‘The Euthanasia Debate …. Why Now?’
By Helen Bichan (InterChurch Bioethics Council)

Introduction
“The Euthanasia Debate...Why now” was the title of a seminar held at Te Papa (April 8, 2011) to address a number of issues around Euthanasia. Sponsored by Hospice NZ and the Nathaniel Centre, I attended as a member of the InterChurch Bioethics Council (ICBC). Presented here is a summary from two of the speakers to highlight the many issues raised by euthanasia that need our thoughtful consideration. A summary of all the speakers’ presentations is available on the ICBC website www.interchurchbioethics.org.nz

Professor Margaret Somerville – Legalising Euthanasia: Why now?
Founding Director, McGill University for Medicine, Ethics, Law and Samuel Gale Professor of Law, McGill University, Montreal, Canada

At the start she assumed that the usual arguments for Euthanasia were known to the audience. She proposed to consider its impact at the levels of the individual; of institutions such as hospitals; of society and government; and at global level. Dying with euthanasia is never private nor individual, it relates to society values and institutions. In her view, even with a Utilitarian approach the harms are more than the benefits. She made the following points:

1. The difficulty of making a case against euthanasia in the context that increased activism has led to its legalisation in some western democracies. In the past personal and societal values were shared on the basis of a common religious understanding, eg ‘Thou shalt not kill’. In today’s secular society the individual feels s/he has the right to choose the time and form of death. If the rights of society trump the rights of the individual how can this be embedded in the moral context without religion? How can the belief in primacy of individual rights be countered? The cost of not countering is ‘respect for life’ and harm to law and medicine – which have become even more important in our society as upholding respect for life in a secular world.

Why now? There is nothing new about terminal illness and euthanasia has been prohibited for centuries/millennia. Factors include:
- A great fear of dying alone or unloved – death has become professionalised, technologised, dehumanised. Euthanasia is seen as a response to intense pre-mortem loneliness.
- ‘Death talk’ needs to happen in people’s daily lives and in medicine – in the past it took place in religion.
- Today’s secular cathedrals are parliaments and law courts – these are handling the moral debates in our society.
- Mass media and the medicalisation of societal debates – make it easy to present in small (scenarios – eg story of a suffering individual) but difficult to respond to ‘relief of suffering’ arguments without turning to religion as a way of making sense of suffering.

2. Confusion as a means of legalising Euthanasia:
Pro-euthanasia deliberately confuses pain relief treatment, which may shorten life, with euthanasia which deliberately ends life. It is agreed by the majority of doctors that one should do everything possible to relieve pain even if it shortens life although the evidence today is that it is more likely to prolong it. The primary intention is critical:
- The physician aims to relieve pain even in the rare case where that may shorten life, ie to kill the pain. It is important that adequate pain relief is available.
- In euthanasia the intention is to cause death – ie to kill the patient with the pain. Supporters of euthanasia present it as ‘relief of pain and suffering’. Note that surveys regularly have a question in those terms – but that is the wrong question. The law regularly and easily recognises such differences in intention.

Another area of confusion is around withdrawal of treatment to allow a person to die. This is also recognised as appropriate and again the intention is critical.
The primary intention differs – letting a person die of their disease is different from intending to kill them.

Patient rights include a right to refuse treatment, a right to be allowed to die, and a right not to be killed.

The cause of death is the underlying disease – not, as in euthanasia, a lethal injection or intervention.

The question is how we die – should some means be prohibited? Her answer is “Yes”

Confusion occurs in definitions of ‘respect’ and ‘dignity’. Those against euthanasia speak of the intrinsic dignity of all humans. Those pro-euthanasia speak of extrinsic dignity in relation to circumstances; quality of life (including how others see you as losing it); and see euthanasia as removing a person from an undignified state. However, respect for human dignity applies to each individual and also to humanity as a whole.

At societal level we need to take the ‘medical cloak’ off euthanasia. It is very important that people should not have reason to fear physicians, the giving of pain relief, hospice care etc.

Confusion occurs with respect to animals and humans - ‘If you would put down a loved animal to put it out of its suffering – why not the same for humans?’ is the argument. She noted Prof Peter Singer’s approach in which he argues that the respect owed to a living entity depends on its ability to suffer; using that argument around animals including a number of animals as “non-humans” deserving consideration for this capacity. He discounts people who are severely intellectually or otherwise disabled as deserving respect as humans. Her short answer is “We’re not just another animal.” Humans deserve “special” respect.

3. The unstoppable expansion of justification of euthanasia
Where legal physician assisted euthanasia has been introduced the following sequence occurs:
- At first - only for some circumstances – terminally ill patient with pain and suffering;
- then - a right so that it need only have the person’s informed consent;
- justification for suicide pacts - to avoid suffering grief and loneliness;
- assisted euthanasia available for over 70 year olds “tired of life”;
- avoidance of health care costs;
- squaring the curve of health decline.

She produced evidence to illustrate this progression from practice in the USA state of Oregon and the Netherlands where euthanasia is legal. Recently the woman who introduced the legislation in the Netherlands has said it was a mistake. Once introduced it appears unstoppable.

4. Why oppose Euthanasia- Importantly because of the effects on the integrity of physicians and nurses in whom society has considerable trust. Euthanasia requires the complicity of doctors/nurses and society. We need to protect the value-creating and value-carrying parts of society and respect for life. She considered the impact on the medical profession of being required to carry out euthanasia and concluded that a sense of respect for the mystery of life and death needs to be inherent in medical practice and to be handed on.

5. Hope - keeping the human spirit alive “Hope is the oxygen of the human spirit ….”
What do dying people need? “Hopelessness” is not the same as depression. In hopelessness people ask for euthanasia because there is absolutely nothing to look forward to. In reality there are many things that dying people may hope for and be assisted to seek.

In conclusion: legalising Euthanasia leads to death losing its moral context; the loss of the sense of a “good dying” and the reduction of emotional and ethical judgement. Euthanasia sends a “better off dead” message – to an ageing population with increasing health care costs.

Respect for all life, especially human, is critical and provides the moral context for opposing the legalisation of euthanasia.

Humans are where the universe meets with a sense of awe, wonder and joy.
Dr Frank Brennan – Euthanasia – the perspective of a Palliative Medicine Physician

Those for or against euthanasia start at the point of human suffering – but their paths then diverge. Euthanasia is a deliberate act intended to end life. Palliative care aims to provide a concentrated effort to control pain, support the patient and family and enable the person to have a dignified death in a loving context.

Common Myths include:
- palliative care is form of euthanasia which it is not – its intention is quite different
- withdrawing treatment is euthanasia – intention is different
- withholding treatment is euthanasia – intention is different
- giving morphine is euthanasia – again untrue and probably reflective of an older generation of doctors who were never taught how to use it appropriately. In practice it is managed to provide a good level of pain relief within the limits of standard practice. Occasionally this may contribute to slightly earlier death but the evidence tends the other way.

His response to a patient who asks for euthanasia is to ask “What is troubling you now?” which often elicits concerns such as, loss of dignity, being a burden on spouse, no joy in life. Then he asks “What can we do for you?” This may lead to changes in symptom management, support to patient and family, etc

The request for euthanasia is a “blind” approach – blind to the advances in physical, emotional, spiritual support now available. He cited treatment of:
- depression by much improved medication;
- loss of hope by broadening hope through identifying possibilities and providing support,
- symptoms by providing relief,
- loss of dignity by recognising the inherent dignity of a person and reminding that the disease does not take away the core/past history/legacy/love – and that these will last.

If society legalised euthanasia what would be the effects?
- The medical profession would split into euthanasia practitioners and those who would not.
- “Right to die with dignity” – a good statement but not if it implies only one method.
- “Rights” might be short changed – it could be argued that there is a right to Palliative Care (supported by international law)
- “Self determination” – people want control in the face of the uncertainties of life and every death is unique. We may yearn for certainty but there is Mystery.
- No-one seeks suffering or ignores it. It is right to speak of it. The challenge is how to respond.

Other speakers:

Dr Martin Sullivan is a senior lecturer in Rehabilitation for the School of Health and Social Sciences at Massey University in Palmerston North. He addressed the concerns of the ‘Disability community’ which already experiences discrimination in society which may make assumptions about quality of life (or its perceived absence).

Amster Reedy, tohunga Re Ao Maori; Tohu Ao (consultant); Pukenga and Director of Nga Kete o re Matauranga noted that Maori have no equivalent word. “Why hasten death when you are surrounded by loved ones? People care and are aware of the spiritual world?”

Dr Chris Perkins is a GP, psychiatrist and Director of Selwyn Centre for Ageing and Spirituality He addressed depression, dementia, advanced directives, capacity, and vulnerability.

Emeritus Prof David Richmond - founder and chairman of HOPE foundation for REsearch on Ageing and Inaugural Masonic Prof of Geriatric Medicine. ‘Why the elderly should fear euthanasia’. He noted their vulnerability in a society that does not value them. They are risk when autonomy is reduced and if misdiagnosis occurs. He concluded that “Practice cannot be controlled by legislation”

Don Mathieson QC - special counsel for the Parliamentary Council Office and former prof of Law at VUW He concluded that “Any safeguards must be examinable by an independent authority and challengeable in Court.” “The safeguards proposed are quite inadequate.”