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The State of Euthanasia — Great Britain, Australia and the United States

John P. Mullooly, M.D.

Doctor Mullooly, editor of Linacre, gave this talk at the 2nd International Conference on Bioethics in Verona, Italy in April, 1988.

Euthanasia, the active, direct termination of a person's life, in Great Britain, Australia and the United States is prohibited by law.

In Great Britain, there is no legislative drive to have this enacted into law, according to Dr. Ian Jessiman, former master of the Guild of Catholic Physicians. He is the chairman of the Catholic Physicians' Committee charged with monitoring parliamentary bills dealing with medical ethics.

I wrote to Prime Minister Margaret Thatcher and received the following. A quote from Britain's Department of Health and Social Security states: "There is no parliamentary legislation which sanctions euthanasia. Past Governments of both political parties have been resolutely against the concept of euthanasia and private members' bills on this subject have made little progress.

"Many people would find the suggestion that people might be 'hurried on their way' distasteful and dangerous particularly if the power to do so should find its way into the hands of those likely to benefit from a death. There are many vulnerable people around and one of the functions of the law, in circumstances like these, is to protect them."

While pro-euthanasia groups are still very active, Doctor Jessiman feels that the hospice movement, with its great successes and favorable publicity, has undermined any efforts by the pro-euthanasia lobby to have its agenda enacted into law.

In addition, the British Medical Association recently released a report by the Working Party of its association against legislation to legalize euthanasia. While this is not an official position of the British Medical Association in regard to euthanasia, it is the perception by the public that this is indeed the position of the B.M.A. Therefore, for the time being, at least, we can rest assured that the present law against mercy-killing or assisted suicide will remain intact in the United Kingdom.

Conclusions of BMA Report

The summary of the conclusions which follow the arguments set out by the body of the British Medical Association report are as follows:

1. Some patients see death as the fitting conclusion to the events of their life. These people may wish neither to hasten their death, not to deter it. For them, death is a mystery which they approach with tranquillity. There are limits to medical science and it is inappropriate for doctors to insist on intruding in these circumstances.

2. There is a distinction between an active intervention by a doctor to terminate life and a decision not to prolong life (a non-treatment decision). In both of these categories there are occasions on which a patient will ask for one of these courses of action to be taken and times when the patient could say, but does not. There are also occasions where the patient is incompetent to decide.

3. An active intervention by anybody to terminate another person's life should remain illegal. Neither doctors nor any other occupational group should be placed in a category which lessens their responsibility for their actions.

4. In clinical practice, there are many cases where it is right that a doctor should accede to a request not to prolong the life of a patient. Appropriate medical skills and techniques should be offered to patients when there is a good chance of providing an extension of life which will have the quality that the patient seeks.

5. Patient autonomy is a crucial aspect of informed patient care. This is achieved most successfully where a trusting and open relationship between the doctor and the patient allows participations in decisions about illness and its treatment. Doctors should regard patients as authorising treatment and should respect those authorisations and any decision to withdraw consent. But autonomy works both ways. Patients have the right to decline treatment, but do not have the right to demand treatment which the doctor, in conscience, cannot provide. An active intervention by a doctor to terminate a patient's life is just such a 'treatment'. Patients cannot and should not be able to *require* their doctors to collaborate in their death. If a patient does make such a request, there should be a presumption that the doctor will not agree.

6. More important than the debate about the limits of autonomy is the need for doctors and everyone else who is involved in the care of the terminally ill, to communicate with their dying patients. Doctors need to be able to elicit the fears of dying patients and to discuss and answer those fears. They need to be able to discuss terminal care openly so that patients can see that they will not be abandoned and left helpless in the face of terminal disease. Only if such communication and good treatment become the norm can society expect to dissipate the pressure to force doctors to do things the medical profession should not accept.

7. The killing of an individual who is certain to suffer severe pain,

and to be isolated from human warmth and compassion as they die, is held by some to be very similar to the situation of a terminally ill patient. In the hypothetical case of the person trapped in a hotel fire, there may appear to be no alternative to a decision to intervene actively to end the person's life. This applies equally to the actions of Army doctors in Burma in the Second World War. Today, however, terminal medical care is offered by individuals and groups dedicated to the relief of suffering and respect for the feelings and worth of the dying patient. These aims are achieved regularly and with considerable success. The two situations are not comparable.

8. Requests from young and severely disabled patients for a doctor's intervention to end their life present one of the hardest problems in day-to-day care. Counseling is essential to reaffirm the value of the person and to counter pressure which may be created by the feeling of being unloved and an embarrassment or inconvenience to those upon whom the patient is wholly dependent. The subtle and dynamic factors surrounding disability and the wish to die make any drastic change in the law unwise for this group of patients.

9. Any move toward liberalising the active termination of a severely malformed infant's life would herald a serious and incalculable change in the present ethos of medicine. Nevertheless, there are circumstances where the doctor may judge correctly that continuing to treat an infant is cruel and that the doctor should ease the baby's dying rather than prolonging it by the insensitive use of medical technology.

10. This kind of decision requires careful communication between doctor, parents, nursing staff and other care-givers. It is imperative that the doctor should start from a position which seeks to preserve and value life rather than, on occasion, to judge it as not worthwhile. It is important to stress that the withholding treatment does not preclude loving care for the dying infant. This will, of course, involve relieving the infant's distress.

11. An overwhelming majority of those who are rescued from serious suicide attempts do not repeat their attempts. This means that individuals who make such a decision about their own deaths do not always affirm this in the light of reflection. The techniques developed in the Netherlands mean that the opportunity for reflection is unlikely to be available to a person when a doctor acts to terminate their life.

12. Advance declarations of the type envisaged are not yet recognised as binding by English or, we believe, Scottish law. They may be a valuable guide to the wishes of a patient who can no longer participate in clinical decisions but should not be regarded as immutably or legally binding prescriptions for medical care. They require respectful attention and sensitive interpretation.

13. The law's deep-seated adherence to intent rather than consequence alone is an important reference point in the moral assessment of any action. A decision to withdraw treatment which has become a burden and is no longer of continuing benefit to a patient, has a different intent to one

which involves ending the life of a person. We accept drug treatment which may involve a risk to the patient's life if the sole intention is to relieve illness, pain, distress or suffering.

14. Any doctor, compelled by conscience to intervene to end a person's life, will do so prepared to face the closest scrutiny of this action that the law may wish to make.

15. The law should not be changed and the deliberate taking of a human life should remain a crime. This rejection of a change in the law to permit doctors to intervene to end a person's life is not just a subordination of individual well-being to social policy. It is, instead, an affirmation of the supreme value of the individual, no matter how worthless and helpless that individual may feel.

No Legislation in U.S.

In regard to the United States there is no legislation for legalizing active euthanasia. A referendum for this failed in California for lack of signatures. The euthanasia lobby has stated that it will introduce legislation in 1990 in Oregon, Florida and several other states.

While the American Medical Association and the World Health Organization are on record as being opposed to active euthanasia, the pressure for this is increasing in the United States. It is being actively discussed in some ethical and medical journals and the media are promoting it to some extent, citing the experience in the Netherlands. Hopefully we will succeed in our efforts to combat these attempts by the euthanasia lobby.

Turning to Australia, the focus of the euthanasia debate occurred in Victoria where the Victorian Parliament's social development committee studied this problem. The "right to die" legislation was introduced into the legislature after a successful public opinion survey was completed, encouraging such a right. This survey was conducted by the pro-euthanasia lobby. After an extensive inquiry by the Social Development Committee, the following recommendations were made to Parliament, which recommendations were later enacted into law by the Victorian Parliament.

Recommendations of the Report of the Inquiry into Options for Dying with Dignity of the Victorian Parliament's Social Development Committee:

The committee recommends:

1. That it is neither desirable nor practicable for any legislative action to be taken establishing a right to die.

2. That legislative action clarifying and protecting the existing common law right to refuse medical treatment is desirable and practicable and should be brought about by the enactment of legislation to establish an offence of medical trespass.

3. That medical trespass be defined as occurring when a medical practitioner carries out or continues with any procedure or treatment where a competent patient freely and informedly refuses the procedure or treatment.

4. That the legislation also encompasses protection from criminal and civil liability on the part of a medical practitioner who acts in good faith and in accordance with the express wishes of the fully informed, competent patient who refuses medical treatment or procedures.

5. That the non-application of medical treatment does not in itself constitute the cause of death, where a medical practitioner is acting in good faith to avoid committing the offence of medical trespass.

Passage of Medical Treatment Act

The passage through the Victorian Parliament of the Medical Treatment Act of 1988 caused widespread interest and debate within the community. As mentioned, the legislation arose from the inquiry by the Parliament's Social Development Committee (SDC) into options for dying with dignity. The committee concluded that it was neither desirable nor practical for any legislative action to be taken establishing a right to die, but recommended the introduction of the offense of medical trespass.

Medical trespass is unique terminology of Australians for a principle with which we are all familiar, viz., a patient must give his or her consent to any medical procedure and physicians cannot treat a patient without his or her consent. The ramifications of this new act are spelled out in the act itself and are, according to some, entirely consistent with the traditional moral norms of the Judeo-Christian medical ethic.

The Medical Practice Act rejects legalizing voluntary homicide for the terminally ill. The fundamental needs of the dying are met when adequate measures for the relief of distressing symptoms are available to them and they know they are supported, valued and respected. The Act ensures the traditional faith and trust of the patient for the physician and buttresses this relationship, rather than undermines it. In passing this new legislation, Parliament clearly saw that in viewing the hospice experience, it was incumbent on them to ensure that good management for the relief of distressing symptoms should be provided along with adequate care and emotional support. In implementing this new legislation, the emotional argument for active euthanasia evaporates. The new act provides for education of patients, doctors, nurses and health care institutions in their rights and duties in regard to palliative care and the care of the terminally ill.

The SDC committee discovered a great deal of misinformation and misunderstanding of sound medical-moral principles, not only among the public, but also among health care personnel and health institutions. In a recent article in the *Australian Medical Journal*, (August, 1988), Dr. Brian J. Pollard acknowledged this and called for the medical profession to get

behind this educational effort.

Reactions to the new Medical Treatment Act of 1988 have been vigorous, especially among the right to life lobby and concerned knowledgeable physicians. These physicians have articulated their concerns in the following statement:

Summary

The Medical Treatment Act of 1988 is about the management of patients. Therefore medical practitioners have a profound interest in the act particularly in relation to its clinical and social consequences.

The act is imperfect and imprecise. It fails to appreciate the many issues involved in medical treatment decisions and places at risk the frail, the handicapped, the elderly and the socially disadvantaged.

It facilitates suicide and opens the way to possible homicide. It will impose emotional pressures on patients who may perceive an obligation to refuse reasonable treatment which would provide significant benefit to them.

It will create problems concerning the competency of patients and will create difficulties in the determination of what constitutes treatment.

It is likely to promote the establishment of undesirable and unjust social values and norms and to erode the ethical principles that determine the quality of medical practice.

We strongly urge wider consultation and public discussion before the act is proclaimed and before amendments are debated concerning incompetent patients.

In summary, it is clear that all efforts to legislate medical practice are fraught with difficulties. In my own mind, it is the supreme duty of the physician to act out in his relationship with his patient, his Hippocratic ethos to do no harm, and to look upon himself as the healer. This role which he takes upon himself requires character, integrity, respect for the patient, personal virtue and purity of mind and heart, always looking toward the ultimate good of those who are in his care. He will keep their best interests uppermost in his mind and treat them as he would wish to be treated. He will relieve them of their suffering and pain, treat them compassionately and when nothing more can be done, be with them until they enter into communion with God Who created them.
