

# “Death talk”: debating euthanasia and physician-assisted suicide in Australia

Margaret A Somerville

*Imprecise language and deliberate confusion of important ethical and legal concepts are clouding our understanding of controversial end-of-life issues. This could affect our decision about whether or not to legalise euthanasia. (MJA 2003: 178: 171-174)*

IN POSTMODERN SOCIETIES, the euthanasia and physician-assisted suicide debate is an important forum for the “death talk” through which we accommodate — with as much comfort as possible — the reality of death into the living of our lives.<sup>1</sup> Recently, I debated Dr Philip Nitschke, at the Australian Medical Association’s Annual General Meeting in Canberra, 24–26 May 2002, on whether euthanasia and physician-assisted suicide should be legalised. Dr Nitschke advocates such legalisation; I oppose it.

In this article, I discuss my impressions of the discussion of euthanasia that took place at that AMA meeting and respond to it. Euthanasia is “a deliberate act that causes death undertaken by one person with the primary intention of ending the life of another person, in order to relieve that person’s suffering.”<sup>1</sup> Throughout, I use the word “euthanasia” to include also physician-assisted suicide (although I recognise that in some situations, not discussed here, they must be differentiated).

## Language matters

Language is not neutral, especially in the euthanasia debate. We must choose and use our words carefully and precisely if we are to avoid inadvertently opening the way for the legalisation of euthanasia. For instance, saying that patients must be offered all treatment necessary *to relieve their pain*, even if that treatment could or would shorten life, or they must be offered all treatment necessary *to relieve their suffering*, may seem the same. But, properly interpreted, the former statement does not open up the possibility of legitimating euthanasia; the latter could do so and could affect the law accordingly.

The language used in some of the resolutions passed by AMA delegates at the meeting can be interpreted several ways, thus creating confusion as to whether delegates had moved from opposing euthanasia absolutely towards approving it. Consequently, the media produced front-page

headlines stating that the AMA had switched its policy on euthanasia and had “cleared [doctors] to ‘hasten death’.”<sup>2</sup>

## Resolution 3

Take, for instance, *Resolution 3*, which stated:

National Conference recommends...that AMA policy be amended to read “that the AMA support doctors whose primary intent is to relieve the suffering and distress of terminally ill patients in accordance with patients’ wishes and interests, even though a foreseen secondary consequence is the hastening of death.”

Most doctors to whom I spoke at the meeting said they saw this resolution as nothing more than a reaffirmation of the AMA’s current position, which, consistent with current ethics and law, rejects euthanasia and supports offering patients all necessary pain-relief treatment, even if it could or would shorten life. However, this resolution might inadvertently go well beyond that.

First, the resolution is not limited to pain relief: it refers to relief of “the suffering and distress of terminally ill patients” — a much broader category of symptoms and situations than just pain. Language to better reflect the present AMA position would be “the relief of pain and other symptoms of serious *physical* distress of terminally ill patients.”

Secondly, *Resolution 3* implies that “the patient’s wishes and interests” justify the life-shortening treatment — a key argument of the pro-euthanasia lobby. They argue that competent individuals’ informed consent to euthanasia justifies giving them lethal injections. Opponents of euthanasia believe that a person’s consent to having death inflicted does not justify another person inflicting death. This latter belief is enshrined in contemporary criminal law, except in countries such as the Netherlands and Belgium, which allow an exception for euthanasia.

Further, *Resolution 3* could be taken as legitimating the pursuit of death as a secondary consequence, not simply tolerating it as an unavoidable, unwanted consequence. In ethics and law, the difference between these two situations is reflected in the very significant distinction drawn between justifying an unwanted consequence (here, death) and excusing it.

## “Double-effect” doctrine

The legal doctrine of “double effect” *justifies* giving pain-relief treatment, provided it is given with the primary intention to relieve pain, and *excuses* any unavoidable, but

**McGill Centre for Medicine, Ethics and Law, McGill University, Montreal, Quebec, Canada.**

Margaret A Somerville, AM, FRSC, LLB, LLD (Hon), Founding Director; and Samuel Gale Professor of Law; Professor, Faculty of Medicine.

Reprints will not be available from the author. Correspondence: Professor Margaret A Somerville, McGill Centre for Medicine, Ethics and Law, McGill University, Suite 201, 3690 Peel Street, Montreal, Quebec H3A 1W9, Canada. [margaret.somerville@mcgill.ca](mailto:margaret.somerville@mcgill.ca)

unwanted, life-shortening effect of doing so. In short, the act of pain relief is justified — it is a right act; its unwanted consequence of shortening life is excused (ie, tolerated) in the circumstances.

Let me explain why the distinction between a justification and an excuse is important in this context: an excuse carries the message that shortening life is wrong, but the person who does so will not be prosecuted (ie, he or she will have legal immunity). The message of a justification — as implied by the wording used in *Resolution 3* — is that the conduct of shortening life is right.

When considered as a justification, *Resolution 3* can also support another pro-euthanasia line of argument: given that doctors have now accepted that hastening death is acceptable and justifiable as a secondary effect, it should not be unacceptable and unjustifiable as a primary intention.

In contrast, interpreting the doctrine of “double effect”, as suggested above, would not be open to such reasoning. It says that the secondary effect of hastening the death of the patient in providing necessary pain-relief treatment is unwanted and must never be a desired consequence, but, to the strict extent necessary to relieve pain, it is excused in law. That approach also reflects many people’s moral intuitions that we must relieve pain, but it is wrong to kill.

The doctrine of “double effect” requires, first, that the act resulting in a bad consequence (such as the shortening of life) is morally neutral. Providing pain-relief treatment would qualify as at least a morally neutral act. Second, the pain relief must not be achieved by shortening life (ie, through a bad consequence). Third, the bad consequence, the shortening of life, must not be primarily intended as either an end or a means; rather, the primary intent must be the legitimate aim of relieving pain. Fourth, there must be no other reasonable way of achieving the pain relief without involving the undesired effect of shortening life. Lastly, the proportionality of good and bad consequences required to justify the bad ones must be present. Providing necessary pain relief, even if it shortens life, fulfils all of these conditions; euthanasia fulfils none of them.

### Confusion

That the delegates might themselves have been confused about the possible meaning of *Resolution 3*, which they passed (65 to 48 votes), could be indicated by their rejection (34 to 79 votes) of *Resolution 4*. That resolution proposed

...that the AMA “work towards...adopt[ing] a neutral position on the issue of voluntary euthanasia.”

The 31 doctors who voted for *Resolution 3*, but against *Resolution 4* (assuming the same 113 doctors voted in each case), obviously had no idea that *Resolution 3* could be interpreted as moving towards acceptance of euthanasia, because they opposed even a neutral stance on it.

A neutral stance would be, in fact, not only a move away from opposing euthanasia, but a move towards euthanasia. Its message is that, in principle, there are no moral, ethical or legal reasons to oppose euthanasia; rather, its acceptability is a matter of personal conscience and whether any associated potential abuse can be prevented.

Yet another indication that the doctors might not have understood the ambiguity of the language of *Resolution 3* and the inconsistency between voting for it and against *Resolution 4* is that *Resolution 1* was passed with only four *against* votes. It expressly rejects euthanasia:

“[T]he AMA...absolutely reject[s] any intervention whose primary intent is to bring about the death of a patient...”

This resolution distinguishes acting with such an intent — euthanasia — from the justified withdrawal of life-support treatment that results in death, and advocates educating the community about palliative care and ensuring that its provision is given high priority. In short, the resolution outlines a comprehensive anti-euthanasia approach to caring for terminally ill people.

### Confusion compounded

After the AMA conference, a well-known euthanasia advocate posted an email on the Deliverance (Voluntary Euthanasia Australia) chat line commenting on its outcome (List Member, Friday, June 21, 2002). The email stated that one of the participants at the meeting:

“...got it absolutely right when he said that the principle of double effect allows doctors and others to hide behind it [to carry out euthanasia].

In light of the AMA’s plan to (re-)educate doctors on the difference between “ethical care” and “euthanasia” this has particular significance : what the AMA “education” campaign is likely to amount to is to tell doctors to keep their minds off the foreseen consequences of what they do — to aim at pain-relief, not death.”

This email reflects an important *modus operandi* of euthanasia advocates — to work for the acceptance and legalisation of euthanasia by intentionally creating multiple confusions between it and other conduct that is ethically and legally acceptable in treating terminally ill patients. I call it “euthanasia by confusion”.<sup>1</sup>

### Disputed distinctions

#### *Pain-relief treatment versus euthanasia*

A key target in creating this confusion is the doctrine of “double effect”. It is attacked through allegations that the doctor’s goal — his or her *intent* — and the cause of the patient’s death — the *causation* — are the same in giving pain-relief treatment that could shorten life and in euthanasia. In other words, euthanasia advocates claim that the doctrine of “double effect” is just legal sophistry and that pain-relief treatment that could shorten life is really euthanasia.

Those who oppose euthanasia argue that provision of pain-relief treatment is different *in kind*, not just degree, from euthanasia, because the intent is different. Necessary pain-relief treatment, even that which could shorten life, does not involve a primary intention to kill the patient; euthanasia does. Profound ethical and legal differences hinge on whether such an intent is present.

As the Deliverance email demonstrates, euthanasia advocates also claim that doctors are hypocritically hiding behind the permissibility of giving pain relief under the doctrine of “double effect” — in fact, to carry out euthanasia. That is, they claim that, in practice, in giving pain-relief treatment, many doctors are acting with a primary intention of killing patients, not of relieving their pain. Often these claims are made on the basis of the large amount of pain-relief treatment given. But provided the dose (even if it is very large) is necessary to relieve the patient’s pain and given with the primary intention of doing so, that is not euthanasia. Where it is clear that these conditions are not fulfilled, it would be euthanasia.

There are serious harms in arguing that giving necessary pain relief is euthanasia: it could make doctors frightened to provide it. They must be reassured that they will not be legally liable; indeed, as the law is now developing, they are more likely to be liable for *not* doing so.

### **Withdrawal of life support versus euthanasia**

Euthanasia advocates also deliberately confuse withdrawal of life-support treatment with euthanasia. They argue there is no difference in either intention or causation between withdrawing life-support treatment when it results in the person’s death and giving that person a lethal injection. They say that in both cases the doctor kills the patient (ie, causes the patient’s death). This commonality of causation means they argue that, if we agree to respect refusals of life-support treatment, we must also agree with euthanasia. Moreover, they claim that, if there is no moral or ethical difference between refusals of treatment that result in death and euthanasia, there ought to be no legal difference.

Those who oppose euthanasia disagree. They argue that refusals of treatment are morally and ethically different from euthanasia and ought to remain legally different. There are long-established, well understood, profound and important differences between allowing people to die, when it is ethically and legally justified, and making them die (ie, putting them to death). Respecting people’s refusals of life-saving treatment belongs in the former category, euthanasia in the latter.

The right to refuse treatment flows from a right to inviolability — a right not to be touched, including by continuing treatment, without one’s consent — not from a right to die. There is therefore a right to have treatment withdrawn, which means that death will result from (ie, be caused by) the patient’s underlying illness, but there is no right to be killed. Causing a patient’s death through administering a lethal injection is different *in kind* from death resulting from refusal of treatment.

The same line of pro-euthanasia argument is also constructed through a confusion of means and ends. This argument is that when death is the inevitable outcome, the means used to achieve that — whether withdrawing life support or a lethal injection — are morally irrelevant and ought to be legally irrelevant. But the means through which we die matter morally and should continue to matter legally.

The issue is not *if* we die — we all die; it is *how* we die. Deep moral intuitions have long informed us that there are important distinctions between “letting nature take its course”, including by refusal of life-support treatment, and killing a dying person.

### **Death: purely private or societal impact?**

Advocates of euthanasia also argue that that how we die is just a private matter. Opponents of legalising euthanasia reject that argument. They believe each person’s death necessarily involves others, including healthcare professionals, and societal values and symbols. Moreover, if euthanasia is involved, how we die cannot be just a private matter of self-determination and personal beliefs, because euthanasia “is an act that requires two people to make it possible and a complicit society to make it acceptable.”<sup>3</sup>

### **Impact of legalising euthanasia**

Changing the norm that we must not kill each other would cause profound damage to society. There would also be serious damage to institutions — in particular, medicine and the law — that maintain respect for human life, especially in a secular, pluralistic society that no longer has a shared religion to carry such values.

### **Fundamental values**

Among the fundamental elements of the case against euthanasia is its contravention of the principle that to act with a primary intention of killing another person is inherently wrong (except in justified self-defence or defence of others). To legalise euthanasia would damage important, foundational societal values and symbols that uphold respect for human life. In fact, the prohibition on intentionally killing is the cornerstone of law and human relationships, emphasising our basic equality.<sup>4</sup>

To legalise euthanasia would be to change the way we understand ourselves, human life and its meaning.

And a more pragmatic, but nevertheless very important, objection is that abuse of legalised euthanasia cannot be prevented, as recent reports on euthanasia in the Netherlands have documented.<sup>5,6</sup>

In response, euthanasia advocates argue, in support of legalising it, that doctors are secretly carrying it out anyway. They claim to have found a high incidence of secret euthanasia by healthcare professionals, for example in Australia.<sup>7</sup> However, that study has recently been severely criticised on the grounds that the respondents replied to questions that did not distinguish between actions intended to shorten life — euthanasia — and other acts or omissions in which no such intention was present — pain-relief treatment or refusals of treatment — that are not euthanasia. Consequently, the researchers’ estimates of the number of cases of hidden euthanasia may be grossly exaggerated.<sup>8</sup> But, even if accurate, the fact that doctors are secretly carrying out euthanasia does not mean that it is right. (Further, if doctors were presently ignoring the law against

murder, why would they obey guidelines for voluntary euthanasia?)

### Lethal impact

What impact might legalising euthanasia have on society? In answering questions of impact we must not look at euthanasia just in relation to individuals or in isolation from the context in which it would operate: at a societal level, the combination of an ageing population, scarce healthcare resources and euthanasia would be a lethal one. And what impact might the consequent message — that suicide is an appropriate response to suffering — have on people who are suicidal?

What impact would legalising euthanasia have on the profession of medicine? Euthanasia “places the very soul of medicine on trial”.<sup>9</sup> Doctors’ absolute repugnance to killing people is necessary to maintaining people’s and society’s trust in them. This is true, in part, because doctors have opportunities to kill not open to other people, as the horrific story of Dr Harold Shipman, the UK physician-serial killer, shows. It would be very difficult to communicate to doctors a repugnance to killing in a context of legalised euthanasia. Harm to medicine also harms society. We need to protect the institution of medicine not just for its own sake, but also because it is a very important value-creating, value-carrying and values-consensus-forming institution, especially in a secular society.

How would legalising euthanasia affect medical education? What impact would physician role models carrying out euthanasia have on medical students and young physicians? Would we devote time to teaching students how to administer death through lethal injection? Would they be brutalised or ethically desensitised? (Do we adequately teach pain-relief treatment at present?)

### Last words

Physician-assisted suicide and euthanasia are simplistic, wrong and dangerous responses to the complex reality of human death. For physicians to give lethal injections to their patients or to assist them to commit suicide is inherently wrong from the perspective of principle-based or deontological ethics. But even on a utilitarian or situational ethics analysis, it is ethically wrong — the risks and harms outweigh the benefits.

Physician-assisted suicide and euthanasia involves taking people who are at their weakest and most vulnerable, who fear loss of control or isolation and abandonment — in a state of intense “pre-mortem loneliness”<sup>10</sup> — and placing them in a situation where they believe their only alternative is to kill themselves.

Nancy Crick, a 69-year-old Australian grandmother, was Dr Nitschke’s patient. Mrs Crick committed suicide in the presence of over 20 people, eight of whom were members of the Australian Voluntary Euthanasia Society. She explained: “I don’t want to die alone.” Another option for Mrs Crick should have been to die naturally with people who cared for her present. Was she offered that option?

Of people who requested assisted suicide under Oregon’s Death with Dignity Act, which allows physicians to prescribe lethal medication, 46% changed their minds after significant palliative-care interventions (relief of pain and other symptoms), but only 15% of those who did not receive such interventions did so.<sup>11</sup>

How a society treats its weakest, most in need, most vulnerable members best tests its moral and ethical tone. Thus, what doctors decide about euthanasia will play a very large part in determining Australia’s moral and ethical tone — far into the future.

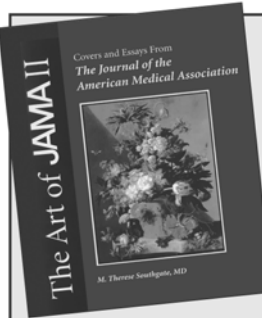
### Competing interests

None identified.

### References

1. Somerville M. Death talk: the case against euthanasia and physician-assisted suicide. Montreal: McGill Queen’s University Press, 2001: xiii.
2. Metherell M. Doctors cleared to ‘hasten death’. Euthanasia backers seize on AMA’s policy switch. *Sydney Morning Herald* 2002; May 27: 1.
3. Callahan D. When self-determination runs amok. *Hastings Center Report* 1992; 22(2): 52-55.
4. House of Lords. *Report of the Select Committee on Medical Ethics*. London: HMSO, 1994.
5. Foley K, Hendin H, editors. The case against assisted suicide: for the right to end-of-life care. Baltimore: The Johns Hopkins University Press, 2002.
6. Nuland SB. The principle of hope. *The New Republic OnLine* 2002; May 22.
7. Kuhse H, Singer P, Baume P, et al. End-of-life decisions in Australian medical practice. *Med J Aust* 1997; 166: 191-196.
8. Kissane DW. Deadly days in Darwin. In: Foley K, Hendin H, editors. The case against assisted suicide: for the right to end-of-life care. Baltimore: The Johns Hopkins University Press, 2002: 192-209.
9. Gaylin W, Kass L, Pellegrino ED, Siegler M. Doctors must not kill. *JAMA* 1988; 259: 2139-2140.
10. Katz J. The silent world of doctor and patient. New York: Free Press, 1984.
11. Foley K, Hendin H. The Oregon Experiment. In: Foley K, Hendin H, editors. The case against assisted suicide: for the right to end-of-life care. Baltimore: The Johns Hopkins University Press, 2002: 269.

(Received 8 Aug 2002, accepted 31 Oct 2002)



## The Art of JAMA II

For over 30 years now the covers of JAMA have displayed reproductions of fine art. Readers will now welcome the second volume in this series, **The Art of JAMA II**, a beautifully illustrated collection of full-page reproductions and instructive, inspiring commentaries by M. Therese Southgate, MD. **The Art of JAMA II** takes up where the first volume leaves off and continues the chronological sequence set up in the first volume, presenting covers selected from among the 150 that appeared in JAMA (the Journal of the American Medical Association) during 1988, 1989 and 1990. The paintings are diverse, presenting major genres and periods such as Impressionism and American primitive. Subjects range from portraits, landscapes and still lifes to abstracts.

**Only \$154.90\***  
Plus \$7.65 P&H  
includes GST

**For further information contact AMPCo: Ph 02 9562 6666  
Fax 02 9562 6662 • E-mail: sales@ampco.com.au**  
\*AMA Members receive a 10% discount (\$139.40)