

The slippery slope to Euthanasia

**Assisted suicide, hard cases
and public policy**

**Comments by the Maranatha Community on the
*'Interim Policy for Prosecutors in respect of
Cases of Assisted Suicide'* issued by
the Director of Public Prosecutions
and published in September 2009**

December 2009

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Foreword

The Maranatha Community is extremely concerned about any attempts to tolerate or even legalise assisted suicide. While high-profile individuals may request assisted suicide, the societal implications of tolerating or even accepting assisted suicide under certain conditions will lead to devaluation of life and will lead to a slippery slope towards euthanasia.

The consultation document issued by the Director of Public Prosecutions (DPP) gives the impression, that – under certain conditions – to assist someone else's suicide would not be prosecuted. However, such a move will send out the message to the public that to help someone in committing suicide, for example if done out of the 'right' motives would be essentially tolerated or even acceptable. The implication of this is that the DPP with this policy, essentially encourages rather than discourages suicide. It is surprising when all professional bodies and the Department of Health are trying to develop strategies to reduce the incidence of suicide that the DPP should consider policies that essentially would be seen by the public as encouraging suicide.

The Director of Public Prosecutions must not be under the illusion that it would be possible to essentially tolerate assisted suicide - even with 'safeguards' in place - without this being the first step towards the full legalisation of euthanasia. Once assisted suicide has been accepted, there soon will be calls for the legalisation of euthanasia. There are a number of reasons for this, not least because of the frequent clinical problems encountered with assisted suicide (see below) where patients do not die as quickly or 'easily' as expected, therefore requiring the doctor to terminate the patient (= euthanasia).

All data from countries where assisted suicide or euthanasia have been legalised show that vulnerable individuals (such as the ones who feel that because of their condition they have become a burden to their family, to others, the health service or the state, those who suffer with depression or severe pain etc.) will feel pressurised into assisted suicide or euthanasia. The unintended consequence of legalising assisted suicide – even with 'safeguards' – is that people will die that otherwise would not have died.

'Hard cases make bad laws'. We urge the Director of Public Prosecutions to seriously consider the societal and public policy implications of essentially tolerating assisted suicide, even with many 'safeguards' in place, 'safeguards' that – in our view – are mostly illusory.

1. Introduction

Euthanasia is the deliberate act of putting an end to a patient's life for the purpose of ending the patient's suffering. Assisted Suicide is the death of a patient as a direct consequence of 'help' by a 'friend', relative or a doctor. Whatever the intentions claimed for euthanasia or assisted suicide, this is nothing less than killing a patient or 'helping' to terminate a life prematurely.

- The ethical question remains – **can it ever be right to help someone to die or even to kill, even with the intention to relieve suffering?** The law of most countries is clear on this. For this reason euthanasia and assisted suicide are illegal in most countries worldwide. Countries that have legalised euthanasia include the Netherlands and Belgium. Physician-assisted suicide (PAS) is also legal in the Netherlands, in Oregon, USA and in Switzerland.
- **Euthanasia, once legalised, would result in patients being killed who had not requested to die.** The experience of the Netherlands in legalizing euthanasia points to the fact that euthanasia, once legalised, cannot be effectively controlled. Euthanasia, initially intended for certain groups such as patients with terminal diseases will soon be performed on other groups of patients including the elderly, incapacitated patients, patients suffering with emotional distress, the disabled, and even children and newborn babies with disabilities who cannot ask for euthanasia. There is clear evidence from the Netherlands that at least **one thousand patients including children and newborn babies are being killed every year without their expressed consent and/or against their will.**

2. Sanctity or inviolability of life

- **Human life has an intrinsic value.** The Judaeo-Christian tradition holds that man is created in the image of God and therefore human life has an intrinsic dignity, sanctity and is inviolable. In that tradition, the principle that one should never kill an innocent human being is based on this very dignity and sanctity. From a non-religious point of view this principle would be based on the dignity and inviolability of human life, independent from the existence of God.
- **The Hippocratic oath** affirms this same principle, not to prescribe a deadly drug and not to give advice causing death nor to procure an abortion. Hippocrates, a Greek physician lived in the fifth century BC and the principle of sanctity of life therefore predates Christian teaching. The **Declaration of Geneva** by the World Medical Association (1948) states: *'I will maintain the utmost respect for human life from its beginning'*. The 'right to life' is also enshrined in the **European Convention on Human Rights**, which states: *'Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally...'*
- **The principle of sanctity or inviolability of life prohibits intentional killing but it does not require that life must be preserved at all cost**, for example through invasive or burdensome treatment, such as ventilation, against the wishes of a competent patient or where treatment would be futile, for example aggressive chemotherapy in advanced metastatic cancer. Doctors may have to decide whether a given treatment is proportionate or burdensome and disproportionate. Refusal of burdensome treatment on the part of the patient is not the same as suicide.
- Intentionally hastening a person's death by omitting some medical interventions – **'passive euthanasia'** – is **entirely different from omitting disproportionate or futile treatment.** The act of withholding or withdrawing disproportionate treatments (because they are disproportionate or futile) is different from the act of omitting proportionate treatment with the 'active' intention to hasten death. The **difference from euthanasia remains that if one accepts the principle of sanctity or inviolability of life, that the patient's life is always considered worthwhile** however the **treatment may not always be considered worthwhile.**

3. Patient autonomy

This will decrease once assisted suicide or euthanasia even with 'safeguards' have been legalised.

Despite all the claims made about 'patient autonomy' by proponents of physician-assisted suicide or euthanasia, ultimately, one or more doctors will inevitably end up making a value judgment, which they should not make, as to whether a patient's quality of life is such as to preserve or terminate his or her life.

- If euthanasia became legalised, the decision whether to terminate or preserve a patient's life or to assist with PAS will rest with the medical profession. To legalise euthanasia and physician-assisted suicide would dramatically *increase* the power doctors have over their patients and severely *decrease patient autonomy*.
- The German physician Christoph William Hufeland wrote in 1806: *'It is not up to [the doctor] whether life is happy or unhappy, worth while or not, and should he incorporate these perspectives into his trade the doctor could well become the most dangerous person in the state.'*

4. The consequences of legalising Euthanasia:

We are convinced that there would be serious consequences to the introduction of euthanasia.

4.1 Assisted Suicide or Euthanasia, once legalised, could not be effectively controlled – even with 'safeguards'. If euthanasia became legal, patients would be killed who had not requested to die.

- Assisted suicide or Euthanasia, initially intended or allowed for certain groups such as patients with terminal diseases will sooner or later be performed on other groups of patients including the elderly, incapacitated patients, patients suffering with emotional distress, the disabled, and even children and newborn babies with disabilities. A change in legislation will lead to further devaluing of human life, especially for the vulnerable members of society. ***'Euthanasia, once accepted, is uncontrollable for philosophical, logical and practical reasons. Patients will certainly die without and against their wishes if any such legislation is introduced.'*** (Statement by the UK Association for Palliative Medicine & the National Council for Hospice and Specialist Palliative Care Services on proposals to legalise euthanasia and physician-assisted suicide. 2003)
- **Three surveys done over a 10-year period by Dutch researchers show that in Holland, where euthanasia has been legalised, at least 1,000 patients are killed every year through euthanasia without consent or without request. This constitutes murder.** The first report, published in 1991 showed that in 1,000 cases (equivalent to 0.8% of all deaths) physicians administered a drug with the explicit purpose of hastening the end of life without an explicit request by the patient. Two further reports from 1996 and 2001 confirm these findings. In 2001, still 1000 deaths (0.7% of total) were due to patients killed against their wishes or without explicit consent. (Van der Maas PJ et al.: Euthanasia and other medical decisions concerning the end of life. Lancet 1991; 338: 669-74. Van der Maas PJ et al.: Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995. NEJM 1996; 335: 1699-705. Onwuteaka-Philipsen BJ et al.: Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995, and 2001. Lancet online 17 June 2003. <http://image.thelancet.com/extras/03art3297web.pdf>)
- The 'slippery slope' is shown by what happens in Holland and in Belgium: ***'Dutch doctors have gone from killing the terminally ill who asked for it, to killing the chronically ill who ask for it, to killing the depressed who had no physical illness who ask for it, to killing newborn babies because they have birth defects, even though, by definition, they cannot ask for it.'*** (Wesley J Smith. Forced exit. Dallas 2003. p 111.)

- Euthanasia does not stop with adults in the Netherlands. **9% of all neonatal deaths in the Netherlands occurred following the administration of drugs with the explicit aim of hastening death.** This was noted in two surveys in 1995 and 2001. **At least 2.7% of deaths of children between the ages of 1 and 17 in the Netherlands are due to euthanasia.** (Vrakking A et al. Medical end-of-life decisions made for neonates and infants in the Netherlands. 1995–2001. *Lancet*, 2005; 365: 1329-1331 Vrakking A et al. Medical end-of-life decisions for children in the Netherlands. *Archives of Pediatrics & Adolescent Medicine* 2005; 159: 802-9.)
- In Flanders, **Belgium, more than half of all neonatal deaths were due to doctors making ‘end of life decisions’, usually stopping the treatment of babies.** However, **7% of all neonatal deaths were due to injection with a lethal dose of medication.** Most of the babies had severe congenital malformations and/or were premature. $\frac{3}{4}$ of all neonatal physicians were prepared to engage in ‘euthanasia’ of newborn babies. (Provoost V. et al Medical end-of-life decisions in neonates and infants in Flanders. *Lancet* 2005; 365: 1315–20.) In 2002, Belgium legalised euthanasia for adults who are suffering ‘constant and unbearable physical or psychological pain’, and who are sufficiently conscious to make the request to die. To kill babies is illegal in Belgium.

4.2 To legalise assisted suicide or euthanasia would put immense pressure on those who are ill and especially those who feel that – due to illness, disability or due to expensive treatment required – they have become a burden to others and to society, especially to relatives.

- This is shown by the following case example from Holland: A 65 year old woman, suffering from incurable cancer, was discharged from hospital. Her doctor discussed euthanasia with her. The patient objected to euthanasia on religious grounds. However, with progressing cancer, she became more ill and considered herself a burden to her husband. She requested euthanasia and died. The case is reported and the public prosecutor couldn’t see anything wrong. While this is obviously a case about euthanasia, the same could happen if assisted suicide would no longer be prosecuted under the proposals by the Director of Public Prosecutions. (Dr Peter Hilderling, President, Dutch Physicians League in a presentation given at the House of Lords, London, UK, May 7th, 2003)
- In a study of terminally ill patients **those patients with substantial care needs** were more likely to feel being an economic burden to others. This group was **more likely to consider euthanasia or physician-assisted suicide.** (Emanuel EJ et al. Understanding economic and other burdens of terminal illness: the experience of patients and their caregivers. *Annals of Internal Medicine*. 2000; 132: 451-9.)
- In Oregon, physician-assisted suicide (PAS) was legalised in 1997. A recent survey found that, **with the increasing acceptance of PAS, the percentage of patients who died through PAS because they felt a burden to others** (not necessarily the only reason, however) **increased from 12% in 1998 to 26% in 1999 and to 63% in 2000.** (Sullivan AD et al. Legalised physician-assisted suicide in Oregon, 1998-2000. *New England Journal of Medicine* 2001; 344: 605-607.) When Oregon legalised PAS, only a minority of patients requested PAS because they felt a burden to others. However, with the increasing acceptance of PAS, nearly two-thirds of those dying through PAS cite being a burden to family, friends or caregivers as one of the main reasons for requesting PAS.

4.3 To tolerate assisted suicide under certain conditions or legalise euthanasia would bring about profound changes in social attitudes to illness, disability, death, old age and the role of the medical profession. Once assisted suicide is accepted (or euthanasia is legalised), assisted suicide or euthanasia will become increasingly an accepted ‘treatment option’ alongside the currently standard medical or surgical treatment.

- **With increasing acceptance of assisted suicide or euthanasia, anyone with a medical condition – not just a terminal one – may consider assisted suicide (or euthanasia) as a ‘treatment option’.** Assisted suicide (or euthanasia) would become an acceptable treatment option for conditions such as depression, stress, loneliness, fear of impending disease or fear of decline, but also for disabled children or adults. Assisted suicide (or euthanasia) would become part of the armamentarium of medical treatment alongside

established medical treatments such as pain relief, antidepressant medication, radiotherapy and chemotherapy.

- Dr Karel Gunning, a Dutch General Practitioner states: ***“Once you accept killing as a solution for a single problem, you will find tomorrow hundreds of problems for which killing can be seen as a solution.”***
- The profound changes in social attitudes can be compared to the changes that occurred after Abortion became legalised with the 1967 Abortion Act. **As abortion is now an option for any woman who finds herself pregnant, euthanasia or assisted suicide, once legal, will become an option for anyone who is (or considers himself/herself to be) ill.** Once the law permits the taking of human life the stage is set for the destruction of all vulnerable human life because the law serves as a guideline to the conscience. What is legal then becomes perceived to be morally permissible.

4.4 To essentially legalise assisted suicide – even with ‘safeguards’ and under certain conditions - will ultimately undermine medical care, especially palliative care and seriously undermined the doctor-patient relationship. It is claimed that assisted suicide (and euthanasia) are about the ‘right to die’ a good death. However, physician-assisted suicide or euthanasia are not about the ‘right to die’. It is about giving doctors the right to kill their patients or assist in a suicide. Many physicians will refuse to become the executioners of their patients or assist in any way with ‘helping’ them to die.

- Legalising euthanasia would mark a fundamental change in doctor-patient relationship where **patients will have to wonder whether ... ‘the physician coming into my hospital room is wearing the white coat of the healer ... or the black hood of the executioner.’** (British Medical Association statement – End of life decisions, 2000).
- The change in attitude among doctors who participate in euthanasia is graphically illustrated by the following conversation between Lord McColl, a professor of surgery, and a Dutch doctor about **what it was like doing the first case of euthanasia. ‘Oh,’** he said, **‘we agonized all day. It was terrible. However,** he said **the second case was much easier, and the third - I quote – ‘was a piece of cake’.** (Lord McColl in a speech in the House of Lords, UK; Lords Hansard, October 10th, 2005.)
- **It is easier and cheaper to essentially tolerate assisted suicide and allow patients to take their own lives than it is to offer treatment.** We have serious concerns about the provision of adequate palliative care services if assisted suicide or euthanasia were legalised. We believe that to tolerate assisted suicide or even legalise euthanasia would undermine the efforts of good palliative care and the immense progress that has been made in palliative medicine in alleviating distressing symptoms and pain in dying patients. In the Netherlands, 84 % of those requesting euthanasia are in pain, and 70 % have difficulty breathing. A report on end-of-life care in the US found that less than 20 per cent of Oregon hospitals had palliative care programs, and it gave Oregon a Grade E for end-of-life care. (Baroness Finlay, Professor of Palliative Care in a debate in the House of Lords, Hansard; Oct. 10th, 2005, column 23f)

5. The ‘wish to die’

The ‘wish to die’ is rarely a truly autonomous decision. The ‘wish to die’ is more often an expression of depression, pain or poor symptom control rather than a genuine wish to die. The desire to die and the will to live frequently changes over time, especially if pain and depression have been treated.

- In Oregon, where physician-assisted suicide (PAS) has been legalised, **nearly one in two patients who initially requested PAS changed their mind after initiation of treatment, such as pain control, prescription of antidepressant medication or a referral to a hospice.** However, among those patients, where no active symptom control was initiated, only 15% of those who initially requested physician-assisted suicide changed their mind. (Ganzini L et al. Physicians’ experiences with the Oregon Death with Dignity Act. New England Journal of Medicine 2000; 342: 557-63.)

- In a survey of terminally ill patients, a total of 60% supported euthanasia in a hypothetical situation, however only 10.6% reported seriously considering euthanasia or assisted suicide for themselves. Factors associated with being less likely to request assisted suicide or euthanasia were feeling appreciated, factors associated with being more likely to request euthanasia were depression, significant care needs and pain. At follow-up interview **two to six months later, half of all terminally ill patients who had considered euthanasia or assisted suicide for themselves changed their minds**, while an almost equal number began considering these interventions. (Emanuel EJ et al. Attitudes and desires related to euthanasia and physician-assisted suicide among terminally ill patients and their caregivers. JAMA 2000; 284: 2460-8.)
- Among terminally ill patients occasional wishes that death would come soon were common in nearly half of all patients but only 9% of these individuals acknowledged a serious desire to die. The desire for death was strongest in those with severe pain and low family support but most significantly in those with severe depression. **Nearly 60% of those patients who expressed a desire to die were depressed whereas depression was found in only 8% of patients without such a desire.** The authors conclude: *'The desire for death in terminally ill patients is closely associated with clinical depression – a potentially treatable condition – and can also decrease over time. Informed debate about euthanasia should recognize the importance of psychiatric considerations, as well as the inherent transience of many patients' expressed desire to die'*. (Chochinov HM et al. Desire for death in the terminally ill. American Journal of Psychiatry. 1995; 152: 1185-91)

6. Physician-Assisted Suicide

This is not the 'good death' hoped for.

One of the main arguments in favour of assisted suicide and euthanasia is that it gives patients the chance of dying a 'good death'. However, the reality is very different. Dutch research shows that very distressing complications occur not infrequently when physician-assisted suicide is being carried out. Rather than dying quickly, some patients took several days to die.

- Even though Dutch doctors have the longest experience with assisted suicide and euthanasia of any country in the world, still distressing 'side effects' occur: In 18% of cases where a patient attempted physician-assisted suicide the doctor had to intervene and kill the patient. The reasons for this were that the patient awoke from coma, or had difficulty taking all the oral medication, vomited after taking the first medication or fell asleep before taking all the medication. Furthermore, in nearly half of the cases which started as physician-assisted suicide, the patient did not die quickly enough and the doctor had to terminate the patient. **While it was planned for the patient to die within half an hour after taking the lethal drugs, 19% of patients took 45 minutes to seven days to die.**
- There were fewer problems observed in euthanasia as opposed to physician-assisted suicide but still **10% of patients took much longer to die, some up to seven days.** In both euthanasia and physician-assisted suicide a small number of patients awoke from coma and had to be terminated. This certainly is not the 'good death' people hope for. (Groenewoud JH et al. Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. New England Journal of Medicine 2000; 342: 551-6.)

7. Conclusion

- 7.1 **While to abstain from prosecution in cases of assisted suicide or to essentially allow assisted suicide under certain conditions may superficially appear attractive, this change in policy will have profound adverse effects on the social fabric of our society, on our attitude towards death and illness and on our attitude towards those who are ill or have disabilities.**
- 7.2 **The Director of Public Prosecutions must be under no illusion that – once there will no longer be prosecution against the 'suspect' in cases of assisted suicide if certain conditions are met that –**

increasingly – these conditions will be softened with time. While perhaps initially cases of assisted suicide in individuals with metastatic cancer may not be prosecuted, with increasing acceptance of assisted suicide, less serious or even non-terminal conditions would be accepted as sufficient reason not to prosecute. Ultimately, we can envisage the situation where anyone with a more than just temporary wish to die would be allowed to ask for assisted suicide.

- 7.3 Furthermore, the Director of Public Prosecutions must be under no illusion that – once there will be an acceptance of assisted suicide – even with ‘safeguards’ – that the pressure of high-profile legal cases will move towards the legalisation of euthanasia. It could be argued by the proponents of the ‘right to die’ lobby that it is discriminatory to permit assisted suicide for those individuals who are still capable of performing the act of suicide, (obviously with some assistance) whereas other individuals with a wish to die may – because of illness, because of circumstances etc – not even be able to perform their own suicide even with assistance. For these cases, and in the not so uncommon case that the assisted suicide ‘fails’ there would then – so could be argued – arise the need to legalise euthanasia which would then allow a doctor to terminate the patient.
- 7.4 Assisted suicide (and euthanasia) place increasing pressure to agree to suicide (or agree to be killed) on those who are elderly or sick or who consider themselves – due to disease, disability or expensive treatment – to be a burden to relatives or to society. The ‘right to die’ soon becomes the ‘duty to die’.
- 7.5 With increasing acceptance of assisted suicide and euthanasia, there will be a change in perception of illness, death and medical treatment. The example of legalised abortion shows what happens. Every woman who finds herself pregnant now has to consider whether to continue with the pregnancy or to opt for an abortion. Similarly, once tolerated or even legalised, assisted suicide or euthanasia will become a ‘treatment’ option for those who are diagnosed with any illness, not just a terminal one, and who consider themselves to be ill.
- 7.6 Euthanasia, once legalised, cannot be adequately controlled. The Dutch experience shows, that around 1,000 patients are killed every year against their wishes, or, without consent, by their doctors. Euthanasia, initially intended for a certain group – for example patients with terminal illness – will soon spread to other groups, to those who are ill or may even only consider themselves to be ill, and even to newborn babies with disabilities.
- 7.7 It is always cheaper and quicker to kill than to treat. To tolerate or legalise assisted suicide (or euthanasia) will undermine medical care and especially palliative care. Where euthanasia and assisted suicide have been legalised - for example in the Netherlands or in Oregon - the provision of palliative care appears to be poor or inadequate.
- 7.8 To legalise physician-assisted suicide or euthanasia will adversely affect the doctor-patient relationship. Despite all possible legal safeguards, patients will be wondering whether the doctor is wearing the white coat of the healer or the black hood of the executioner.

15th December 2009

This Submission is made to the Director of Public Prosecutions, Mr. Keir Starmer by the Maranatha Community which has thousands of members throughout the United Kingdom, many of whom are concerned in a professional or voluntary capacity with the care and welfare of the aged, the vulnerable and the disabled. It's Leader is Mr. Dennis Wrigley.

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