; this possibility is as old as the human species itself.

It could be, however, that a fear of the overuse of medical technology has contributed to calls for euthanasia. This fear is summed up by people who say they would rather be dead than left "to the mercy of doctors 'and their machines.' "[74] The development of rights to refuse treatment has been one response to these fears. Rights are a major currency of the law. In contrast, medicine tends to give priority to fulfilling needs. Fulfilling needs and respecting rights can give rise to conflict, especially in relation to refusals of treatment with modern medical technology. Allowing patients to refuse treatment at the expense of fulfilling major and serious needs (which they have or are perceived to have) has been described as "rotting with your rights on."[75] Whatever we choose as the "correct" approach, it could be very important to ensure that "people die with their rights on." This would help prevent the overuse of medical technology and, equally important, the fear of this overuse – which is not only harmful in itself but also likely to promote the advocacy of euthanasia.

It is true also that developments in medical technology have given rise to "the secularization of the human image"[76] and possibly to a different vision of human identity. Transplantation could mean that we no longer each see the self as one integral whole, for instance, but as a collection of interchangeable parts. That would translate into a modular theory of human identity.[77] This theory has mechanistic connotations, which could be linked with the increasing number of people who consider euthanasia acceptable. We are, in general, unsentimental about disposing of outdated, worn-out, or no-longer-efficient machines. If we see ourselves as machines, at least in some respects, we might apply the same attitude to others. Euthanasia could be an expression in practice of this very attitude.

Individual Rights

Emphasis on the rights of individuals has been a phenomenon of major importance in many Western societies. It might have peaked by now, which means that we must take care to continue to protect such rights. Other concerns also should be incorporated into analysis and practice, but emphasis on the rights of individuals has been essential to ensure respect for each person. And such respect is crucial in the context of health care – if it is to be humane.

Calls for the legalization of euthanasia have often been phrased in terms of respect for individual rights. Most of us recognize a claim to a death that is respectful of the person – sometimes called a "dignified death," although that term can be misleading – but disagree on the limits for achieving this goal. In particular, we disagree on whether anyone has a right to it because that could require actions with which

we disagree. And the right of one person necessarily connotes the duty of another, even if only to refrain from doing anything that would infringe on that right. It is important to recognize points of consensus first, when they exist, and only then points of disagreement. The latter, especially with regard to such strongly held beliefs as those on euthanasia, can have a very different tone when discussion begins with agreement rather than disagreement.

I suggest tentatively that the pro-choice on euthanasia stance might result from failure to balance a very strong (and necessary) emphasis on individual rights by any (or at least enough) consideration for communal claims. Communities, too, need protection. Moreover, it can be argued, protecting the community is also a way of protecting the individual.[78] We need protection of our relationships and bonds to others as well as of ourselves. Hermits aside, people need communities in order to develop fully as individuals. The requirement of a balance between individual rights and protection of the community (between individualism and communitarianism) can be compared with Young's finding of an increase in euthanasia whenever societies failed to maintain the balance between religiosity and secularity; movement towards either pole provoked an increase.[79] By analogy, we could postulate an increase in pro-euthanasia sentiment if the claims of individuals become too strong in comparison with those of the community, or vice versa. It could well be that the greatest danger of overusing euthanasia in the future, were it introduced, would come from an overemphasis on communal claims (for example, cost saving in health care) at the expense of individual rights. Such an outcome would be ironic if the introduction of euthanasia were seen as necessary, as often claimed by advocates, to respect and promote individual rights.

In light of this discussion, it is interesting to note that some of the strongest opposition to anonymous HIV seroprevalence surveys (anonymous screenings of populations to establish the incidence of HIV infection) occurred in the Netherlands. There, on the basis of upholding respect for individual rights, "opposition to any compulsory public health measure is so strong that even professional and popular support for blinded studies is unlikely to overcome the barriers."[80] In contrast, these surveys have met with general approval in both the United States and Canada; they have been carried out after careful consideration of the ethical requirements.[81] Could the Dutch situation with respect to euthanasia be related? I argue that a purely individualistic approach to euthanasia is more likely to result in its being seen as justified and acceptable than one in which communal needs, too, are taken into account.

We all recognize the right to life of every individual born alive. But does this mean that everyone has a duty to go on living? There could be

a moral duty to do so, depending on the circumstances, but there is certainly no legal duty. Denying a legal duty, though, is not the same as recognizing a claim or a right to have death inflicted – that is, euthanasia.[82] Recognition of a right to life means that, even if one approves of euthanasia, it should not be carried out against the wishes of those concerned. Involuntary[83] or non-consensual[84] euthanasia would be prohibited. But what of avoluntary euthanasia? If euthanasia were allowed, could it be carried out on incompetent people – those unable to consent or to refuse consent? The ethical and legal presumption in favour of life would mean that those who had never been competent must not be subjected to euthanasia unless it were held that the presumption could be rebutted and that, in the circumstances, it would not take priority. Allowing euthanasia for competent people might or might not set a precedent that the presumption in favour of life can be rebutted to allow avoluntary euthanasia. If one focuses on the right of people to decide for themselves, and if one uses this criterion as the basis for rebutting the presumption in favour of life, it would not set a precedent. But if one focuses on the fact that permitting euthanasia for competent people recognizes that the intentional infliction of death is legitimate in some circumstances (for example, to eliminate suffering), it could set a precedent for the legitimation of avoluntary euthanasia of incompetent people whose circumstances are similar to those of competent people who die through euthanasia. Whatever our approach to people who had never been competent, that would still leave the matter of whether previously competent people should be able to give "advance directives" permitting euthanasia if they become incompetent.

We need to consider also the wider effects of recognizing a right to die with dignity and holding that it includes a right to euthanasia. That right could be converted into a duty to die with dignity. And that, in turn, could become a right of society to insist that the people die "with dignity" (which is likely to involve involuntary euthanasia in some cases) or even an obligation to die[85] (the corollary of which is a right to kill through euthanasia). To explore what is implied by some of the positions contemplated here, compare the right to treatment with the right to be offered treatment. The former is sometimes proposed as the basis for a corresponding duty to treat, which is then converted into a right to impose treatment. The corollary of a right to be offered treatment, in contrast, is a duty to offer treatment – which people may either accept or refuse.

It is also worth noting, in relation to "the language of euthanasia," that the language of a right to a dignified death is often, although it need not be, used as a euphemism for euthanasia.

We cannot recognize as rights all the claims of individuals. Moreover, the claims of people, when viewed as a group or a community, can

conflict with their claims as individuals. Two questions – whether collective claims should ever be recognized as collective rights, and whether these rights should override individual rights in given circumstances – will not be pursued here. They are relevant to the euthanasia discussion, though, in at least one important way. Even if one accepts that people have a right to a dignified death, that it includes a right to euthanasia, and that the benefits of recognizing this right at an individual level outweigh the harms, the impact at a macro, or a societal, level would still have to be considered. I suggest that the harms and risks to society would outweigh any claim of an individual to euthanasia. Stated another way, we must not consider individual rights, including any right to euthanasia, only from the perspective of individuals; we must consider also the impact at the macro, or societal, level. The need to protect human values, sympbols, and networks, which establish the web that constitutes society, must be given proper consideration. Euthanasia is unacceptable at the societal level, even if that were not true at the individual level; its unacceptability at the societal level outweighs the acceptability of the best-case argument for it at the individual level.

Sanctity of Life and Quality of Life

Our society has moved from relying exclusively on a sanctity-of-life, or vitality, principle to relying as well, or sometimes alternatively, on a quality-of-life principle. The latter includes concepts such as "a life not worth living" and even "wrongful life." Initially, wrongful life was a claim for damages in tort, usually on the part of handicapped children; they argued that their very lives – that is, being born – constituted a damage for which compensation should be available through the courts. Although most of these plaintiffs were not successful, some were.[86] Those precedents have been used for a case involving the other end of life. The plaintiff had refused cardio-pulmonary resuscitation, but was given it after a cardiac arrest; when resuscitated, he was hemiplegic. He sued for damages for "wrongful life."[87]

Recognition of the quality-of-life principle is often linked with euthanasia by the same two opposing groups, each of which argues for a broad definition of euthanasia. I refer to the group consisting of some streams in the pro-life movement and the group of people who are pro-choice on euthanasia. The former oppose consideration of quality of life in the context of making decisions at the end of life – especially in connection with euthanasia; the latter would give it priority over sanctity of life. But one does not necessarily advocate euthanasia or oppose sanctity of life if one agrees that quality of life is a valid consideration. Taking quality of life into account is not always unjustified. Indeed, it might be ethically required in making decisions about the

allocation of medical resources at a governmental or institutional (macro) level. The need to consider quality of life arises in part from the possibilities made available by modern medical technology. It has been well said that we were once "reasonably well or dead."[88] Today, we can be very sick for a very long time at the end of our lives because life can be prolonged by modern technology. This can create legitimate concerns about the quality of these prolonged lives.

The reasons for our various approaches to quality of life, as is true of various approaches to euthanasia,[89] could be more complex than we realize at first glance. Ethicist Bridget Campion points out that when we describe people with Alzheimer's disease or Huntington's chorea as "better off dead" or "not the person he or she used to be" – implying that these people no longer have a quality of life adequate to make them want to go on living (or even that they should not be allowed to go on living) – we need to inquire what we mean by what these people were. People are always evolving. They are never what they were previously "and many times … stopped being … the [people they] used to be."[90] Do these statements indicate that the problem is defined as a lack of evolution, or the potential for evolution, to what we regard as an acceptable quality of life? Is this a good enough reason for saying, sometimes to justify euthanasia, that someone's life is not worth maintaining, owing to "loss of dignity," and may therefore be "terminated"?[91] Can we not accept either ourselves or others simply for being rather than becoming – as human beings rather than human doings?[92] Is it, as novelist Milos Kundera proposes,[93] a state of just being, without potential to become something else, that is unbearable? If so, we need to ask precisely whom we would be treating with euthanasia: the patient, ourselves, or society.

Part of the problem when we react inappropriately in relation to ill or dying people, according to Campion, is that we see examples of lives that terrify us.[94] We see these patients – and ourselves if we were in similar situations – as unlovable. This perception raises fear of abandonment because, in a consumer society, we get only what we pay for. We believe that we need to earn love. If we cannot earn it, we will not be given it. We will die abandoned and unloved, and we would rather be dead than unloved. Euthanasia is a way to ensure that we are already dead before the abandoning and unloving occurs. "The demand for active euthanasia would be greatly reduced if we could alter this perception that love is very tenuous, that it is conditional and must be deserved."[95]

I have noted the possible connection between euthanasia and a mechanistic approach to people. That approach, too, is associated with consumer societies. Characteristically, this type of society disposes of worn-out or useless products. This outcome becomes mandatory when

these products result in economic loss. If we see ourselves simply as products, cogs in the wheel of production, then we would be disposed of as cheaply and efficiently as possible once we are no longer valuable products or producers. Although euthanasia is promoted as a merciful response to suffering, and most of those who advocate it have this as a primary aim, euthanasia does fit into this consumer philosophy. Further, the practice of euthanasia could itself be seen as consistent with the philosophy of a consumer society because it means "death becomes a matter of management." This, in turn, means that several "choices become necessary and several practical points must be discussed: the day and the hour of euthanasia; those to be present; the method to be used."[96] The bizarre thought comes to mind that, in the future, people studying for master's degrees in business management could take courses in "death administration."

The connection between an increasing number of calls for euthanasia and the influence of consumerist philosophy (or, more precisely, its domination) becomes particularly convincing, I suggest, if we consider the circumstances of many people with AIDS. Jay Katz describes powerfully how these terminally ill people can find themselves in a situation of intense "pre-mortem loneliness."[97] In this respect, it is of sad interest to note that, according 1989 to a report, "11.2% of Dutch AIDS patients died by active euthanasia."[98] In 1991 one report put the figure at 23 per cent.[99] Either way, these statistics are well above the average for the number of deaths that occur through euthanasia in the Netherlands.[100] People with AIDS have been among the most stigmatized, most likely to be abandoned, dying people. Without minimizing or ignoring the intense physical and mental suffering that AIDS can cause, these other features of their dying could well correlate with an increased likelihood that patients with AIDS will seek euthanasia (or be offered it), especially in a society that is governed by consumerism. People with AIDS can be viewed not only as useless products but also as potentially harmful ones. Moreover, isolating them from society, whether in practice or through symbols, may serve an additional function – that of a purification ritual – and euthanasia may well be part of that process. The calls, often strident, to test the population in general for HIV, to quarantine those who are antibody positive, to exclude them from schools, hospitals, or the workplace (especially if they are health-care professionals) may all originate from a desire, even if unconscious, for symbolic ways of purifying society. Euthanasia could be the ultimate way.[101]

We should consider as well whether language has an impact on the views of and reactions to euthanasia in the context of AIDS. Military terminology, especially, the concept of a war on AIDS, is often used.

Could there be some connection, even if an unconscious one, between this language and the notion that euthanasia is acceptable for patients with AIDS? Could euthanasia in that context even be some form of killing of the enemy, in that the patient with AIDS, not HIV, is mistakenly identified as the enemy?

WHY DO WE WANT TO MEDICALIZE EUTHANASIA?

Does euthanasia seem kinder, gentler, and in a "safer forum" if it is carried out in a clinical context?[102] Does this association show "approval, acceptance and care of the patient"[103] and of the patient's decision for euthanasia? In speaking of physician-assisted suicide, it has been said that "seeking a physician's assistance, or what can almost seem a physician's blessing, may be a way of trying to remove … stigma and show others that the decision for suicide was made with due seriousness and was justified under the circumstances. The physician's involvement provides a kind of social approval, or more accurately helps counter what would otherwise be unwarranted social disapproval."[104] Could euthanasia provide a precedent for other interventions that would be carried out "in the medical context"? The involvement of American physicians in capital punishment is a case in point. Would it make any difference that these interventions could be given trial runs, or attempts made to make them acceptable, in the clinical, or purportedly clinical, context of euthanasia, before their equally controversial application in the context of capital punishment? These questions might sound alarmist, but we need to ask them and to do so with some degree of equanimity.

It is not uncommon to medicalize situations in order to deal with those that make us feel uncomfortable or that are prohibited outside a medical situation. For example, infringement of even constitutionally protected rights to liberty and security of the person can be justified by virtue of powers given under mental health acts or public health legislation. Interventions are allowed to protect either the patients themselves or others from serious threats to their lives or health. We should be careful in adopting tactics such as medicalization that we do not dull our sensitivity to some of the basic issues involved. It has been said that nowhere are human rights more threatened than when we act purporting only to help others. We assume that acting within a medical context means we have at least a primary intention of doing good. This assumption would apply to euthanasia no less than to other medical interventions. Although it is usually argued that euthanasia is most appropriately provided within a medical context, and that allowing euthanasia promotes human rights, the claim that good would result from legalizing euthanasia would be more

clearly tested by dealing with it outside the medical context.[105] We would then need to prove – not simply assume – that making euthanasia available would be to do good, whether to individuals or to society.

Bill C-261 was proposed legislation on euthanasia in Canada, but was withdrawn. It would have required euthanasia to be dealt with partly outside a medical context. This legislation, possibly unique, proposed "referees in euthanasia." They would issue "euthanasia certificates," which would permit physicians to carry out euthanasia on those with certificates.[106] There was no suggestion that the referees should be physicians. Indeed, application could have been made for reviews by the attorney general of Canada – who is unlikely to be a physician – in cases of negative decisions.

In summary, we might be dealing with euthanasia in a medical context at least partly to eliminate or reduce reactions that we would otherwise have to one person killing another. To the extent that we expect modern medicine to be our source of miracles, moreover, it could be that, when no miracle is possible, death itself can be seen as a miracle – a different kind of miracle, but one still provided by medicine if it occurs through euthanasia carried out by a physician.

WHY DO WE TECHNOLOGIZE EUTHANASIA?

Consider the much publicized case of Jack Kevorkian assisting Janet Adkins's death. Why did Dr Kevorkian and Mrs Adkins resort to a suicide machine that was even given a special, trademarked name, the Thanatron™?[107] One obvious reason was to avoid prosecution for murder by eliminating the possibility that Kevorkian could be held, in law, to have caused Adkins's death. By using the machine, she could be regarded, in law, as causing her own death. In that case, the situation was one of suicide – and assistance in suicide was not then a crime in Michigan[108] – not murder. It is worth noting, however, that even though Kevorkian did not intervene after the initial intravenous lines had been inserted, and even though Adkins herself activated administration of the lethal drugs, a charge of murder was considered. In two subsequent cases, Kevorkian did intervene (in one, to fix a defect in the machine after it had been started); charges of murder were laid against him, but found to be without foundation.[109]

Kevorkian is now serving a ten-to-twenty-five-years prison sentence as a result of being convicted for second-degree murder in another case. He video-taped himself helping Thomas Youk, a seriously ill, fifty-three-year-old man, to take his own life by lethal injection. The film was subsequently shown on television and was used as the basis of the charge against Kevorkian.

There could be a less obvious reason why we technologize euthanasia. We often speak of the technological imperative in medicine. We have technology and, therefore, believe that we must use it. The presence of technology elicits a response to use it. Much discussion in bioethics has been concerned with attempting to work out principles and guidelines for when we ought (there is a duty), "need not" (there is no duty), or ought not (there is a duty not) to use technology. Could the case of euthanasia be a variation on this technological-imperative response? In euthanasia cases, such as those involving Kevorkian, could it be that, rather than a technology preceding and eliciting a response, a desired response – namely, euthanasia – precedes the development of the technology, which is thus developed precisely to generate the desired response?

Does the use of technology somehow come between us and the person to whom we apply the technology,[110] such that we do not feel that it is our act that creates the result – in the case of euthanasia, death of the person – but, rather, that it is caused by the technology? Does the use of technology allow us to distance ourselves, to disidentify in some degree, from the fact that we are killing another person in the act of euthanasia?

When we apply technology to other people, it has been alleged, there is a risk of depersonalizing them – seeing them as mere objects for the application of technology. We find it easier to act towards others in ways about which we have deep concerns, moreover, when we do not regard those affected as people like ourselves. For example, researchers found it very much more difficult, and sometimes impossible, to carry out medical research on people when they were forced to relate personally to their subjects by participating in a detailed informed consent process.[111] This reaction could provide insight into why people would develop technology to carry out euthanasia. Technology allows us to distance ourselves from those on whom we act and to depersonalize them; without doing so, it would be very difficult to kill them. As an aside, it is worth noting here that we can use language to achieve similar effects. The choice of words, or labels, makes it easier to distance ourselves from others and to depersonalize them. One example is the use of derogatory terms for enemies killed in wartime. A more everyday example is the failure to use words such as "person" or "people" when describing an individual or a group. This almost always occurs in connection with derogatory characterizations: criminals, delinquents, mental incompetents – we do not speak of "mental competents," by way of comparison, but rather of "mentally competent persons" – and the aged.

In summary, consider the following statement by George Annas: "Machines have a tendency to depersonalize death and to make us

seem less responsible for it … The use of military metaphors in medicine tends to obliterate the patient, just as the use of medical metaphors by the military tends to obliterate the horrors of war. In both cases, we prefer to concentrate on the technology because, unlike death, it seems clean and controllable."[112]

WHY WOULD EUTHANASIA BE ALLOWED, OR NOT PROSECUTED, BUT NOT LEGALIZED?

The criminal laws of all countries prohibit culpable homicide – murder and manslaughter. Euthanasia, too, is prohibited by these laws, except now in the Netherlands. Most countries prohibit assisting suicide, although suicide itself is seldom a crime in modern criminal law. In the Netherlands, euthanasia has been allowed under specific conditions since the early 1970s, but it is only very recently that it has been legalized even there – at least in a strict juridical sense.[113]

Dutch criminal law, the Penal Code, prohibits murder (which, until the recent legislation, included euthanasia) in section 293 and prohibits assisted suicide in section 294. But since the early 1970s, prosecution has been unlikely,[114] if guidelines established by the Dutch Supreme Court in a case involving euthanasia by a physician (some aspects of which were codified as guidelines in 1990 and, subsequently, enacted as regulations in 1993) were respected. In any case, decisions to prosecute had to be approved by five senior prosecutors.[115] The jurisprudential bases used to validate these guidelines were a few articles in the Penal Code "listing possible grounds for non-punishment" for any offence.[116] The conditions for legitimating euthanasia were, "among other things, that there be an explicit and repeated request by the patient that leaves no reason for doubt concerning his desire to die; that the mental or physical suffering of the patient must be very severe with no prospect of relief; that the patient's decision be well-informed, free, and enduring; that all options for other care have been exhausted or refused by the patient; and that the doctor consult another physician (in addition, he may decide to consult nurses, pastors, and others)."[117] One physician has even been disciplined by a Dutch Medical Disciplinary Board for "breach of trust" for "misleading a patient into supposing he was being given a lethal dose of drugs, when the doctor knew this was not so."[118] "The doctor was in effect found guilty for 'not … unlawfully killing his patient.' "[119] In the Netherlands, moreover, there has been intense debate over whether euthanasia should be available when the patients concerned are incompetent to consent. As I have already noted, some (probably many) of these cases have occurred, although they would clearly have been outside the guidelines applicable at the time. These cases included not only incompetent adults but also handicapped newborn babies.[120]

The new Dutch legislation, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2000), codifies and, in some respects, clarifies the existing practice in such respects. Euthanasia may only be carried out on people who, among other requirements, give a fully informed consent either at the time or through a "euthanasia declaration" – that is, they express their wishes about termination of life in advance. Minors sixteen years of age or older can, in principle, decide on euthanasia for themselves. Children aged between twelve and sixteen years may also request euthanasia, but the consent of both parents or the guardian is required. If, however, a physician is convinced that euthanasia is necessary to prevent serious harm to a child who requests it, the physician may fulfill the child's request despite the refusal of consent by the parents or guardian.

What insights does the Dutch approach to euthanasia provide? First, until the recent legislation, the law was not changed to legalize euthanasia, although euthanasia was practised without attracting legal liability. In individual cases, euthanasia was justified (excused?[121]) in situations of "force majeure, in the sense of conflicting duties."[122] The commentary on Dutch law, with respect to what constitutes this defence, is not always consistent or easy to understand, which could reflect some lack of clarity as to either the exact characteristics of the defence or its application in practice. For example, Diana Brahams states that "force majeure," in the sense of irresistible force, was rejected as a defence to criminal liability for euthanasia. She equates the defence of irresistible force with the defence of necessity and, likewise, finds this defence rejected.[123] According to Brahams, a "conflicting duties situation," which she describes as "the emergency defence," was recognized by Dutch courts: "The court ruled that a physician's duty to abide by the law and to respect the life of his patient 'may be outweighed by his other duty to help a patient who is suffering unbearably, who depends upon him and for whom, to end his suffering, there is no alternative but death.'"[124] In contrast, John Keown says that the defence available to Dutch physicians to justify euthanasia was one of necessity (*overmacht*) contained in Article 40 of the Penal Code. In a 1986 case, he says, the Dutch Supreme Court "accepted that the defense of necessity in the sense of 'psychological compulsion' experienced by the doctor was also available."[125]

Is there any equivalent in Anglo-American common law to this "conflicting duties" defence? The only possibility might be a defence of necessity. A defence of necessity is available in Anglo-American common law when the harm done by breaking the law is clearly outweighed by the harm avoided in doing so; when the harm avoided is of a serious nature; when there is no reasonable alternative to breaking the law if

the harm is to be avoided; and when the least harmful approach is used. The critical issue is whether the harm done by breaking the law (killing someone) could ever be outweighed by the harm avoided by doing so (relief of suffering). This possibility seems highly unlikely because it is only if the necessity in question is to save a human life that killing may be excused, though not justified, under a common law doctrine of necessity.[126] Leaving aside the morality of euthanasia, the harm done at a precedent-setting and societal level in allowing euthanasia would not, in my view, be outweighed by harm avoided at the individual level.

Before enacting the recent legislation legalizing euthanasia, the legitimation of the euthanasia process that the Dutch used had managed to maintain at least an impression that each case of euthanasia constituted only an individual event – not only in practice but also symbolically – despite the fact that the total number of cases there was probably very high.[127] The previous Dutch system could have helped to achieve this outcome because (as is also true of the new system) each case of euthanasia must be justified individually and reported;[128] each case, technically, was *prima facie* a breach of the law; and, in each case, the conduct could be found unjustifiable and be prosecuted. This approach could more easily generate a sense of the individuality and uniqueness of each case (not one of institutionalization) than if, as is now the situation, euthanasia were generally legalized – but only under specified conditions. Why, however, would the Dutch have adopted this approach, assuming, as must have been the case, that euthanasia was regarded as acceptable by the majority of the public? One reason might have been that this approach confined cases of euthanasia to the micro level; as exceptions to a general principle against the taking of human life, the latter could still operate at the macro or societal level. Now that euthanasia has been legalized directly by the legislature, the impact of euthanasia is likely to be much greater; the general principle or presumption that governs society has been changed to one that says life may be taken in some circumstances.

In short, the previous Dutch approach maintained the symbolism of the sanctity-of-life principle while allowing practices that were inconsistent with it. This same mechanism can be seen in the French legal and medical systems. A report entitled "French Health Ministry Supports Doctor over Euthanasia" reads as follows:

> Leon Schwartzenberg, an eminent French Cancer Specialist, has been suspended for one year by the Paris board of the French Medical Association. The suspension follows Schwartzenberg's admission that he had helped an incurable patient to die. Claude Evin, the French Health Minister, has now joined

Schwartzenberg in filing an appeal, and in calling for broad public debate on euthanasia. Evin said: "The main thing is to relieve suffering, even if that means the end of life." Neither Evin nor Schwartzenberg favour a change in legislation, however. Schwartzenberg has said: "*For the French, anything that is law is normal, and euthanasia can never be normal.*"[129]

A similar approach of *de facto*, but not *de jure*, legalization of euthanasia has been advocated for Canada. The proposal of Barry Sneiderman, a law professor who does not oppose euthanasia, is summarized in the headline accompanying an article written by him: "Don't make it murder, but don't make it legal." Sneiderman writes that

> In the rare situation in which the physician is driven to desperate measures (as [occurred] in a Montreal case [in which a physician gave a lethal injection of potassium chloride to a terminally ill person with AIDS who was suffering greatly]), the law has the capacity to stay its hand as a merciful response to a merciful act. But that is a far cry from granting physicians the legal authority to practise euthanasia. As philosopher John Rawls says, "It is one thing to justify an act; it is another to justify a general practice." Given the current crisis over a health-care system unable to meet the reasonable needs of all our ailing people, we cannot guarantee that euthanasia would be practised solely as the medical measure of last resort. In short, one cannot say that the time for euthanasia has come to Canada.[130]

In summary, even those who do, or would, allow euthanasia at an individual level recognize the danger at the societal level. An important question, therefore, is whether we can prevent approved micro-level practices from establishing macro-level precedents. Almost certainly, we cannot. Consequently, quite apart from moral arguments, euthanasia should not be allowed even at the micro level.

HIDDEN DECISION-MAKING AND EUTHANASIA

It is often alleged that euthanasia takes place, but that it is performed secretly. It is further alleged that this situation is the result of euthanasia being illegal. Studies show many cases of hidden (at least in the sense of unreported) euthanasia in the Netherlands,[131] however, when it was *de facto* legal. Consequently, the cause of euthanasia being hidden might not be the fact that it is illegal; even if legal, it might still be hidden. In this regard it will be interesting to see whether the new Dutch legislation legalizing euthanasia leads to an increase in the compliance with the reporting provisions by physicians who carry out

euthanasia. Modern Western societies usually react strongly against hidden decision-making and actions, but should they always do so? To respond to this question some distinctions must be made. Do we believe that hidden decision-making is wrong in all circumstances or only in some? Or do we believe that most cases of hidden decision-making involve unethical or illegal decisions and that they can be prevented most effectively by eschewing such decision-making? We must be open-minded enough to ask whether there is a place for hidden decision-making and actions by individuals, though not by institutions or society, in some very unusual situations. Also, we must ask whether trying to eliminate all hidden decision-making in connection with euthanasia would do more harm than good. In particular, we must ask whether legalizing euthanasia, to avoid hidden decision-making, would do more harm than good even if we were to achieve our goal.

With those questions in mind, let us compare euthanasia with abortion. Whether or not we agree that abortion is morally acceptable (always, never, or depending on the circumstances), prohibiting all abortions can involve situations that give rise to its being carried out secretly. This recourse causes a major increase in serious risk for women who have abortions. And because this risk might not even deter women from having abortions, it constitutes an argument against using the law to prohibit abortion in the early stages of pregnancy. Another argument is that the law is ineffective in preventing abortion, especially in light of new methods – for instance, the "morning after" or "abortion pill" – that do not require the use of complex medical techniques or sophisticated facilities.

But to accept the idea that laws prohibiting abortion can create unacceptable levels of harm without compensating benefits (protecting fetuses from abortion), or that these laws are totally ineffective, does not address or alter the morality of abortion. No matter whether the law allows or prohibits abortion, those who believe that abortion is immoral must try to convince those who do not so believe and persuade them to alter their conduct accordingly.

Causing euthanasia to be carried out secretly, because it is illegal, is unlikely to produce similar risks and harms to those who seek it – unless one regards as a harm not being killed when one wants to be killed. (Hidden euthanasia is, almost certainly, far less readily available than legalized euthanasia would be; those who would have access under an overt, legalized system of euthanasia might not have access in the absence of one.) I am assuming here that hidden euthanasia involves only those who want to be killed and who would be eligible for euthanasia if it were legalized. Whether or not euthanasia is legalized, these people would die by that means. Some people argue, however, that the potential

for abuse is vastly increased by forcing acts of euthanasia to be hidden, as occurs when it is illegal. But it could be argued also that the potential for abuse is increased even more when euthanasia is legal. For instance, the Dutch policy, before the enactment of the recent law legalizing euthanasia, had been criticized "for creating a 'private place' for euthanasia which is both spacious and poorly policed."[132] Further, those in favour of euthanasia often require opponents of voluntary euthanasia to provide evidence of a "slippery slope,"[133] though this is the opposite burden of proof from the expected one. Usually, leaving aside for the moment questions about the morality of euthanasia, those who want to change the status quo – that is, to legalize euthanasia – would be required to show that change would not be dangerous either to individuals or to society (at least no more dangerous than the present situation), and possibly that the proposed change would do more good than harm.

Euthanasia can occur secretly. Deciding not to take all possible measures to prevent it (even though it is illegal and it causes more harm than good) does not mean that one finds euthanasia morally acceptable. If hidden cases were to become known, moreover, they would have to be prosecuted if the general effectiveness and symbolism of the law is to be maintained. The law allows discretion and, in some rare cases involving euthanasia, this discretion might be exercised best by deciding not to prosecute. These cases must be clearly exceptional and very rare, however, if they are not to become a message to health-care professionals that they may carry out euthanasia with impunity. Suspended or light sentences for euthanasia could have the same effect. In handing down a lenient sentence in a euthanasia case, a Canadian court explicitly noted that health-care professionals should not interpret its judgment in this way.[134]

Great care must be taken with some current research on attitudes to euthanasia, surveys that abandon the distinction between euthanasia and other interventions or non-interventions at the end of life. These surveys often promote the idea that there is much hidden euthanasia, that many health-care professionals – physicians and nurses – have carried out euthanasia for a long time. The implication is that this evidence provides support for the idea of bringing the law into line with reality on the grounds that this conduct has "obviously" not caused any harm; that it must be necessary; that those who undertake these interventions are of "good conscience" and good will; and that they are neither sought out nor prosecuted.[135] According to a report from Boston, one in five American physicians has deliberately caused a patient's death. The report refers to terminally ill patients who asked for assistance in committing suicide; but it is not clear what, if any, were the limits to the conduct engaged in by their physicians in order to "help death."[136]

In interpreting these surveys, a much more accurate assessment would have to be made of exactly what the physicians surveyed meant by "helping death." For example, respecting refusals of treatment or giving necessary pain-relief treatment, even if it could shorten life, might have been included. We should acknowledge that there are major legal and ethical differences between these kinds of assistance and, for instance, giving someone a lethal injection. This distinction is true whether or not one agrees with euthanasia.

Even if some physicians are carrying out unethical or even illegal practices, moreover, it does not mean that the law should be changed to legitimate them. Nor does it mean that the law should be used relentlessly to prosecute every last one of them. In some very unusual circumstances, at the level of an individual case, prosecution might be inappropriate. The symbolism created by legal prohibition is required at the macro level. Great care must be taken in handling individual cases not to damage this symbolism. Sometimes these cases must be treated in a way that can seem harsh for the individual involved in order to maintain the message of respect for human life that is contravened by euthanasia.

Some people argue that, because euthanasia is illegal, those who carry it out fear prosecution, yet they should not have to be burdened by fear. But such immensely serious decisions as euthanasia should never be easy. That they are difficult at both cognitive and emotional levels for those who carry out euthanasia is an essential and enormously important safeguard. Even those who feel morally justified in performing it should have to consider the views of society as expressed in its law and be prepared to accept the consequences of not conforming. This approach might seem very "hard hearted." It might be thought to originate in a failure to appreciate the anguish that can arise for those who believe that, in particular cases, the availability of euthanasia is not only morally acceptable but also morally required. I propose, however, that euthanasia is a situation in which accepting it as the appropriate response for dealing with "hard cases" would make very "bad law" for society as a whole.

Leaving aside for the moment the morality of euthanasia, we sometimes have to choose between the law that we need for symbolism – the law that would be best for establishing principles at the macro level – and what would be the best approach in some very difficult individual cases. Euthanasia, in my view, is one of the situations where the needs of the community – society – must take priority over the claims of the individual. We cannot afford to routinize and institutionalize, let alone legalize, killing. That can be avoided, even if some very rare cases are not prosecuted, provided that the cases involved are each regarded as

isolated instances, outside the norm. In short, it is simply wrong to argue that, because prohibited conduct occurs – because "everyone's doin' it" – there is justification for legalizing it.

Our most ancient laws and moral proscriptions are against killing, at the very least, members of our own species. It is true that there have always been exceptions to this rule which had to be restrictively interpreted, and their application in any given circumstances clearly justified by the person relying on them as exceptions. The major examples in Western cultures, apart from what were rightly or wrongly considered "just" wars, were self-defence and capital punishment after "fair trials" for offences that "merited" them (not all, or most, or even any of which everyone agrees should still be allowed as exceptions). In any case, these exceptions should not be extended by legalizing euthanasia.

In considering the legalization and institutionalization of euthanasia, we are considering an alteration to the fundamental presumption against killing each other on which the morality and law of civilized society are based. Why are so many of us apparently actively considering a change? Could there be some socio-biological, genetic, or environmental factor that is causing the current rise of interest in and promotion of euthanasia? One would need to examine other periods and other cultures, probably other species, even to begin formulating an answer.[137] But we should be aware that what we perceive or believe our primary motives to be could hide more complex realities. Empathy, compassion, and mercy, though dominant motives for most advocates of euthanasia, might not be the only ones. It is just possible that factors such as an increasingly crowded world or even overwhelming fear about one's own death (especially in the context of a secular, pluralistic, postmodern, and multicultural world) could be involved as well.

THE LANGUAGE OF EUTHANASIA

Language is not neutral. Although this proposition is obvious, it is so important in relation to the euthanasia debate that it merits stating. We form our narratives, and our narratives form us. We are, at least in part, the stories we tell. Stories about "bad deaths" and "good deaths" are especially influential. They give us access to experiential knowledge. They often help us to identify our emotional responses and provide opportunities to examine them. It is essential to acknowledge the necessity of such examination if we are to respond wisely to problems associated with death – including euthanasia. At a conference in Boston,[138] Timothy Quill and Susan Tolle told "stories," in which a potentially "bad death" was converted to a "good death" by their respective interventions. The two speakers were clearly concerned about the

doubtful legality of what they had done. These were powerful pro-euthanasia narratives. In contrast, Christine Mitchell read a deeply moving essay written by an intensive-care nurse who created a situation in which the family of a patient were included in his dying through the nurse's unusually sensitive approach. As the nurse said, this man's dying was a very important event not only in his own life but also in the lives of his family and friends. Mitchell proposed that, in characterizing the kinds of death people experience, we should include what their families and friends will remember and weave into their own lives.

With the power of language in mind, I would like to analyze, briefly, one document: a report of the Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death,[139] which was based in London, England. It contains many examples of the way in which language can be used to influence the euthanasia debate, and provides additional insights as to how our reactions to euthanasia can be modified, depending on the way in which it is presented. (The quotations that follow in this discussion, except where otherwise indicated, are all taken from this report.)

The report speaks of "hasten[ing] death by administration of narcotic drugs." This procedure can be compared with the use of curare in the Netherlands, after the injection of a short-acting narcotic, such as pentothal, to induce sleep.[140] One can query the basis of the decision to use only narcotic drugs. Could these drugs be chosen because they are less likely to make people react to euthanasia as a different kind of intervention from, for example, the pain-relief treatment regarded as acceptable and even required? Is the use of narcotics less likely to elicit different emotional reactions from those we have to pain-relief treatment, and more likely to elicit similar reactions of the appropriateness and acceptability of the intervention than would the use of other drugs? Curare, which causes total body paralysis, is used in many surgical operations that require paralysis to give surgeons easier access to, for example, the abdominal cavity. As one Dutch anaesthetist said in conversation, it is not very difficult for an anaesthetist to carry out euthanasia; it simply requires giving "half a general anaesthetic and just not doing the other half – the resuscitation." General anaesthetics are almost always given for therapeutic reasons and to promote healing. Does linking euthanasia with this procedure, even its confusion with it, cause us to see and react to euthanasia as a healing, therapeutic intervention?[141] If so, this association is undesirable – which is not necessarily to say that one would oppose euthanasia if it could not be viewed in this way. Rather, euthanasia itself must be thought and felt about as clearly as possible. To achieve this realization, one needs to