INTRODUCTION

The current debate has been stimulated by recent court cases such as that of Tony Bland and the House of Lords Ethical Committee which has just published its report. The voluntary euthanasia societies have also been active throughout the world although they have been directing attention more obliquely to the main issue promoting the legalisation of advance directives or "living wills". The whole debate is of great importance to all clinicians because any change in the law will severely affect our management decisions in the critically ill. It will also affect the way in which the profession is seen particularly as the proponents of euthanasia and "living wills" portray those who wish to maintain the fundamental principles of the Hippocratic oath as being without compassion and committed to the maintenance of life at all costs.

In the utilitarian climate of our age it seems to be a general perception that the answer to ethical problems should be a pragmatic compromise which resolves all dilemmas. To maintain a position on any issue which creates a commandment ("one should never . . . ") is likely to be regarded as narrow minded, and lacking in the compassion necessary to resolve the difficult problem. Certainly, those who press for the legalisation of euthanasia highlight their own idea of compassion for the terminally ill whose mental or physical suffering is not relieved. Those who argue against euthanasia do so because they maintain that it can never be justified for one human being deliberately to take the life of another. Is the answer to this divergence of opinion to be found in a legal accommodation?

Since everyone assumes that euthanasia will be the responsibility of the medical profession, doctors all need to study the evidence of the consequences of any change in the law before the profession departs further from the principles of the Hippocratic oath.

It is important to define the terms we use and understand their contractual meaning. Euthanasia involves a contractual relationship between a "doctor" and a "patient" as opposed to suicide which only involves the "patient".

DEFINITIONS

Voluntary euthanasia: the killing of a "patient" with his expressed consent by a "doctor". It requires a contract between the two parties to secure the premature death of the "patient". Both hold equal responsibility for the decision and its fulfillment but the scenario enhances the responsibility of the "doctor" who supplies the means, while the "patient" passively submits.

Assisted suicide: the administration of the means of death to a "patient" intent on suicide who will administer the fatal drug, bullet, etc himself. There is a contract between the two parties to secure the premature death of the "patient". Both parties hold equal responsibility for the decision and its fulfillment but the scenario publicly enhances the responsibility of the "patient".

Involuntary euthanasia: the killing of a "patient" by a "doctor" without the expressed consent of the "patient"; justified as distinct from criminal homicide because of the subnormal condition of the "patient" judged by the doctor who may or may not be acting with the approval of society or the state. Only the "doctor" is responsible because there is no contract between the parties.

Passive euthanasia: the withholding of therapeutic regimes from a patient with the intention of shortening the patient's life. It is killing by intentional omission. Although therapeutic regimes may be withheld in the case of terminal illness, e.g. antibiotics for chest infections in a terminally ill patient) this is done where the balance of benefit is weighed against the overall benefit to the patient's condition. The legal judgement in the Tony Bland case has recently thrown the law into intellectual confusion because it permitted the withdrawal of normal human sustenance on the basis of a patient's quality of life although the patient was not dying.

DISCUSSION

Euthanasia, whatever euphemism is used, is the intentional killing of one person by another. Voluntary euthanasia requires the approval and support of the "doctor" who is therefore not only a supporter but a motivator. There is little difference from giving the man who is reluctant to leap off the cliff a push.

The Hippocratic oath was formulated 400 years before Christ in response to society's need for a medical profession that could be trusted to defend and protect all human beings recognising no distinction of form, belief or ability. Every major international medical ethical body has reinforced these principles in response to assaults on the integrity of the profession, such as the actions of psychiatrists and other doctors in Germany during the last war. Article One of the Declaration of Human Rights, to which this country is a signatory, states that "everyone's right to life shall be protected by law".

The consequences of breaching this most fundamental Hippocratic principle, which is the foundation of the respect and trust with which the medical profession is still vested, were summed up by Goethe's physician, Christoph Hugeland, writing in 1806: "The physician should and may do nothing else but preserve life. Whether it is valuable or not
is none of his business. If he once permits such considerations to influence his actions, the doctor will become the most dangerous person in the state”.

In a more modern idiom Dr Horner, in his address as Chairman of the BMA Ethics Committee to the ARM in 1993, said “Doctors have a licence to heal the sick. If they are given a licence to kill, patients would never be sure under which licence they were operating”.

 Those who seek to adjust the doctor’s licence may do so in the name of compassion but is this their only motivation? From the earliest beginnings of the Voluntary Euthanasia movement in this country there has been a wider agenda which is to extend the licence from the terminally ill to more vulnerable sectors of the community.

Dr Killick Millard in his address to medical officers of health in 1931 which started the public debate said “The great task of medicine is to prevent disease and failing that to cure it. If it fails in both, science at least enables us to shorten the sufferings caused by disease.”

Five years later at the inaugural meeting of the Voluntary Euthanasia Society the chairman, a Leicester surgeon, said “Today we are only concerned with voluntary euthanasia but as public opinion develops and it becomes possible to form a truer estimate of the value of human life, further progress along preventative lines will be possible . . . The population is an ageing one with a large proportion of elderly persons, individuals who have reached a degenerative stage of life. Thus the total number of useless lives must increase”.

The Bishop of Birmingham was not the only cleric to speak up at that time in the same vein when he said “The cost of social derelicts and especially the feeble minded is harmful . . . I cannot think it right to keep individuals alive whom doctors know are doomed to a subhuman existence”.

The views of leading proponents for legislative change have not altered over the years. Barbara Smoker, former chairman of the VES said in the April 1991 newsletter that the real targets were the chronic sick and disabled. Dr Pieter Admiraal, who runs a hospice for the dying in Holland and who has been at the forefront of the practice of euthanasia as well as the medicolegal debate and process, has stated that he is dissatisfied with current legislation and wishes to see it applied to the handicapped newborn, to the comatose and dementing.

We do not have to speculate fruitlessly about what will happen if legalised euthanasia is introduced because we already have “pilot studies” in Europe. The German experience can be dismissed because the laws were specifically amended to allow the killing of the mentally ill and the elderly. But we should not forget that there was no difficulty in finding a cadre of willing doctors to train others in medical techniques of murder which led to the holocaust.

The experience from Holland is, however, entirely pertinent because the movement for the legalisation of euthanasia has been led by the medical profession in the name of compassion. Over the past twenty years the liberalisation of attitudes has occurred because of the failure of the courts to punish or even prosecute those who openly flouted the law. Now euthanasia is permitted under certain criteria (Table 1).

Although there is no systematic audit of the practice of euthanasia in Holland, several recent studies have highlighted the prevalence of the practice. The most enlightening is the report by Attorney General Remmelink in September 1991 which showed that there were 2000 cases recognised specifically as voluntary euthanasia and 1000 cases of involuntary euthanasia out of a total of 160,000 deaths in the year studied. The report clearly shows that involuntary euthanasia is an inevitable consequence of the legalisation of euthanasia.

The detailed study by Professor van der Maas on which the Attorney General’s report was based, exposed the failure of the guidelines of the Dutch regulatory procedures to which protagonists of euthanasia refer so enthusiastically. These criteria (Table 1) are clearly ineffective in controlling the practice of euthanasia even on apparently compassionate grounds.

| 1 | The request for euthanasia must come only from the patient and must be entirely free and voluntary |
| 2 | The patient’s request must be well considered, durable and persistent |
| 3 | The patient must be experiencing intolerable (not necessarily physical) suffering, with no prospect of improvement |
| 4 | Euthanasia must be a last resort. Other methods to alleviate the patient’s situation must have been considered and found wanting |
| 5 | Euthanasia must be performed by a qualified physician |
| 6 | The physician must consult with an independent physician who has experience in this field |
| 7 | The decision must be written down, registered and reported to the coroner |

*Table 1 – Dutch criteria for legal euthanasia*

Because of the particularly strict criteria used in the official studies the number of cases of voluntary and involuntary euthanasia is certainly much higher and probably at least twice the officially stated number. Certainly the social climate in Holland has been changed so that it puts pressure on patients to seek this way out and reinforces euthanasia as an option for the chronically sick who do not wish to burden others. This pressure has become so worrying to the elderly that some nursing homes advertise that they do not practice euthanasia.

<table>
<thead>
<tr>
<th>Sudden and unexpected deaths</th>
<th>30%</th>
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<tbody>
<tr>
<td>Withholding of treatment</td>
<td>17.5%</td>
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<tr>
<td>Palliative drugs</td>
<td>15.5%</td>
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<tr>
<td>Euthanasia</td>
<td>1.8%</td>
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<tr>
<td>Assisted suicide</td>
<td>0.3%</td>
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<tr>
<td>Voluntary</td>
<td>0.6%</td>
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<tr>
<td>Involuntary</td>
<td>0.6%</td>
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<tr>
<td>Other deaths</td>
<td>32.5%</td>
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</tbody>
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*Table 2 – Dutch causes of death 1991 (Van der Maas et al)*

That the durability of a patient’s voluntary decision is rarely tested is evident from a 1990 survey by the medical examiner Van der Waal who found that 13% of acts occurred within one day of the patient’s request and 35% within one week. Since depression is so often an early and prolonged feature of severe chronic and terminal illnesses, durability and sustainability of such requests is rarely absolute. If doctors accede rapidly to such requests then logically they should be anxious to create laws to aid the suicidal even without other illnesses.
The case of Dr Cox illustrated how subjective can be a doctor’s decision that no other treatment is possible. It has been the apparent hopelessness of many conditions that has been the driving force behind many of the therapeutic triumphs of the last century as well as the development of palliative care. The Palliative Care Society, in its submission to the House of Lords Ethical Committee, clearly set out the options that are available, their increasing ability to control the symptoms of terminal disease, the decreasing number of failures and the added value of the last days of those who in Holland would be candidates for euthanasia.

Throughout the world it is understood that euthanasia would be a medically administered service in which individual doctors’ consciences would be respected by special legal safeguards. But no conscience clause could stop any doctor from becoming involved because (as in Holland) those who are opposed to euthanasia become compelled to refer such patients to doctors who are willing to carry it out. This is how the abortion law already operates in this country. The Dutch Medical Association has already reprimanded one doctor for not carrying out his patient’s wishes in this respect.

That legal strictures would work no better in Great Britain can be seen from the fact that the abortion laws were introduced with legal strictures to restrict it to medical indications only. These have failed to prevent abortion on demand. Recent surveys by the Department of Health have shown that 13% of green forms submitted do not even bother to detail the reasons for which the abortion is carried out. A more local survey has shown that the requirement for two independent signatures is more honoured in the breach than the fulfilment. Van der Maas showed that the majority of physicians in Holland openly admit that they do not report such deaths (Table 3). They feel euthanasia is an essentially private matter; reporting to the coroner, as required, continues the trauma for relatives after death and should the coroner decide on an inquest this needlessly protracts the agony.

The plea that cases of involuntary euthanasia have been of the terminally ill or dementing is no longer borne out by the evidence which details cases of the feeble minded, the congenitally disabled and even accident victims before there may have authority to take that decision. It will take the active role and that even an agent of the patient’s life as perceived and demented. The compassionate answer, however, is to extend our commitment to these patients and not to limit or withdraw it. It is neither compassionate nor humane to put a value on the quality of an individual’s life as a prerequisite for their being allowed to live in this society. The extended agenda which hides behind the compassionate pressure for euthanasia is, in fact, an entirely selfish expression of a desire by the fit to command a greater share of available resources for themselves.

The Dutch experience demonstrates the effect of euthanasia on the development of compassionate services. Holland is renowned in Europe for its comparative lack of hospice and community programmes for the terminally ill. George Chalmers referred to this when he said “It is ironic that at a time when we are technically more able to relieve suffering, to correct abnormality and indeed sustain life itself that there should be so much clamour to end life as if there was nothing else to be done and as if life was ours to dispose of”.

It is not possible to produce a solution to all the medical dilemmas which face us but the intention to respect and protect each individual’s life should be the stimulus to compassionate care which tries to balance the benefits and disadvantages of therapeutic action while never intentionally seeking to end a life. All the evidence points to the inevitability that changes in euthanasia legislation would lead rapidly to abuse.

We must be grateful that the BMA at the ARM in 1993 and the Walton Report of the House of Lords Select Committee rejected the legalisation of euthanasia. Because they have left the debate open on Advance Directives, however, which are a direct expression of the increasing lack of trust in the medical profession, there are still great dangers that euthanasia will creep in by the back door, as the Voluntary Euthanasia Society hopes. The legal judgement in the Tony Bland case has also left confusion in the law since it permitted the withdrawal of care on the basis of the quality of life of the patient and not on the relative benefits of the particular treatment to the patient.
There has never been a time when it has been more necessary for the Hippocratic Principle to be reaffirmed by all doctors if they are to retain the trust of patients, and maintain the respect due to all human beings whatever their condition.

References


QUIZ

1. For what was Bernardino Ramazzini (1633-1714) famous?
2. Which workers are at risk of contracting orf?
3. What inorganic dust might you inhale if you worked in Cornwall?
4. What are Blackpool Tables?
5. What is a drugget?

Answers on page 42.