

Euthanasia

1. Palliative care can address the suffering of a terminally ill person

Advocates of euthanasia suggest that it would enable persons, who become terminally ill and find themselves in an unbearable situation, to avoid suffering a slow, drawn-out death.

In response to this the SCHB notes that:

Physical suffering can be adequately alleviated in all but the rarest of cases with up to 95% of patients having their pain and/or symptoms effectively relieved when treated by healthcare professionals with the relevant expertise^{1,2}.

Similarly, patients with an illness such as motor neurone disease (a serious progressive neurological disorder) are often afraid of choking to death. But studies from the most experienced hospice units have demonstrated that, with appropriate palliative care, this virtually never happens.

In addition, the administration of short episodes of sedative drugs can be considered as an appropriate alternative, when persons are in the dying stages, to manage distress and restlessness. This can happen when patients are often barely conscious as a result of their disease (not because of the drugs) and are no longer capable of consciously working through their issues. In this case, palliative care helps patients (and sometimes also their families) by calming their terminal agitation.

Usually, the treatment is a matter of gradually increasing the level of drugs according to effect. However, there are occasions when a patient is very agitated and rapid use of large doses of drugs is essential for the safety and comfort of the patient and others.

Nonetheless, there will always be rare occasions where a patient's symptoms cannot be completely controlled. Often these are patients who cannot resolve an issue or cannot cope with a symptom, such as with severe breathlessness. Some may also have significant psychological and/or spiritual distress which they find difficult to resolve. Indeed, almost all patients with uncontrolled pain have elements of this pain which cannot be recognised as physical.

These individuals, who are already drowsy and dying of their illness, may then request some form of sedation to relieve the burden of otherwise intractable suffering, in which case it may be possible to manage their distress and agitation without side effects. In other words, drugs are administered and monitored to induce a state of decreased or absent awareness (unconsciousness) in order to increase comfort in the dying process rather than, in any way, shortening life³.

It is very unusual for palliative care to have to use continuous sedation to keep a lucid patient asleep in order to address the intolerable physical and/or mental distress. Indeed, sedating people deliberately to deal with their suffering is a rare occurrence in the UK.

Of course, it is important that patients with difficult symptoms are not promised complete relief since this is beyond the realm of medicine. In this regard, it should be noted that palliative care does not only seek to work in the area of medicine since it also endeavours to provide non-clinical support and the right environment for patients to express and work through their distress⁴. Thus, few patients request euthanasia when their physical, emotional and spiritual needs are properly catered for.

¹ Organisations such as the Hospice Movement reveal that suffering can be adequately alleviated in all but the rarest cases. See also Pain Control - BBC - http://www.bbc.co.uk/religion/ethics/euthanasia/euth_pain_control.shtml; Using Opioids to Control Pain <http://www.painlaw.org/opioids.html>

² When correctly used to relieve pain in a patient who is terminally ill, morphine should never cause death. By contrast it usually lengthens life and improves its quality. This is because the therapeutic dose of morphine, which relieves pain, is virtually always well below the toxic dose which ends life and because the relief from pain which it brings removes stress factors in the patient's condition. In addition, toxic doses risk causing increased agitation in some patients.

³ Nathan I Cherny, Sedation for the care of patients with advanced cancer, *Nature Reviews Clinical Oncology* 3, 492-500 (September 2006)

⁴ For example, with the consent of the patient, the number of visitors may be reduced so that he or she can work things through.

2. It is wrong to suggest that any person can ever lose his or her intrinsic human dignity

Advocates of euthanasia suggest that individuals should be able to determine their own dignity and quality of life, unrestricted by the moral, cultural, religious, or personal beliefs of others. For example, it has been proposed that persons who fear that they will lose their dignity during the final stages of a terminal illness should be able to 'die with dignity' before these stages occur.

In response to this, the SCHB notes that:

It is incorrect and disturbing to suggest that any person can ever lose his or her human dignity. Though human dignity is not a scientific concept, it is something that everyone should always accept is found in everyone to an equal extent. This is in accordance with the **United Nations' Universal Declaration of Human Rights** which affirms in its preamble "*the inherent dignity and...the equal and inalienable rights of all members of the human family*" as "*the foundation of freedom, justice and peace in the world*".

At present, we live in a society where human dignity is universal and where each and every person is expected to acknowledge, respect and recognise the same dignity in other individuals. It cannot be created, modified or destroyed by an individual, a majority or a State.

However, legalising euthanasia would mean that the whole of society would accept that some individuals can actually lose their inherent human dignity and have lives which no longer have any worth, meaning or value.

It would also mean denying the human dignity which is due to an individual, in order for him or her to be legally killed. In other words, it would give the message that human dignity is only based on subjective choices and decisions and whether a life meets certain quality standards.

In this regard, it should be noted that a society that no longer believes in the inherent dignity of human life cannot offer any valid argument against the taking of life of others, who may be considered unworthy of human dignity. It becomes a society that has lost its trust in the intrinsic value and meaning of life and cannot comprehend why it should be endured.

This is in complete opposition to a responsible benevolent and compassionate society which continues to affirm and defend the lives of all its members and the notion that every human life is full of value, meaning and richness even though persons may be aged, dependent on others or may have lost their autonomy. Therefore, in order to function consistently, society must reject the option of euthanasia if it does not want to undermine basic societal and fundamental values.

3. Full and complete autonomy undermines the concept of human dignity

Advocates of euthanasia suggest that a person's fear of disability and dependency should enable him or her to die while he or she is still autonomous and that euthanasia would enable self-determination to exist. In other words, individuals have the right to take decisions concerning their own life and death situations in accordance with their own values and beliefs. These should not be imposed by a court, a physician or a family member. It is a question of freedom and equality in the face of death.

Thus, advocates of euthanasia suggest that nobody has the right to impose on the terminally-ill and the dying an obligation to live out their lives when they themselves have persistently expressed the wish to die.

In response to this, the SCHB notes that:

The recognition of every person's full, complete and total autonomy does not enable the concept of human dignity nor, for that matter, an interactive society to exist. Accepting such an extreme form of autonomy would mean the atomisation of each human being whereby every individual would live on a completely free and independent island. Society, as such, would then cease to exist.

Indeed, the very concept of human dignity is dependent on persons having relationships with one another in an interactive society. It is not based on an individual's own limited personal subjective views of himself or herself. In this respect, it should be noted that it is only because society believes in the human dignity of persons, that it respects their autonomy.

Moreover, being dependent on others should never be associated with a loss of dignity. All are born dependent on others, and many will die dependent on others. Being dependent on others is a basic characteristic of human existence.

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In addition, the legalisation of euthanasia may undermine the autonomy and constitute a level of coercion on medical and other health care practitioners or individuals. They may then feel obliged to carry out an act of euthanasia against their wishes or personal beliefs.

4. Human dignity is grounded on an interdependent society

Some supporters of euthanasia argue that persons should be able to decide, for themselves, whether or not they have lost their dignity and that this decision does not have any consequence for other members of society.

In response to this, the SCHB notes that:

In an interactive society, making a choice about the value of a life (even one's own) means making a decision about the value of other lives.

In other words, persons who consider that their lives are no longer worth living or that they have lost their dignity are, in a way, indirectly indicating that the lives of persons in similar or in worse medical situations are also not worth living and should be ended.

Similarly, persons who believe that their lives are no longer worth living or that they have lost their dignity must also reject the worth, value and meaning that others, such as their family, friends and even society, are giving to their lives. But to consciously deny and reject (without attenuating circumstances such as a psychological disorder) the value, meaning and worth given by others to our lives means putting oneself at the centre of all that matters. Moreover, to reject the intrinsic dignity that another person is seeking to give to our lives represents a denial of this other person's capacity to confer dignity which is tantamount to rejecting him or her as a person.

As Lord Walton of Detchant indicated in 1994 in the House of Lords: *"dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole"*⁵.

Thus, personal opinions about worth, meaning and value of human life matter to the whole of society.

5. Euthanasia should not be considered as a medical procedure

It is often suggested that euthanasia should be considered as a medical procedure undertaken by healthcare professionals.

In response to this, the SCHB notes that:

Euthanasia actually undermines the traditional goal of medicine, namely to cure and care but not to harm or kill patients.

Moreover, research demonstrates that most sustained demands for euthanasia are actually considered by persons suffering from existential problems or because they have an extreme concept of control and independence⁶.

In other words, the argument in favour of euthanasia is more about control than medicine. This is reflected in the fact that most physicians are opposed to the practice⁷ and that in some of the places where assisted suicide is legal, such as in Switzerland and the US state of Oregon, a physician does not need to be actively involved in the final administration of the lethal poison.

6. Euthanasia would undermine the relationships of health care professionals with their patients

Advocates of euthanasia suggest that curing disease and bringing about death are not mutually exclusive roles since the intention in both cases is to relieve suffering. It is further argued that the primary role of the physician is to care for his or her patients, which must therefore entail respecting their autonomous wish to die.

In response to this, the SCHB notes that:

⁵ Lord Alton of Liverpool, Lords Hansard Text, 7 July 2009, Column 630.

⁶ Linda Ganzini, et. al., Physicians' Experiences with the Oregon Death with Dignity Act, The New England Journal of Medicine, Vol 342, February 2000.

⁷ Doctors change euthanasia stance, BBC News, 29 June 2006, <http://news.bbc.co.uk/1/hi/health/5123974.stm>

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Crossing the boundary between acknowledging that death is inevitable and taking active steps to bring about death, with intent, fundamentally changes the role of the physician, changes the doctor-patient relationship and changes the role of medicine in society.

Some physicians may become hardened to death and to causing death, particularly when patients are old, terminally ill, or disabled. Legalising euthanasia would give persons, such as physicians, power that could be too easily abused, and a responsibility that they should not be permitted to have. It is not up to physicians to decide whether a life is happy or unhappy and worthwhile or not. If this happened they could become the most dangerous persons in a country. In very rare cases, physicians such as Harold Shipman⁸, may actually feel empowered in being able to provoke death.

In the light of these cases, many vulnerable groups of people may begin to mistrust the real intentions of their doctors.

Historical precedent in the Netherlands demonstrates that progression to involuntary euthanasia requires only four accelerating factors: favourable public opinion, a handful of willing physicians, economic pressure and no convictions for those involved. If legislation allowing euthanasia comes into effect, and political and economic interests are brought to bear, the generated momentum could prove overwhelming.

7. Euthanasia should not be legalised just because it is occurring in secret

Advocates of euthanasia suggest that the practice of clandestine, illegal euthanasia carries the greatest potential for abuse. They argue that the pressures that can influence end-of-life decisions will be more pernicious if euthanasia remains an underground practice. Further, the gap between law and practice must be reconciled if respect for the rule of law is to be maintained.

In response to this, the SCHB notes that:

The law should not be changed just because something, which is illegal and unethical, such as murder, is being practised in secret. If this happened it would completely undermine the rule of law in a country.

In addition, by prohibiting euthanasia, it is also possible to consider hard cases in which there is a measure of ambiguity, on a case by case basis, in an appropriate court of law and judged according to a good standard of fairness and compassion.

8. It is wrong to believe that opposition to euthanasia is only based on non-secular belief systems

It has been suggested that only those with religious or other non-secular beliefs are opposed to euthanasia and that they should not be able to oppose those who believe, instead, in the autonomy of the individual to choose when to die.

In response to this, the SCHB notes that:

The belief in the inherent dignity and inviolability of human life is, in fact, based on international globally accepted secular principles such as the ***United Nations' Universal Declaration of Human Rights***.

Moreover, the ***Council of Europe Parliamentary Assembly Recommendation 1418 (1999) on the Protection of the human rights and dignity of the terminally ill and the dying***⁹, which is the latest text on the issue, indicates in Article 9.c. that:

The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

- i. recognising that the right to life, especially with regards to a terminally ill or dying person, is guaranteed by member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";*

⁸ Harold Shipman: The killer doctor, BBC News, 13 January 2004, <http://news.bbc.co.uk/1/hi/uk/3391897.stm>

⁹ Council of Europe Parliamentary Assembly Recommendation 1418 (1999), Protection of the human rights and dignity of the terminally ill and the dying, <http://assembly.coe.int/documents/adoptedtext/ta99/erec1418.htm>

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- ii. *recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;*
- iii. *recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.*

These texts emphasise the universal, absolute, inalienable and intrinsic nature of the concept of human dignity. In other words, they support the notion that *no person* (including oneself) can lose his or her human dignity at any time in his or her life. Indeed, to reject such a notion would not only seriously challenge the whole concept of human dignity but would be an extremely serious precedent in a world that has fought so hard to endow all persons with the same dignity.

9. Distinction between acts and omission

Proponents of euthanasia frequently refer to the lack of distinction between acts and omission. They argue that there is not a significant difference between actively killing someone and refraining from an action that may save or preserve that person's life¹⁰.

In response to this, the SCHB notes that:

In a medical context, there is a moral duty for the physician to undertake what is reasonable to save and preserve life.

If a physician consciously refuses to initiate certain lifesaving intervention in order to allow a patient to die, then this action could be considered as murder. If, on the other hand, a physician follows good medical practice and addresses the best interests and well-being of the patient and does not initiate futile and burdensome interventions and this, as a side effect, shortens the patient's life, then no objections would normally be brought against the physician.

In other words, the critical distinction between murder and good palliative care is related to the physician's intention, which is an extremely important concept in law.

10. Euthanasia would undermine the protection due to the most vulnerable persons in society

Legalising euthanasia is dangerous because vulnerable people may begin to consider death as a possible option for releasing family members, carers and the broader society from the responsibility of providing assistance. These vulnerable people, such as the elderly, may then believe that their death is a greater good and that they have a duty to pursue euthanasia.

Vulnerable people need to know that they are valued and unconditionally accepted by the community. They need to know that society is committed first and foremost to their well-being, even if this does involve expenditure of time and money. Indeed, the manner in which the weakest and most vulnerable members of society are treated reflects the true identity of a society because it reveals its core values.

11. The request to die may not reflect the patient's real wishes

Generally, experience shows that once people receive palliative care and are comfortable, with their fears concerning suffering being addressed, they often change their minds about wanting to end their lives¹¹.

There is also good evidence that a desire for death in terminally ill patients can vary with time and is closely associated with clinical depression which can often be treated¹². States of delirium and/or confusion are common in palliative care patients and are sometimes so subtle that they are difficult even for clinicians to recognise. It is impossible to be absolutely confident that a request for a life to be ended does not arise from a disordered state of mind.

In other words, whilst many people are competent to make decisions about their wish for euthanasia, many are not. This opens the possibility that a decision to end a person's life could be made by a

¹⁰ For example, it is considered morally wrong to push someone into a river to his or her death but there may not be a moral duty to leap into the river to save someone who is drowning.

¹¹ Van Der Maas PJ, Van Delden JJM, Pijnenborg L, Looman CW. Euthanasia and other medical decisions concerning the end of life, *Lancet*, Vol. 338, 1991.

¹² Linda Ganzini, et. al., Physicians' Experiences with the Oregon Death with Dignity Act, *The New England Journal of Medicine*, Vol 342, February 2000.

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second person such as a nominated proxy. The complexities arising from such conditions could lead to a serious abuse of power.

12. Neither suicide nor euthanasia should be seen as acceptable alternatives

The attempted suicide of an individual, such as a young person, is never seen as something to be encouraged in society. Instead, great concern is raised regarding the individual's state of mind and the fact that he or she may need psychological assistance or counselling. In other words, it would be completely unethical to help someone commit suicide in these circumstances. In the light of this, it is difficult to consider how any form of assisted suicide can be considered.

Conversely, if assisted suicide were decriminalised, a risk would then arise that the suicide of individuals, such as healthy young persons, would also be considered as acceptable to society at the very moment when the Scottish government is trying to reduce the very high suicide rates in some parts of the country with programmes such as **Chooselife** (www.chooselife.net).

Moreover, with euthanasia or assisted suicide, as opposed to suicide, another person must believe that it would be preferable for the person wishing to die not to continue living. In other words, euthanasia and assisted suicide, reflect the unacceptable belief by one person that another person has lost, or will lose, his or her dignity to such an extent that his or her life is not worth living and should be ended.

When society acknowledges the acceptability of one person being willingly involved in the death of another person, dangerous consequences as to the manner in which the whole of society considers the value, meaning and worth of human life are to be expected.

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Euthanasia

1. Definitions and general information

Euthanasia: Comes from the Greek roots *eu* (well) and *thanatos* (death), literally 'to die well' or 'a good death'. The term is generally understood as an intervention (an intentional act or omission) with the aim of ending the life of a person by someone else who believes that, because of suffering, it would be preferable for this person to die rather than to continue living¹³. The key motive is intent. Euthanasia has, as its first objective, to bring about intentionally the death of a person.

Intervention in the health field: Any intentional activity, withholding of activity or the withdrawal of activity in the health field. Interventions include:

- Medical treatment: Any positive intentional activity designed to address a specific physical or mental disorder in the best interest of the person. Assisted nutrition and hydration are not generally recognised as treatments.
- Basic care: Any positive healthcare activity which is part of the fundamental needs of a person and does not specifically address a physical or mental disorder.

Direct Euthanasia may take the form of:

- Active Euthanasia: Generally understood as an active intervention to end the life of a person by someone else, by the use of drugs or other methods¹⁴.
- Passive Euthanasia: Euthanasia without active intervention, whereby life sustaining treatment, nutrition and/or hydration are withheld or withdrawn from a patient by someone else with the primary intent of hastening a patient's death. In the UK, these terms are not generally used within the medical profession¹⁵. Passive euthanasia should be distinguished from the practice whereby medical treatment, nutrition and/or hydration can be withheld or withdrawn in specific circumstances but without having as its primary intent to bring about the death of a person. Passive euthanasia should also be distinguished from passive suicide in which a capable patient decides not to accept or to withdraw from life sustaining treatment, nutrition and/or hydration.

Indirect Euthanasia: Term sometimes mistakenly used to describe the Principle of Double Effect.

Principle of Double effect: In the context of 'end of life' circumstances, the Principle of Double Effect may include the administration of drugs to a patient in order to relieve pain, the consequence of which may shorten his or her life though this is not the intent. Such an administration of drugs is generally considered 'good medical practice' and not euthanasia. In this regard, it should be noted that the principle of double effect is becoming less relevant to end of life care since the drugs that alleviate pain do not generally reduce life expectancy.

Palliative Sedation: Sedation in the context of palliative medicine is the monitored use of medications to induce varying degrees of unconsciousness to bring about a state of decreased or absent awareness (i.e. unconsciousness) in order to relieve the burden of otherwise intractable suffering¹⁶.

Voluntary Euthanasia: Emphasises the express intent of the person wanting to die, and distinguishes it from mercy killing or any other form of killing. Voluntary euthanasia is performed by another person and at the autonomous request of an informed and competent patient. It takes place when the request is either given contemporaneously to the action of killing or beforehand if the request still represents the view of the person.

¹³ <http://www.euthanasia.com/definitions.html>

¹⁴ Replies to the questionnaire for member States relating to euthanasia, Council of Europe, 20 January 2003, http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp

¹⁵ Ibid.

¹⁶ Nathan I Cherny, Sedation for the care of patients with advanced cancer, *Nature Reviews Clinical Oncology* 3, 492-500 (September 2006)

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Non-Voluntary Euthanasia (sometimes defined as 'Mercy Killing'): Generally indicates an intervention by a person to end the life of a patient who is, at the time of its performance, incompetent and therefore incapable of assenting to it.

Involuntary Euthanasia: Generally indicates an intervention by a person to end the life of a competent patient who has capacity and which is performed against his or her will. In other words, where the patient is not consulted or where the patient's opposition to euthanasia is ignored (whether or not it is assumed that it is in the person's best interests).

Suicide: An intervention by which a person ends his or her own life.

Passive Suicide: Suicide without an active intervention, whereby a person makes a conscious and contemporaneous decision not to accept or to withdraw from life sustaining treatment, nutrition and/or hydration with the aim of hastening his or her own death. Passive suicide recognises the fundamental right of a patient not to accept a medical intervention even if it may save his or her life. This right is recognised in most countries¹⁷.

Assisted Suicide: The act whereby a person aids, abets, counsels or procures a suicide or an attempted suicide of another person.

Physician Assisted Suicide: The act whereby a physician prescribes a lethal medication to a person, but the person administers the dose himself or herself.

2. Principles and purpose

The key issue in euthanasia is intention since allowing terminally ill patients to die when there is nothing more that can be done to relieve their symptoms or treat their illness has long been part of good medical practice.

On the other hand, letting patients die when useful symptom-relief or treatment can be given is negligent.

Some argue that certain forms of pain relief can shorten the lives of patients with terminal disorders and therefore the doctor is actually aiding the patient's death. But under the Principle of Double Effect this is deemed ethically acceptable, since the doctor's intended outcome is pain relief and the unfavourable result of shortening life is not the intent. In reality, however, successful pain relief can extend life as appetite and well-being improve¹⁸.

3. History

Euthanasia has had a long history, having been practised by the ancient Greeks in the city-state of Sparta, whereby unhealthy new-borns were left to die on exposed mountains.

However, the Hippocratic Oath, which was written in the 4th Century BC and attributed to the Greek Hippocrates (c.a. 460-380 BC) who was considered as one of the father of western medicine, unequivocally prohibits euthanasia and assisted suicide. It states that: *"I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan."*

In the 16th century, Thomas More, described a utopian community as one which would facilitate the death of those whose lives had become burdensome to them as a result of 'torturing and lingering pain'. A century later, Francis Bacon suggested that it was part of a physician's duty to alleviate pain even if that meant killing the patient¹⁹.

Recent debates, however, emerged in the United States and Britain in response to ideological currents gaining ascendancy in the late 19th and early 20th centuries. This culminated with probably the greatest abuse taking place under the Nazi euthanasia program which was code-named T-4. This referred to Tiergartenstrasse 4, the headquarters of the corresponding administrative system which

¹⁷ In the case of Airedale NHS v. Bland, Lord Mustill indicated that "If the patient is capable of making a decision whether to permit treatment and decides not to permit it his choice must be obeyed, even if on any objective view it is contrary to his best interests. A doctor has no right to proceed in the face of objection, even if it is plain to all, including the patient, that adverse consequences and even death will or may ensue ...".

An example of an application of this judgement is given in the case where a woman paralysed from the neck down was given the right to die - BBC - 2002: <http://news.bbc.co.uk/1/hi/health/1887281.stm> See also The right to die for Jehovah – BBC - 2007 - <http://news.bbc.co.uk/1/hi/health/7078673.stm>

¹⁸ Euthanasia, CMF, <http://www.cmf.org.uk/index.htm?ethics/ethics.htm>

¹⁹ End of Life Assistance (Scotland) Bill, Policy Memorandum, Scottish Parliamentary Corporate Body 2010.

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set-up the T-4 establishments. The order underlying the so-called T-4 programme empowered selected physicians to grant "mercy killing to those deemed incurable according to the best available judgement of their state of health".²⁰

In the course of the T-4 programme, some 70 000 institutionalised psychiatric patients were euthanised from the end of 1939 onwards. Most killings were concealed by false declarations of death, and the death notices bore false signatures. Under the earlier child euthanasia programme, a start had already been made on the identification and killing of children with disabilities of whom at least 5,000 were euthanised.

A further 20,000 disabled inmates fell victim to searches conducted in the concentration camps. The euthanasia programmes were officially terminated in August 1941 after their existence was discovered and gave rise to public protest, including strong opposition by the Catholic clergy^{21,22}. Unofficially, however, euthanasia practices continued in Germany until the summer of 1943²³.

4. England and Wales – Legislation, Case Law

4.1. Developments

There was a series of cases during the 1970s and 1980s in which defendants who had helped another person to die were prosecuted for manslaughter. Several were allegedly advised to plead not guilty on the grounds of diminished responsibility²⁴.

In 1992, Dr. Nigel Cox was found guilty of giving a lethal dose to a dying woman whose pain he could not relieve. However, he was neither imprisoned nor dismissed from his hospital job.

In 1994, an all-party committee of the House of Lords unanimously agreed that the law should not change to permit euthanasia. The committee argued that "*It would be next to impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law was not abused.*"

The House of Lords committee also rejected the suggestions that a new offence of 'mercy-killing' should be created: "*To distinguish between murder and mercy-killing would be to cross the line which prohibits any intentional killing, a line which we think it essential to preserve*"²⁵.

However, the committee supported the right of physicians to withdraw medical treatment from patients, particularly those in a persistent vegetative state. Thus a treatment need not be given if it would "*add nothing to the patient's well-being as a person*".

Following a proposal by Lord Joffe to introduce a *Patient (Assisted Dying) Bill*, in February 2003, a House of Lords Select Committee prepared a report entitled "**Assisted Dying for the Terminally Ill Bill**" in April 2005. This report indicated that if an assisted dying bill was considered, it should distinguish clearly between assisted suicide and voluntary euthanasia. This led Lord Joffe to re-introduce a new version of his bill entitled **Assisted Dying for the Terminally Ill Bill** into the House of Lords on the 9th of November 2005 in a form which would legalise assisted suicide but not euthanasia. However, this was unsuccessful.

4.2. Present situation:

In England and Wales, the term euthanasia is not defined in law and would be regarded as murder. It is murder or manslaughter for a person to do an act that ends the life of another, even if he or she does so on the basis that he or she is simply complying with the wishes of the other person concerned²⁶. In these countries, murder is a common law offence.

Case Law:

²⁰ This is a quotation from the personal authority granted by Adolph Hitler to Reichsleiter Bouhler Dr. Brandt in October 1939, backdated to 1 September 1939. In German National Ethics Council, Self-determination and care at the end of life, Opinion, 2006, page 33.

²¹ German National Ethics Council, Self-determination and care at the end of life, Opinion, 2006, page 33.

²² J.A. Emerson Vermaat, 'Euthanasia' in the Third Reich: Lessons for Today?, Ethics & Medicine, 18:1 (2002):21-32.

²³ Ibid.

²⁴ Sunday Times 8 October 1996

²⁵ House of Lords: Report of the select Committee on Medical Ethics, HL 21 - I, January 1994.

²⁶ Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide Issued by The Director of Public Prosecutions, Crown Prosecution Service, February 2010, http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.pdf

In the medical setting, *R v Cox (1992) 12 BMLR 38* confirmed that if a medical professional carried out an action with the intention of ending a life, whether or not for compassionate reasons or at the patient's request, this would constitute murder²⁷.

The current position in England and Wales is that euthanasia is unlawful and anyone alleged to have undertaken such an intervention is open to a charge of manslaughter. Similarly, medical treatment which is given to a patient with the specific intention of hastening or inducing death, whether at the patient's wish or not, is considered as being an illegal act. The UK Government has given careful consideration to the issues involved and its position remains that there are no plans to change the current law in this area²⁸.

5. Scotland – Legislation, Case Law

5.1. Developments

Euthanasia and assisted suicide became devolved matters for the Scottish Parliament under the **Scotland Act 1998**, Schedule 5 (Reserved Matters), Part II (Specific Reservations), Head J (Health and Medicines).

In this regard, it should be noted that the term euthanasia is not defined in Scottish law and would be regarded as murder (a common law offence)²⁹.

Moreover, in a response before the Scottish Parliament on the 11th of November 2004, the Deputy Minister for Health and Community Care indicated that the Scottish government had “*no plans to change the law*.”³⁰

However, on the 23rd of April 2009, Ms. Margo Macdonald MSP lodged a Private Member's **Proposed End of Life Choices (Scotland) Bill** to the Scottish Parliament which obtained 20 signatures out of the required 18 parliamentary supporters within the specified time of one month after the draft bill was submitted³¹. This meant that the proposed bill could continue through the legislative process and on the 20th of January 2010, Ms. MacDonald submitted her **End of Life Assistance (Scotland) Bill** to the Scottish Parliament.

5.2. Present situation

The present situation is best characterised by the Deputy Minister for Health and Community Care, who indicated in a response before the Scottish Parliament on the 11th of November 2004, that “*Under Scots law, an act of euthanasia by a third party, including physician-assisted suicide, is regarded as the deliberate killing of another and would be dealt with under the criminal law relating to homicide. The consent of the victim would not be a defence and no degree of compassion on the part of the person who carried out the act would amount to a legal justification. There might be cases in which the circumstances of the offence would make a charge of culpable homicide more appropriate than one of murder, and a court would take all the circumstances of the case into account before sentence was pronounced. However, if the accused was convicted of murder, a sentence of imprisonment would be mandatory*.”³²

Case Law:

After a landmark case in 1996, the then Lord Advocate issued a statement declaring that he would not authorise the prosecution of a physician who, acting in good faith and with the Court of Session's authority, withdrew life-sustaining treatment from a patient in a persistent vegetative state with the result that the patient died. The case had been brought by the patient's Health Board, seeking

²⁷ [Replies to the questionnaire for member States relating to euthanasia, Council of Europe, 20 January 2003, http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp](http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp)

²⁸ Briefing for the UK Parliamentary Delegation, First Part of the 2004 Session of the Parliamentary Assembly of the Council of Europe.

²⁹ [Replies to the questionnaire for member States relating to euthanasia, Council of Europe, 20 January 2003, http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp](http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Answers%20Euthanasia%20Questionnaire%20E%2015Jan03.asp)

³⁰ Scottish Parliament Official Report - 11.11.04:

<http://www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-04/sor1111-02.htm#Col11876>

³¹ <http://www.scottish.parliament.uk/s3/bills/MembersBills/index.htm>

³² Scottish Parliament Official Report - 11.11.04:

<http://www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-04/sor1111-02.htm#Col11876>

assurances that the withdrawal of food would not result in civil or criminal actions against healthcare professionals³³.

6. Legislation, Case Law and Regulations - International

6.1. Council of Europe

European Convention on Human Rights:

Two articles of the European Convention on Human Rights (ECHR) protect the right to life, namely:

Article 2.1:

Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

Article 8:

1. Everyone has the right to respect for his private and family life.....

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Council of Europe Parliamentary Assembly Recommendation 1418 (1999):

The latest provisions on euthanasia are included in Article 9.c. of the Council of Europe Parliamentary Assembly Recommendation 1418 (1999) which states that:

The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

i. recognising that the right to life, especially with regards to a terminally ill or dying person, is guaranteed by member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";

ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;

iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.

6.2. Other countries

On the 20th of January 2003, the Council of Europe published a document regarding euthanasia and assisted suicide containing the replies to a questionnaire from 34 countries of the Council of Europe and the USA,. In this report, only three countries (The Netherlands, Estonia and Switzerland) indicated that their legislation would not regard such an undertaking as an offence provided certain conditions were met³⁴.

Australia:

In the Northern Territories of Australia the ***Rights of the terminally III Act 1995*** was in force between 1st of July 1996 until the 5th March 1997 when the Australian Federal House of Representatives passed an anti-euthanasia Bill. During this time, seven people officially sought to use the legislation to die.

³³ Scottish Parliament Official Report - 11.11.04:

<http://www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-04/sor1111-02.htm#Col11876>

³⁴ **Ministers' Deputies**, CM Documents, CM(2003)21 Addendum 2, 12 March 2003, Steering Committee on Bioethics -Report on laws and/or practices of member states with regard to the issues raised by Parliamentary Assembly Recommendation 1418 (1999) on the protection of the human rights and dignity of the terminally ill and the dying. https://wcm.coe.int/rsi/common/renderers/rend_standard.jsp?DocId=29357&SecMode=1&SiteName=cm&Lang=en

Luxembourg:

As of March 2009, Luxembourg is the most recent country to have legalised euthanasia and assisted suicide. In the new legislation, individuals suffering from a terminal or incurable illness are able to have their lives ended after receiving the approval of two doctors and a panel of experts.

Netherlands:³⁵

In the Netherlands, though a person does not have a right to euthanasia, the **Termination of Life on Request and Assisted Suicide (Review Procedures) Act** came into effect on the 1st of April 2002. The Act incorporates an amendment to Article 293 of the Criminal Code to the effect that although any person who terminates another person's life at that person's express and earnest request remains liable to a term of imprisonment or a fine, such an act shall not be an offence if it is committed by a physician who notifies the municipal pathologist of this act in accordance with the relevant legislation and fulfils the stipulated due care criteria, by which the attending physician must:

- *be satisfied that the patient has made a voluntary and carefully considered request;*
- *be satisfied that the patient's suffering is unbearable, and that there is no prospect of improvement*
- (note: it is not a condition that the patient is terminally ill or that the suffering is physical);*
- *have informed the patient about his or her situation and his or her prospects;*
- *have concluded, together with the patient, that there is no reasonable alternative in the light of the patient's situation;*
- *have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to in the four above indents; and*
- *have terminated the patient's life or provided assistance with suicide with due medical care and attention.*

Similarly, any person who intentionally incites another to commit suicide, if suicide follows, is normally punishable under Article 294 of the Criminal Code by a term of imprisonment or fine, but commits no offence if the above due care criteria are fulfilled.

The new legislation also includes regulations regarding termination of life on request and assisted suicide involving minors. Children of 16 and 17 can, in principle, make their own decisions. Their parents must, however, be involved in the decision-making process regarding the ending of their life. For children aged 12 to 16, the approval of parents or guardian is required.

Finally, the legislation offers an explicit recognition of the validity of a written declaration of will regarding euthanasia. The presence of a written declaration of will means that the physician can regard such a declaration as being in accordance with the patient's will. The declaration has the same status as a concrete request for euthanasia. Both oral and written requests allow the physician legitimately to accede to the request. However, he or she is not obliged to do so.

In all cases, the physician must report his or her act to the municipal pathologist. The report is then examined by a regional review committee to determine whether it was performed with due care. The judgement of the review committee is then sent to the Public Prosecution Service which uses it as a major factor in deciding whether or not to institute proceedings against the physician in question.

If the committee agrees that the physician has practised due care, the case is closed. If not, the case is brought to the attention of the Public Prosecutor who has the power to launch his or her own investigation if there is a suspicion that a criminal act may have been committed.

Estimated frequencies of medical end-of-life decisions and continuous deep sedation in the Netherlands in 2005 and 2001 (death certificate study)³⁶:

³⁵ Parliamentary Assembly, Euthanasia, Doc. 9898, 10 September 2003, Report, Social, Health and Family Affairs Committee

³⁶ Evaluation of the Dutch Legislation on Euthanasia and Assisted Suicide, European Journal of Health Law 14 (2007) 369-379.

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| | 2005 | | 2001 | |
|---|--------|-----------------|--------|------|
| | Abs. | % ³⁷ | Abs. | % |
| Medical decisions on end of life: | | | | |
| Demand for euthanasia within the foreseeable future | 9,700 | | 8,400 | |
| Euthanasia undertaken | 2,325 | 1.7 | 3,500 | 2.6 |
| Assisted Suicide undertaken | 100 | 0.1 | 300 | 0.2 |
| Ending of life without an explicit request of the patient | 550 | 0.4 | 950 | 0.7 |
| Intensified alleviation of pain or symptoms with hastening of death as a possible side effect | 33,700 | 25.0 | 29,000 | 21.0 |
| Abandoning potential life prolonging treatment | 21,300 | 16.0 | 28,000 | 20.0 |
| Continuous deep sedation | | | | |
| With medical end-of-life decisions | 9,700 | 7.1 | 8,500 | 6.0 |
| Without medical end-of-life decisions | 1,500 | 1.1 | - | - |

The decline in euthanasia between 2001 and 2005 is linked to a number of developments. First of all, the absolute number of deaths in 2005 was less than in 2001³⁸, whereas the proportion of persons aged 80 and over (euthanasia and assistance in suicide occur relatively infrequently in this age group) was actually greater. Secondly, an increase was found in other methods of controlling the symptoms of patients in the terminal phase of their lives. In addition, the majority of the physicians thought there is a clear connection between improvements in palliative care and the decrease in life-terminating action taken by physicians³⁹.

Belgium:⁴⁰

Belgian Law on euthanasia came into force on 23 September 2002. Doctors who practise euthanasia commit no offence if they respect the prescribed conditions and procedures, and have verified that:

- the patient is an adult or a 'mature' minor who must be a least 15 years old person⁴¹, possessing legal capacity and aware of what he or she is doing when he or she formulates the request (which must be made in writing);
- the request is made voluntarily, carefully and repeatedly, and is not the result of outside pressure;
- the patient's medical state is hopeless, and he or she is experiencing constant, unbearable physical or mental suffering, which cannot be relieved and is caused by a serious and incurable injury or pathological condition.

Like in the Netherlands, the law recognises the validity of advanced directives for euthanasia. This enables physicians to practice euthanasia on persons who are no longer capable of expressing their wishes, but who have done so in writing when they still had capacity.

Belgium has also established a system of control, whereby the physician has to declare the act of euthanasia to a Federal Evaluation and Control Commission.

Although no physician is bound to perform euthanasia, a physician who, exercising his or her freedom of conscience, refuses to perform euthanasia, must transfer the patient's medical record to a colleague of the patient's choosing.

³⁷ Percentage of all deaths

³⁸ Approximately 16 million people live in The Netherlands, of who around 140,000 die every year, House of Lords, Select Committee on Assisted Dying for the Terminally Ill Bill, Assisted Dying for the terminally ill Bill, Volume I, Report, 2005, paragraph 171; <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.htm>

³⁹ Evaluation of the Dutch Legislation on Euthanasia and Assisted Suicide, European Journal of Health Law 14 (2007) 369-379.

⁴⁰ Parliamentary Assembly, Euthanasia, Doc. 9898, 10 September 2003, Report, Social, Health and Family Affairs Committee

⁴¹ However, a new bill permitting euthanasia on children is before the Belgian Parliament: Euthanasia debate in Europe focuses on children - Knight Ridder Newspapers - 14.10.04: <http://www.grandforks.com/mld/grandforks/news/world/9890729.htm>

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The law does not allude to "assisted suicide". Thus it does not specify the method to be used by the physician, even though he or she must describe it in the official form to be forwarded to the Federal Evaluation and Control Commission.

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