Euthanasia
– Ethical issues

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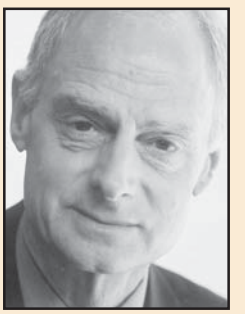

As part of a caring profession, medical practitioners can all support the general meaning of euthanasia as 'a gentle and easy death' and it may appear to be a simple matter to assist in the death of a patient or loved one who is terminally ill, to relieve suffering.

However, the word euthanasia is now used commonly to refer to the killing of terminally ill patients or those who experience unbearable pain and this raises a number of issues for medical practice. Killing patients is not ethical behaviour.

It is necessary to have some definitions. **Active euthanasia** is an action performed within a medical setting that is done with the intention of terminating a human life. A lethal injection is an example. **Passive euthanasia** describes the withdrawal or withholding of some necessary treatment for the maintenance of human life which may mean switching off a ventilator of a patient who has no prospect of recovery, the intention being to discontinue medical treatment that many would regard as futile and intrusive. **Voluntary euthanasia**, which is available in the Netherlands and was available, briefly, in the Northern Territory of Australia, is the bringing about of a person's death by somebody else, at the request of the person. **Involuntary euthanasia** occurs when a patient is killed without his or her consent, which is murder, and no jurisdiction permits it. **Non-voluntary euthanasia** is used to describe situations in which the patient is not capable of understanding the difference, or making the decision, between life and death and people in this category include those who have developed a persistent vegetative state. Usually in such conditions, decisions concern the futility of prolonging life or saving life. **Assisted suicide** allows patients to end their own lives by means organised in conjunction with a doctor. This is a crime in NZ. The definition of death since 1968 has been accepted as a state of irreversible coma when the brain has gone without hope of recovery, with an irreversible inability of the brain to organise cardio-respiratory functions.

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Any discussion about euthanasia touches on the sanctity of life. A profound respect for the sanctity of human life is embedded in the law in NZ and in the moral philosophy of most New Zealanders. Most people will agree that life holds intrinsic value even when one's prospects seem bleak. The importance of an individual's right to life cannot be over emphasised even when that individual him or herself loses sight of it, as in a genuine suicide attempt. In medical practice over the centuries, there has been a conviction that human life has inestimable value and ought to be protected and cherished.

The debate in NZ about euthanasia has been reactivated by a Private Member's Bill in the name of Mr Peter Brown, Deputy leader of NZ First, and entitled Death with Dignity Bill. Although MPs have recently voted, by a narrow margin, against sending this Bill to a select committee, the debate has not ended and consideration of the Bill's proposals is warranted. The purpose of the proposed Act was:

a. to allow terminally and/or incurably ill persons the opportunity of requesting assistance from a medically qualified person to voluntarily end their lives in a humane and dignified way; and
b. to provide for that to occur after medical confirmation, a psychiatric assessment, counselling, and personal reflection.

The Bill had a process which included referral by the patient's medical practitioner to a consulting medical practitioner to confirm the diagnosis and options, to a psychiatrist who would assess the presence or absence of a mental disorder, a counsellor and the next of kin, all organised by the medical practitioner who then would coordinate the reports and carry out the killing of the patient. If this Member's Bill had been passed, the Act would have come into force after the Chief Electoral Officer had declared the final result of a national referendum asking the question 'should the *Death with Dignity* Bill become law?'. A requirement would have been that a majority of those voting in the referendum answer 'yes' to the question.

This *Death with Dignity* Bill is essentially the same as one promoted by Michael Laws when he was a Member of Parliament and that Bill prompted the NZMA to seek advice about the ethics of euthanasia. A report was prepared by the Bioethics Centre of the University of Otago with the principal authors being Drs Grant Gillett and Sam Bloore and assisting author Dr Pat Ngata. The report was dated September 1996 and it forms the basis of this editorial. An opinion poll prior to the report asked the question *'should euthanasia be permitted for a person who is terminally ill and has given their prior consent?'*, to which 79% of respondents said 'yes'.

The important points include:

1. The distinction must be made between the various types of euthanasia and precise terms are important.
2. Killing is different from letting die.
3. Hastening death is not necessarily the intention in 'passive' euthanasia.
4. Respect for life is one of the fundamental human values and any change in the current legislation will lead to a devaluation of the sanctity of life.
5. The issues for patients, including loss of dignity, pain, suffering, being a burden and causing a fuss all have remedies that do not include killing the patient.
6. Increasingly, care in hospices is available together with specialised palliative care and relief of pain.
7. For medical practitioners there may be the need to learn how to listen better to people who are dying, be judicious in the use of pain relieving drugs and not strive officiously to keep a patient alive when there is no hope of recovery.

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The current legislation includes:

1. The Crimes Act 1961 Section 151(i), which prohibits the denial to others of *'the necessaries of life'*.
2. The Crimes Act 1961 Section 164, which forbids the hastening of death.
3. The NZ Bill of Rights 1990, which gives an adult person the right to refuse any medical treatment. The Bill of Rights safeguards the interests of the patient from *'fickle or unjustifiably intrusive treatment without consent'*.
4. The Health and Disability Commissioner Act 1995 which is the legal foundation for the Code of Rights for Consumers of Health and Disability services which, as readers will know, incorporates informed choice and consent, the right to refuse treatment and the right to complain.

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The sanctity of death is a personal matter but most human beings have a deep-seated belief that a person's mode of dying is an important part of the whole that is his or her life. Some people fear death and most people dread being left in a state with serious and irreversible neurological damage which is incompatible with anything that a reasonable person would call a life worth living.

The traditional Maori belief is that all natural things have a mauri or life principle and that every human life is a taonga, a precious, unique and treasured gift. The spiritual dimension of each person is accorded its most sacred and paramount honour around natural events like death and dying.

The world's major religions place great emphasis on the preservation and protection of human life. Acts such as active euthanasia are precluded and unacceptable.

Suicide has been decriminalised in NZ so that desperate people can have help and understanding rather than condemnation and punishment, but there is not a right to commit suicide and anyone who is found to have assisted in a suicide can be arrested, charged and punished.

The important point is that there is no bar to life ending peacefully without excessive medical treatment and there is no bar to withdrawing treatment that is regarded as futile and intrusive. There are safeguards

that protect patients from the spectre of prolonged dying as a result of intrusive medical treatment. However, an adult patient is the only person who can accept or refuse medical treatment on his or her own behalf. For children, it is a matter of each individual's understanding of the issues. There is legal precedent in NZ for the idea that a life-sustaining treatment can be discontinued if it is regarded as being of no benefit to the patient and this does not comprise culpable homicide.

The arguments for euthanasia are:

1. The patient wants to die and should have a choice.
2. A kind death requires that we allow active euthanasia.
3. We are already doing the same thing.
4. Many people agree with active euthanasia.

The arguments against active euthanasia are:

1. Active euthanasia undermines the sanctity of life.
2. Active euthanasia is open to abuse.
3. Active euthanasia changes the nature of doctors.
4. To allow killing and not just letting die changes the nature of the dying process.
5. Active euthanasia is the beginning of a slippery slope.

The respect for life underpins the four principles of medical ethics of non-maleficence, beneficence, autonomy and justice.

Autonomy of patients recognises a right to make decisions about their own lives but there are limits. There is a distinction between the right to be informed about and authorise any treatment that is contemplated or recommended by professional caregivers and the right to demand a treatment that does not accord to the best standards of medical or health care practice.

The fear of the manner of dying may, in part, result from medical interventions regardless of the costs to patient autonomy and dignity. It behoves us as doctors to withdraw futile treatment and avoid the prolongation of life by, for example, treating pneumonia in a sufferer of dementia.

The law in NZ allows a treatment to relieve suffering even if in doing so it hastens death. In general where we intend to relieve pain with a risk of hastening death, we should opt for the most effective and the safest treatment available for the relief of pain.

It is necessary to be clear about the distinction between killing and letting die, the difference between active voluntary euthanasia and withdrawing futile treatment

A recent survey, which received publicity in the daily press, suggested that many doctors are already practising active euthanasia. The sample was small, the questions somewhat ambiguous and the author, herself, urged caution in the interpretation of the findings. It is necessary to be clear about the distinction between killing and letting die, the difference between active voluntary euthanasia and withdrawing futile treatment.

The survey did show that 90% of respondents had access to care in a hospice and to palliation. The argument for active voluntary euthanasia is strongest where there is not adequate hospice care as well as where there is active and aggressive intervention to prolong life whatever the patient's condition. With adequate hospice care, a change in attitude of medical practitioners, extension of the specialty of palliative care and improvements in relief of pain, there should be only a tiny minority of people who die in agony and indignity.

The authors of the report from the Bioethics Centre of the University of Otago expressed deep misgivings about any legislative move to legalise euthanasia, noting that we should be cautious about change in the law which interferes with principles that have guided medicine and health care in general down through the centuries to good effect for most people.

It is worth repeating the last two paragraphs of the summary.

'It seems important that we continue to move towards empowering the patient in the New Zealand health care system. This allows choices about management of serious illness to take maximum account of the values of patients. For this to be an effective move, patients and the public in general need to be educated about their rights and responsibilities in the health system and encouraged to seek and use information about their own health. The result of this process is, ideally, a genuine partnership by patient and health care professional in the enterprise of health care. This is particularly important in choices about death and dying.

'In NZ we have a number of measures available to us in death and dying. These include the right of patients to decline life-saving treatment, the provision of good palliative care, the permission for doctors to achieve symptom relief even at the cost of risking life, and specific guidelines about futile treatment. These measures reduce to a very small number the cases in which active euthanasia would seem to be the only alternative to a cruel death. The issue before us is whether this very limited need justifies the massive change we would make to the ethos of care in dying in NZ.'