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# Euthanasia: Human Rights and Inalienability

by

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## 1. Introduction

The point of departure for this paper is the universal commitment to fundamental human values expressed in our own time as human rights. In the aftermath of the Second World War the nations of the world determined that flagrant abuses of human rights would never be tolerated again, and that nation states must have regard to fundamental human rights in the enunciation of public policy.

Notwithstanding that determination, abuses of human rights go on and, in the case of bioethics, are commonly promoted. One such area is euthanasia. It will be argued in this paper that the State cannot allow or tolerate euthanasia because it violates international law, and constitutes a threat to the social contract whereby the ruler is bound to secure the right to life of the citizenry.

## 2. Human Rights

### 2.1 *The Right to Life*

In any discussion on human rights, full account has to be taken of the provisions of the U.N. Charter, and the *Universal Declaration of Human Rights* which seeks to specify Article 55 of the U.N. Charter. Article 55 commits the United Nations to "promote respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion."<sup>1</sup>

The *Universal Declaration of Human Rights* is founded upon the notion that there are human values and that these values are inherent in the human individual. In the *Preamble* the Declaration states that "the foundation of freedom, justice and peace in the world" is the "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family".

As far as the Declaration is concerned there are human values *inherent* in all members of the human family because of their "inherent dignity". Since "dignity" is about true worth or excellence ["dignus" L. means worthy], and, in the context, human worth, then the claim for the dignity of human beings is a claim for basic human values.

Further, the *Preamble* links human dignity, human values with human rights which are described as "inalienable rights", rights of which we may not be deprived and cannot deprive ourselves. I must not be sold into slavery and I am to be restrained from selling myself into slavery.

These human rights which reflect human values must, says the *Preamble*, "be protected by the rule of law" otherwise humankind may be driven, "as a last resort, to rebellion against tyranny and oppression". This protection of the rule of law is necessary not only for human beings to live together peaceably within the State, but also so that nations may live together in peace.

The *Universal Declaration of Human Rights* presents itself to the world as "a common standard of achievement for all peoples and all nations" and as a guide for every structure in society and for every individual in order that the rights identified in the Declaration may have "their universal and effective recognition and observance" secured.

In Article 1 the Declaration asserts certain things about human beings which affect the understanding of the rest of the document. Human beings, it says, "are born free and equal in dignity and rights". This value of equality of human beings, this injunction not to show preference between individuals in the recognition of "the rights and freedoms set forth in this Declaration" is further specified in Article 2. In particular, in the entitlement to the rights and freedoms in the Declaration there is to be no distinction of any kind, "such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

In this way the Declaration excludes discrimination against the elderly and the very young, the physically and mentally disabled and the chronically ill. All have equal claim to the rights and freedoms enunciated in the Declaration.

In Article 3 the Declaration begins the articulation of the human values to be defended in terms of human rights. "Everyone has the right to life, liberty and the security of person." Thus is human life held to be both inviolable and inalienable. The Declaration does not begin with hard cases or exceptions, but with the general proposition which concerns the value of human life. It is also interesting to note the order of the rights articulated - life first, then freedom [liberty], and then security of person. Unless the right to life can be guaranteed by the State then there is no meaningful right to freedom or to security of person. The right to life is logically prior to considerations of the quality of the individual's life.

## 2.2 *Human Rights and International Law*

The member nations of the United Nations are committed to the promotion of "universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion"<sup>2</sup> by way of a pledge.

All members pledge themselves to take joint and separate action in cooperation with the Organisation for the achievement of the purposes set forth in Article 55.<sup>3</sup>

What we have here is the idea of a *consensus gentium*, an agreement among the nations, a consent to be bound by certain values expressed as human rights. This doctrine of consent involves the idea that the "basis of obligation of all international law, and not merely of treaties, is the consent of States."<sup>4</sup>

Legal positivism, the dominant theory of the early part of the twentieth century, "combined with a strict application of the doctrine of national sovereignty . . . effectively excluded the possibility of judging, and therefore criticizing, the treatment of any people by its own government." Paul Sieghart has observed that the apotheosis and consequent downfall of that position "came in National Socialist Germany" when that regime perpetrated "historically unprecedented atrocities".

According to the strict doctrine of national sovereignty, any foreign criticism of those laws was therefore formally illegitimate; according to the strict positivist position, it was also meaningless. And precisely the same position could be, and was, taken in relation to the atrocities perpetrated at much the same time upon some millions of its citizens by the régime then legitimately in power in the USSR.<sup>5</sup>

As far as the *ius gentium* is concerned, Bruno Simma and Philip Alston understand human rights in terms of international law by "treating the Universal Declaration and the body of soft law built upon it as an *authoritative interpretation* of the obligation contained in Articles 55 and 56 of the U.N. Charter."<sup>6</sup> In these articles the members of the United Nations "pledge themselves to take joint and separate action in cooperation with the Organization" in order to achieve "universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language or religion". Importantly, they also refer to Article 38 of the Statute of the International Court which gives as a basis for unwritten international law "the *general principles of law* recognised by civilised nations".<sup>7</sup> Both of these ways of grounding "substantive obligations to respect human rights in positive international law" are commended by Simma and Alston as "more acceptable under the premises of consensual international law-making."<sup>8</sup>

Who, then, is bound by the *ius gentium*? N.A. Maryan Green holds, in company with many others, that the subjects of international law are (1) states, (2) international organisations, (3) certain special entities such as the Vatican, (4) special individuals such as diplomats, aliens, refugees, slaves, minorities, and (5) persons, corporations and governments with respect to human rights.<sup>9</sup> Individuals are bound by the *ius gentium* in so far as human rights are at issue.<sup>10</sup>

In his discussion of the development of international law D. J. Harris observes that the "demise of Oppenheim's doctrine that 'States solely and exclusively are the subject of International Law' is also evident . . . it is . . . the case that inter-state treaties are increasingly concerned with the 'trans-national' affairs . . . of private individuals and companies."<sup>11</sup> Harris, in a later discussion of the activities of the UN Commission on Human Rights, draws attention to the fact that "the idea that the treatment of a state's own nationals is a matter within its own jurisdiction has

been abandoned.”

The practice of the Commission shows clearly the acceptance by states, as they respond without question to allegations against them, that *the protection of human rights is now within the domain of international law.*<sup>12</sup> [my emphasis]

One may take the view, following John Humphrey or Oscar Schachter that, because of a *consensus gentium* relating to the actual behaviour of nations, the Universal Declaration has become part of the customary law of nations. Or, one may accept the alternative views of Simma and Alston, put slightly differently by Ivan Shearer, that the *consensus gentium* refers to

a widespread conviction that certain principles of conduct are binding in law - or at least in morality - without the necessity of applying the usual proofs of customary law; indeed, that even widespread evidence of non-observance of these norms will not invalidate them. It is in this way, for example, that one would argue that genocide and torture are contrary to international law.<sup>13</sup>

The *consensus gentium* on human rights has now gathered the force of international law, despite the fact that “there are no legally binding sanctions available.”<sup>14</sup>

The Universal Declaration is, then, something which is morally and legally binding in the sense that member states assent to it by virtue of their membership of the United Nations and in the sense that it embodies human values expressed as human rights on which civilised people are agreed. And by the end of 1998 there were 159 member states of the United Nations representing a total estimated population of 5,040,770,000.<sup>15</sup> The world population in 1988 was estimated to be 5,130 million.<sup>16</sup> This means that about 97% of the world belonged to nations that were member states of the United Nations and were thereby committed to the U.N. Charter and to the Universal Declaration of Human Rights. Indeed, even those states which are not members of the United Nations are bound to observe human rights because human rights now form part of the *ius gentium*.

*The evidence, then, for a consensus gentium* on human values is evident not just in terms of the current overwhelming human agreement on human rights, but also in terms of the consistent support for these values throughout human history in every culture. That governments and individuals have not always behaved consistently with those values is obvious. But the human agreement on human values represents the opportunity to adjust practice to principle.

### 2.3 Human Rights and Inalienability

As I have already observed, fundamental rights are inalienable as well as inviolable. These are rights of which I may not be deprived and of which I may not deprive myself. To deprive myself of these rights threatens the rights of others. Thus the State cannot allow the slave trade even if individuals for very compassionate reasons decide, quite voluntarily, to sell themselves into the slave trade.<sup>17</sup>

Contemporary human rights discourse has, as its origin,<sup>18</sup> the modern doctrine of natural law inaugurated by Thomas Hobbes riding on the back of Machiavelli's realism about the way human beings actually behave. Hobbes, like Machiavelli before him, rejected the Aristotelianism of the Schoolmen as

building castles in the air. But Machiavelli's substitution of political virtue for moral virtue created difficulties as did his admiration for "the lupine policies of republican Rome". Hobbes attempted to restore the moral principles of politics, the natural law, "on the plane of Machiavelli's 'realism.'"<sup>19</sup>

Human beings, said Hobbes, act in a self-interested manner and are inclined to "a perpetual and restless desire of power after power, that ceaseth only in death."<sup>20</sup> Traditional philosophy had failed to deal with scepticism. Hobbes believed that the only way to come to terms with the truth contained in a scepticism which persisted despite all attempts by dogmatism to overcome it, was to give full range to scepticism. Whatever "survives the onslaught of extreme scepticism is the absolutely safe basis of wisdom."<sup>21</sup> The only fact about human existence that survived the full blast of scepticism was the impulse to self-preservation.<sup>22</sup> From this fact Hobbes deduced the natural right to live, the right of individuals to use their own power for their self-preservation. The law of nature

... is a precept or general rule, found out by reason, by which a man is forbidden to do that, which is destructive of his life, or taketh away the means of preserving the same; and to omit that, by which he thinketh it may be best preserved.<sup>23</sup>

Thus the notion of inalienability finds its origins as far as modern human rights discourse is concerned in the modern doctrine of natural law as proposed by Hobbes. In its fullest formulation it is a recognition that the right to life is as fundamental to the social contract as the right to liberty, and that any exceptions to the laws against the intentional killing of the innocent, even when a competent adult asks for it, threatens the right to life of other citizens. Just as the State cannot condone a citizen alienating his or her right to freedom because this would legitimate the slave trade into which others far less willingly would be drawn, so the State cannot license any citizens to kill other innocent citizens, even at their own request, because this would lead to the killings of others who did not ask to be killed. Is there any empirical evidence to suggest the truth or otherwise of Hobbes's philosophical insight? There is. It may be found in the practise of euthanasia in The Netherlands, and in a recent survey of the practice of physicians and nurses in the State of South Australia.

### 3. The Evidence

#### 3.1 *The Netherlands*

The recently published Rimmelink reports contain overwhelming evidence that, in a country in which voluntary euthanasia is legally tolerated, at least as many if not more patients are killed without their knowledge and consent by the medical profession.

*The Lancet Dutch Report* indicates that about 0.8% of the 38.0% of all deaths involving MDEL were "life-terminating acts without explicit and persistent request".<sup>24</sup> The need for the request to come from the patient, for it to be well-considered, durable and persistent, as well as a free and voluntary request forms part of the strict medical guidelines laid down by the Dutch courts and summarised by Mrs. Borst-Eilers, Vice-President of the Dutch Health Council.<sup>25</sup> This means that *The Lancet Dutch Report* acknowledges the deaths of about 1,000

Dutch citizens in a single year which were the result of the doctor hastening the death of the patient, without the patient's explicit request and consent. *The Lancet Dutch Report* summarises it in this way:

Sometimes the death of a patient was hastened without his or her explicit and persistent request. These patients were close to death and were suffering grievously. In more than half such cases the decision had been discussed with the patient or the patient had previously stated that he would want such a way of proceeding under certain circumstances. Also, when the decision was not discussed with the patients, almost all of them were incompetent.<sup>26</sup>

In the light of the fact that Dutch doctors do not always tell the truth in these matters<sup>27</sup>, that some 1,000 patients are killed outside of the 'strict medical guidelines', the lack of concern by the authors of the *The Lancet Dutch Report* is noteworthy. Ten Have and Welie have suggested that the Rummelink Committee's interpretation of the facts "reveals a political bias".

The committee clearly tried to remove any societal anxieties about the practice of euthanasia. Similar practices are brought under dissimilar headings to keep the numbers low. And at crucial places, particularly with the 1,000 non-voluntary cases, the committee uses fallacious rhetoric to emphasize that there is nothing to worry about.<sup>28</sup>

There are two other matters which also give cause for concern.

Firstly, the definition of euthanasia used in the report is a very narrow one: "active termination of life upon the patient's request". This definition does not include those who die of non-voluntary euthanasia, and so does not include the 1,000 patients to which I have already referred. Nor does it refer to those whose death is intentionally brought about by 'omission', by either withdrawing treatment or refusing to initiate treatment. As John Keown recently pointed out: "If a doctor's intent is to kill his patient, it morally matters not whether he does so by (say) giving him poisoned food or by starving him."<sup>29</sup> Far from understanding that the matter of intention is fundamental both in law and morals to an understanding of the blameworthiness of a person's act or omission, the authors of the Rummelink Report go so far as to suggest, somewhat petulantly, that both the present writer and Brian Pollard "must have missed at least two decades of ethical debate" because each of us included under the general rubric of "euthanasia" (voluntary, non-voluntary, and involuntary) the 5,800 cases<sup>30</sup> of non-treatment decisions "in which the patient explicitly requested to withhold or withdraw a treatment."<sup>31</sup> What van Delden, et al, do not say is that each of us included those cases precisely because they were done either with an explicit or implicit *intention* to accelerate the end of life.

Without an understanding of *intention* it is almost impossible to distinguish, morally and legally, theft from borrowing, theft from a prank, murder from accidental killing. Two acts which look the same such as stealing a pencil from another person and borrowing a pencil may be distinguished by intention. Theft involves an *intention* to permanently deprive. Having no articulated moral theory upon which to proceed, and having no doctrine of intention to help sort out morally acceptable acts or omissions from morally unacceptable acts or omissions, van Delden, et al, then suggest that if Fleming and Pollard want to be consistent

“they would have to accept any NTD (non-treatment decision), even those to which the patient is opposed, as long as the doctor does not think about hastening the end of life of the patient.”<sup>32</sup> Well, the doctor can think anything he likes including thinking about Mozart. That is not morally relevant. What is morally relevant is whether in removing or not starting treatment he intends to kill his patient, or whether his non-treatment decision is based upon his best clinical judgement that that treatment would either be futile or burdensome disproportionate to benefit. In cases where it is the patient who wishes no further treatment then, at least in Australian law, the doctor cannot proceed to treat. This is true even when such a refusal is thought to be suicidal. Even here in many jurisdictions in the world there is legal room for a doctor or private citizen to ‘rescue’ someone about to commit suicide. And since in many instances the call to be killed reflects a patient in physical pain or suffering from depression, there is ample room for the depression or physical pain to be treated bringing forth a different attitude in the patient.

This is not to suggest a “treat at all costs” mentality, or a domination of the physician over the patient. Far from it. It is to suggest that treatment can be foregone or discontinued in a morally sound way when such a refusal carries with it no intention to kill. One may foresee that one’s death is near. One may even welcome one’s own death. That, however, is not the same thing as wanting to be killed. And if a doctor believes that the patient’s lawful refusal of treatment is in fact suicidal, and he does not want in any way to cooperate with suicidal omissions, he may retire from the case and allow another physician to be appointed.

Moreover, van Delden, et al, simply confuse motive with intention.

No physician who performs euthanasia does so with the sole intent to kill his or her patient. His or her intention can always be described as trying to relieve the sufferings of his or her patient. This is exactly what infuriates Dutch physicians when, after reporting the case they are treated as criminals and murderers.<sup>33</sup>

They appear not to understand that the doctor’s motive in killing the patient to relieve pain may be a very understandable and laudable motive. It doesn’t change the fact that, *motivated* by a desire to relieve the patient’s suffering, the particular act or omission chosen is chosen because the doctor *intends* to kill the patient and is therefore committing a homicide. Since the R Emmelink Report provides evidence that in over 10,558 cases it had been the doctor’s *explicit intention to shorten life*, then not surprisingly many people do evaluate what has happened as murder even if such an evaluation infuriates those who commit the murders.

If reference is then made to the two Dutch reports upon which *The Lancet Dutch Report* is based, then a very disturbing picture emerges. The number of physician assisted deaths estimated by the R Emmelink Committee Report<sup>34</sup> is 25,306, all of which involve intentional (sometimes implicit, sometimes explicit) killing by act or by neglect, some voluntary and others non-voluntary. They are made up of:

2,300 euthanasia on request<sup>35</sup>

400 assisted suicide<sup>36</sup>

1,000 life-ending treatment without explicit request<sup>37</sup>



4,756 patients died after request for non-treatment or the cessation of treatment with the intention to accelerate the end of life<sup>38</sup>

8,750 cases in which life-prolonging treatment was withdrawn or withheld without the request of the patient either with the implicit intention (4,750) or with the explicit intention (4,000) to terminate life<sup>39</sup>

8,100 cases of morphine overdose with the implicit intention (6,750) or with the explicit intention (1,350) to terminate life.<sup>40</sup> Of these 61% were carried out without consultation with the patient, i.e. non-voluntary euthanasia.<sup>41</sup>

This total of 25,306 deaths amounted to 19.61 per cent of total deaths [129,000] in The Netherlands in 1990. A large proportion of them involve intentional (either implicitly or explicitly) killing by act or by neglect, i.e., euthanasia.

To this should be added the unspecified numbers of handicapped newborns, sick children, psychiatric patients, and patients with AIDS, whose lives were terminated by physicians, according to the *Remmelink Report*.<sup>42</sup> The narrow definition of euthanasia masks the real number of individuals whose lives are ended by interventions from the medical profession, and also masks the fact that more people are killed by physicians without their consent than with their consent.<sup>43</sup>

This situation is clear if we take only those cases from the Dutch evidence where the doctors were "acting with the explicit purpose of hastening the end of life."<sup>44</sup> This explicit intention or purpose is explained as follows: "If a physician administers a drug, withdraws a treatment or withholds one with the explicit purpose of hastening the end of life, then the intended outcome of that action is the end of the life of the patient."<sup>45</sup>

In short, 'explicit' intent is synonymous with the natural (and legal) meaning of 'intent', as purpose, goal or aim.<sup>46</sup>

Now the Dutch evidence shows us that in 1990 there were 10,558 cases where there was an "explicit" intention to hasten the end of life by act or by omission. As John Keown has put it:

This total comprises the 2,300 cases classified as 'euthanasia' in the survey; the 400 cases classified as 'assisted suicide' in the survey' 1,000 cases of administering drugs 'with the explicit purpose of hastening the end of life' without explicit request; 1,350 cases of the administration of opioids 'with the explicit purpose of shortening life'; 4,000 cases of withholding or withdrawing treatment, without explicit request, 'with the explicit purpose of shortening life'; and 1,508 cases of withdrawing or withholding treatment on explicit request, 'with the explicit purpose of shortening life'.<sup>47</sup>

Simple mathematics shows that of the 10,558 cases where there was an "explicit" intention to hasten the end of life by act or by omission, 55% were non-voluntary. This justifies the conclusion that it is impossible to quarantine non-voluntary euthanasia from voluntary euthanasia, that where voluntary euthanasia is practised more are killed without their consent than with their consent. That voluntary euthanasia inevitably leads to non-voluntary euthanasia has now been accepted by the authors of the Remmelink study:

But is it not true that once one accepts [voluntary] euthanasia and assisted suicide, the principle of universalizability forces one to accept termination of life without explicit request, at least in some circumstances, as well? *In our view the answer to this question must be affirmative.*<sup>48</sup> (my emphasis)

Secondly, *The Lancet Dutch Report* blandly observes:

Many physicians who had practised euthanasia mentioned that they would be most reluctant to do so again, thus refuting the 'slippery slope' argument.<sup>49</sup>

This begs the question as to why such physicians "would be most reluctant" to practise euthanasia again. Is it that they feel they have done something very wrong? Was it, all things considered, an unpleasant experience, and, if so, in what way? It further begs the question as to how the "slippery slope argument" is refuted. To be "most reluctant" to do so again doesn't mean that one will not do it again. And in the light of the actual information in the *Dutch Euthanasia Survey Report*, on which *The Lancet Dutch Report* is based, there is ample evidence of the slipperiest of slopes,<sup>50</sup> thereby giving support to Thomas Hobbes' observation that to voluntarily agree to be killed threatens the right to life of other members of the community as well. The "slippery slope" is between voluntary and non-voluntary forms of euthanasia. Proponents of euthanasia talk about only wanting *voluntary* euthanasia. The truth is, that once voluntary euthanasia is practised, non-voluntary and involuntary forms of euthanasia are bound to follow as Paul van der Mass et al have now conceded.<sup>51</sup>

The *Rommelink Report*, in the context of dealing with the nature of medical decisions at the end of life,<sup>52</sup> does not effectively deal with the questions of palliative care<sup>53</sup>, patient depression, patient fears, and subtle and not too subtle pressure brought to bear on patients to end it all now, rather than to continue being a burden on others. The *Rommelink Report* fails to give reasons why patients who were close to death "were suffering grievously",<sup>54</sup> and why a wealthy country like The Netherlands does not offer patients effective means to relieve that suffering. "Good care is not cheap; it is much cheaper to kill people."<sup>55</sup>

Alexander Morgan Capron<sup>56</sup> attended a meeting at the Institute for Bioethics, Maastricht, The Netherlands, in December 1990, which brought together, by invitation, 14 experts to examine the practice of euthanasia in The Netherlands. Capron considered the two basic requirements for the justification of euthanasia in The Netherlands, self-determination and the relief of suffering.

Proponents of euthanasia began with a "narrow" definition (limited to voluntary cases) as a strategy for winning acceptance of the general practice, which would then turn to the second factor, *relief of suffering*, as its justification in cases *in which patients are unable to request euthanasia.*<sup>57</sup> [my emphasis]

Capron went on to cite the evidence of one of the Dutch participants, a physician, who "mentioned that in perhaps thirty cases a year, patients' lives were ended after they had been placed in a coma through the administration of morphia."

When asked about the apparent discrepancy, she replied that the latter cases were not

instances of euthanasia *because they weren't voluntary*: discussing the plan to end the patients' lives would be "rude," she said, particularly as they know they have an incurable condition. Comments from several other physicians made clear that this practice is neither limited to one particular hospital nor of recent vintage. Nevertheless, a number of the Dutch participants were plainly discomfited to find that at least in some situations the number of instances of physicians causing death without consent overshadowed the number that met the Dutch definition of "euthanasia."<sup>58</sup>

In a recently completed research project carried out in The Netherlands, John Keown argues that the "guidelines" for euthanasia in The Netherlands are not strict or precisely defined, and that there is no "satisfactory procedure, such as an effective independent check on the doctor's decision-making, to ensure that they are met".<sup>59</sup> Keown doubts that the requirement that the request for euthanasia be "entirely free and voluntary" is met. "Although the K.N.M.G. Guidelines state that the request must not be the result of pressure by others, they do not prevent the doctor or nurse from either mentioning euthanasia to the patient as an option or even strongly recommending it."<sup>60</sup>

Having developed his case that the guidelines are not strictly enforced Keown goes on to remark that the "overwhelming majority of cases are falsely certified as death by natural causes and are never reported and investigated . . . a doctor who has acted in breach of the law is no more likely to admit having done so in his report than a tax evader is likely to reveal his dishonesty on his tax return."<sup>61</sup> The fact that the "vast majority of deaths from euthanasia are illegally and incorrectly reported as natural deaths itself casts doubt on the lawfulness of much of the euthanasia which is being carried out."<sup>62</sup>

Brian Pollard makes similar observations to Keown. He also refers to this statement by the Advocate General of The Netherlands: "The medical profession is in all likelihood the only academically trained group of professionals, who by virtue of their profession, are guilty of making false statements in writing with great regularity when, after a euthanasia procedure, they make inaccurate death declarations which conceal the unnatural death cause."<sup>63</sup>

### 3.2 South Australia

In a recently published report of a sociological survey of the attitudes and practices of medical practitioners and nurses in South Australia<sup>64</sup>, Christine Stevens and Riaz Hassan found that 19% of medical practitioners and nurses had ever taken active steps to bring about the death of a patient.<sup>65</sup> Their most striking discovery, however, was that 49% of them had ever received a request from a patient to take such active steps<sup>66</sup>. That is, in a jurisdiction in which euthanasia in any form is legally prohibited, 19% of the medical profession agreed that they had been involved in euthanasia, but half of those 19% had done so without reference to the patient. Again, one wonders why proponents of voluntary euthanasia imagine that law-breaking doctors will suddenly become law-abiding if voluntary euthanasia is legalized. If a group of medical practitioners (a minority) will break the law now, it would be naive to imagine that they and others will not break a voluntary euthanasia law and kill those they consider ought to have the benefit of euthanasia if only they were competent enough to ask for it.

Dr. Stevens recently revealed on radio and in private correspondence that at the time when she conducted the study she was not in favour of euthanasia as some had imagined, nor was she opposed. "I was entirely neutral and impartial in my views, neither in favour nor opposed, until completion of the analysis of the survey results."<sup>67</sup> She formed views opposed to legalized voluntary euthanasia because of her finding of views "albeit minority ones, that poor quality of life, mental disability and physical handicap should be valid circumstances for active euthanasia, whether this was requested or not."<sup>68</sup>

Advocates of euthanasia often argue in its favour from the perspective of individual rights, autonomy and dignity, but the research demonstrates that these very principles are abused by its practice. There is a danger that legislation of active euthanasia, voluntary or involuntary, may expand the potential for further abuses. Further, I consider legalisation could undermine the value placed on human life, and erode our sense of security. We need to ensure that the state continues to protect people.<sup>69</sup>

#### 4. Conclusion

It is not possible to quarantine voluntary euthanasia from non-voluntary euthanasia. The belief that the killings of some innocent human beings leads to the killings of many others is justified by the evidence. In any case the bioethical literature is replete with examples of bioethicists and philosophers who urge the decriminalization of not only voluntary euthanasia but also infanticide and other acts of non-voluntary killings of certain classes of human beings. The ultimate justification for the non-voluntary killings of some human beings is that they are not persons. However, the Universal Declaration on Human Rights forbids the dividing up of the human family into persons and non-persons (*vid* Article 6), and presents the right to life and certain other rights as inviolable and inalienable. The provision of legal euthanasia represents a violation of international law and exposes the citizenry in general to an unreasonable risk to their right to life.

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10. *Ibid.*, 114-125
11. D. J. Harris, *Cases and Materials on International Law*, (London: Sweet & Maxwell), 18
12. *Ibid*, 604
13. Private correspondence, January 4, 1993. Professor Shearer is the Professor of International Law at Sydney University, New South Wales, Australia
14. D. J. Harris, *op. cit.*, 604
15. *Monthly Bulletin of Statistics, Statistical Office, United Nations*, vol. XLIV, No. 2, February 1990

16. Ibid.

17. Cf Daniel Callahan's response to John Lachs in which he notes the inconsistency of Lachs having no difficulty in rejecting in principle either voluntary or involuntary slavery from a perspective of social protection, yet unable to see that euthanasia is socially harmful too. Daniel Callahan, "Ad Hominem Run Amok: A Response to John Lachs", *Journal of Clinical Ethics*, 5:1, Spring 1994, 13-15

18. In 1215 the English barons extracted the Magna Carta from King John. Perhaps the most notable feature of the Magna Carta was the right not to have a punishment imposed without due process of law. That right, however, only applied to "free men".

19. Leo Strauss, *Natural Right and History*, (Chicago: University of Chicago Press, 1953), 179

20. Thomas Hobbes, *Leviathan, or the Matter, Forme and Power of a Commonwealth Ecclesiasticall and Civil*, edited by M. Oakshott, (Oxford: Blackwell, 1960), 64

21. Leo Strauss, op. cit., 171

22. In this matter Hobbes followed the scepticism of Justus Lipsius and Michel de Montaigne who both "condemned public spiritedness and patriotism, for such feelings exposed their possessor to great danger", a conclusion which Hobbes did not endorse, of Richard Tuck, *Hobbes*, (Oxford: Oxford University Press, 1989), 6-11.

23. Thomas Hobbes, op. cit., 84

24. Paul J. van der Maas, Johannes, J.M. van Delden, Loes Pijnenborg, and Caspar W.N. Looman, "Euthanasia and other medical decisions concerning the end of life", *The Lancet*, 338:8768, September 14, 1991, 670

25. Else Borst-Eilers, "The Status of Physician-Administered Active Euthanasia in The Netherlands", (Unpublished paper delivered at the Second International Conference on Health Law and Ethics, London, July 1989), and cited in John Keown, I.J. Keown, "The Law and Practice of Euthanasia in The Netherlands", in *The Law Quarterly Review*, 108, January 1992, 7-8

26. Paul J. van der Maas, et al, op. cit, 673

27. Paul J. van der Maas et al, 669. Here the *Lancet Dutch Report* acknowledges that "in cases of euthanasia the physician often declares that the patient died a natural death."

28. Henk A.M.J. ten Have and Jos V.M. Welie, "Euthanasia: Normal Medical Practice?" in *Hastings Center Report*, 22:2, March-April 1992, 36

29. John Keown, "'Dances with Data': A Riposte", *Bioethics Research Notes*, vol 6 no 1, 1994,1

30. Actually, I didn't. I included only 82% of the 5,800 cases, ie 4,756 because only 82% of these patients in fact died. Cf John I Fleming, "Euthanasia, The Netherlands, and Slippery Slopes", *Bioethics Research Notes Occasional Paper No. 1*, June 1992, footnote 35.

31. Johannes JM van Delden, Loes Pijnenborg, and Paul J van der Maas, "Dances with Data", *Bioethics*, vol 7, no 4, July 1993, 326 and see footnote 7.

32. Johannes JM van Delden et al, loc. cit.

33. Johannes JM van Delden et al loc. cit. 325

34. *Medische Beslissingen Rond Het Levenseinde* - Het onderzoek voor de Commissie Onderzoek Medische Praktijk inzake Euthanasie, (The Hague, The Netherlands: Sdu Uitgeverij, 1991) [*Dutch Euthanasia Survey Report*] and *Medische Beslissingen Rond Het Levenseinde* -Rapport van de Commissie Onderzoek Medische Praktijk inzake Euthanasie. The Hague, The Netherlands: Sdu Uitgeverij, 1991)[*Remmelink Report*]. I am indebted to Dr. Daniel Ch. Overduin for translating the relevant sections of the two reports, thereby making the detailed evidence contained in them accessible to the English-speaking non-Dutch-speaking public.

35. *Remmelink Report*, 13

36. Ibid., 15

37. Ibid.

38. There were 5,8000 such cases, cf. Ibid, 15. However only 82% [ie 4,756] of these patients actually dies. Cf *Dutch Euthanasia Survey Report*, 63ff

39. There were 25,000 such cases, cf. Ibid., 69. However, only 35% (8,750 cases) were done with the intention to terminate life. Cf Ibid., 72; cf also *Remmelink Report*, 16

40. There were 22,500 patients who received overdoses of morphine, cf. Ibid., 16. 36 per cent were done with the intention to terminate life, cf *Dutch Euthanasia Survey Report*, 58

41. *Dutch Survey Report*, 61, Tabel 7.7. ["Besluit niet besproken"]
42. The *Rommelink Report*, 17-19
43. Other reviews of the evidence from the two Dutch reports supporting the present writer's analysis may be found in Richard Fenigsen, "The Report of the Dutch Governmental Committee on Euthanasia", *Issues in Law & Medicine*, 7:3, 1991, 337-344; Henk A.M.J. ten Have and Jos V.M. Welie, "Euthanasia: Normal Medical Practice?" loc. cit., 34-38
44. P.J. van der Maas J.J.M. van Delden, and L. Pijnenborg, *Euthanasia and other Medical Decisions Concerning the End of Life*, (Amsterdam: Elsevier, 1992), 21
45. *Ibid.*
46. John Keown, "'Dances with Data': A Riposte", loc. cit. 1
47. John Keown, "'Dances with Data': A Riposte", loc. cit. 1
48. Johannes J.M. van Delden, Loes Pijnenborg and Paul J. van der Maas, "The Rommelink Study Two Years Later", *Hastings Center Report*, November-December 1993, 26
49. Paul J. van der Maas et al, "Euthanasia and other medical decisions concerning the end of life", op. cit., 673
50. Helga Kuhse, referring to the "social experiment" with active voluntary euthanasia currently in progress in The Netherlands, has stated that "as yet there is no evidence that this has sent Dutch society down a slippery slope." Helga Kuhse, "Euthanasia", in *A Companion to Ethics*, ed. Peter Singer, (Oxford: Basil Blackwell Ltd., 1991), 302. The evidence cited together with I.J. Keown, loc. cit. 70-77 suggests a less encouraging conclusion should be drawn from the facts.
51. See footnote 46 above.
52. The *Rommelink Report*, 21ff, Part II, par, 6 deals with "De aard van medische beslissingen rond het levenseinde."
53. This stands in sharp contradistinction to the Report of the Committee on the Environment, Public Health and Consumer Protection on "care for the terminally ill" [European Communities-European Parliament, *Session Documents (English Edition)*, 30 April 1991 A3-0190/91] which contains a "Motion For a Resolution" on care for the terminally ill which refers in its preamble ("E") to the proposal that "the right to a dignified death" be enshrined in the *European Charter on the Rights of Patients*. However, the emphasis in the motion itself is on palliative care, rather than on assistance in dying.
54. Paul J. van der Maas et al, op. cit., 673
55. Ian Maddocks, *The Advertiser*, (Adelaide, South Australia, November 2, 1991), 1. Professor Maddocks is the Professor of Palliative Care, Daw Park Repatriation Hospital in South Australia. He was referring to allegations that some doctors in South Australia help patients to die by lethal injection.
56. Alexander Morgan Capron is the Henry W. Bruce University Professor of Law and Medicine, University of Southern California, and codirector of the Pacific Center for Health Policy and Ethics.
57. Alexander Morgan Capron, "Euthanasia in The Netherlands. American Observations", *Hastings Center Report*, 22:2, March-April 1992, 31
58. Alexander Morgan Capron, loc. cit., 31
59. I.J. Keown, loc. cit., 62.
60. *Ibid.*, 62-63.
61. *Ibid.*, 67-68.
62. *Ibid.* 67.
63. Brian Pollard, "Medical aspects of euthanasia", *Medical Journal of Australia*, 154:9, 1991, 613-616.
64. Christine A. Stevens and Riaz Hassan, "Management of death, dying and euthanasia: attitudes and practices of medical practitioners in South Australia", *Journal of Medical Ethics*, March 1994, vol 20 no 1, 41-46
65. *Ibid.*, 43
66. *Ibid.*
67. Private correspondence between Dr. Brian Pollard and Dr. Christine Stevens, August 1, 1994
68. *Ibid.*
69. *Ibid.*