

Helen Watt

It is always helpful, when discussing euthanasia, to begin by looking at the meaning of the term, as definitions vary widely. The definition I will use reflects the way the word is often used in the bioethics literature, though as we shall see, the word is used in a more narrow sense in the Netherlands. By euthanasia, I mean the intentional shortening of life, by act or omission, on the grounds that it is not worth living. On this definition, euthanasia can be voluntary or non-voluntary, active or passive, depending on the method used and on whether the patient has consented. Note that it is *not* euthanasia if life is shortened as a side-effect of trying to achieve some other goal. It is not euthanasia to give high doses of painkillers with the aim of alleviating pain, if we only foresee, and do not intend, that the patient will die sooner as a result.¹ Nor is it euthanasia to refrain from giving (for example) some burdensome treatment, if we only foresee, and do not intend, that the patient will die sooner as a result. Only if our *aim*² is to shorten life, by act or by omission, can one speak of euthanasia.

The Netherlands

In the Netherlands the term 'euthanasia' is normally used to refer solely to *voluntary* euthanasia. Moreover, use of the term is often further restricted to voluntary *active* euthanasia. Partly for

this reason, there has been a lot of controversy over empirical data from the van der Maas Survey³ and a subsequent survey by van der Maas and van der Wal.⁴ Doctors in the Netherlands were asked what their intentions were in making medical decisions concerning the end of life. The way the figures were added up by the authors of the Surveys tends to minimize the incidence both of *voluntary* euthanasia - euthanasia in the Dutch sense - and of *non-voluntary* euthanasia. If, however, we count all the cases of euthanasia in the broad sense, including non-voluntary euthanasia and euthanasia by omission, we get a much higher total for euthanasia and doctor-assisted suicide. Counting all those cases in which doctors acted, or refrained from acting, with the 'explicit purpose' of shortening life,⁵ the original van der Maas Survey gives us a figure of 9,050 cases in 1990, of which 5,450 - more than half - were without the explicit request of the patient.⁶ Non-voluntary euthanasia was thus more common than voluntary euthanasia in 1990,

³ Maas PJ van der *et al.* *Euthanasia and other medical decisions concerning the end of life* (English translation). Amsterdam: Elsevier, 1992.

⁴ Wal G van der, Maas PJ van der. *Euthanasie en andere medische beslissingen rond het levenseinde. De praktijk en de meldingsprocedure*. Den Haag: SDU uitgevers, 1996.

⁵ This gives us a highly conservative figure for euthanasia in 1990, since it excludes those cases where the doctor acted, or refrained from acting, 'partly with the purpose' of shortening life. In view of this purpose, such cases are also euthanasia (see note 2).

⁶ Keown J. The First Survey: The Incidence of 'Euthanasia'. In: Keown J. *Euthanasia, Ethics and Public Policy*. Cambridge: Cambridge University Press, 2002.

¹ Often, in fact, the use of palliative drugs is more likely to lengthen than to shorten the patient's life, as the patient is more rested.

² It is worth remembering here that the doctor may have several different aims in what he or she is doing. If one aim is to shorten the patient's life, while the other is to end the patient's pain or that of his or her family, this will still be euthanasia.

notwithstanding guidelines laid down by the courts, the Royal Dutch Medical Association and the Ministry of Health, to the effect that euthanasia must be voluntary. Nor was the requirement that euthanasia be voluntary the only guideline being breached. Other requirements, such as that the patient be suffering intolerably, that euthanasia be a last resort and that euthanasia be reported, were also being freely disregarded, on the admission of doctors themselves.

Apart from a few procedural changes, such as an increase in reporting, there was no improvement in the situation five years after 1990. The van der Maas and van der Wal Survey dealing with the year 1995 found an increase both in voluntary euthanasia and in requests for euthanasia.⁷ There was a slight *decrease* in life-terminating acts without the patient's request, as these were counted in the Survey. However, the Survey did not include in this category 1,537 cases where palliative drugs were given with the explicit intention of hastening death, and without the patient's request. If these cases had been included, an increase would have been seen in the incidence of non-voluntary life-termination.⁸ There was certainly a marked increase in euthanasia by omission,⁹ which in a

large majority of cases took place without the patient's request. The Survey also recorded both passive and active euthanasia of newborn babies - clearly without the request of the babies whose lives were so curtailed. It would therefore be rash indeed to claim that euthanasia in the Netherlands is wholly or largely voluntary - or, indeed, that it is otherwise proceeding according to plan.

The slippery slope

The Dutch experience is, in fact, a powerful example of what can be called the 'practical' slippery slope: of what can happen in practice when voluntary euthanasia is accepted by the courts and by the medical profession. However, it is also worth exploring what can be called the 'theoretical' slippery slope: the theoretical reasons why, in particular, non-voluntary euthanasia might be accepted, once voluntary euthanasia has been accepted. To explore these reasons, we will need to return to the definition of euthanasia with which we began.

Euthanasia was defined as the intentional shortening of life, by act or omission, *on the grounds that it is not worth living*. It may be objected that the doctor who performs euthanasia need not make a judgement on the value of the life of the patient who is killed. The doctor may simply ascertain that the patient has requested euthanasia, and perform it simply on the basis that this is what the patient wants.

However, in practice few doctors would perform euthanasia *just because the patient wants it*. If a patient was temporarily depressed, but was otherwise in reasonable health, we would expect even a pro-euthanasia doctor to refuse to end a life which he

⁷ Keown J. The Second Survey. In: Keown J. *Euthanasia, Ethics and Public Policy*. Cambridge: Cambridge University Press, 2002.

⁸ Hendin, H. The Dutch Experience. *Issues in Law & Medicine* 2002; **17**: 231.

⁹ The situation is, however, complicated by an explanatory note to the relevant question doctors were asked, which suggested that an intention to 'hasten the end of life' could also be understood as an intention 'not to prolong life'. In fact, the two intentions are by no means identical: a choice to refrain from life-prolonging treatment could be made not in order to hasten death, but simply on the grounds that the treatment was too burdensome.

or she would see as having value. Doctors are not, after all, mere tools to be used by their patients, but professional people with some responsibility for evaluating what they are asked to do. A doctor who supports euthanasia will therefore distinguish between those patients who have *reason* to want to die, because their lives are not worth living, and those patients who *do not* have reason to want to die, because their lives *are* worth living, in the doctor's estimation. While the doctor may defend euthanasia in terms of the autonomy of the patient, he or she in fact believes that only *some* patients - namely, those whose lives are not worth living - should be helped to exercise autonomy by choosing to be killed.¹⁰

However, if some human lives are not worth living, as euthanasia advocates believe, not all these lives not worth living will have owners who are competent to choose. If a patient's life has no value, but the patient is mentally disabled and cannot consent to euthanasia, it is not clear there is anything to stand in the way of our killing the patient, at least if the *relatives* give their consent. It is therefore not surprising that many supporters of *voluntary* euthanasia also support (whether openly or discreetly) *non-voluntary* euthanasia. For if death is either a benefit, or at least no harm, why should we deny it to those who cannot request it? The practical slide from voluntary to non-voluntary euthanasia has in this way a theoretical basis in the notion that some human lives have no value, and may be ended on those grounds.

Euthanasia in Britain

Belief in this notion is not, of course, confined to doctors in the Netherlands. In Britain, non-voluntary euthanasia by omission was, in effect, enshrined in law by the judgement on the Bland case. Tony Bland was a young man left in a state of permanent unconsciousness after the Hillsborough football stadium disaster. In judging his case, the Law Lords accepted what they saw as the view of a body of responsible medical opinion that life in Tony Bland's condition was in no way a benefit. Three out of five Law Lords stated (the others not dissenting) that the aim of withdrawing tube-feeding was to bring about Tony Bland's death. Withdrawal of feeding, including oral feeding, is now being extended to adults who are not in a 'persistent vegetative state' (PVS) and not in the final stage of dying. In addition, there are reports from time to time of the sedation and starvation of newborn babies with disabilities. If a patient's life is not seen as having value, it is harder to resist that patient's killing not so much for the *patient's* sake as for the sake of his or her relatives. Acceptance of the view that some lives are not worth living paves the way not merely for non-voluntary euthanasia, but for non-voluntary euthanasia for the benefit of others, such as parents or society. Thus when the Bland case was discussed by the media, stress was laid not only on the supposed worthlessness of Tony Bland's life in PVS, but on the suffering his condition caused his parents, and the desirability of putting an end to that suffering. While it is true that to see a family member in PVS can be a cause of real distress, it is surely remarkable that the suffering of others should be seen as a reason for ending the life of an innocent human being. One might also question whether the experience of helping to bring about the death of their son was

¹⁰ Watt H. *Life and death in healthcare ethics: A short introduction*. London: Routledge, 2000: 31-32.

really of benefit to Tony Bland's parents, as it was predicted that it would be.

'Personal' life

In a case of serious mental impairment like that of Tony Bland, it may be claimed not so much that life is not worth living, but that there *is* no life - or no 'personal' life - involved. Thus Tony Bland's body was described by one of the judges of his case as a 'shell' from which his spirit had flown. This was despite the fact that Tony Bland's brainstem was functioning, that he was breathing spontaneously, his heart was beating, and so on. Here there is a tendency to see the *human person* as a *separate individual* from the *living human organism* - a view which many philosophers (and others) reject as incompatible with our experience of ourselves and each other as bodily beings.¹¹

The value of life

While it is sometimes claimed that the soul or 'person' has departed from a patient's living body, it is perhaps more common to accept that the patient is still alive, but to claim that his life is not worthwhile. The view that life can have literally no value, such that it need not and should not be protected, is, however, a radical departure from the traditional view of human life: radical both in itself and in its implications when it is used as the basis of law. Someone accused of killing another human being can say, 'I admit I took a *human life* - but it was a life *with no value*.' We should note that

¹¹ To say that human persons are essentially bodily is not to deny they have a spiritual aspect. It is to say, rather, that the human subject is a living individual, not a ghost. The Christian tradition, in particular, sees the soul as the source of the life of the body, and the soul after death as something incomplete, awaiting the body's resurrection

this is not the way in which, for example, killing in self-defence is rightly seen as justifiable. If I kill a person who is trying to kill me, this is quite compatible with my recognizing the value of the life of my aggressor, which I endanger only with reluctance on the grounds that he or she has deliberately chosen to endanger my own. To kill a person on the grounds that his or her life has *no value* is to demonstrate an attitude to human life not found elsewhere in justifiable homicide.

What, then, is the basis for rejecting killing on the grounds that life has no value? The basis is the fact that human beings are in possession of a fundamental human dignity which cannot be eliminated. We have this dignity in virtue of our nature: in virtue of the fact that we are human beings, with a nature directed at rational behaviour even in situations in which we are currently incapable of rational behaviour. As human beings, we have morally significant interests in the 'goods' or benefits appropriate to human beings: goods such as knowledge, friendship, and, indeed, life itself.¹² Many of our actions are premised on the fact that these things are good for us and other people: not just good instrumentally, but good or fulfilling in themselves. Not all human beings have the exercisable ability (as opposed to the radical capacity) to participate in human goods other than life. However, life is one human good in which human beings can *always* participate, as long as they exist at all. It is never something bad in itself, or a matter of indifference, that a person is alive. There is an objective value not simply to a person's enjoyment of

¹² Grisez G, Boyle J, Finnis J. Practical principles, moral truth, and ultimate ends. *American Journal of Jurisprudence* 1987; 32: 99-151.

human goods in general, but to his or her presence in the world.

Respect for life

What this value means is not, of course, that life should be preserved at all costs. Those who believe in the value of human life have always recognized that there are limits to the duty to preserve the lives of patients. What steps we must take to preserve a patient's life will depend on such variable factors as his or her medical condition and the healthcare resources available. If, for example, the patient has just a few days or hours to live, we may not be obliged to do *anything* to preserve the patient's life, providing we at no stage have the intention of accelerating his or her death, whether by act or by omission. Similarly, we are not obliged to provide a competent patient with treatment which he or she rejects as too burdensome for what it can achieve.

What the value of life *does* demand is that we recognize this value at all times, always refusing to attack a human life on the grounds that it is not worthwhile. We should not, in other words, buy into the assumption that the lives of some human beings have no value and may be ended on those grounds. Such an assumption is, as the Dutch experience shows, extremely harmful to the doctor-patient relationship and to society at large. It is also highly demoralizing to sick and disabled people, who receive the message that life with their condition is considered intolerable by doctors and society.¹³ We should not encourage

¹³ Compare this with the message conveyed to suicidal people who are physically well. These people are assured that their lives are worthwhile, and that suicide is not the right response to their current situation. In contrast, if euthanasia is socially accepted, both suicidal and non-suicidal people with certain conditions

despair on the part of patients by espousing the view that their lives are not worth living and may be deliberately curtailed. Instead, we should provide patients with the kind of support - physical, emotional and spiritual - which affirms their worth as human beings.

© The Linacre Centre for
Healthcare Ethics,

38 Circus Road,
London NW8 9SE
England

Tel. +44 (0)20 7266 7410
Fax +44 (0)20 7266 5424
admin@linacre.org

Registered Charity No. 274327

will receive the message that society sees their lives as not worthwhile. On this and other aspects of euthanasia, see Gormally L. ed. *Euthanasia, clinical practice and the law*. London: The Linacre Centre, 1994.