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ARTICLES

THE SONG OF DEATH: THE LYRICS OF EUTHANASIA

*Margaret A. Somerville**

This text began its existence as one of a series of lectures on medical decisions at the end of life.[1] In preparing and delivering these lectures, two common, but powerful and important, insights were strongly reinforced. First, our debate about euthanasia concerns much more than that matter, itself, for both individuals and society; and, second, the role of language is immensely important in forming the issues in this debate and responses to those issues. This is true, because consideration of euthanasia requires both thinking and feeling, and language forms and affects how we both think and feel, and whether these functions are integrated or separated.

In order to explore some of the complex dilemmas and interactions that confront us in dealing with euthanasia, we need to examine the way in which language is used in this context, including in, but not limited to, the law. Language is used in describing and formulating the issues raised by euthanasia, in handling these, and in eliciting responses to the approaches taken.

* Director, McGill Centre for Medicine, Ethics and Law, Quebec, Canada. This text is dedicated to Knut Hammarskjöld and Michael Kirby, whose friendship with each other and me, has been of great importance in my life.

I am indebted to Sharifa Janmohamed for a great deal of assistance and exceptional patience and tolerance in preparing this text.

1. Brendan F. Brown Lecture, The Catholic University of America, Washington, D.C., November 1990. Other lectures included, "Reasonably Well or Dead: Squaring the Curve", the Walter Zuckerman Memorial Lecture on Medical Ethics, Mount Auburn Hospital, Cambridge, Massachusetts, November 1990; "The Polemics of Euthanasia", speech delivered at the Joint Assembly of the Catholic Health Association of Canada and the United States, Montreal, Quebec, June 1991; "Euthanasia as a Mirror: Visions of Self and Society", speech delivered at the Seventh International Hospice Institute Symposium, "Management of Terminal Illness: An Update", Washington, D.C., July 1991; " 'This Way to the Egress': Legal and Illegal Exits - The Euthanasia Debate", speech delivered at the XV Conference on the Law of the World, World Jurist Association, Barcelona, Spain, October 1991; and "Legalizing Euthanasia: Which Way The Tide?", speech delivered at the 9th International Congress on Care of the Terminally Ill, presented by Palliative Care Medicine, McGill University, Montreal, Quebec, November 1992; "Euthanasia: The Death(ly) Debate", Lowther Lecture, York University, Toronto, Ontario, January 1993.

This examination also needs to include exploration of how language is used to label or characterize situations in order to deal with these situations in certain, pre-determined ways. Moreover, we also need to recognize that language is relevant both to "talking about" euthanasia and to "doing" (carrying out) euthanasia.[2] Perhaps, the most striking recent example of this is the book, *Final Exit*[3]. This book "talks" about euthanasia in order to advocate euthanasia, but it, also, can be directly involved in "doing" euthanasia, for example, in those cases where people have been found dead with the book beside them, open at the pages containing the detailed instructions which they have followed to kill themselves.

I. DEFINITION

No where is the use of language more important and, sometimes, more confused and confusing, than when it is employed for the purposes of definition. This is especially true with respect to the definition of euthanasia. Even when one has an over-riding aim of neutrality and precision, it is difficult to define, accurately and clearly, which interventions or non-interventions should and which should not be regarded as constituting euthanasia. Such a definition is, however, essential and the range of possibilities with respect to it, are explored in this section.

The etymological origins of the word euthanasia - "good death" - are today common knowledge, as a result of the publicity that has surrounded the topic. The use of this terminology, quite apart from its definitional content (that is, what does and does not constitute euthanasia), merits consideration. For everyone, at some level, death is "bad" in the sense of sad and unhappy, but some ways of dying are "less bad" and "less unhappy" than other ways and these are "good deaths". We all hope, and hope to be assisted, to be in the latter category with respect to our own deaths. The issue on which we disagree, is what should be the limits, if any, placed on such assistance.

It is interesting that both the pro-choice (pro-euthanasia) advocates and some segments of the pro-life (anti-euthanasia) movement have argued for a wide definition of the term euthanasia. They propose that it should include all interventions or failures to intervene - mainly in terms of medical treatment - that shorten life or mean that life is not prolonged.[4] The two "sides"

2. For a discussion of the difference between the use of language to "talk about" an activity (e.g. law or psychiatry) and "to do" that same activity, see, M.A. Somerville, "Labels vs. Contents: Variance between Psychiatry, Philosophy and Law in Concepts Governing Decision-Making" (forthcoming publication).

3. D. Humphry, *Final Exit* (Oregon: The Hemlock Society, 1991).

4. M.A. Somerville, "The Definition of Euthanasia - A Paradoxical Partnership", *Bioethics Research Notes* 1991; 3(3):17-18.

have, however, argued for this wide definition for exactly the opposite reasons. The pro-choice group argue for a broad definition of euthanasia in order to propose that all interventions or non-interventions that would promote a "good death" should be allowed, including those undertaken with a primary intention of killing the person subject to them. Some pro-life groups argue that all interventions or non-interventions that would shorten life should be prohibited, not just those undertaken with a primary intention of killing the person.

I have argued elsewhere[5] that the pro-life groups who have taken this position, have done much harm to the cause of those who are against euthanasia, in the narrow sense defined below, but who would allow valid refusals of treatment; with-holding or withdrawal of futile treatment or that in which the harms of the treatment are disproportional to any benefit it offers; and access to necessary pain relief treatment, even that which could shorten life, if this is reasonably necessary to relieve pain and similarly access to treatment for the relief of other symptoms of serious physical distress (for example, intractable vomiting).[6] To define these interventions or non-interventions as euthanasia, forces persons to take a position either for or against all interventions or non-interventions which could result in the shortening of life, and does not allow them to take a separate position on the issue of euthanasia in a narrow sense of this term. In other words, pursuant to such an approach, persons must be either in favour of allowing all such interventions or non-interventions, or against all of them. It is proposed that the acceptability of various interventions or non-interventions at the end of life, varies from moral, ethical, legal, medical, social and societal points of view, and that these different acts or omissions cannot be dealt with as a unified whole. In short, the full spectrum of issues raised by medical intervention or non-intervention in our dying, should not be included in one term, as occurs when the word euthanasia is used to cover all means of promoting "good (or less bad) deaths" as the pro-choice groups argue, or all interventions or non-interventions that could result in shortening of life as some pro-life groups argue. The terms in this most important, sensitive,

5. Ibid..

6. It could be argued that the inclusion of this latter exception opens up the possibility of extending the range of interventions which I argue should be permitted, to include those that would constitute euthanasia, as defined below. It is proposed that this will not occur, if we respect the principle of treating the patient's symptoms by an intervention, and not seeking to eliminate the patient in order to eliminate the symptoms. Further, the occasions on which treatment of this kind that may shorten life would be needed, would be very infrequent. (Personal communication, Professor Norelle Lickiss, Director, Palliative Care Services, Royal Prince Alfred Hospital, Sydney Australia, December 1992.)

nuanced and delicate area need to be precisely used. In particular, the term euthanasia needs to be very precisely used.

With the above in mind, it is proposed that euthanasia be defined as AN INTERVENTION OR A NON-INTERVENTION BY ONE PERSON, TO END THE LIFE OF ANOTHER PERSON, WHO IS TERMINALLY ILL, FOR THE PURPOSE OF RELIEVING SUFFERING, WITH THE INTENT[7] OF CAUSING THE DEATH[8] OF THE OTHER PERSON, EXCEPT WHERE THE PRIMARY INTENT IS EITHER TO PROVIDE TREATMENT NECESSARY FOR THE RELIEF OF PAIN OR OTHER SYMPTOMS OF SERIOUS PHYSICAL DISTRESS, OR NON-PROVISION OR WITHDRAWAL OF TREATMENT IS JUSTIFIED, IN PARTICULAR, BECAUSE THERE IS A VALID REFUSAL OF TREATMENT OR THE TREATMENT IS FUTILE. This definition excludes the provision of reasonably necessary treatment for the relief of pain or other symptoms of serious physical distress, which could or would shorten life, provided that, although there could be an intent to cause death in giving such treatment, the primary intent is to relieve the pain or other symptoms of serious physical distress, not to cause death. The definition also excludes justified with-holding or withdrawal of treatment, in par-

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7. Normally, in law one is responsible for acts which one intends. Intention to kill another person, in a legal sense, is present when either there is a desire to kill the other person, or death is the certain or almost certain result of the act or omission (in a situation in which there is a duty to act) in question. The difficulty, in the context of the present discussion, is to establish legal immunity for (i) giving adequate treatment for the relief of pain or other symptoms of serious physical distress, even when this could shorten life, if this is reasonably necessary to relieve pain or other symptoms of serious physical distress (which would be given with an intention to kill, in the technical legal sense, if the treatment was certain or almost certain to shorten life); and (ii) respecting valid refusals of treatment; and (iii) with-holding or withdrawing futile treatment, when this will or could result in death; while prohibiting other interventions undertaken with an intention to cause death. There are two possible approaches. Either to define euthanasia as including all interventions in which there is an intention to cause death, except the provision of reasonably necessary treatment for the relief of pain or other symptoms of serious physical distress, or respect for a valid refusal of treatment, or withholding or withdrawing futile treatment. Or, alternatively, one can require a motive to kill (which is not present in giving treatment necessary to relieve pain or other symptoms of serious physical distress, or in respecting a valid refusal of treatment, or with-holding or withdrawing futile treatment) as part of the definition of euthanasia. The former approach is adopted here. It should be noted that in this text, the terms *primary intent*, *primary purpose* and *motive* are used synonymously. The term *direct intent* is not used, but also, means the same.

8. In general, I have chosen to use the term "to cause death", rather than "to kill", but these terms can be synonymous. It is interesting to consider the difference in nuance between the two terms, and to compare them with the term "to allow to die". The words "to kill" most often are used to describe interventions or non-interventions causing death, that are regarded as unjustifiable. In contrast, "allowing to die" tends to be used to describe non-interventions that are regarded as justifiable. The provision of reasonably necessary pain relief treatment that could or would shorten life is an intervention often referred to as causing death, but not in general as killing, probably because it is regarded as justified, indeed, required. For a discussion of futility, see Addendum p. 76.

ticular, respect for valid refusals of treatment[9] on the basis that, in such cases, first, there is no intention to cause death, although there is an intention to allow the person to die; second, the primary intent is either to respect the person's right to refuse treatment or not to impose futile or useless treatment; and, third, death is not caused, from the perspective of the law, by the failure to provide or by the withdrawal of treatment, rather it is caused by the person's underlying condition.

It should be noted that the proposed definition covers both voluntary and involuntary euthanasia, that is, euthanasia with or without the informed consent of the person subject to it, and is limited tó terminal illness, and requires a purpose of relief of suffering. This can be compared with, for example, the definition given by the Netherlands' State Commission on Euthanasia in 1985:

> "Euthanasia is the deliberate action to terminate life, by someone other than, and on the request of, the patient concerned".[10]

First, this definition covers only voluntary euthanasia, that is, on the request and with the consent of a competent person. There is on-going debate about involuntary euthanasia in The Netherlands and whether or not this should be allowed, and some recent, disturbing evidence in this respect. It appears that some Dutch physicians have used the definition of euthanasia currently accepted in their country, which only includes "voluntary" interventions, to classify "involuntary" interventions undertaken with a primary intention of causing the death of the person as not constituting euthanasia, precisely because these interventions were not voluntary.[11] It would seem that these physicians have not regarded involuntary euthanasia as prohibited because it did not fall within the guidelines compliance with which has the effect of providing immunity from prosecution euthanasia. Rather, they appear to

9. A valid refusal of treatment is an informed refusal of treatment given by either a competent adult person or a factually competent minor; or a refusal pursuant to a valid advance directive, whether in the form of a "living will" or a durable power of attorney for health care, or given by some other legally recognized substitute decision-maker, when such a refusal is within the scope of the authority of this decision-maker.

10. Cited in H. Rigter, "Euthanasia in the Netherlands: Distinguishing Facts from Fiction", *Hastings Center Report* 1989; 19(1)(Spec. Supp.):31. The term *deliberate action* can be compared with that used in this text of *primary intention*. It may or may not mean the same. One problem with using the term *deliberate action* as part of a definition of euthanasia, is that, at least, in legal systems based on Anglo-American common law, it has no specific meaning and would, therefore, be likely to lead to further confusion.

11. See, A.M. Capron, "Euthanasia in the Netherlands: American Observations", *Hastings Center Report* 1992; 22(2):30,31, referring to the Remmelink Report, which is summarized in P.J. van der Mass, J.J.M. van Delden, L. Pijnenborg, and C.W.N. Looman, "Euthanasia and other medical decisions concerning the end of life", *The Lancet* 1991; ii:669-674.

have regarded such interventions as not requiring compliance with the guidelines and procedural safeguards applicable to euthanasia, in particular, those requiring that the person on whom euthanasia is carried out be competent and consenting, and reporting of each act of euthanasia. This is a striking example of use of the power of definition. In fact, it is to turn the definition of euthanasia "on its head" to achieve exactly the opposite result from that which it is intended to promote, namely, that only voluntary euthanasia will be undertaken, and this only when there is compliance with strict procedural safeguards. As de Wachter warns, "definitions are not morally neutral. They are not just innocent tools that allow us to describe reality. Rather they shape our perceptions of reality . . ."[12] and, one could add, our actions based on those perceptions.

Second, the definition of the Netherlands State Commission on Euthanasia does not necessarily limit euthanasia to terminally ill persons. Although judicial guidelines[13] in The Netherlands only allow euthanasia for terminally ill persons, euthanasia has been held to be legitimate in the case, for example, of a quadriplegic young woman, who requested it and who was not within any usual definition of being terminally ill.[14] There are arguments for and against including terminal illness as a criterion in the definition of euthanasia. Arguments against it include that terminal illness is difficult to define, or at least is an arbitrary determination (at one extreme, life can be seen as a fatal illness) and is even more difficult to apply in practice - for instance, it may be difficult to say that a person is very likely to die within a given short period of time, when such a prediction is required in order for the person to be regarded as terminally ill. Another approach is to leave it to the discretion of physicians to determine when a person is terminally ill, in any given case. Although this would act as a restriction on euthanasia, in general, because there would need to be some objective reality to a finding that a person is terminally ill, it may be too open-ended and open to abuse. Further, if a similar use were made of a definition of euthanasia that included terminal illness as a criterion, to that which occurred in relation to the Dutch definition that euthanasia be voluntary (requiring that euthanasia be voluntary was interpreted to mean that involuntary euthanasia was not eu-

12. M.A.M. de Wachter, "Euthanasia in The Netherlands", *Hastings Center Report* 1992; 22(2):23.

13. Rigter, supra, note 10, p.31. On February 9, 1993, the Second Chamber of Parliament in The Netherlands passed, by a vote 91-45 in favour, a bill approving the regulatory system set up by these judicial guidelines. The Bill now goes to the First Chamber for consideration. See also, infra, p.35 et seq. and note 126.

14. R. Doerflinger, "Assisted Suicide: Pro-Choice or Anti-Life?", *Hastings Center Report* 1989; 19(1)(Spec. Supp.):16,18.

thanasia[15]), then killing persons who were not terminally ill might not be regarded as euthanasia. Moreover, in a context in which euthanasia was allowed, such cases may not be regarded as homicide because these cases have all the features, other than terminal illness, required to make them euthanasia, not homicide.

Third, the Netherlands Commission's definition does not, expressly, require that the person be experiencing severe and untreatable suffering, but this, also, is one of the conditions required if Dutch physicians, who carry out euthanasia, are to be immune from criminal prosecution.[16] Fourth, the definition does not limit the carrying out of euthanasia to physicians which is, also, required for immunity under the Netherlands' guidelines.[17]

It would also seem that the Netherlands Commission's definition of euthanasia only extends to acts, although the phrase, "the deliberate action to terminate life", could include withdrawal or omission of treatment, for example, unplugging a respirator or with-holding artificial hydration and nutrition. This leads to consideration of the much criticized active/passive (act/omission) distinction in relation to euthanasia - the distinction between so-called actively killing ("active euthanasia") and killing by either not providing or withdrawing treatment ("passive euthanasia"). It is agreed, that the terms "active" and "passive" are confusing when applied to euthanasia and that the distinction between "active" and "passive" euthanasia can be an artificial one[18] and should be abandoned in order to define euthanasia precisely.[19] Some failures to provide or withdrawals of treatment should be classified as euthanasia, but others should not. In particular, respect for valid refusals of treatment should not be characterized as euthanasia. For example, respecting a competent adult patient's informed refusal of life-support treatment,[20] or of blood transfusions for religious reasons[21] which could or will in all probability result in death, should not be regarded as euthanasia

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15. Supra, p.5.
16. Rigter, supra, note 10, p.31.
17. Ibid..
18. See, for example, H. Kuhse, *The Sanctity-of-Life Doctrine in Medicine - A Critique*, (Oxford: Clarendon Press, 1987).
19. See, Law Reform Commission of Canada, "Euthanasia, Aiding Suicide and Cessation of Treatment" Working Paper 28, Protection of Life Series, Minister of Supply and Services, Ottawa, 1982, pp.7-8, p.43.
20. See, for example, *Nancy B.(N.)* v. *Hôtel-Dieu de Québec* [1992] R.J.Q. 361 (S.C.Qué.). [Hereinafter *Nancy B.*]
21. See, for example, *Malette* v. *Shulman* (1990) 67 D.L.R. (4th) 321; 72 O.R. (2nd) 417 (C.A.Ont.), in which the Ontario Court of Appeal awarded $(C)20,000 damages for battery, to a woman who was given a blood transfusion which saved her life after being admitted to a hospital emergency room in a semi-conscious state, but carrying a card stating she was a Jehovah's Witness and refused all blood products or blood transfusions.

and confused with this. This is not to say, however, that one cannot disagree with both euthanasia and respecting rights to refuse treatment. Euthanasia involves an intention to cause death which, it is proposed, apart from necessary treatment for the relief of pain or other symptoms of serious physical distress that could be given with this intention, is always wrong. With-holding or withdrawing treatment involves an intention of allowing the person to die. Sometimes, this is not justified when it should be regarded as constituting, or as equivalent to, an intention to cause death and characterized as euthanasia. Sometimes, allowing a person to die is justified (when it is pursuant to a valid refusal of treatment or any treatment is futile) in which cases it should not be regarded as euthanasia.

In short, one can have euthanasia, in the narrow sense of this term, by omission as well as by act. What is important is to distinguish omissions that constitute euthanasia from omissions of treatment which do not constitute euthanasia.

There is sometimes a fine line between allowing a person to die and causing the death of another person. This is especially true in relation to withdrawing or not providing treatment other than pursuant to a competent patient's informed refusal of treatment or "advance directives" to this effect. But the important point is that there is a line and, it is proposed, the nature of interventions on one side of this line is different in kind from those on the other side. In another context, I have described such lines as "marker events,"[22] such that what occurs on one side of the line can be seen as different in kind, in particular regarding precedent setting effect, from that which occurs on the other side of the line. In relation to differentiating conduct that constitutes euthanasia from that which does not, the "marker event" is comprised of a "mens rea" (state of mind) of an intention to cause death *and* an "actus reus" (conduct) of an act or omission that causes, in the legal sense of this term, the death of the other person, except where the situation involves the provision of necessary treatment for the relief of pain or other symptoms of serious physical distress.

It needs to be considered how we can justify failure to provide or withdrawal of treatment in cases that involve either a valid refusal of treatment or in which the treatment is futile or disproportional. These can be dealt with on the basis of either intention or causation. In such cases, there is an intention to allow the person to die when it is certain, or almost certain, that death will result from the "act" or omission in question. But not all acts or omissions that allow a person to die are equivalent to an intention to cause

22. M.A. Somerville, "Birth and Life: Establishing a Framework of Concepts", (1989) 21 *Connecticut Law Review*, 667-683.

death and culpable. In particular acting pursuant to a valid refusal of treatment is a non-culpable act or omission, although there is an intention to allow the person to die. Indeed, not acting in this way could be culpable. To impose treatment on a patient who refuses it, is usually battery[23] and could constitute criminal assault.

Yet, another possible legal analysis that results in the same outcome, is that in some circumstances there is no duty to treat or to continue treatment and, therefore, an omission to treat in such circumstances that results in death is not legally actionable. This would not seem to be a strong argument, especially as, when a person is in a "treatment relationship" with a physician, omissions are not likely to be held to be "mere" omissions which do not attract legal liability. Rather these omissions of treatment would need to be justified on some other basis such as a valid refusal or futility of the omitted treatment. An alternative or additional analysis leading to the same result, is that the intentional act (for example, turning off the respirator) is not, in law, the cause of the person's death, rather, the person dies from his or her underlying disease. Those who oppose euthanasia, but agree with respecting refusals of treatment even when this could or will result in death, may have made a mistake in denying that, as in euthanasia, their actions in such circumstances involve an intention to allow the person to die or even to cause death. They do involve such an intention, but intention alone does not make an act culpable. The act must be *regarded by the law* as the cause of the prohibited outcome, here death of the person. The person's death is *caused in fact* by the act of treatment withdrawal *and* by the underlying disease. In contrast, the person's death is *caused in law* only by the underlying disease when the withdrawal of treatment is justified, and this "cause" is not one which attracts legal liability. In other words the withdrawal of treatment is not regarded in law as the cause of the person's death.[24] This can be compared with giving a person a lethal injection. The injection is the *sole* cause of the person's death and is clearly the cause of this in fact and in law, and is a "cause" that attracts legal liability.

The argument that there is no justifiable distinction between "active" and "passive" euthanasia (which is correct, if, in each case, *euthanasia*, as defined above, is involved) and, therefore, that there is no justifiable distinc-

23. See, for example, *Malette* v. *Shulman*, supra, note 21.

24. It is recognized that deciding when justification is present and when it is not and consequently when there is not and is causation-in-law, respectively, is a value judgment. But this does not mean that distinctions based on such a judgment are illegitimate or simply arbitrary or a matter of semantics, as is argued by some persons who support euthanasia.

tion between euthanasia and respecting persons' refusals of treatment,[25] has been put to a further use, recently. It could be that confusion between "passive" euthanasia and respecting persons' refusals of treatment, has been generated, deliberately, in the case of the pro-choice on euthanasia groups, in order to convince people that their agreeing with rights to refuse treatment means that they - as logical, rational and consistent thinkers - must agree with euthanasia and, moreover, that in respecting refusals of treatment they are committing euthanasia.[26] It also seems to be implied that if these persons feel comfortable with having carried out "euthanasia" of this kind, that is, by respecting persons' refusals of treatment, they should feel equally comfortable with undertaking euthanasia as defined in this text. Similarly, some groups in the anti-euthanasia movement seek to eliminate any distinction between so-called "active" and "passive" euthanasia, it would seem for the same purpose, namely, to argue that agreeing with so-called "passive" euthanasia, necessarily, implies agreeing with "active" euthanasia - if one is to be logical, rational and consistent. They do this, however, to promote the opposite result, namely, that, therefore, both "active" and "passive" euthanasia should be opposed and prohibited.

Yet another "pro-euthanasia" argument, a sophisticated one, also based on regarding rights to refuse treatment as a form of euthanasia, has recently appeared in the *Harvard Law Review*.[27] To summarize, this argument is that to recognize patients' refusals of treatment recognizes a "right to die". It is, then, proposed that if there is a "right to die", there are no convincing moral, political, social or legal distinctions between allowing somebody to die from an underlying disease through non-treatment, pursuant to his or her refusal of that treatment, or helping the person to die with active assistance.[28] This "right to be assisted in dying" is argued to include a right to choose and to control the time, place, conditions and manner of one's dying, whether through "passive" or "active" means.[29] This argument interprets recognition by some courts of a "right to die" as, not only, encompassing a right to be allowed to die, for instance by refusing treatment, but also, a right

25. See, for example, D.W. Brock, "Voluntary Active Euthanasia", *Hastings Center Report* 1992; 22(2):10,19.

26. A recent newspaper report of a survey of nurses in the State of Victoria, Australia, suggests that the survey may have asked questions which could have been interpreted in this way. See "Nurses Admit Helping Eighty to Die", [Adelaide, Australia] *The Advertiser*, 2 March 1992, p.3.

27. Notes: "Physician Assisted Suicide: The Right to Die With Assistance", (1992) 105 *Harvard Law Review*, 2021.

28. See, also, G.P. Smith, II, "All's Well That Ends Well: Toward a Policy of Assisted Suicide or Merely Enlightened Self-Determination?", (1989) 22 *University of California Davis Law Review*, 275.

29. Notes: *Harvard Law Review*, supra, note 27.

to be assisted in dying, in the sense of euthanasia as defined in this text. None of the cases in which courts have, with respect, loosely, used the term "a right to die", contemplated legitimizing euthanasia through use of such language. One question, therefore, is whether these cases do provide any precedent for a "right to die with assistance" as is proposed.

The term "a right to be assisted in dying", standing alone, is ambiguous. It could be meant to articulate only a right to palliative care and an obligation to provide this, and as Capron eloquently states, "[t]here are so many things - including simple companionship and love - that one might do to 'aid' a dying person, that the phrase 'aid-in-dying' cannot help but disguise more than it reveals".[30] The *Harvard Law Review* article is clear, however, that what is meant is that there should be immunity for the physician for killing the patient, when this action fulfils certain conditions.[31] It is also possible that a right to die could have a juridical correlate of an obligation to kill the person with the right. This possibility is rejected: ". . . the right to die with assistance would provide only a right against state interference, not a right to force an unwilling physician to assist in a patient's suicide."[32]

The "language of euthanasia" is discussed in more detail later,[33] but this use of language in the article merits noting. It is much more difficult to oppose a "right against state interference" in medical decisions at the end of life (a characterization which can include euthanasia, as defined), than an immunity for a physician who kills a patient. Yet, the two are identical in content and result.

The argument for a right to die with assistance is supported in the *Harvard Law Review* article, paradoxically, by a close investigation of how the American courts have *not* recognized an absolute right of persons to refuse treatment and by equating this to a "right to die". The authors demonstrate that American courts have put conditions on exercising the right to refuse treatment, and therefore, it is argued, on the "right to die". In particular, the courts have balanced the exercise of this "right" against "state interests in preserving life, protecting third parties, and preserving the medical profession's ethical image",[34] any one of which can be given priority. These cases show, the authors propose, that in some situations (those where there are no over-riding state interests), but not all (those where there are over-riding state interests), a person's refusal of treatment, which will result in death, will be respected: that is, the person has a "right to die". It

30. Capron, supra, note 11, p.30.
31. Notes: *Harvard Law Review*, supra, note 27.
32. Ibid., p.2024.
33. Infra pp. 44-56.
34. Notes: *Harvard Law Review*, supra, note 27, p.2022.

is, then, argued that if none of these same state interests would be contravened by "assisting death" (which it is proposed they would not be in some cases), there is, likewise, no reason not to assist death in such cases, through "active means".

This position can be compared with that, for example, in the Common Law jurisdictions of Canada and the Civil Law jurisdiction of Quebec, in which the right to refuse treatment tends to be regarded as much more absolute[35] and, possibly, of a different nature or origin. The Canadian approach has been to focus on the person's right not to be touched without his or her consent - the right to inviolability[36] - rather than on any "right to die". These cases which recognize a more absolute right to refuse treatment, pursuant to respect for a right to inviolability, in fact, do not lend themselves so readily, if at all, to the type of argument outlined above.

There is a valuable lesson to be learned from the possible consequences, such as those described above, of promoting a non-absolute approach to the right to refuse treatment. What would appear to be initially a more life-favouring position (and one promoted by some pro-life groups), namely that the right to refuse treatment is not absolute, can in fact be used to achieve exactly the opposite outcome, and indeed used in support of the pro-choice on euthanasia position, as occurs in the *Harvard Law Review* article discussed.

Pain relief treatment, which could or even would shorten life, but which is reasonably necessary to relieve pain, can also be seen as raising difficulties with respect to intention to cause death and potential criminal liability. Such treatment must be able to be given with legal immunity. Consequently, where the motive is to relieve pain and *not to kill*, the intervention must be justified, despite the possible presence in a technical legal sense of an intention that death will result.[37] In other words, motive can be regarded as an excuse or a justification - a defence - protecting against or negating, respectively, criminal or other liability in such circumstances, which is the analysis most consistent with traditional theory in criminal law.[38] We need also to

35. See, M.A. Somerville, "Refusal of Medical Treatment in 'Captive' Circumstances", (1985) 63 *Canadian Bar Review*, 1:59-90.

36. For a discussion of the differences and relationship between rights to inviolability and to autonomy, see, M.A. Somerville, "Consent to Medical Care", Law Reform Commission of Canada, Ottawa, 1983.

37. There is increasing evidence, however, that medically advanced pain relief regimes do not shorten life, in which case concerns that they do, may become obsolete. Personal communication Professor Norelle Lickiss, Director, Palliative Care Services, Royal Prince Alfred Hospital, Sydney, Australia, December 1992.

38. M.A. Somerville, "Medical Interventions and the Criminal Law: Lawful or Excusable Wounding?", (1980) 26 *McGill Law Journal*, 82-96.

keep in mind that providing adequate pain relief treatment could extend life, as the person is less physically and psychologically distressed, in which case failure to provide it shortens life.

The subject of pain relief treatment is a critical one in the context of a discussion of euthanasia. Fears of being left in unbearable pain, or even more horrific, the reality of this occurring, which still far too often happens, is probably a strong impetus for many persons to argue that euthanasia should be made available. We need to be acutely aware that some of our attitudes and systems contribute to failure to provide adequate pain relief treatment. For instance, I recently learnt of a case in which a man, dying of disseminated carcinoma, was being given Tylenol(TM) for severe pain. A physician on night rotation changed the order to morphine. The next night, she was again called to see the man, because he was in very severe pain. She found that during the intervening day, the man's attending physician had cancelled the order for morphine and written another order for Tylenol(TM). When questioned, the attending physician said that he thought the man was "a complainer" and, in any case, he did not want to have "addicted patients", two responses that one would hope not to hear from any physician practising medicine in the 1990's. In another case, I was told that a young resident considered giving a dose of potassium chloride to a dying patient in severe pain, because the hospital ward supply of morphine had run out that night and no more could be obtained until the hospital pharmacy opened the next morning. We must ensure that not only health care practitioners are humane, but also, that we have humane systems in our health care institutions.[39] The most effective and important means of achieving this in the area of medical interventions at the end of life, is to promote the teaching and provision of high standards of palliative care. *All* physicians need some familiarity with the concept and practice of this area of medicine, as well as there being a need for specialization in it.

Leaving people in pain is not only a human tragedy and contrary to the most fundamental concepts of human rights, it should be treated as at least legally actionable medical malpractice and possibly as a crime. Certainly, to provide necessary pain relief treatment, even that which could shorten life, must not be seen as criminal. This has been explored in much greater depth elsewhere,[40] the point here is that those who oppose euthanasia, but fail to

39. It, also, merits considering whether establishing a system, such as that described, could be regarded as "systems negligence" and, therefore, could give rise to a possible action in negligence directly against the hospital, for damages by persons who are harmed as a result. See *Yepremian v. Scarborough General Hospital* (1980) 110 D.L.R. (3d) 513 (C.A. Ont.).

40. M.A. Somerville, "Pain and Suffering at Interfaces of Medicine and Law", (1986) XXXVI *University of Toronto Law Journal*, 286-317.

take steps to ensure that adequate pain relief treatment is provided (or even worse, oppose this, if it could shorten life) do much to promote the case for euthanasia.

In summary, no matter whether one promotes the view that euthanasia should be available to those who request it or believes that euthanasia should be prohibited, it is important to deal with the various situations, which require decision-making concerning interventions at the end of life, separately from each other. In particular, situations which involve an intention to cause death should be dealt with separately from other situations in which there is no such intention, and within the former group further distinctions are necessary. In order to undertake such a discussion, the terminology must be very clear. Consequently, in the remainder of this text, to repeat, the term "euthanasia" is used in the strict sense of meaning an intervention (other than the provision of reasonably necessary treatment for the relief of pain or other symptoms of serious physical distress) or a non-intervention (other than pursuant to a valid refusal of treatment or where the treatment is futile) undertaken for the purpose of relieving suffering in circumstances of terminal illness, with the intention of causing the death of the person who is subject to the intervention or non-intervention. A narrow definition is needed because euthanasia, as defined, is *different in kind not just degree* from other measures, which can also mean that life is not prolonged or even that death is "caused" in the sense that it occurs sooner than it would otherwise do. In particular, it is argued that the "analogy between forgoing treatment and active euthanasia is simply false".[41] Most persons who are in favour of euthanasia would disagree with this statement. They argue that the outcome is the same - namely death - and that once allowing death to occur is justified, how this is brought about is morally, and ought to be legally, irrelevant.[42] Recognizing for the sake of argument that this could be true, does not justify making it true by treating all interventions at the end of life as the same, in particular, regardless of whether or not they involve an intention or a primary intention to cause death. Rather, each category of intervention needs separate justification, if it is to be justified.

If one imagines a continuum with a very liberal pro-euthanasia position at one end and a very stringent pro-life position at the other, the position which is being advocated in this text is somewhere in the middle. This position is much more difficult to articulate, define and defend than either of the poles, and moreover one can be and is attacked from both sides. In part this may explain why some persons choose one or the other pole. I have suggested

41. de Wachter, supra, note 12, referring to arguments presented by Capron.
42. See, for example, *Notes: Harvard Law Review*, supra, note 27.

elsewhere that living in "the purple-pink middle" may represent what we see, at least initially, as an "impossible combination" of attitudes, values and beliefs.[43] But while it is usually the most difficult position, it may also be the most honest one, in that it best accommodates and even reconciles what we say and what we do. It is proposed that the most acceptable position with respect to interventions or non-interventions at the end of life, is to recognize rights to adequate treatment for the relief of pain and other symptoms of serious physical distress, and rights to refuse treatment, and that there is no obligation to provide futile treatment, even when any of these approaches could or will shorten life, and to prohibit all other interventions or non-interventions undertaken with an intent of causing the death of the person to whom they relate.

II. The Context of Discussion of Euthanasia

There is wide-spread discussion of euthanasia. This discussion ranges from cartoons, to the pulpit, to Parliament. For example, a recent "Far Side" cartoon showed an old rooster lying in bed, hooked up to many life-support machines, being visited by his hen-wife. The wife says to him: "It is a miracle you have survived, George. Just yesterday, we were wondering whether or not to wring your neck". Media coverage of euthanasia has been intensive - although, there seems to be much misconception in the media as to what constitutes euthanasia, in particular, it is confused with respecting refusals of life-sustaining treatment, and one can only question whether or not this is intentional.[44]

Political debate concerning euthanasia and related issues has been intense and has included, for example, in North America, the California Humane and Dignified Death Initiative (Physician Assisted Death Bill), which failed to obtain sufficient signatures to be submitted to a ballot in 1988; the sequel to this just voted on by Californian electors, November 3, 1992 and defeated by a 54% to 46% margin;[45] the Washington State Initiative 119, of 1991, which was rejected by voters; and two Private Members Bills introduced into the Canadian Parliament in 1991 - one seeking to clarify that persons who respect others' rights to refuse treatment or who provide pain relief treat-

43. See M.A. Somerville, "New Perceptions, Old Values From Inner and Outer Spaces", *Canadian Speeches* 1992; 6(5):65-68. (Convocation Address, "Spacing-in and Spacing-out: Searching for the Purple-Pink Middle", University of Windsor, Windsor, Ontario, June 1992.)

44. For example, the Nancy B. case (supra, note 20), a recent court case in Canada, in which the request of a young, competent, quadriplegic woman to be disconnected from a respirator was upheld, was, frequently, discussed in the media in terms of euthanasia.

45. "California voters reject doctor-aided suicides", Associated Press/Southam News, [Montreal] *The Gazette*, 5 November 1992; p.A11.

ment, even that which could shorten life, but which is necessary to relieve pain, are not thereby liable to criminal prosecution,[46] the other going far beyond this, to propose a system of legalized euthanasia for Canada[47]. Both of these Bills have now lapsed.

There is, also, wide-ranging academic discussion and research being undertaken in this area. Just one example, is the current work of Young, who has investigated self-willed or other-willed death in eastern religions, in order, through comparative religion methodologies and techniques, to gain insights into how we are handling and should handle issues surrounding euthanasia in our societies.[48] It merits noting that her preliminary results show that when a society is either "too religious" or "too secular", there is a similar increase in belief at both individual and societal levels, that euthanasia is acceptable. Once again, seeking the balance of the "purple-pink middle",[49] in this instance between religiosity and secularity, would seem to be an important safeguard.

Quite apart from the arguments raised either for or against euthanasia, and by whom and in what manner these are being explored or promoted, the "context" or forum, itself, in which the euthanasia debate takes place, is not necessarily a neutral factor, but can be a "player" in the discussion. For instance, it has been alleged that "[t]he [Dutch] media have been virtually monopolized by the euthanasia proponents, and a whole generation of Dutch people has been raised without even hearing any serious opposition to it".[50]

Further, some events, for example, the fact that Derek Humphry's book on how to commit suicide, *Final Exit*, which strongly advocates euthanasia, was number one on the New York's Times Best-Seller List, have an effect on the context of the discussion of euthanasia, as a whole. Moreover, that it became a best-seller can be interpreted in radically different ways. On the one hand, it can be argued that this shows that the book is needed and is acceptable. On the other hand, it can be argued that this indicates that the

46. Bill C-203, "An Act to Amend the Criminal Code (terminally ill persons)", The House of Commons of Canada, 3rd Session, 34th Parliament, 40 Elizabeth II, 1991. First reading May 16, 1991; the Bill failed on second reading in January 1992.

47. Bill C-261, "Euthanasia and Cessation of Treatment Act", The House of Commons of Canada, 3rd Session, 34th Parliament, 40 Elizabeth II, 1991. First reading June 19, 1991. The Bill was withdrawn, prior to second reading.

48. K. Young, "Euthanasia: Traditional Hindu Views and the Contemporary Debate", in H.C. Coward, J.J. Lipner, K.K. Young, *Hindu Ethics: Purity, Abortion and Euthanasia* (Albany: State University of New York Press, 1989).

49. Somerville, supra, note 43 .

50. R. Fenigsen, "A Case Against Dutch Euthanasia", *Hastings Center Report* 1989; 19(1)(Spec. Supp.):22,24.

book has a morbid appeal and could foster psychopathological tendencies - for instance, suicide by seriously depressed persons - to the grave detriment of persons with these tendencies. Certainly, there is a major difference, including in practical impact, between this book and one that is similarly promotive of the option of euthanasia, but is neither a "do-it-yourself" euthanasia text, nor heavily promoted, as *Final Exit* was, to become a best-seller.

The tone of the debate on euthanasia - whether relatively impartial or partial - and, an often related characteristic, whether theoretical issues and analysis or practical, how-to-commit euthanasia instructions are the focus of the debate, also affect and change the context of that debate.

Moreover, as Wolf[51] points out, not all contexts or the discussion which takes place in them are equally accessible to or aimed at all persons. She compares the "propaganda and diatribe"[52] of Humphry in *Final Exit*, which has clearly caught major public attention, with the perceived failure of bioethics to label the issues raised by euthanasia in a broad enough manner to engage in the "momentous public debate, with profound ethical, legal, religious, psychological and medical implications"[53], which must take place. She argues that "bioethicists must strive to reach a popular audience and convey arguments effectively".[54] In other words, it is the obligation of bioethicists to ensure that the context of bioethics extends to encompass all who should participate in the euthanasia debate, which must include the public. This provides an insight, that definition of an appropriate context for the euthanasia debate can be a way of expanding or limiting the participants in the debate, which will undoubtedly affect the outcome of the debate. This potential for manipulation needs to be recognized and steps taken to ensure the widest possible participation.

III. Why Are We Talking of Euthanasia Now?

(A) Is It an Indirect Way of Talking About Death?

We need to ask whether our "euthanasia talk" is covering-up some other reality. There is much discussion of euthanasia, but, I suggest, less of death - talking about death is difficult. Indeed, we have been described as a society that is unusually fearful of death - a death-denying society.[55] This term is

51. S.M. Wolf, "Final Exit: The End of Argument", *Hastings Center Report* 1992; 22(1):30-33.
52. Ibid., p.30.
53. Ibid., p.32.
54. Ibid..
55. H. Becker, *The Denial of Death* (New York: The Free Press, 1973).

interesting, because denial requires some minimal level of consciousness of the "thing" feared, in order to suppress the larger consciousness of that "thing". Could it be that euthanasia is the conscious mechanism that we use to suppress our larger awareness of death? Is it less fearful to talk of euthanasia than death and, consequently, our discussion of death is being carried out in the context of euthanasia? We used to talk about death "in religion", but the major decline in adherence to organized religion means that many of us no longer talk about death in that context. In recent times, we have not talked about death in any context, except possibly, in symbolic and ritualized form in literature and the arts. Could it also be that talk of euthanasia de-conditions us to the fear of death, especially, because at the same time as we speak of the feared "event", we simultaneously speak of controlling it through the use of euthanasia? As Winslade has said, "[t]he need to control death whether by postponing it or hastening it - seems to rest on a deep fear and denial".[56] Could it even be that our "euthanasia talk" is a terror management device, for both individuals and society? Greenberg[57] and his colleagues propose that the thought of death raises the deepest terror, which we then need to manage. We do this by seeking to achieve a consensus that affirms our most important values, which, in turn, provides reassurance. Could this explain the strong polarization and conflict on euthanasia, in that each "side" wants consensus in order to have the reassurance that results from having its values affirmed? Could it also be that this terror is so great that we would rather be dead, than living in fear of death, particularly, imminent death, and euthanasia is seen as allowing us to achieve this outcome?

It seems that advocacy of euthanasia is connected with a desire for control. Control is related to relief of suffering. Suffering is present when one has a sense of one's own disintegration and a loss of control over what happens to one.[58] To move from chance, which the occurrence of death has largely been, to choice, which is the promise of euthanasia, can be to reduce suffering. Persons may see euthanasia as avoiding present suffering (either because they seek euthanasia at the time, or because it allays present fears - which are a form of suffering - that they can avoid suffering at some time in the future) or future suffering. Euthanasia may, also, fulfil a need or desire for certainty, which is related to a need or desire for control. Stated in another way, euthanasia can be viewed as reducing uncertainty which reduces

56. Quoted in de Wachter, supra, note 12.

57. J. Greenberg, "At Different Times, in Different Ways, We All Board the Same Train: The Management of Terror in Everyday Life", Plenary Address, 9th International Congress on Care of the Terminally Ill, November 3, 1992, Montreal.

58. E. Cassel, "The Nature of Suffering and the Goals of Medicine", *New England Journal of Medicine* 1982; 306(11):639-644.

anxiety, and, consequently, it provides reassurance. Euthanasia could also be a "do something" response. When faced with fearful situations our anxiety tends to be increased by inactivity and decreased by activity, because in the latter case we feel that we can and are "doing something" to remedy the situation. This also provides a feeling of greater control which likewise reduces anxiety. Further, it is interesting to note in this context, that an attitude on the part of physicians that is manifested in their telling patients that they can do nothing more for them, may be a precipitating cause of some patients seeking euthanasia.[59]

The availability of euthanasia could, also, inflict suffering. There could be a fear that it would be practised in ways that would mean that the individual loses rather than gains control. Similarly, there could be present fear about future use of euthanasia - not simply fear at a future time about its use at that time. It has been alleged that some old persons in The Netherlands fear physicians and hospitals, because they fear that they may be subjected to euthanasia.[60] That is, instead of giving more control to the individual, euthanasia may, overall, result in less control. Even such situations as seeing oneself as a burden on society when one is old and ill, and as needing to do the "right thing" by requesting euthanasia is a loss of individual control and freedom of spirit. Both the anticipation and experience of this are suffering inflicting. It has, also, been suggested that allowing euthanasia means that persons must face a choice whether or not to use it and could have to justify their choice to continue existing, because "the existence of the option becomes a subtle pressure to request it".[61] Situations that raise such issues are very likely to be a source of suffering.

Euthanasia may, also, be a vehicle for addressing much wider and deeper realities that operate at conscious, unconscious and symbolic levels.[62] In a study, currently in progress, Young et al. propose "that 'reason alone' has never been the sole guiding principle by which individuals have killed themselves or others when ill or old. Rather, reason has often been used either to affirm or to cover the operation of deeper values that are not expressly identified. These have included the heroic ideal of the self-willed death among warriors threatened with defeat or the derivative ideal among ascetics or philosophers of self-willed death to demonstrate their version of courage. Unlike the ancient world's desire for a heroic form of death and Nazi Germany's legitimation of euthanasia to create a 'super race', today's societies

59. See, L. Israel in interview with Jacques Nerson, "Pr. Lucien Israel: L'Euthanasia est un meurtre", Le Figaro, 6 mars, 1993, 111-112, 111.

60. Fenigsen, supra, note 50, p.26.

61. Brock, supra, note 25, p.17, referring to Velleman.

62. See, also, discussion, infra pp.28-31.

are entertaining the idea of self-willed or assisted death to avoid suffering or ensure 'dignity'. Since the pain of dying can be effectively treated in most cases, what accounts for the current movement to legalize euthanasia?"[63] As well as seeking consensus on values for the sake of consensus, because we need the reassurance that such consensus provides,[64] what deeper values could we be seeking to affirm or to cover, in arguing for, or likewise against, euthanasia?

The analysis of the French psychoanalyst, De Hennezel, is of great interest in this respect, because it shows some of the enormous complexities we are dealing with in our discussion of euthanasia. In particular, it shows that two emotions, fear and love, and the relationship between them, are central to the euthanasia debate. De Hennezel argues "that a fine death is an illusion, a myth . . . which people tell themselves to appease their anguish",[65] and that our society is "governed by th[e] myth of a good death".[66] She proposes that there are two versions of this myth. One view sees a "good death" [as] . . . a discreet and rapid death, unconscious, and, particularly, of no bother to anyone else".[67] This corresponds to a view of the world in which death is denied; medicine is all powerful; caregivers see death of their patients as a failure; and death is "experienced in great solitude and with no guideposts or values"[68]. This is "[a] world of effectivity, efficiency, performance, with priority given to cost-effectiveness [and] consumption . . . [a] world of objects not of subjects - in short, a world stripped of souls and spirit, a world without love".[69] The other view of a good death comes from "a new humanism . . . try[ing] to bring life and death together as one. An accompanied death, a socialized death, one experienced in lucidity up to the end becomes the desired good death".[70] The view of the world behind this vision is a much less certain one. In fact, its essence is recognition: of the uncertainty of many of us about the meaning of life and death; of the need for sensitivity to others and the humility to allow others to experience in their own, not our, way; and that there are possibilities of the extremes of either "nothingness or . . . mystery of the beyond".[71] It is "an appeal to

63. K.K. Young et al., unpublished abstract (1992).

64. Supra, p.17.

65. M. de Hennezel "The Myth of the Perfect Death: The New Meaning of Death in the Context of AIDS", Plenary Address, "Caring Together/Entraide: Conference Proceedings", Ottawa, 1991, 33-38, 34.

66. Ibid..

67. Ibid..

68. Ibid..

69. Ibid., see, also, Campion infra, note 97.

70. Ibid..

71. Ibid., p.35.

change our way of loving".[72] This "new concept of 'dying well' . . . is no longer an illusion or a myth, but a permission to experience one's death as one wishes, to experience it fully, with the assurance of being loved and accepted no matter what. This of course requires that someone else be capable of that degree of true love".[73]

If we accept the propositions set out above, it could lead to the conclusion that we should reject euthanasia, because it is too "easy", in the sense of simplistic, rational, cold and unloving, as an approach or response in dealing with death. And yet, those in favour of euthanasia argue exactly the contrary, namely, that euthanasia is among the great humanitarian causes.[74] The important point to note here is that our arguments are of this nature. This means that in dealing with euthanasia, we are dealing with some of the most fundamental and critical issues of our humanness, as both individuals and a society. In short, whether we are "pro" or "anti" euthanasia, we agree that euthanasia is a central focus in our discussion of these fundamental issues; where we disagree, is whether allowing or prohibiting euthanasia best promotes our human spirit and our humaneness and humanity.

(B) Is There a Newly Perceived Need for Euthanasia?

Polls, for example, in California[75] and The Netherlands[76] have shown that approximately 70% of persons approve of euthanasia being available and this percentage seems to be increasing. But care needs to be taken with how polls are interpreted, in that responses within the same survey may not be consistent. For instance, some polls on abortion have shown that the majority of persons approve of abortion on demand, but the same majority do not approve of a woman having an abortion for any reason at all.[77] Surveys on willingness to donate organs give inconsistent results, in that, approximately 70% to 80% of persons declare themselves willing to donate, but only about 10% to 20% of these same persons have actually done so.[78] In short, there may be a large gap, as is shown in Washington State by the recent vote on

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72. Ibid..

73. Ibid..

74. L. Israel in interview with Jacques Nerson, supra, note 59, p.112, referring to a statement by Bernard Rapp.

75. A. Parachini, "The California Humane and Dignified Death Initiative", *Hastings Center Report* 1989; 19(1)(Spec. Supp.):11.

76. H.J.J. Leenen, "Euthanasia in the Netherlands", in Peter Byrne ed., *Medicine, Medical Ethics and the Value of Life*, (New York: Wiley, 1990), 1-14, 2.

77. W. Saletan, "There is No Pro-Choice Majority Either", *The Wall Street Journal*, 27 June 1990, p.A12.

78. L. Shelley, "Practical Issues in Obtaining Organs for Transplantation", *Law, Medicine and Health Care* 1985; 13:35,37.

"Initiative 119, A Voluntary Choice for Terminally Ill Persons: Death With Dignity", between what we say we are willing to accommodate and what we decide to accommodate, when it comes to making an actual rather than a hypothetical decision. The polls, prior to the voting on the Initiative, indicated that it would succeed, but it failed by a 46% to 54% margin.

Moreover, the results of polling 2,000 randomly chosen Washington State physicians regarding this Initiative, 1,105 of whom responded, show comparable discrepancies and have been described as "mystifying".[79] "Seventy-five percent of physicians said they did not believe they should have the legal right to give a terminally ill patient a lethal injection. Sixty percent said doctors should not be allowed to prescribe a lethal dose of medication to be self-administered by the patient. And 75 percent said they would not be willing to be personally involved in aiding a patient's death. Yet in answer to the question, Should the WSMA [Washington State Medical Association] support or oppose Initiative 119?, respondents were split down the middle, with 543 doctors saying the WSMA should support the initiative, and 562 indicating the organization should oppose it."[80] These results may contain an important warning. First, it is possible that our sense of responsibility for the outcomes of our decisions is diminished when that responsibility is shared with a group and exercised through group decision-making. Second, it could be that some physicians make decisions concerning their own conduct according to their own personal morality, but they do not necessarily seek to impose the same morality on others. Third, discrepancies of the type outlined above could show that we may need to talk about doing (or possibly more accurately the doing of) some things that we would not do and do not want others to do, that is, the discussion itself might have a purpose other than promoting the carrying out of the conduct (here euthanasia) which forms its content.[81]

The warning having been sounded, that what we say does not necessarily reflect what we will do and that what we say may not be inherently consistent, it is true, however, that there is a very major increase in most western democracies, in the discussion of euthanasia and promotion of this as a valid option that should be made available and, certainly, not prohibited. We need to inquire why this is occurring. Why is there a perceived need for euthanasia now?

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79. R. Carson, "Washington's 1-119", *Hastings Center Report* 1992; 22(2):7,8.
80. Ibid..
81. See, infra, p.70.

(i) Modern medical technology

Some people attribute the augmented perceived need for euthanasia as being yet one more effect of modern medical technology. It is possible that our sense of "playing God" to keep alive, persons who in past times would certainly have been dead, may have given us a sense of power not only over death, but also over life.[82] In short, once we use technology to prolong life, perhaps, there is some correlative sense in which we feel we may use it to shorten life. Certainly, we do not need new technology to kill; this possibility is as old as the human species, itself.

It may be, however, that a fear of the over-use of medical technology has contributed to calls for euthanasia. This fear is summed up in statements such as persons would rather be dead than left "to the mercy of doctors 'and their machines' ".[83] The development of rights to refuse treatment has been one response to these fears. Rights are a major currency of the law. In contrast, medicine tends to give priority to fulfilling needs. Fulfilling the needs of persons and respecting their rights can sometimes give rise to a situation of conflict, in particular, in relation to refusals of treatment with modern medical technology. Some such situations in which rights have predominated to allow persons to refuse treatment at the expense of fulfilling major and serious needs (which they have or are perceived to have) have been described as "rotting with your rights on".[84] Whatever we may view as the "correct" approach in such cases, it may be very important to ensure that "people die with their rights on", if we are to prevent the abuse of over-use of medical technology and, equally as importantly, the fear of this. Such fear is harmful in itself and is likely to promote advocacy of euthanasia.

It is also true that developments in medical technology have given rise to "the secularization of the human image"[85] and possibly to a different vision of human identity. For instance, transplantation may mean that we no longer each see our self as one, integral whole, but as a collection of interchangeable parts, which translates into a modular theory of human identity.[86] This theory has mechanistic connotations, which may also be linked

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82. See, discussion infra, p.51.

83. Fenigsen, supra, note 50, p.24.

84. T.G. Gutheil, "In Search of True Freedom: Drug Refusal, Involuntary Medication, and 'Rotting With Your Rights On' ", *American Journal of Psychiatry* 1980; 137(3):340-346.

85. de Wachter, supra, note 12, p.27, quoting a 1972 pastoral manual of the General Synod of the Dutch Reformed Church, "Euthanasia: Meaning and Boundaries of Medical Treatment".

86. M.A. Somerville, "Messages from Three Contemporary Images of Medicine: Failed Medicine, Miracle Medicine and Science Fiction Medicine", in W.R. Shea and A. Spadafora, eds., *From the Twilight of Probability: Ethics and Politics*, (Canton, Massachusetts: Science History Publications/ U.S.A., 1992), pp.91-105.

to increasing numbers of persons regarding euthanasia as acceptable. We are, in general, unsentimental about disposing of out-dated, worn out, or no-longer-efficient machines. If we see ourselves as machines, at least in some respects, we may apply this same attitude to ourselves and others. Euthanasia could be an expression in practice of such an attitude.

(ii) Individual rights

Emphasis on rights of individuals has been a phenomenon of major importance in many of our western societies, but it may now have peaked, which one hopes does not mean that it will decline from that peak, although other concerns also need to be incorporated into our analysis and practice. In particular, emphasis on the rights of individuals has been essential to ensure respect for each person, which is crucial in the context of health care, if that context is to be humane.

Calls for the legalization of euthanasia, have, frequently, been phrased in terms of respect for individual rights. Most of us recognize a claim to a death that is respectful of the person - sometimes called a dignified death, although this term can be misleading - but disagree on what are the limits for achieving this. In particular, we disagree whether there is a right to this, because such a right may require actions with which we disagree and a right of one person necessarily connotes a duty of another, even if only to refrain from doing anything that would infringe on that right. It is important to recognize points of consensus when they exist, and then where our disagreement begins. Differences of opinion, especially, regarding such strongly held beliefs as those concerning euthanasia, can have a very different tone when a discussion starts from a point of agreement rather than disagreement.

It is tentatively suggested that development of a pro-choice on euthanasia stance by a society might be a result of a failure to balance a very strong (and necessary) emphasis on individual rights by any (or at least sufficient) consideration of claims of the community. We need to keep in mind that not only individuals, but also communities need protection if they are to survive. Moreover, we can regard a requirement that we protect the community, as being also for the sake of the individual.[87] Hermits aside, most of us need community in order to develop fully as individuals. An insight into one possible function of the maintenance of a balance between individual rights and protection of the community (between individualism and communitarianism) may be provided by comparing this requirement with Young's finding

87. This can be compared with the opposite situation, for instance, originally a primary purpose of the criminal law in protecting individuals was not to protect the individual as such, but to maintain the king's fighting men in order to protect the community.

of an increase in euthanasia where there was a failure to maintain balance between religiosity and secularity, movement towards either pole giving such an increase.[88] If the same were true for emphasis on individual rights as compared with claims of the community, or vice versa, we could postulate an increase in euthanasia if the claims of individuals became relatively too strong in comparison with those of the community, as well as vice versa. It may well be that the greatest dangers of over-use of euthanasia in the future, were it to be introduced, would come from over-emphasis on community claims at the expense of individual rights, which is paradoxical if the introduction of euthanasia is, as is often claimed by its advocates, necessary in order to respect and promote individual rights.

In light of the above discussion, it is interesting to note that some of the strongest opposition to anonymous HIV seroprevalence surveys (anonymous screening of a population to determine the incidence of HIV infection) occurred in The Netherlands, where "opposition to any compulsory public health measure is so strong that even professional and popular support for blinded studies is unlikely to overcome the barriers".[89] In contrast, such surveys have met with general approval in both the United States and Canada and have been carried out after careful consideration of the ethical requirements that need to be fulfilled.[90] Could the situation in The Netherlands in this regard and with respect to euthanasia be related, in that, both reflect a more or less purely individualistic approach? It is argued in this text that a purely individualistic approach to euthanasia is more likely to result in its being seen as justified and acceptable, than when a perspective on its impact from a more societal point of view is also taken into account.

We all also recognize a right to life of each individual. One question is whether this means that there is a duty to go on living. It is proposed that there may be a moral duty to do so, depending on the circumstances, but there is no legal duty. But to deny such a legal duty, is not the same as recognizing a claim or right to have death inflicted, that is, euthanasia.[91] Recognition of a right to life also means that, even if one agrees with euthanasia, it would not be allowed to be carried out against the wishes of the person concerned, that is, involuntary or non-consensual euthanasia would

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88. Young, supra, p.16.

89. C. Levine, "AIDS and the Ethics of Human Subjects Research", in F.G. Reamer, ed., *AIDS and Ethics*, (New York: Columbia University Press, 1991), 77-104, 83.

90. See, for example, Federal Centre for AIDS (Canada) Working Group on Anonymous Unlinked HIV Seroprevalence, "Guidelines on ethical and legal considerations in anonymous unlinked HIV seroprevalence research", *Canadian Medical Association Journal* 1990; 143(7):625-627.

91. For an argument to the contrary, see, supra, pp.10-11 and *Notes: Harvard Law Review*, supra, note 27.

be prohibited. This raises the issue of avoluntary euthanasia, that is, whether if euthanasia were allowed, it could be carried out in a situation where the person is not able to consent or to express wishes and these are not known. The ethical and legal presumption in favour of life would mean that persons who had never been competent could not be subject to euthanasia, unless it were held that the presumption was a rebuttable one and that, in the particular circumstances, it did not take priority. Allowing euthanasia for competent persons may or may not set a precedent to the effect that the presumption in favour of life can be rebutted to allow avoluntary euthanasia. If, on the one hand, one focuses on the person's right to decide for himself or herself and uses this as the basis for rebutting the presumption in favour of life, it would not set such a precedent. If, on the other hand, one focuses on the fact that permitting euthanasia for competent persons is to recognize that intentional infliction of death on another is legitimate in certain circumstances, for example, to eliminate suffering, this could set a precedent for the legitimization of avoluntary euthanasia of incompetent persons who are in similar circumstances to the competent persons who die through euthanasia.

We also need to consider what could be the wider effects of recognizing a right to die with dignity and holding that this includes a right to have access to euthanasia. Such a right could be converted to a duty to die with dignity. This could become a right of society to insist that the person dies "with dignity" (which is likely to involve involuntary euthanasia in some cases) or even an obligation to die,[92] the corollary of which is a right to kill which would be implemented through euthanasia. To explore what is implied by some of the positions contemplated here, one can compare, for example, a right to treatment with a right to be offered treatment. Rights to treatment are sometimes proposed as a basis for corresponding duties to impose treatment, which are then converted to rights to impose treatment. The corollary of a right to be offered treatment, in contrast, is a duty to offer treatment which the recipient of the offer can accept or refuse.

It is also worth noting in relation to "the language of euthanasia", that the language of a right to a dignified death is often, although it need not be, used as a euphemism for euthanasia.

We cannot recognize as rights all the claims of individuals, in particular, the claims of individuals when viewed as a group or community may conflict with their claims as individuals. The issue of whether collective claims should ever be recognized as collective rights and whether these should override individual rights, will not be pursued here. It is relevant, however, to

92. M.P. Battin, "Age Rationing and the Just Distribution of Health Care: Is there a Duty to Die?", *Ethics* 1987; 97(2):317-340.

the euthanasia discussion, in that, if one accepts that persons have a right to a dignified death, and if one accepts that this includes a right to euthanasia and that at an individual level the benefits of recognizing this right outweigh its harms, nevertheless, the impact at a macro or a societal level of recognizing such a right, would still need to be considered. It is proposed that at this level, the harms and risks of such recognition would outweigh any claim of an individual to have euthanasia made available. Stated another way, we cannot only consider individual rights, including any right to euthanasia, from the point of view of the individual, we must also consider the macro or societal level impact of recognition of such individual rights. The need for protection of human networks which, at their most macro level, establish the web which constitutes society, itself, must also be given proper consideration. It is proposed that euthanasia is not acceptable at the societal level, even if one has no personal moral inhibitions against it at the individual level and that its unacceptability at the societal level outweighs the acceptability of the best case argument for it at the individual level. The reasons for my views in this regard are articulated in various places throughout the remainder of this text.

(iii) Sanctity of life and quality of life

There has been a move, in our society, from relying exclusively on a sanctity of life or vitality principle, to relying as well or sometimes alternatively, on a quality of life principle, which includes concepts of a life not worth living or even "wrongful life". Initially "wrongful life" was a claim for damages in tort, usually on the part of handicapped children arguing that in their cases, life itself, that is, being born constituted a damage for which compensation should be available through the courts. Although in most of these cases the plaintiffs were not successful, some were.[93] There has been a relatively recent case in which the precedent set in these cases has been used at the other end of life. The plaintiff had refused cardio-pulmonary resuscitation, but was given it after a cardiac arrest and, when resuscitated, was hemiplegic. He has sued for damages for "wrongful life".[94]

Recognition of a quality of life principle is often linked to euthanasia, in particular, by the same two opposing groups who argue for a broad definition of euthanasia - that is, some groups in the pro-life movement and persons who are pro-choice on euthanasia. The former oppose use of the principle, the latter would give it priority over a sanctity of life principle.

93. See, for example, *Curlender* v. *Biosciences Laboratories*, 106 Cal. App. 3d, 811; 165 Cal. Rpt. 477 (1986), (Ct. App.).

94. D. Margolick, "Patient's Lawsuit Says Saving Life Ruined It", *New York Times*, 18 March 1990, p.A24.

But one is not necessarily a proponent of euthanasia or an adversary of a sanctity of life principle, if one agrees that quality of life is a valid consideration in making decisions concerning treatment at the end of life. Consideration of quality of life is not unjustified, indeed, it may be ethically required in some circumstances, for example, in making decisions concerning the allocation of medical resources at a governmental or institutional (macro) level. The need to consider quality of life arises in part from the possibilities made available by modern medical technology. It has been well said that once we were "reasonably well or dead"[95] - today we can be very sick for a very long time at the end of our lives, because life can be prolonged by the use of modern medical technology. Such circumstances can sometimes raise valid concerns about the quality of life of the persons whose lives are prolonged.

The reasons for our various approaches to use of a quality of life principle, as is true of various approaches to euthanasia,[96] may be more complex that we realize at first glance. Campion[97] points out that when we describe a person with Alzheimers disease or Huntington's chorea as "better off dead" - "not the person he or she used to be" - and by this imply that the person does not now have a sufficient quality of life, as compared with what he or she had, to want to go on living (or even to be allowed to go on living), we need to inquire, what *was* the person. Persons are always evolving. No one is what they were previously "and many times . . . stopped being the person [he or] she used to be".[98] Does this indicate that it is lack of evolution or a potential for evolution to what we regard as an acceptable quality of life, that we perceive as the problem? Is this the basis of one category of statements related to assessment of quality of life, sometimes made in order to justify euthanasia, that there is a "loss of dignity" of the patient and, therefore, the person's life is not worth maintaining or may justifiably be terminated?[99] Can we, as humans, not accept either ourselves or someone else simply being, rather than becoming? Is it, as the novelist Kundera proposes,[100] a state of just being, without potential to become something else, that is unbearable? If this is true, we need to ask, whom would we be treating with euthanasia - the patient, ourselves or society?

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95. J.F. Fries, "Aging, Natural Death, and the Compression of Morbidity", *New England Journal of Medicine* 1980; 303(3):130-135.

96. See, supra, p.19-20 and de Hennezel, supra, note 65.

97. B. Campion, "Love and the Quality of Life", [Toronto] *The Globe and Mail*, 4 August 1990, p.A4.

98. Ibid..

99. If "dignity appears compromised, the argument goes, the patient's life no longer has the quality that obliges us to preserve it. Indeed, there may even be the obligation to end this caricature of human existence". (Campion, ibid.).

100. M. Kundera, *The Unbearable Lightness of Being* (New York: Harper & Row, 1984).

Campion[101] proposes that part of the problem when we react inappropriately in relation to ill or dying persons, is that we see an example of a life that terrifies us.[102] We see the patient and ourselves, if we were in the same situation, as unloveable. This raises fear of abandonment, because in a consumer society we only get what we pay for. We feel that we need to earn love. If we cannot earn it, we will not be given it. We will die abandoned and unloved, and we would rather be dead than unloved. Euthanasia is a way to ensure that we are dead before the abandoning and unloving occurs. "The demand for active euthanasia would be greatly reduced if we could alter this perception that love is very tenuous, that it is conditional and must be deserved".[103]

The possible connection of euthanasia with a mechanistic approach to persons has been mentioned already. Such an approach is also related to a consumer society. It is characteristic of this type of society that it disposes of worn-out or useless products. This becomes mandatory when these products result in a nett overall economic loss. If we see ourselves simply as products or cogs in the wheel of production of a consumer society, then, once we are no longer valuable products or producers, according to the dictates of a strict consumer philosophy we would need to be disposed off as cheaply and efficiently as possible. Although euthanasia is promoted as a merciful response and most of those who advocate it have this as a primary aim, it does fit within this consumer philosophy. Further, the practice of euthanasia, itself, could be seen as consistent with the philosophy of a consumer society, because it means that "death becomes a matter of management".[104] This in turn means that in carrying out euthanasia "a number of choices become necessary and several practical points must be discussed: the day and the hour of euthanasia, those to be present, the method to be used".[105] The bizarre thought comes to mind that, in the future, persons studying for master's degrees in business management, could have the possibility of taking a course in "death administration".

The argument that euthanasia being seen as acceptable by increasing numbers of persons in a society is connected with that society being influenced (or more precisely dominated) by a consumer philosophy, becomes particularly convincing, it is proposed, if we consider the circumstances of many

101. Supra, note 97.

102. It is interesting to compare the trigger for this terror reaction - a fear of a certain kind of *life* - with the trigger for the other terror reaction -intense fear of *death* - which is also arguably relevant to euthanasia. See, supra, pp.17-19 and the work of Greenberg et al., supra, note 57.

103. Ibid.. See, also, supra, pp.20-21, and de Henezel, supra, note 65.

104. See, de Wachter, supra, note 12, p.25, referring to Cohen.

105. Ibid..

persons with AIDS. Katz powerfully describes the situation in which terminally ill persons can find themselves, as one of intense "pre-mortem loneliness".[106] In this respect it is of sad interest to note that in 1989 it was reported that "11.2% of Dutch AIDS patients died by active euthanasia".[107] In 1991, one report put this figure at 23%.[108] But in either case, these statistics seem to be well above the average number of deaths that occur through euthanasia in The Netherlands.[109] If we consider who are the most stigmatized, most-likely-to-be abandoned, dying persons in our societies, almost certainly they are persons with AIDS. Without minimizing or ignoring the intense physical and mental suffering that AIDS can cause, these other features of their dying may well correlate with an increased likelihood that persons with AIDS will seek euthanasia (or be offered it), especially in a society that is governed by a consumer ideology. In such a society persons with AIDS may be viewed, not only as useless products, but also as potentially harmful ones. Moreover isolating persons with AIDS from society, whether

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106. J. Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1986), 207 ff..

107. Fenigsen, supra, note 50, p.22.

108. T.W. Gremmem and F.M. Van der Boom, "AIDS, Euthanasia and Grief", Paper presented at First International Conference on Biopsychosocial Aspects of HIV Infection, Amsterdam, 22-25 September, 1991, Final Program and Abstract Book, p.203. See, also, J. Beckett, et al., "Physician Attitudes Towards Assisted Suicide and Euthanasia", ibid., p.202.

109. It is very difficult to find non-disputed statistics on the number and percentage of deaths occurring through euthanasia in The Netherlands. Figures are given, but "[t]he extent . . . is not known. According to a recent report, there were some 200-300 cases of euthanasia in Amsterdam in 1987, 10 percent of which were reported to the public prosecutor. The frequently cited figure is 5000-8000 cases per year but the Amsterdam data suggests this figure is too high. According to one estimate, the average general physician has recourse to euthanasia once every three years". (Rigter, supra, note 10, p.32). Reasons for this difficulty include non-reporting (Rigter, p.31) and possibly under-exaggeration or over-exaggeration of "soft" data in order to promote a position either for or against euthanasia. It seems that exaggeration in either direction can occur with respect to both positions, that is, that "for" or that "against" euthanasia. For example, it can be argued by those opposing euthanasia, that so few people need euthanasia that society is not justified in legalizing it; alternatively, it can be argued that the number of cases that have occurred or will occur is so large that euthanasia should not be legalized because this indicates a great potential for wide abuse. Similarly, pro-euthanasia advocates argue that the numbers are so small that abuse is very unlikely; or that the numbers are or will be so large that this demonstrates a major societal need for euthanasia and for approval of it. A recent report (van der Mass, van Delden, Pijnenborg, and Looman, supra, note 11) presents the results of three nationwide studies in The Netherlands on euthanasia and other medical decisions concerning the end of life, undertaken for the Dutch Remmelink Commission. (This report has elicited further discussion. See, for example, *Hastings Center Report*, Vol.22, March-April 1992, which features articles on euthanasia, including, in The Netherlands.) But even this report does not resolve some important uncertainties since its "findings require cautious interpretation, because there are no universally accepted definitions of such terms as 'euthanasia' and 'killing', and what is 'euthanasia' for one person is but 'good medical practice' or the withholding of 'futile treatment' for another". (H. Kuhse and P. Singer, "From the Editors", *Bioethics* 1992; 6(4):iii-vi, v.)

in practice or symbolically - including through euthanasia of persons with AIDS having these effects - may serve a further function for the society, that of a purification ritual. It could be that use of euthanasia in the context of AIDS, is an example of euthanasia functioning as a purification ritual, which it should be recognized it has the capacity to do. Calls, often strident, to test everyone in general for HIV and quarantine those who are antibody positive, or to exclude them from schools, hospitals or the workplace - including practice in the health care professions -can originate from a desire, even if unconscious, for acts that will serve a function of symbolic purification of the group or society and affirm that this purity exists. Could euthanasia be the ultimate example of this type of ritualistic phenomenon?[110]

It also merits considering whether the language we have used in relation to AIDS could have an impact on our views and reactions to euthanasia in the context of AIDS. Military terminology, especially, the concept of a war on AIDS, is frequently encountered. Could there be some connection, even if an unconscious one, between this language and views that the use of euthanasia is acceptable in relation to persons with AIDS? Could the use of euthanasia in AIDS even be some form of killing of the enemy, in that one of us, and not HIV, is mistakenly seen as the enemy?

IV. Why Do We Wnat to Medicalize Euthanasia?

Does euthanasia seem kinder, gentler and in a "safer forum" if it is carried out in a clinical context?[111] Does this show both "approval, acceptance and care of the patient"[112] and of his or her decision for euthanasia? In speaking of physician assisted suicide, it has been said that "[s]eeking a physician's assistance, or what can almost seem a physician's blessing, may be a way of trying to remove . . . stigma and show others that the decision for suicide was made with due seriousness and was justified under the circumstances. The physician's involvement provides a kind of social approval, or more accurately helps counter what would otherwise be unwarranted social disapproval".[113] Could euthanasia provide a precedent for some other

110. For a discussion of attitudes and behaviour in relation to HIV/AIDS and persons with AIDS, which serve functions other than their apparent or proclaimed practical aims, for instance, symbolic and ritual functions, see, M.A. Somerville, "Law as an 'Art Form' Reflecting AIDS: A Challenge to the Province and Function of Law", in James Miller, ed., *Fluid Exchanges: Artists and Critics in the AIDS Crisis* (Toronto: University of Toronto Press, 1992), 287-304.

111. See, M.A. Somerville, "Human Rights and Medicine: The Relief of Suffering", in Irwin Cotler and F. Pearl Eliadis, eds., *International Human Rights Law: Theory and Practice*, (Montreal, Quebec: The Canadian Human Rights Foundation, 1992), 505-522.

112. Campion, supra, note 97.

113. Brock, supra, note 25, p.21.

interventions which will, also, be carried out "in the medical context", which have important, potentially dangerous, societal impact? For example, in the United States, physicians' involvement in carrying out capital punishment, is a case in point. Such interventions can be given trial runs or attempts made to make them acceptable through their utilization in a clinical or purportedly clinical context, before their much more controversial application outside such a context. These questions may seem alarmist, but they are ones which we need to ask and with a certain degree of equanimity.

We should keep in mind that it is not uncommon to medicalize situations in order to deal with these situations in ways in which we would not feel comfortable or even that would be prohibited outside a medical situation. For example, infringement of even constitutionally protected rights to liberty and security of the person can be justified pursuant to powers given under mental health acts or public health legislation, which allow interventions necessary to protect either the persons themselves or others from serious threats to their lives or health. We need to be careful in adopting tactics and devices such as medicalization, that we do not dull our sensitivity to some of the basic issues involved. It has been said that nowhere are human rights more threatened than when we act purporting to do good to others. There is a presumption that when we act within a medical context, we at least have a primary intention of doing good. This presumption would apply equally to euthanasia, as to other interventions in a medical context. Consequently, although it is usually argued that euthanasia is most appropriately provided within a medical context and it is often argued that to allow euthanasia is to promote human rights, this claim would be more clearly tested by dealing with euthanasia outside the medical context rather than within it.[114]

Some proposed legislation for Canada[115] mentioned previously, which has now been withdrawn, is of note in this respect, in that, it would have required euthanasia to be dealt with in part outside a medical context. This legislation, possibly uniquely, proposed that there should be "referees in eu-

114. See, Somerville, supra, note 111. See, also, M.P. Battin, "Assisted Suicide: Can We Learn from Germany?", *Hastings Center Report* 1992; 22(2):44. Battin describes the situation in Germany, in which assisted suicide in terminal illness seems to be regarded as de facto acceptable in certain circumstances provided it is carried out entirely outside the medical context. Such assistance within the latter context, in particular by physicians, is regarded as entirely unacceptable. This can be contrasted with the situation in The Netherlands, where assistance in euthanasia is only regarded as acceptable if provided by a physician. See also, A. Tuffs, "Germany: Scandal over euthanasia", *The Lancet* 1993;i:551, in which it is reported that "[u]nder cover of humane euthanasia a network of couriers has been selling cyanide capsules for years and making a fortune out of it".

115. Supra, note 47.

thanasia"[116] for Canada, who would issue "euthanasia certificates"[117] which would permit a physician to carry out euthanasia on the person to whom the certificate had been issued.[118] There was no suggestion that the "referees in euthanasia" should be physicians. Indeed, under the proposed legislation application could be made for review of a negative decision of a "referee in euthanasia", by the Attorney General of Canada who is unlikely to be a physician.

In summary, we must enquire whether we may at least in part be dealing with euthanasia in a medical context in order to eliminate or reduce reactions that we would otherwise have to one person killing another. Moreover, to the extent that we expect modern medicine to be our source of miracles, could it be that when no miracles are possible, death is a miracle substitute or even a different kind of "miracle", but one still provided by medicine if it occurs through euthanasia carried out by a physician?

V. Why Do We Technologize Euthanasia?

We need to ask, for example, in the much publicized case of Dr. Kevorkian assisting Mrs. Janet Adkin's death, why did Dr. Kevorkian and Mrs. Adkins, resort to a suicide machine which was even given a special, trademarked name, the Thanatron™?[119] One obvious reason is in order to try to avoid prosecution for murder by eliminating the possibility that Dr. Kevorkian could be held, in law, to have caused Mrs. Adkins' death. Through use of the machine, Mrs. Adkins could be regarded, in law, as causing her own death, in which case the situation was one of suicide - and if anything, assistance in suicide on the part of Dr. Kevorkian, which was not at that time a crime in Michigan[120] - not murder. It is worth noting, however, that even in the case of Mrs. Adkins, where Dr. Kevorkian did not intervene after the initial intravenous lines had been inserted and Mrs. Adkins herself activated administration of the lethal drugs, a charge of murder was considered. In two subsequent cases, Dr. Kevorkian did intervene, in one instance to remedy a defect in the machine after it had been started. With respect to these cases, charges of murder were laid against him[121] but were found to be with-

116. Ibid., sec.2.

117. Ibid., sec.8.

118. Ibid., sec.12.

119. A. Hister, "Kevorkian Offers Cold Comfort on Euthanasia Debate", [Toronto] *The Globe and Mail*, 14 September 1991, p.C8.

120. Since these events, legislation has been passed in Michigan making it a crime to assist a person to commit suicide. Act 84, *Public Acts of 1992*, 1992 Mi. ALS 84; 1992 Mi. P.A. 84; 1992 Mi. HB5501.

121. Reuters News Agency, "Doctor Charged with Murder in Assisted Suicide", [Toronto] *The Globe and Mail*, 6 February 1992, p.A9.

out foundation.[122]

There may, however, be a less obvious reason why we technologize euthanasia. We often speak of the technological imperative in medicine, that is, that we have technology and, therefore, think or feel that we must use it. The presence of technology elicits a response to use it and much discussion in bioethics has been concerned with attempting to work out principles and guidelines for when we ought (there is a duty), not ought (there is no duty), or ought not (there is a duty not) to use technology. Could the case of euthanasia be a variation on this technological imperative response? Could it be that in euthanasia cases, such as those involving Dr. Kevorkian, that rather than the technology preceding and eliciting a certain response, a certain response - namely, euthanasia - is desired and recognition of this precedes and elicits the technology which will generate the desired response?

Does the use of technology somehow come between us and the person to whom we apply the technology,[123] such that we do not feel that it is our act that creates the result - in the case of euthanasia, death of the person - but rather, that this is caused by the technology? Does the use of technology allow us to distance ourselves, to dis-identify in some degree, from the fact that we are killing another person in the act of euthanasia?

It has been alleged that when we apply technology to other persons in the medical context, there is a risk that we de-personalize the others and see them simply as the objects for the application of our technology. Further, we find it easier to act towards others in ways about which we have deep concerns, when we do not regard those affected by our acts as persons similar to ourselves. For example, researchers found it very much more difficult and sometimes impossible to carry out certain medical research on persons, when they were forced to relate personally to the potential subjects through themselves participating in a detailed informed consent process.[124] Could this provide insights into why persons would develop technology to carry out euthanasia? In summary, technology allows us to distance ourselves

122. M. Betzold, "Cleared 'suicide doctor' urges other physicians to join him", [Montreal] *The Gazette*, 22 July 1992, p.B5. Editorial, "Who has the final choice?", [Montreal] *The Gazette*, 28 July 1992, p.B2.

123. It is of interest that the way in which I wrote this sentence, initially, was "Does the use of technology somehow come between us and the person to whom the technology is applied . . .", as though there was not necessarily a human agent involved in applying the technology. This, in itself, would seem to demonstrate the point I am making here, that the use of technology (or even just contemplation of its use) causes or at least allows us to depersonalize situations in which it is employed.

124. J.J. Lally, B. Barber, "The Compassionate Physician: Frequency and Social Determinants of Physician-Investigator Concern for Human Subjects", *Social Forces* 1974; 53(2):289-96.

from others on whom we act and to depersonalize them, and, unless we do this, it may be very much more difficult to kill the other person. As an aside, it is also worth noting here that we can use language to achieve similar effects. The choice of certain language facilitates our distancing ourselves from others and depersonalizing them. One example of this is the use of derogatory terms for those killed as the enemy in wartime. A more everyday example is the failure to use the word person when describing an individual or a group, which almost always occurs in relation to derogatory characterizations, for example, criminals, delinquents, mental incompetents (in comparison, we do not speak of mental competents, but rather of mentally competent persons) and the aged.

In summary, as Annas says: "Machines have a tendency to depersonalize death and to make us seem less responsible for it. . . . The use of military metaphors in medicine tends to obliterate the patient, just as the use of medical metaphors by the military tends to obliterate the horrors of war. In both cases, we prefer to concentrate on the technology because, unlike death, it seems clean and controllable."[125]

VI. Why Would Euthanasia Be Allowed or Not Prosecuted, but not Legalized?

The criminal law of all countries prohibits culpable homicide - murder and manslaughter. Euthanasia is prohibited pursuant to such laws. A majority of countries also prohibit assisting suicide, although in modern criminal law suicide itself is often not a crime. There are also examples, of which The Netherlands is the main one, of countries which allow euthanasia under certain conditions, but have not legalized it at least in a strict legal sense.[126]

The criminal law of The Netherlands, the *Penal Code*, prohibits murder (euthanasia) in section 293 and prohibits assistance in suicide in section 294.

125. G.J. Annas, "Killing Machines", *Hastings Center Report* 1991; 21:33,35.

126. It seems that this situation will be maintained even after legislative approval of "Netherlands Reporting Procedure for Euthanasia", supra, note 13. A press release (dated February 1993) provided by the Embassy of the Netherlands, Ottawa, Canada, states that "[e]uthanasia is a crime under Dutch Criminal Law" and that the 1990 guidelines "on the reporting procedure for euthanasia . . . have now been codified". In short, the existing situation has been legislatively recognized, but not changed, except to the degree that such recognition, itself, constitutes change. For analysis of the operation and effect in law of the guidelines, which while undertaken prior to codification of the guidelines remains valid, see H.J.J. Leenen, supra, note 74; Diana Brahams, "Euthanasia in the Netherlands", *The Lancet*, 1990; i:591-592; H.D.C. Roscam Abbing, "Dying with Dignity, and Euthanasia: A View from The Netherlands", *Journal of Palliative Care* ("Special Issue on AIDS") 1988; 4:70-75, 71; Rigter, supra, note 10; de Wachter, supra, note 12; Capron, supra, note 11; H.A. ten Have and J.V.M. Welie, "Euthanasia: Normal Medical Practice?", *Hastings Center Report* 1992; 22(2):34.

In The Netherlands, however, prosecution is unlikely[127] if certain guidelines are respected and, in any case, decisions to prosecute must be approved by five senior prosecutors.[128] The jurisprudential basis used to validate these guidelines are a few articles in the Dutch Penal Code "listing possible grounds for non-punishment" for an offence.[129] The conditions for legitimizing a given act of euthanasia are, "among other things, that there be an explicit and repeated request by the patient that leaves no reason for doubt concerning his desire to die; that the mental or physical suffering of the patient must be very severe with no prospect of relief; that the patient's decision be well-informed, free, and enduring; that all options for other care have been exhausted or refused by the patient; and that the doctor consult another physician (in addition, he may decide to consult nurses, pastors, and others)".[130] It is reported that there has even been a case of a physician being disciplined by a Dutch Medical Disciplinary Board for "breach of trust" for "misleading a patient into supposing he was being given a lethal dose of drugs, when the doctor knew this was not so".[131] "[T]he doctor was in effect found guilty for 'not . . . unlawfully killing his patient'."[132] There is also in the Dutch context an intense debate over whether euthanasia should be available where the person concerned is incompetent to consent. As already noted,[133] some and probably a substantial number of such cases of euthanasia occur, although they would clearly seem to be outside the guidelines. These cases include, not only incompetent adults, but also handicapped newborn babies.[134]

What insights does the Dutch approach to euthanasia provide? First, it is

127. Leenen, ibid.; Brahams, ibid.. It would seem that prosecution, while unlikely, is still possible, even if the guidelines are followed, that is, euthanasia remains punishable and whether the physician has a defence is "assessed by the prosecution and the judge" (Leenen, p.9). However, see, P.A. Singer and M. Siegler, "Euthanasia - A Critique", *New England Journal of Medicine* 1990; 322(26):1881-3, who seem to imply the contrary. See, also, Rigter who states that ". . . the present government has *not* adopted a long-standing proposal to legalize euthanasia. Instead, it has decided that physicians who terminate life on request of the patient will not be punished only if they invoke a defense of *force majeure* and have satisfied . . . [certain] criteria . . . and then only on condition that the court accepts this defense. Such possible immunity from prosecution applies only to doctors". (Ibid., p.31.) This approach will be codified, if the proposed legislation (supra, note 13, and ibid.) is fully ratified.

128. Brahams, supra, note 126, p.592.

129. ten Have and Welie, supra, note 126, p.36.

130. Rigter, supra, note 10, p.31.

131. Brahams, supra, note 126, p.591.

132. Ibid, quoting B. Levin "Under patient's orders to kill", [London] *Times*, 11 December 1989.

133. Supra, p.5.

134. Associated Press, "Mercy killing for newborns spurs euthanasia debate", [Montreal] *The Gazette*, 30 July 1992, p.A6.

important to recognize that, unless the codification of the guidelines on the procedure for reporting euthanasia is interpreted as changing the previous situation, which does not seem to be intended or likely, the law has not been changed to legalize euthanasia. Rather, individual cases are justified (query, excused[135]) in situations of "*[f]orce majeure*, in the sense of conflicting duties".[136] The commentary on the Dutch law with respect to what constitutes this defence is not always easy to understand or consistent, which may reflect some lack of clarity as to either the exact characteristics of the defence itself or its application in practice. For example, Brahams states that "force majeure" in the sense of irresistible force has been rejected as a defence to euthanasia.[137] She equates the defence of irresistible force to a defence of necessity and, therefore, likewise, also finds this defence rejected.[138] Rather, Brahams states, a "conflicting duties situation", which she describes as "the emergency defence", is recognized by Dutch courts: "The court ruled that a physician's duty to abide by the law and to respect the life of his patient 'may be outweighed by his other duty to help a patient who is suffering unbearably, who depends upon him and for whom, to end his suffering, there is no alternative but death' ".[139] In contrast, Keown[140] says that the defence available to Dutch physicians to justify euthanasia is one of necessity ("overmacht") contained in Article 40 of the Dutch Penal Code. He says that in a 1986 case the Dutch Supreme Court "accepted that the defense of necessity in the sense of 'psychological compulsion' experienced by the doctor was also available".[141] In any case, it can be queried whether there is any equivalent to such a "conflicting duties" defence in anglo-american common law. The only possibility would seem to be a defence of necessity. A defence of necessity is available in anglo-american common law when the harm done by breaking the law is clearly outweighed by the harm avoided in doing so; the harm avoided is of a serious nature; there is no reasonable alternative to breaking the law, if the harm is to be avoided; and the least harmful approach that will avoid the harm is used. The critical issue regarding possible use of a defence of necessity in relation to euthanasia is whether the harm done by breaking the law - killing a person - could ever be out-

135. See, M.A. Somerville, supra, note 38, for discussion of the difference between justifications and excuses. The former renders the conduct in question legally acceptable, the latter does not, but excuses the actor from liability for it.

136. Leenen, supra, note 76, p.5.

137. Brahams, supra, note 126, p.592.

138. Ibid..

139. Ibid., citing B. Sluyters, "Euthanasia in The Netherlands", *Medico-Legal Journal* 1989; 57:34-43.

140. J. Keown, "On Regulating Death", *Hastings Center Report* 1992; 22(2):39.

141. Ibid., p.41.

weighed by the harm avoided by doing so - relief of suffering. This seems highly unlikely because it is only if the necessity in question is to save a human life, that killing can be excused, although not justified, under a common law doctrine of necessity.[142] Further, leaving aside the morality of euthanasia, the harm done at a precedent-setting and societal level in allowing euthanasia, would not, in my view, be outweighed by harm avoided at the individual level.

One query that can be raised is whether in establishing this system of legitimation of euthanasia, the Dutch have managed to maintain at least an impression that each case of euthanasia constitutes only an individual event, not only in practice, but also symbolically, despite the fact that the total number of cases of euthanasia in The Netherlands is probably very large.[143] The features of the approach taken in The Netherlands could help to achieve such an outcome, namely, that each case of euthanasia must be justified individually and reported;[144] each case, technically, is prima facie a breach of the law; and in each case, there is the potential for the conduct to be found not justified and prosecuted. This approach may generate more of a sense of individuality and less one of institutionalization of euthanasia, than there would be if euthanasia were generally legalized, but only on certain conditions. Why, however, would the Dutch adopt this approach if euthanasia is regarded as acceptable by the public, in general? One reason might be that such an approach helps to keep cases of euthanasia confined to the micro level and as exceptions to a general principle or presumption against the taking of human life, the latter of which can still then operate at the macro or societal level. To the contrary, were euthanasia to be legalized directly by the legislature, rather than indirectly as is currently and will remain the case, the level of impact of euthanasia would certainly include major impact at the macro level and the general principle or presumption that governs in the society would be changed to one that life may be taken in certain circumstances.

In short, the current approach in The Netherlands may maintain a certain symbolism of upholding the principle of the sanctity of life, while allowing practices that are inconsistent with this. This same mechanism can be seen

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142. de Wachter, supra, note 12, p.27, quoting B. Dickens. See also, Somerville, supra, note 38.

143. See, supra, note 109.

144. Recent studies, show, however, widespread non-compliance with reporting provisions. See, ten Have and Welie, supra note 126; and Keown, supra, note 140, p.40, who says that in fewer than 2% of the cases of euthanasia, in The Netherlands, was the prosecutor notified. The new "Reporting Procedure" guidelines (supra, notes 13, 126) are aimed at remedying this situation. If they do, they might make euthanasia less, rather than more, available, despite its having been "recognized" by the Dutch Parliament, which can be seen as a paradoxical result.

operating in the French legal and medical systems. A report entitled "French Health Ministry Supports Doctor Over Euthanasia", reads as follows:

> Leon Schwartzenberg, an eminent French Cancer Specialist, has been suspended for one year by the Paris board of the French Medical Association. The suspension follows Schwartzenberg's admission that he had helped an incurable patient to die. Claude Evin, the French Health Minister, has now joined Schwartzenberg in filing an appeal, and in calling for broad public debate on euthanasia. Evin said: "The main thing is to relieve suffering, even if that means the end of life." Neither Evin nor Schwartzenberg favour a change in legislation, however. Schwartzenberg has said: *"for the French, anything that is law is normal, and euthanasia can never be normal."*[145]

A similar approach of *de facto*, but not *de jure*, legalization of euthanasia, has recently been advocated for Canada. The proposal of Sneiderman, a law professor, who does not oppose euthanasia, is summarized in the headline accompanying an article written by him: "Don't make it murder, but don't make it legal".[146] Sneiderman writes that "[i]n the rare situation in which the physician is driven to desperate measures (as [occurred recently] in a Montreal case [in which a physician gave a lethal injection of potassium chloride to a terminally ill person with AIDS who was suffering greatly]), the law has the capacity to stay its hand as a merciful response to a merciful act. But that is a far cry from granting physicians the legal authority to practice euthanasia. As philosopher John Rawls says, 'It is one thing to justify an act; it is another to justify a general practice'. Given the current crisis over a health-care system unable to meet the reasonable needs of all our ailing people, we cannot guarantee that euthanasia would be practised solely as the medical measure of last resort. In short, one cannot say that the time for euthanasia has come to Canada."[147]

In summary, even those who do or would allow euthanasia at an individual level, recognize the danger of this at the societal level. An important issue, therefore, is whether it is possible to prevent approved micro level practices from establishing macro level precedent. Almost certainly, it is not. Consequently, quite apart from moral arguments, it is proposed that euthanasia should not be allowed at the micro level because of the macro level effect of this.

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145. *New Scientist*, 28 July 1990, 22 (emphasis added).

146. B. Sneiderman, [Toronto] *The Globe and Mail*, 17 August 1992, p.A19.

147. Ibid..

VII. HIDDEN DECISION-MAKING AND EUTHANASIA

It is often alleged that much euthanasia takes place in our society, but that it is performed secretly and the fact that it occurs is hidden. It is further alleged that this situation is the result of euthanasia being illegal. Recent studies, however, show much hidden (at least in the sense of unreported) euthanasia in The Netherlands,[148] where euthanasia is de facto legal. Consequently, the cause of euthanasia's being hidden may not only (or even not at all, because even if legal it may still be hidden) be the result of its being illegal. We usually react strongly in modern, western societies, against hidden decision-making and actions, but should we always do so? To respond to this question requires that some distinctions be made. Do we believe that hidden decision-making, itself, is wrong and in all or just some circumstances, or do we rather believe that most cases of such decision-making involve unethical or illegal decisions, that these need to be prevented and this can best be achieved by eschewing hidden decision-making? We need to be open-minded enough to ask whether there is a place for hidden decision-making and actions by individuals, although not by institutions or society, in some very unusual situations. We need also to ask whether, beyond taking certain steps, trying to eliminate all hidden decision-making regarding euthanasia would do more harm than good. In particular, we need to ask whether legalizing euthanasia, in order to try to avoid hidden decision-making, would do more harm than good even if we were to achieve the aim of eliminating hidden decision-making concerning euthanasia.

We can compare euthanasia with abortion regarding possible effects of hidden decision-making. Whether or not one agrees that abortion is morally acceptable, abortion is an example where creating circumstances which give rise to its being carried out in a hidden manner, causes a major increase in serious risk for women who have abortions, and may not deter women from having abortions. This is one argument against using law to prohibit abortion in the early stages of pregnancy. Another argument is that the law is ineffective to prevent abortion, especially in light of the availability of new methods of abortion, in particular, the "abortion pill", which do not require the use of sophisticated medical techniques or facilities.

But to accept that certain law prohibiting abortion may create unacceptable levels of harm without compensating benefits, in particular, protecting fetuses from abortion, or is totally ineffective, does not address or alter the morality of abortion. Rather, no matter whether the law allows or prohibits

148. See, Keown, supra, note 140, p.40 citing C.F. Gomez, "Regulating Death: Euthanasia and the Case of The Netherlands", (New York, The Free Press, 1991) who states that in less than 2% of cases of euthanasia was the prosecutor notified.

abortion, those who believe abortion is immoral must try to convince those who do not believe this and persuade them to alter their conduct accordingly.

Causing euthanasia to be carried out in a hidden manner because it is illegal, is not likely to give rise to similar risks and harms to the person subject to it. At least, this is true, first, if one does not regard *not being killed* when one desires this as a harm. (Hidden euthanasia is, almost certainly, far less readily available than legalized euthanasia would be and some persons who would have access under an overt, legalized system of euthanasia, may not have access in the absence of such a system.) And, second, this is true provided hidden euthanasia only involves persons who want to be killed and would be eligible for euthanasia if it were legalized, since these persons would also be killed if euthanasia were overt and legal. Some persons argue, however, that the potential for abuse is vastly increased by forcing acts of euthanasia to be hidden, which occurs when it is prohibited by law. But it could also be that the potential for abuse is increased more when euthanasia is legalized than when it is not. For instance, Dutch public policy allowing euthanasia has been criticized "for creating a 'private place' for euthanasia which is both spacious and poorly policed".[149] Further, it is not uncommon for those in favour of euthanasia to demand that opponents of voluntary euthanasia provide data or evidence of a "slippery slope" in order to justify continuing to prohibit it.[150] But this is the opposite burden of proof from that which one would usually expect. Normally, those who wish to change the "status quo", that is, to legalize euthanasia, would be required to show leaving aside for the moment questions regarding the morality of euthanasia that the change in the law is not dangerous to individuals or society or at least no more dangerous than the present situation, and possibly that the proposed change will do more good than harm.

It should be noted that recognizing that euthanasia may occur in a hidden manner and deciding that to take all possible measures to try to prevent these instances, even though they are in serious breach of the law, would cause more harm than good, does not mean that, therefore, one finds euthanasia morally acceptable. Moreover, if such hidden instances become known, they would need to be prosecuted, if the general effectiveness and symbolism of the law prohibiting euthanasia is to be maintained. It is simply noted here that there is always a discretion whether to prosecute and, in some rare cases involving euthanasia this discretion may be best exercised by

149. Keown, supra, note 140, p.40, quoting C.F. Gomez, *Regulating Death: Euthanasia and the Case of The Netherlands* (New York, The Free Press, 1991).

150. For example, Brock, supra note 25, p.20

deciding not to prosecute. Such cases, however, should be clearly exceptional, if they are not to become a message, in particular, to health care professionals, that they can carry out euthanasia with impunity. Likewise, suspended or light sentences for euthanasia can have the same effect. In handing down such a sentence very recently, a Canadian court expressly noted that health care professionals should not interpret it in this way.[151]

One needs to take great care with some current research on attitudes to euthanasia, that involves surveys that abandon the distinction between euthanasia, as defined in this text, and other interventions or non-interventions at the end of life. Such surveys often promote the idea that there is much hidden euthanasia, in that, many health care professionals - physicians and nurses - have carried out euthanasia for a long time. There is at least an implication, and sometimes articulation of an argument, that this provides evidence that the law should be brought into line with such practice on the grounds that this conduct has "obviously" not caused any harm; that it must be necessary; that the persons who have undertaken these interventions are of "good conscience" and good-will; and that these persons have neither been sought out nor prosecuted.[152] For example, there has been a recent report from Boston that one in five United States physicians has deliberately caused a patient's death. The report, however, speaks of terminally-ill patients who asked for assistance in committing suicide and it is not clear what, if any, were the limits to the conduct engaged in by the physicians in order to "help death".[153]

In interpreting such surveys, first, a much more accurate assessment would need to be done of exactly what the physicians surveyed meant by "helping death". For example, respecting refusals of treatment or giving necessary pain relief treatment, even if this could shorten life, might have been included. It needs to be acknowledged that there are major legal differences and it is proposed major ethical differences between these kinds of assistance and, for instance, giving a person a lethal injection, and that *this is true whether or not one agrees with euthanasia.*

Second, even if some physicians are carrying out practices about which we disagree with respect to their ethical acceptability and which are legally unacceptable, this does not mean that the law should be changed to legitimize

151. C. Mungan & G. Abbate, "Sentence suspended in euthanasia case", [Toronto] *The Globe and Mail*, 25 August 1992, p.A1. But see also, Canadian Press, "Euthanasia: M.D. gets suspended sentence," [Montreal] The Gazette, 4 April 1993, p.A1, a later case in which the judge gave a similar sentence without any such caveat.

152. "Nurses Admit Helping Eighty Die", [Adelaide, Australia] supra, note 26.

153. As reported in "One in Five Doctors Helps Death", *Weekend Australian*, 29 February, 1 March 1992, p.13.

such practices. Neither, however, as discussed above, does it mean that in all cases the law should be relentlessly used to prosecute them. It may be that in some very unusual circumstances, at the level of an individual case, prosecution is inappropriate. At the same time, the symbolism that is created by the law prohibiting the conduct concerned, is required at the macro level and great care must be taken not to damage this in dealing with such cases.

It is also argued that, because euthanasia is illegal, persons who carry out euthanasia are fearful of prosecution and that they should not have to be subject to this fear. There are, however, arguments to the contrary. First, such immensely serious decisions as euthanasia should never be easy. That such a decision is difficult, at both cognitive and emotional levels, for the person who will carry it out, is an essential and enormously important safeguard. Second, even for those persons who feel morally justified in performing euthanasia, it can be argued that there is some validity, and a safeguard, in the fact that they must at least consider the views of society as expressed in its law and be prepared to take the consequences of not conforming with this. This may seem a very "hard-hearted" approach and it may be thought to come from a failure to appreciate the anguish that can arise in some individual cases for persons who believe that in those particular cases the availability of euthanasia is not only morally acceptable, but morally required. This is not the case. Rather, it is proposed, euthanasia is a situation in which individual "hard" cases would make very "bad" law for society as a whole, if the law were changed to legalize euthanasia.

Leaving aside, for the moment, questions of the morality of euthanasia, in short, we may sometimes have to choose between the law that we need for symbolism - the law that would be best for establishing principles at the macro level - and what would be the "best" approach, in the sense of most compassionate and merciful, in some very difficult individual cases. This, in my view, is one of the situations where the needs of the community - the society - must take priority over claims of the individual. We cannot afford to routinize and institutionalize, let alone legalize, killing. Such routinization and institutionalization can be avoided, even if some very rare cases in which a physician intentionally kills a patient are not prosecuted, provided that the cases involved are each regarded as individual instances, and as outside the norm and, in particular, are not regarded as a group of cases which as a collective establish the norm. In short, it is simply wrong to argue, as some do, that because prohibited conduct, such as euthanasia, may be or even is occurring, this in itself provides justification for legalizing it.

Our most ancient laws, prescriptions and proscriptions are against killing

at least members of our own species. There have, it is true, always been exceptions to this rule, which needed to be restrictively interpreted and their use clearly justified by the person relying on such an exception. The major examples in western cultures, apart from so-called "just war", were self-defence and capital punishment after a "fair trial" for an offence which "merited" it, not all or most of which everyone agrees should still be allowed as exceptions. In any case, such exceptions should not be extended, in particular by legalizing euthanasia.

In considering legalizing and institutionalizing euthanasia, we are considering altering the fundamental presumption against killing each other on which the morality and law of a civilized society are based. Why apparently are so many of us so actively considering such a change? Could there be some socio-biological, genetic or environmental factor that is causing the current rise in interest in and promotion of euthanasia? One would need to examine other historical periods and other cultures and probably other species to even begin to have some idea whether this could be the case.[154] It is, however, important to be aware that what we perceive or feel as our primary motives in carrying out certain acts may be covering other very complex realities in this regard. For instance, empathy, compassion and mercy, while dominant motives on the part of most persons in situations in which they advocate euthanasia, may not be the only motivations present. It is just possible that factors such as an increasingly crowded world or even overwhelming fear about one's own death, especially in the context of a secular, pluralistic, post-modern societal ethos, could be playing a part in persons advocating euthanasia.

VIII. THE LANGUAGE OF EUTHANASIA

Language is not neutral. Although this proposition is obvious, it is so important in relation to the euthanasia debate, that it merits stating. We form our narratives and our narratives form us - we are, at least in part, the stories we tell. In particular, "bad" and "good" death "stories" are especially influential. They also give us access to experiential knowledge and, often, help us to identify properly our emotional responses and provide opportunities to examine these, all of which are essential if we are to respond wisely to issues raised by death, including by way of euthanasia. At a recent conference in Boston,[155] Dr. Timothy Quill and Dr. Susan Tolle told "stories", where a potentially "bad" death was converted to "good" death by

154. See, Young, supra, note 63.

155. The American Society of Law and Medicine, "Health Care Professionals and Treatment at the End of Life", 1992 Annual Meeting, October 30-31, 1992, Cambridge, MA.

their respective interventions, which, clearly, they were concerned were of doubtful legality, at best. These were powerful pro-euthanasia narratives. In contrast, Christine Mitchell read a deeply moving essay written by an intensive care nurse, who created a situation in which the family of the patient were included in his dying, through the nurse's unusually sensitive approach. As the nurse said, this man's dying was a very important event in the lives of his family and friends, as well as in his. Mitchell proposed that in characterizing the kind of death a person experiences, we should include what the person's family and friends will remember about that death and weave into their own lives.

With the power of language in mind, I would like to analyze, briefly, a relatively recent document which contains many examples of the way in which language can be used to influence the euthanasia debate. It also provides other insights as to how our reactions to euthanasia can be modified depending on the way in which euthanasia is presented. This document is a report of the "Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death",[156] which was based in London, England. The following quotes, except where otherwise indicated, are all taken from this report.

The Report speaks of *". . . hasten[ing] death by administration of narcotic drugs".*[157] This can be compared with the use of curare in The Netherlands after administration of an injection of a short-acting narcotic, for example, pentothal, to induce sleep.[158] One can query the basis of the decision to use only narcotic drugs. Could it be because this is less shocking to persons, less likely to make them react to euthanasia as a different kind of intervention from, for example, the administration of pain relief treatment which we regard as acceptable and even required. In particular, is the use of narcotics to carry out euthanasia less likely to elicit different emotional reactions than those we have to pain relief treatment and also more likely to elicit similar reactions of the appropriateness and acceptance of the intervention than would the use of other drugs? Curare which causes total body paralysis is used in many surgical operations which need such paralysis, in order to give a surgeon easier access, for example, to the abdominal cavity. As one Dutch anaesthetist said in conversation, it is not very difficult for an anaesthetist to carry out euthanasia, because it simply requires giving "half a general anaesthetic and just not doing the other half - the resuscitation". General anaesthetics are almost always given for therapeutic reasons and in order to heal.

156. "Assisted Death", *The Lancet* 1990; ii:610-613.

157. Ibid., p.610.

158. M. Angell, "Euthanasia", *New England Journal of Medicine* 1988: 319:1348-50. See also R.G. Twycross, "Assisted Death: A Reply", The Lancet 1990; ii:796-798.

Does the linking of euthanasia with this procedure, even its confusion with it, cause us to see and to react to euthanasia as a healing, therapeutic intervention?[159] If so, this is undesirable, which is not necessarily to say that one would be opposed to euthanasia, if it were not able to be viewed in this way. Rather, euthanasia, itself, must be *thought and felt* about as clearly as possible. In order to achieve this, one needs to guard against surrounding consideration of euthanasia with circumstances likely to cause confusion between how one thinks and feels in these circumstances about certain decision-making at the end of life *other than euthanasia*, and how one thinks and feels *about euthanasia* in the same circumstances. As Callahan has said, "[i]t is important in all moral debates to use very accurate terms that do not anaethetize our feelings".[160]

The Report refers to the terms *"assisted suicide"* or *"homicide upon request"*, and states that *"these terms are not used lest their legal implications confuse the ethical issues [of euthanasia]"*.[161] This is to disconnect law and ethics - to stop the law informing ethics. Too often, in the past, we have simply equated ethics with the law, that is, we have tended to assume that if certain conduct is legal, it is also ethical. This approach can be characterized as law informing ethics. More recently, we have realized that ethics must inform law and, indeed, that often the ethical analysis should be primary and the legal analysis secondary. But it still remains necessary for law to inform ethics. The approach proposed in the Report has the effect of stopping legal precedent and history from informing our reactions to and decisions concerning euthanasia. It stops our conditioned response that these acts are wrong, because the law has always viewed them as wrong. We need to be aware of this reaction and to consider whether or not we are correct in thinking that any given act, including euthanasia, is wrong. But we should not eliminate this reaction, in order to allow ourselves to believe that conduct, that otherwise we would regard as wrong, is acceptable.

The Report then continues: *"more important is rejection of the word 'killing'. This word is generally used to indicate a violent act in war or crime, rather than to describe a gentle act of merciful clinical care."*[162] This latter description is the characterization of the act of euthanasia advocated by persons who are pro-choice regarding euthanasia. While the word merciful,

159. See, for example, de Wachter, supra, note 12, p.24, who quotes a Dutch physician as saying that "there are situations in which the best way to heal the patient is to help him die peacefully and the doctor who in such situation grants the patient's request acts as the healer *par excellence*".

160. As quoted by de Wachter, supra, note 12, p.29.

161. Supra, note 156, p.611.

162. Ibid. (emphasis added).

almost always correctly describes the motives of persons carrying out an act of euthanasia, it needs to be queried whether it should be regarded as, or is truly, an act of clinical care or a gentle act. Some of the reasons that might cause persons to seek to medicalize euthanasia have been discussed above[163]. The danger in such medicalization is, again, that we could automatically think and feel about euthanasia in the same way that we think and feel about other clinical care, and this is neither appropriate nor honest, no matter whether we are "pro" or "anti" euthanasia.

The Report continues: *"If . . . the doctor is confident that the patient's disabilities, coupled with his genuine distress about the trouble and expense of the care he needs, make continued life devoid of any enjoyment, the doctor's response [whether or not to provide euthanasia] will depend on the more general question of how he regards his ethical responsibilities in relation to assisting death".*[164] This statement raises many issues. Very importantly, economic cost factors are recognized as being relevant. Their introduction as a valid consideration in the context of euthanasia is, however, attributed to the altruism of persons seeking euthanasia, rather than to concerns of the family or the society which must pay. This leads to consideration of two very different principles on which arguments in support of euthanasia can be based - one is that of individual liberty, the other is the right to kill in the interests of others, for example, the family or society. The justifications that are argued in the latter context can include cost saving, eugenics, justice and punishment - for example, capital punishment - or protection, as in a "just war". Usually the justifications within this latter category that could arguably be relevant to euthanasia, are not presented overtly in that context. Rather the focus, as in the above quotation, even when the interest being promoted in allowing euthanasia might be an interest of society, for example, cost-saving, is on the individual who is the subject of euthanasia and on that person's individual liberty, in this case, to be able to choose to avoid the distress of causing costs to others. In a similar vein, there are claims that in The Netherlands "the highest terms of praise have been applied to the request to die: this act is 'brave,' 'wise,' and 'progressive.' All efforts are made to convince people that this is what they ought to do, what society expects of them, what is best for themselves and their families. The result is, as [Dutch] Attorney General T.M. Schalken stated in 1984, that 'elderly people begin to consider themselves a burden to the society, and feel under an obligation to start conversations on euthanasia, or even to request it.' "[165]

163. Supra, pp.31-33.
164. Supra, note 156, p.611 (emphasis added).
165. Fenigsen, supra, note 50, p.24.

It also needs to be recognized that the two principles which can be argued as justifications for euthanasia - individual liberty and interests of society - may be in conflict. For example, if a person's right to live is denied on the basis of society's right to cut short a life when the interests of society require this, a choice must be made between upholding individual liberty - in this case exercised as a choice to live rather than to die - and the interests of society. In this respect, it is interesting to note the allegation that "a majority of the same [Dutch] public that proclaims support for voluntary euthanasia . . . also accepts involuntary active euthanasia - that is denial of free choice and of the right to live".[166] This is a very disturbing statement and many such statements by its author, have been challenged.[167] Nevertheless, the statement merits consideration and the claim that "involuntary active euthanasia" is regarded as acceptable, may be reflected in practice in The Netherlands to a much greater degree than has, in general, been believed.[168] The statement could indicate that there is a view on the part of the public, that when individual interests, including liberty, and perceived interests of society are in conflict, the latter take priority. It is worth noting that community interests can be used, as here, as an argument in favour of euthanasia or as an argument against it. The position taken in this paper, namely, that even if one finds euthanasia acceptable at an individual level, it is unacceptable at a societal level and that the interests of society take priority and require that euthanasia remain prohibited, is an example in the latter respect. Different community interests are involved in each case. The community interests served by allowing euthanasia would be, for instance, saving on economic costs to the community. The community interests served by prohibiting euthanasia include maintaining the symbolism and practice of not killing other persons.

The Report also proposes that to assist death is *"a moral advance rather than a moral decline"*.[169] This leads to the argument that it is unethical not to allow euthanasia and, indeed, this argument has been espoused.[170] Ethics

166. Ibid., p.23. The term "involuntary active euthanasia" is probably not intended to include (at least one hopes this is the case) euthanasia carried out against the refusal of consent of a person. Rather it probably contemplates allowing the possibility of euthanasia on those unable to consent or to refuse consent for themselves.

167. See, for example, correspondence *Hastings Center Report* 1989; 19:47 et seq.

168. See, Keown, supra, note 140, pp.41-42.

169. Supra, note 156, p.611 (emphasis added).

170. CBC Radio, "Cross Country Check-up", conversation between Dr. David Lewis and M.A. Somerville, November, 1991. Dr. Lewis, a Vancouver psychologist with AIDS, who assisted eight other persons with AIDS to commit suicide, after announcing in the media that he would kill himself, did so.

has long been an argument against euthanasia, now it also becomes an argument for euthanasia.

It is also argued in the Report that *"it would be unjust if only some doctors, as at present, continued to relieve terminal suffering by assisting death in the privacy of the home, while others, especially in hospital, did not do this"*.[171] It seems to be proposed here, that justice requires that euthanasia be available. What would this proposition mean, if applied to other illegal acts? For example, to take an extreme case, if child prostitution is available to some (as it is), is this in itself an indication that it should be available to all? Moreover, to repeat, the fact that acts of euthanasia occur, does not mean that it is morally acceptable or that it should be legalized and institutionalized in our society.[172]

The Working Party in its Report also argues that the act/omission distinction is not morally relevant, that is, that *"killing and letting die"*[173] are morally equivalent. It states that *". . . although, allowing death to occur often seems less wrong than deliberate killing, intent, circumstances, and outcome all have a role in determining moral judgment on the act. When the intention and outcome of killing and letting die are equivalent (in each case a good intention and a fatal outcome) then the circumstances become the crucial factor in the moral evaluation of killing and letting die"*.[174] This is to adopt a situational ethics approach, that is, that there are no absolute rights and wrongs, including, with respect to killing another person; rather the morality of a situation depends on all the circumstances. The Working Party is correct, as has already been discussed,[175] that some omissions could constitute euthanasia, and that such omissions and the act of killing can be morally and even legally equivalent, for example, when there is a duty to treat and death results from with-holding treatment. But there is not always a duty to treat, for instance, when treatment is futile or when the patient has given a valid refusal of treatment. In summary, not all situations of killing by an act and letting die through an omission are morally equivalent. Moreover, recognition that "there are circumstances, in clinical practice as well as in hypothetical debate, where the logical difference between act and omission, between killing and letting die, might be unable to bear decisive weight . . . does not imply that a decision in favour of killing is therefore permissible in situations where a decision not to maintain life is permissible".[176]

171. Supra, note 156, p.611.
172. See, supra, pp.39-44.
173. Supra, note 156.
174. Ibid. (emphasis added).
175. Supra, pp.7-10.
176. B. Callaghan, Correspondence "Assisted Death", *The Lancet* 1990; ii:1012.

From a legal point of view, many of the cases in which the act/omission distinction is relevant, involve the connected issues of duty and causation, the latter of which has already been discussed.[177] The common law imposes a duty to take reasonable care not to harm others by one's acts. There is, however, no general duty not to harm others by omissions. One is only liable for an omission if there was a pre-existing duty to act. In other words, one is not liable for "mere" omissions, that is, omissions in a situation in which there was no duty to act. In cases in which there is a pre-existing duty to act, liability for an omission can be avoided if it is regarded, in law, as not having caused the damage or prohibited outcome. The court used just this distinction in the case of *Re Nancy B.*[178]. The Judge held that a physician who disconnected a respirator, pursuant to the informed request of the patient, would not be held, in either criminal or civil law, to have caused the death of the patient.

In some ways, the argument based on criticism of the act/omission distinction, that it is irrelevant to distinguish between the cause of death being withdrawal of the respirator, or underlying disease, or a lethal injection, because whichever one is involved the patient ends up dead, says too much. At one point, we all end up dead, but when and how we die is relevant to whether or not another person could be considered morally culpable or held legally liable for causing our death. It is true that use of the concept of causation in the law, involves an exercise of discretion through which a court can find either culpability or non-culpability for prohibited outcome according to whether or not it finds causation on the part of the accused or defendant, with respect to this outcome. But it is not true, as is sometimes alleged, that the presence of such discretion means that the concept of causation is without substance and simply a manipulative tool for, as the case may be, either attributing or not attributing culpability. Callahan explains that "the mistake here . . . lies in confusing causality and culpability, and in failing to note the way in which human societies have overlaid natural causes with moral rules and interpretations. Causality (by which . . . [Callahan] means the direct physical causes of death) and culpability (by which . . . [he] means our attribution of moral responsibility to human actions) are confused . . . [in some] circumstances".[179] It may well be, however, that some instances of the use of the legal concept of causation exhibit such confusion.

The matter of drawing lines, such as in relation to causation, which are, sometimes, alleged to be simply artificial or semantic distinctions, is often

177. Supra, p.9.

178. *Nancy B.* supra, note 20.

179. D. Callahan, "When Self-Determination Runs Amok", *Hastings Center Report* 1992; 22(2):52,53.

raised as an argument against the persons who oppose euthanasia, but agree with rights to refuse treatment. For example, it is also argued that there are only artificial differences between legally actionable omissions and non-actionable ones which result in death, because whether or not a duty is found to be present is a matter of discretion and value judgement which has only a facade of objectivity. Likewise, it is argued that the distinctions between suicide and euthanasia will not bear moral weight and should not be of legal import. These lines, although in some cases fine, are, however, both real and important. They are lines that correspond not just to logic, but also, I would suggest, to collective wisdom, precedent and deeply felt intuitive, moral and emotional responses. These "other ways of knowing" must be given space within which to function and the knowledge to which they give access must be properly taken into account. Moreover, even the critics of drawing lines, who are usually pro-choice on euthanasia, need themselves to draw lines between those instances of euthanasia which are acceptable and those which are not, which usually depends on circumstances, purpose and consent in relation to the act causing death.[180] In summary, unless all acts of euthanasia were to be allowed, which has never been proposed, the drawing of lines is unavoidable. Therefore, that they draw lines which allow respect for refusals of treatment and provision of necessary treatment for the relief of pain and other symptoms of serious physical distress, even if this could shorten life, but prohibit euthanasia, should not be a basis of objection to the case of the persons who are anti-euthanasia. All participants in the euthanasia debate draw lines. It is, rather, that different lines are drawn by those who are "pro" as compared with those who are "anti" euthanasia.

The Working Party then puts forward another interesting argument. *"Doctors, after all, have no religious scruples about interfering with predestined death in formerly fatal illnesses which they can now cure. In what circumstances, then, is a doctor ever ethically justified in assisting death?"*[181] There is about this statement, something of an aura that we have accepted "playing God" with respect to curing, therefore, why should we not accept "playing God" with respect to killing. It seems to be implied that interfering in the "natural order" to cure in some way helps to justify interfering in the "natural order" to kill. We need to consider whether we need to justify interfering in the "natural order" in either case. I would suggest, that we do. When the purpose was to cure, or at least therapeutic, there probably used to be a presumption that the interference was justified. In more recent times, however, with our concern about respect for persons and their rights and

180. See, for example, *Notes: Harvard Law Review*, supra, note 27.
181. Supra, note 156, p.612.

freedoms, and about over-use of medical technology and its potential to do harm and not just good, this presumption may no longer operate. This could be indicated by the fact that, for example, we have evolved principles that require informed consent to a medical intervention, and we have always required that the anticipated benefits of an intervention will outweigh its anticipated harms and risks, before it can be justified. Consequently, one could regard the presumption that one is justified in interfering in the "natural order" to cure as partial, but not sufficient, justification for proceeding with a medical intervention on a person aimed at cure. In other words, without necessarily identifying it as such, whether through presumption or proof, we do justify interfering in the "natural order" to cure and, likewise, we would need to justify interfering in it to kill. The latter cannot be justified simply by the argument that we interfere in the "natural order" to cure and this in itself justifies interfering to kill when this is "ethically justified".

The Working Group was probably addressing, here, the argument raised against euthanasia, that hastening death is to interfere in the natural order and such interference is wrong. They are correct that this is not necessarily a strong argument, although whether or not it is, depends on the circumstances, the way in which we interfere in the natural order, and the consequences of this interference. In particular, there is a great difference between interfering to cure as compared with to kill. Consequently, allowance of the former provides no automatic justification for the latter, as seems to be implied in the Report. Again, this does not necessarily mean that such interference to kill cannot be justified, it just cannot be justified in this way.

A more subtle argument along the same lines as the above, is that medicine, itself, creates "an obligation to honour requests for euthanasia. When life-prolonging technology has led to what the patient believes is a life not worth living . . . does this create a special responsibility for the medical profession in general and the patient's doctor in particular to consider sympathetically sustained requests for active voluntary euthanasia?".[182] One possible interpretation of the rationale that underlies this question, is that when we have prolonged a person's life through interference in the natural order, that life can be stopped through euthanasia without offence to the natural order, because if it were not for our initial interference the person would be dead. A wide application of this reasoning and the precedent it could establish, would be terrifying. Any person whose life was probably or certainly saved by antibiotics or, for example, surgery for appendicitis, would come within its parameters.

In the context of examining the language of euthanasia, it is worth noting

182. de Wachter, supra, note 12, p.28, quoting R. Gillon.

the description of what the Working Party sees as being at issue, namely, "*. . . the useless prolongation of miserable life . . .*".[183]

The Report continues: "*a doctor's duty to prolong life is not concerned with all forms of life, but only human life of a quality that the person concerned wishes to have prolonged*".[184] One would need to ask here what counts as "quality human life", as compared with a "form of life", because these are contrasted? First, it is noteworthy that the word human is left out in the first mention of life, although it would seem that is what is being spoken of. Physicians, as such, are not in general concerned with other forms of life. Second, there is presently a state of high activity in our modern, western societies, with respect to use of a quality of life principle. This concept was developed largely in order to found a claim to health care. It is now being used, as in the Report, as a justification for denying such care.[185] There are many other relevant questions raised here which are well-known. Who judges quality of life? Can it be judged by persons, even in relation to themselves, in advance of experiencing a certain quality of life? Should a person's quality of life be judged in relation to the cost of maintaining his or her life? Moreover, what would we do with respect to persons who do not have, or who never have had, the capacity for wishes? Is there no duty to prolong their lives?

The Report is unclear in this respect. It states that it is "*concerned solely with occasions when assisted death is requested -not the related issues of ending the lives of infants, or of patients who are unconscious or unable to make a valid request*".[186] But later, it states that "*[w]ith a patient who cannot express a wish, the doctor's duty is to prolong life only if it can be assumed to be such that this would be the patient's wish, or if, as in the case of infants or mentally handicapped patients, there is nothing to contradict the presumption in favour of prolonging life*".[187] Although there is reliance on a presumption in favour of life, clearly it is contemplated that this can be rebutted in the case of a person who is not, and possibly has never been, competent. The conditions in which such a rebuttal would occur are entirely unstated. Moreover, the difference in nuance between the language that the doctor has a "*duty . . . to prolong life only if . . .*", that the Report uses, and *a doctor has a duty to prolong life unless . . .*, which more accurately reflects the position of the law,

183. Ibid. (emphasis added).

184. Ibid. (emphasis added).

185. See M.A. Somerville, "Autonomy in Health Care", Proceedings of the 25th Anniversary Congress of the Dutch Association on Medical Law, "Healthy By Right (Met Recht Gezond)", Nijmegen, The Netherlands, May 1992 (forthcoming publication).

186. Supra, note 156, p.611.

187. Ibid., p.613.

should be noted. The former is a suspensive condition, that is, the duty to prolong life only arises on certain conditions being fulfilled. The latter is a resolutive condition, that is, there is a duty to prolong life unless certain conditions negating the duty occur. Opposite basic presumptions underlie these two approaches. The latter is much more protective of life than the former, in circumstances of equal doubt as to whether or not life should be prolonged.[188]

The Report concludes that "*if . . . relief is not possible, distress is severe, and the patient asks to have his life ended, the circumstances are analogous to those of the soldier's wounded comrade, the soldier's gun being replaced by the doctor's syringe . . . the balance of the moral argument . . . shift[s] towards asking why death should not be assisted. The greater the unrelieved pain and distress, the more ethical a doctor's decision to assist death if the patient desires it*".[189] This is to propose a change of basic presumption from one against euthanasia, to one for euthanasia. It also raises the issue of whether there are degrees of "ethicality" in relation to euthanasia, and if so, at what point can it be characterized as ethical or, more importantly, unethical. Or does this imply that decisions to terminate life in the circumstances described are never unethical, but some are more ethical than others? Finally, the military analogy is one not usually encountered in the literature on euthanasia. If it is true that soldiers shoot their wounded comrades, is this morally and legally acceptable? If so, does it have relevance to the arguments for and against euthanasia? Certainly, not only pacifists would agree that we need to rethink our attitudes to war, including our justifications for engaging in it, and, as part of this re-consideration, rules governing conduct in that context. It is also noteworthy that according to this statement, patients need not be terminally ill, they need only have an incurable disease, to justify providing them with euthanasia.

Certainly, more extreme examples of the use of language to promote suicide by terminally ill persons and euthanasia, are to be found in a text previously referred to, *Final Exit*[190] by Derek Humphry. Just a few of these examples will be given here. For instance, the hospice movement and the pro-choice on euthanasia movement are presented as consistent and compatible with each other: "*Quality of life, personal dignity, self-control, and above all, choice, are what both hospice and the euthanasia movement are concerned with*".[191] But many, if not most, persons in the hospice movement, while

188. See, infra, pp.62-67.

189. Ibid..

190. Supra, note 3.

191. Ibid., p.36.

agreeing with these aims, in general, strongly disagree with euthanasia as a means of achieving them.

There are efforts to normalize the carrying out of euthanasia. Humphry writes that *"[i]f you are unfortunately obliged to end your life in a hospital or motel, it is gracious to leave a note apologising for the shock and inconvenience to the staff. I have also heard of an individual leaving a generous tip to a motel staff"*.[192] This could also be seen as implying that a hospital offers nothing more to a dying person than a motel, and that one's committing suicide in a motel is nothing more than a serious inconvenience to the staff, for which, at least in some measure, they can be compensated by a tip. Other examples of the use of language to normalize euthanasia include that of spousal love and devotion: *"[A] surprising number of people, particularly devoted couples, want to handle the process themselves. It is their final act of love together"*.[193] It merits noting that, while Humphry claims that his book is only intended as a guide to suicide for terminally ill persons, he contemplates that it could be used by a non-terminally ill spouse in a double suicide with his or her terminally ill spouse.[194]

One of Humphry's most highly recommended methods of suicide, that of the plastic bag and *"either a large rubber band or a ribbon"*,[195] plus *"[s]ufficient sleeping pills to ensure two-hours sleep"*,[196] could also be seen as seeking normalization of self-willed death, including euthanasia, by reducing reactions of repugnance or horror in relation to it, in several ways. First, part of the equipment suggested - "a ribbon" - can be associated with events such as tying-up a little girl's hair or wrapping a present - warm, caring, gratifying and life-affirming activities.[197] One can query whether this word was chosen to elicit such associations, in order to help to normalize suicide and, by association, euthanasia. Then, there is a suggestion that persons should undertake trial runs both of the sleeping pills and the plastic bag. A trial run of the plastic bag so impressed the author that he performed it for *". . . [his] Hemlock Chapter meeting a week or so later. Everyone was both amused and impressed . . ."*.[198] He *"urged them to go home and try it on for themselves in order to get more comfortable with the whole concept"*.[199] The final decision, Humphry says, is *"should you use a clear plastic bag or an*

192. Ibid., p.89.
193. Ibid., p 96.
194. Ibid., Chapter Twenty, "Going Together?", pp.100-102.
195. Ibid., p.97.
196. Ibid., pp.97-98.
197. Moreover, in wet weather, one's daily newspaper can even be delivered in a potential "suicide machine", a plastic bag secured with a large rubber band.
198. Ibid., p.99.
199. Ibid..

opaque one. That is a matter of taste. Loving the world as I do, I will opt for a clear one if I have to".[200] At one level, this statement indicates some sense of unreality, some hint of fantasy, of disbelief that death - the final exit - will result. The story told of Barnum's and Bailey's circus comes to mind. When the tent in which the circus' sideshows (the most tattooed man, the two-headed serpent, the giant woman, etc.) were exhibited became too crowded, a man would walk around the tent ringing a bell and displaying a board on which was written "this way to the egress". People would follow him, thinking that they were being led towards some other even more exotic exhibit, often imagining it would be a rare bird, only to find that they had been led out of the tent. When they exclaimed that they had not finished looking at the exhibits, they were told that they could re-enter the tent on paying another admission fee, to which they objected. With euthanasia, however, re-entry is not an option, unless we believe in reincarnation.

IX. STRUCTURING THE ANALYSIS

(A) Placing Euthanasia in Context

Euthanasia must be viewed, first, in the context of other medical interventions and non-interventions at the end of life and, second, in a broader context. These contexts can only be very broadly and superficially sketched here. The first context referred to can be described as a continuum which ranges from rights to refuse treatment; to withdrawal of "life support", for example, respiratory support; withdrawal of artificial nutrition and hydration;[201] provision of treatment for the relief of pain or other symptoms of serious physical distress (even that which could shorten life, if this is necessary to relieve pain or other symptoms of serious physical distress); suicide; assisted suicide; and euthanasia.

It is proposed that there is a difference in kind not just degree, between, on the one hand, euthanasia and, on the other hand, interventions comprising all the other "categories" leaving aside the category of assisted suicide. This raises the question of where assisted suicide, in particular, physician assisted suicide, fits. Opinion is divided as to whether it should be classified with euthanasia or with suicide, or even as some "sui generis" category. If emphasis is placed on the fact that assisted suicide involves an act of an individ-

200. Ibid., p.98.

201. Although artificial hydration and nutrition are, also, life support treatment and recently have been characterized as no different from other forms of life support treatment - see, for example, *Cruzan* v. *Harmon*, 760 SW 2d 408 (1988) (U.S.S.C.) - in the past, their withdrawal has been regarded as different from withdrawal of other forms of life support. In part, this was because of fear of inflicting serious suffering by allowing a person to die from dehydration and starvation and also the effect on societal symbolism of doing this.

ual with respect to himself or herself, it could be treated as suicide - a private act. Or should we emphasize that the assistance of another is required, so that we have "concerted communal action" and, therefore, have a public action which should not be legitimized and institutionalized?[202] Moreover, when physicians are involved, the profession of medicine itself is implicated. The profession of medicine is a public enterprise, which means that physicians' involvement in assisting suicide is not, essentially, a private matter.[203]

Some incidents of "assisted suicide" belong in the category of suicide, for instance, a patient uses medication not prescribed primarily for this purpose, to commit suicide. Others belong in the category of euthanasia: for example, where a physician's action is morally equivalent to euthanasia and legally equivalent to this except for the absence of causation, because the patient's act in killing himself or herself is held to be a *novus actus interveniens* cutting the chain of causation between the physician's act and the infliction of death; or, likewise, where the physician provides the means to commit suicide to the patient, with an intention[204] of helping the patient to do so. In general, the term physician assisted suicide is only used to describe the latter types of intervention, not the former, that is, those that are characterized here as being equivalent to euthanasia. Sometimes the term assisted suicide is also extended to include an act of euthanasia that involves a physician administering a lethal injection. Again, in this context the use of language is important. In particular, the term "physician assisted death" tends to be used to replace or to include physician assisted suicide and then interpreted to include euthanasia. The language of physician assisted death, rather than that of euthanasia, is almost certainly employed to try to avoid the disapproval and win the support of some persons who oppose euthanasia, but do not oppose suicide or, in the case of some of these persons, physicians assisting in this.[205]

It is, also, interesting to note that in Germany, physician assisted suicide is not tolerated, but assistance in suicide by non-physicians is, apparently, regarded as acceptable.[206] This can be compared with the approach of most of the persons in North America who are promoting physician assisted death. They propose that an exception to the crime of assisting suicide should be

202. D. Callahan, "Can We Return Death to Disease?", *Hastings Center Report* 1989; 19(1)(Spec.Supp.):4,5.

203. Keown, supra, note 140, p.40.

204. For a definition of intention in the law, see, supra, note 7.

205. See, M.P. Battin, supra, note 114, who says that, "because permitting assisted suicide would require a less dramatic change in the law, I think that the United States will come to accept assisted suicide in the relatively near future, officially as well as tacitly, but is likely to resist legalizing active euthanasia for a longer time".

206. Ibid..

allowed, but only for physicians. Clearly, important cultural and historical facts influence such attitudes, as well as individual and societal attitudes to physicians and the medical profession. It is essential to be aware of such differences, because they can both shake us out of a complacency that our way of viewing a situation is the only way, and provide crucial insights into the positions which we choose to adopt.

From a legal point of view, the very recent Canadian case of *Rodriguez* vs. *Attorney General of British Columbia and Attorney General of Canada*[207] is unique with respect to the claim that the plaintiff sought to enforce. The plaintiff, Mrs. Rodriguez, suffers from amyotrophic lateral sclerosis (Lou Gehrig's disease) a degenerative neuromuscular condition which affects among other physiological functions breathing and swallowing. She sought a ruling from the court that the prohibition on aiding and abetting suicide in section 241 of the Canadian *Criminal Code*[208] is invalid on the grounds that it contravenes the *Canadian Charter of Rights and Freedoms,*[209] in particular, section 7, which protects "the right to life, liberty and security of the person"; section 12, "the right not to be subjected to any cruel and unusual treatment or punishment"; and section 15, which provides for equality before and under the law, and equal protection and equal benefit of the law without discrimination, in particular, on the basis of physical disability. In a detailed judgement, the Supreme Court of British Columbia, the court of first instance, acknowledged that "the state's interference through criminal law when a person's life or health may be in danger may violate an individual's right under s. 7 to security of the person".[210] However, section 7 is not violated by the prohibition on assisting suicide, because in the absence of this prohibition, the plaintiff would still have no *right* to assistance in committing suicide, therefore, no right protected by the *Charter* is affected by the prohibition. The court noted that sections 7 through 14 of the *Charter* are placed under the heading "Legal Rights" and relying on this characterization and a judgement of the Supreme Court of Canada as authority, adopted a narrow interpretation of the rights protected by section 7. In summary, the court held that the restrictions on liberty and security of the person against which section 7 protects, are only "those that occur as a result of an individual's interaction with the justice system and its administration".[211] The court

207. The Supreme Court of British Columbia No.4040/92, Victoria Registry, December 29, 1992, Melvin, J.

208. R.S.C. 1985 c. C-46 (as amended).

209. *Constitution Act*, 1982, Part I.

210. Supra, note 207, p.9.

211. Ibid., p.13, citing Lamer, C.J. in *Reference re: ss. 193 and 195.1(1)(c) of the Criminal Code* (1990), 56 C.C.C. (3d) 65.

found that the plaintiff was not involved in any such interaction and, therefore, section 7 was inapplicable. Moreover, the cause of the plaintiff's inability to carry out her decision to commit suicide would not be any restriction on her rights, but, as her health deteriorates, her illness, and this "does not amount to an infringement of a right to life, liberty or security of the person by the state".[212]

The right against cruel and unusual treatment or punishment was held to be limited to "state-imposed punishment in the context of criminal law regarding a person brought into the legal system"[213] and, consequently, not applicable to the plaintiff's case. Likewise, the prohibition on assisting suicide was held not to offend the prohibition in section 15 on discrimination on the basis of physical or mental disability, because the former "is designed to protect, not discriminate",[214] regardless of a person's "condition or the cause of any vulnerability which may result in them expressing a desire to terminate their lives".[215] Moreover, even if rights and freedoms guaranteed by the *Charter* were violated by the prohibition on assisting suicide, such a restriction would be demonstrably justified in a free and democratic society and, therefore, would fall within the "saving provision" of section 1 of the *Charter* and be constitutionally valid.

The case was appealed to the Court of Appeal of British Columbia[216] which split in the judgements handed down - two judges dismissed the appeal and one, the Chief Justice, upheld it, finding for the plaintiff Ms. Rodriguez. The judgements will not be analyzed in any detail here, except to note that they each include consideration of how section 7 of the *Charter* should be interpreted in the "legislative, social and philosophical context of our society",[217] in relation to continuing to prohibit or allowing physician assisted suicide for terminally ill persons, in particular, competent persons, who are unable to commit suicide without such assistance. The Court of Appeal focused on establishing the breadth of the right to security of the person in section 7 of the *Charter* and what constitutes a justifiable infringement of this - that is, an infringement that is "in accordance with the principles of fundamental justice", to quote the section itself.

The Chief Justice, in dissent, found that Ms. Rodriguez was deprived of both her right to security of her person by the state in enacting the prohibi-

212. Ibid., p.15.

213. Ibid., p.19.

214. Ibid., p.21.

215. Ibid..

216. Court of Appeal for British Columbia, No.V01800, Victoria Registry, March 8, 1993, McEachern, C.J., Proudfoot, J., and Hollinrake, J..

217. Ibid., p.46, per Hollinrake, J..

tion on assisted suicide in section 241(b) of the *Criminal Code* and that this deprivation was "not in accordance with principles of fundamental justice", or saved by being a limitation on a guaranteed freedom which can be demonstrably justified in a free and democratic society, as provided by section 1 of the *Charter*. The Chief Justice held "that any provision [of law] which imposes an indeterminate period of senseless physical and psychological suffering upon someone who is shortly to die anyway cannot conform with any principle of fundamental justice".[218]

Like the Chief Justice, Mr. Justice Hollinrake held that the prohibition on assisted suicide in section 241(b) of the *Criminal Code*, deprived Ms. Rodriguez of her section 7 right to security of the person, but, unlike the Chief Justice, he held that this deprivation was in accordance with the principles of fundamental justice and, therefore, section 241(b) was not unconstitutional.

Mme. Justice Proudfoot took a much narrower interpretation of the section 7 right, at least in relation to the facts of the case before her. Indeed, she may, similarly to the court of first instance, have viewed the scope of the protection given to security of the person by section 7, as being limited to the "criminal context". Regardless of how her judgement should be interpreted in this respect, she expressly limits the scope of the rights in section 7, with the statement that "obviously death is the antithesis of the s. 7 guarantee of 'life, liberty and security of the person' ".[219] This observation raises a complex issue that can only be mentioned here. There could be conflict between respecting a person's right to liberty and security of the person and that same person's life, if the former rights are broadly interpreted, in particular, to include respect for the exercise of "positive content" rights to autonomy and self-determination. One possible response that would accommodate such conflict is that a right to life is just that, a right and not an obligation, and, moreover, rights can be waived. An alternative response is that the rights in section 7 must be interpreted consistently with each other and, consequently, rights to liberty and security of the person may not be used in such a way as to detract from respect for a person's life. This latter position can be further supported by reliance on a doctrine of "abuse of rights". It can be argued that for a person to use his or her rights to liberty or security of the person in a way that contravenes respect for his or her life, would be to abuse these rights (that is, to use them for a purpose exactly the contrary to that which they were intended to achieve) and that such an "abusive" use is an invalid exercise of those rights.[220]

218. Ibid., p.30.

219. Ibid., p.66, per Proudfoot J..

220. See *Procureur Général du Canada* c. *Hôspital Notre-Dame et un autre (détendeurs) et Jan Niemic (mis en cause)* [1984] C.S. 426 (Qué. S.C.); M.A. Somerville, supra, note 35.

Mme. Justice Proudfoot did not, however base her judgement on section 7 of the *Charter*. Rather, she held that there was no "lis pendens", no justiciable issue, before the court. Ms. Rodriguez had sought a declaration that if a physician were willing to help her commit suicide, that unnamed physician would be exempt from future criminal liability.[221] Mme. Justice Proudfoot concludes that "[t]here can be no doubt that this is a hard case but it ought not, in my opinion, be allowed to influence the court to make bad law. I would regard as bad law a precedent which would pave the way for persons not defendants in either civil or criminal proceedings to seek and obtain immunity from liability for unknown persons for offences not yet committed and which may never be committed".[222]

Leave to appeal the case to the Supreme Court of Canada, has now been granted. Therefore, the case will be subject to further analysis and commentary by the judiciary, as well as by parliamentarians, the public, the media and academics in a wide variety of disciplines. While cases that provoke such discussion are valuable, we need to keep in mind, as the judge at first instance states, that "[i]n the case at bar this court is asked to move . . . beyond the judicial domain and into the realm of general public policy".[223] Although the judgements in the Court of Appeal recognize that courts can be seen as "shying away from the full force of the power entrusted to them under the *Charter*",[224] in saying that "it is the function of Parliament to legislate",[225] ultimately, it will almost certainly be for the legislature to decide whether to continue to prohibit or to allow assistance in committing suicide.[226]

To return to the descriptive categorization of interventions at the end of life, with which this section commenced, overlying this is another analysis that can be applied to classify such interventions in order to determine whether there are obligations to treat, no such obligation, or obligations not to treat. This analysis depends on distinguishing between prolonging living and prolonging dying. The former may or may not be required, for example, prolonging living is not required when there is valid refusal of treatment by a competent adult person. Prolonging dying is never required, except possibly if a competent adult person requests treatment that could have this effect

221. Supra note 216, p.68.

222. Ibid..

223. Supra, note 207, p.16.

224. Supra, note 216, p.55, per Hollinrake, J..

225. Ibid..

226. The Parliament of Canada has just voted 140-25 against considering a law to allow assisted suicide, Canadian Press, "MPs won't consider right-to-die law", [Montreal] The Gazette, 23 March 1993, 8.

and is able to give informed consent to this treatment.[227] Concepts relevant to not prolonging dying include those of "futility"[228] - there is no obligation to provide futile or useless treatment - and an included or related concept "proportionality", which recognizes that there can be over-use, as well as under-use and proper use, of medical treatment, especially when it involves technology.

A proportionality principle postulates that when the burden of treatment - harm and suffering inflicted by treatment - is out of proportion to any hoped for benefit from that treatment, there is no obligation to provide that treatment. There are, of course, very personal and deep value judgements involved in judging such harms and benefits. Consequently, although the principle is easy to state in theory, it is not always easy to apply in practice. One way in which the principle becomes easier to apply, in some cases, is through the mechanism of "advance directives" - legal devices such as the "living will" and "durable power of attorney" -because as far as possible these implement the patient's own value judgements regarding harms and benefits.

Such legal mechanisms mean that a person's right to self determination can bridge "the incompetence gap", that is, the person's own wishes can still govern, even after the person has become incompetent to express those wishes. These legal mechanisms are based on and implement a principle of respect for persons and for persons' rights to self-determination and autonomy. However, a secondary effect may be to benefit others. For example, withdrawal of treatment, pursuant to patients' own wishes, which has beneficial symbolism of respect for persons and for their wishes concerning themselves, also saves the community or family the cost of treatment. This can be compared with withdrawing such treatment on the basis of the decision of another, which can have harmful symbolism, for example, that the lives of such persons are not worth living and, therefore, not worth the cost of maintaining.

Issues raised by the rapidly evolving use of "advance directives" in decision-making at the end of life will not be discussed here. It needs to be kept in mind, however, that this area forms the "surroundings" of euthanasia

227. It is arguable whether there are duties to provide treatment in such circumstances and, indeed, it is likely that this matter will be litigated in the near future. There has, recently, been a case in Quebec involving a comatose man whose family wanted life support treatment continued, when the physician and hospital wished to withdraw it. The case was settled out of court. The *Wanglie case* in the United States, also, raises this issue. See, M. Angell, "The Case of Helga Wanglie: A New Kind of 'Right to Die' Case", *New England Journal of Medicine* 1991; 325:511-512.

228. See, S. Wolf, "Conflict Between Doctor and Patient", (1988) 16 *Law, Medicine and Health Care*, 197-203. See also addendum, p. 628.

and, although it is argued that there is a difference in kind between euthanasia and other situations involving decision-making and interventions at the end of life, what happens in one of these areas clearly can influence what happens in the others.

(B) Identifying Basic or Initial Presumptions

The are four possible prima facie presumptions from which analysis of euthanasia can commence. These are: (i) "no . . .", that is, euthanasia is absolutely prohibited; (ii) "no . . . unless . . .", that is, there is a basic presumption against euthanasia, unless certain conditions are fulfilled, but it will be allowed in some circumstances; (iii) "yes . . . but . . .", that is, euthanasia is allowed, but in some circumstances it will be prohibited; and (iv) "yes . . .", that is, euthanasia is allowed.

The choice of the first or last presumption clearly reflects a major difference with respect to whether or not euthanasia is acceptable in a given society. The second and third presumptions are closer to each other, but the choice between them is not neutral. The symbolism of a "no . . . unless . . ." presumption is closer to the traditional symbolism against euthanasia, whereas the symbolism of a "yes . . . but . . ." presumption is that of a society which accepts euthanasia. Moreover, the basic presumption will govern in situations of equal doubt as to whether or not conditions for an exception are fulfilled. Therefore, a "no . . . unless . . ." presumption would *rule against* euthanasia in conditions of doubt, and a "yes . . . but . . ." presumption would *rule in favour* of euthanasia in the same conditions. Further, a person relying on an exception normally has the burden of proving that the exception applies. Therefore, a person carrying out euthanasia under a "no . . . unless . . ." presumption would have the burden of proving that euthanasia was justified in any given circumstances. In contrast, a person opposing euthanasia would have the burden of showing that euthanasia was unjustified, in any given circumstances, under a "yes . . . but . . ." presumption.

It is interesting to analyze the situation in The Netherlands in terms of these presumptions. The Netherlands seems to have adopted a "no . . . unless . . ." prima facie presumption in practice, and a "yes . . . but" prima facie presumption in theory - because, as already noted, the legal justification for carrying out euthanasia is that the defence of "force majeure" - in the sense of conflicting duties - applies to excuse the otherwise prohibited conduct which reflects a "no . . . unless" approach. It would seem, however, that the practical effect of the procedural guidelines for instituting a prosecution for allegedly unjustified euthanasia, is that a burden of proof of lack of justification is on the persons who wish to prosecute, rather than any burden

of justification being on those who carried out euthanasia. This reflects a "yes . . . but . . ." prima facie presumption.

Probably, and paradoxically, the most basic presumption relevant to the area of euthanasia is that in favour of life, which may differ from sanctity of life in that the former, while primary, may be rebuttable, the latter is often argued to be absolute. The presumption in favour of life operates as a fundamental principle in both our legal and ethical systems. The questions raised by this principle in the context of euthanasia include: When would quality of life considerations, if ever, displace this presumption? Could a doctrine of necessity ever apply, such that it justifies over-riding the presumption in favour of life? Pain relief treatment that is necessary, but could shorten life, is such an example. Can respect for the person and the person's rights to autonomy and self-determination displace this presumption? Respect for competent persons' informed refusals of treatment provide an example in this respect. Can claims of the community, for example, cost saving, ever displace it? Is respect for the person a reason different in kind from other reasons proposed as justifications for displacing the presumption in favour of life? Is respect for the person a preferable reason for displacing a presumption in favour of life, because it is less of an affront, or at least a less direct one, to the sanctity of life value, because, arguably, this also is based on respect for the person? But is this true; is sanctity of life based on respect for the person, or is it a value that principally protects the community? For example, does it have a function similar to that of early criminal law, the aim of which was not so much to protect the individual for the sake of the individual, but to protect the individual for the sake of the society to which that individual belonged? It is also not irrelevant whether detraction from an important value, such as sanctity of life, is latent or overt. We are much more tolerant of latent detractions from important values, than overt ones, because the former do not threaten society and its symbolism in the same way. We need to keep this in mind in relation to euthanasia, legalization of which would be an overt threat to the value of sanctity of life.

Moreover, as we know, not only are ends important, but also means, which include the principles used and reasoning applied in justifying a course of conduct. For example, death resulting from respect for a competent person's refusal of treatment does not cause damage to the value of the sanctity of life to the same extent, if at all, as euthanasia as defined in this text[229] would do. Further, there can be a vast difference in terms of the precedent set by different lines of reasoning used to support decisions concerning treatment of persons at the end of life, although the conduct and

229. See, supra, pp.3-4.

outcome in the case that sets the precedent would be the same whichever line of reasoning were used. For instance, there is a great difference between, on the one hand, regarding respect for a person's refusal of treatment as being necessary in order to respect the person, and, on the other hand, classifying this as euthanasia and, therefore, regarding withdrawal of treatment in these circumstances as setting a precedent for euthanasia. While ends or results can set precedents, often, the stronger precedent-setting force is the reasoning used to justify and the means used to attain those results. Death itself cannot set a precedent, because all of us ultimately face death, and if death itself set a precedent, this could mean that there would be no restrictions on the way in which death could be inflicted. The important precedents are how death may and must not be allowed to occur and the reasons on which these conclusions are based.

Proponents of euthanasia argue for a presumption in favour of allowing euthanasia on the grounds that it is a rational response. But rationality, itself, is not a sufficient justification for euthanasia or other conduct. We also need to consult our moral intuition and even our emotions. While in some individual cases, for some persons, compassion could make euthanasia "feel" right, it is proposed that it does not (or, at least, should not) "feel" right as one of the fundamental principles on which to found our society. While feelings can sometimes be misleading in terms of determining what is and is not acceptable conduct (as indeed can rationality as we have sometimes found to our sorrow), we ignore our feelings at our peril. We need to take into account "examined" emotions, as well as cognitively based analysis, in deciding whether or not euthanasia is acceptable at the societal level.[230] Our feelings can act as important warnings that although, rationally and logically, two situations may seem to be the same, there may be additional considerations that differentiate them which it is important to take into account.[231]

230. M.A. Somerville, "Justice Across the Generations", *Social Science & Medicine* 1989; 29:385-394.

231. The very recent work of Dr. Mildred Solomon, presented at the American Society of Law and Medicine conference, supra, note 155, seems to demonstrate this phenomenon. She reported that she and her colleagues have found that two out of three physicians surveyed feel that there is a difference between with-holding and withdrawing treatment, and are much more uncomfortable with the latter, despite the general consensus in bioethics and "medicine, ethics and law" literature, that these are ethically and legally equivalent. Solomon et al. suggest this feeling may have a deeper ethical purpose - to keep us from becoming insensitive to the seriousness of withdrawing treatment and making this too easy to do. As she said, it needs to be a difficult decision and act, in particular, because cases of withdrawal of treatment are often not ethically clear cut. In contrast, cases in which treatment is not commenced are, in general, ones in which there is little doubt that non-treatment is justified and, consequently, they do not raise the same ethical concerns.

It, also, needs to be considered which basic presumption should govern, initially, with respect to intervention by the state in decisions regarding treatment at the end of life. If the decision is a purely private one, the presumption is that the state should not intervene; however, if the decision has public aspects, this is not the case. Whether there is an initial presumption either for or against state intervention in a person's decision regarding treatment at the end of life, does not make a great deal of difference in relation to competent adults with respect to decisions falling within a range of conduct that is not considered contrary to "public policy" in common law systems, or "public order and good morals" in civilian legal systems. This is true, because whether respecting the person's decision concerning himself or herself is regarded as a basic presumption or an exception, and likewise, but alternatively, the claim of the state to intervene, *the person's decision will govern*. However, the choice of presumption is determinative when incompetent persons are involved, because the initial presumption cannot be displaced and will govern.

It can be suggested that in the *Cruzan case*[232], for example, the majority of the United States Supreme Court utilized a basic presumption that the state has a right to govern decisions concerning medical treatment of a person, unless the person's decisions in this regard fall within certain parameters. Similarly, in the *Quinlan case*, the court held that "the state's right to protect life weakens and the right to privacy strengthens as the prognosis dims".[233] In contrast, the dissent in the *Cruzan case* utilized a presumption that persons have a right to decide for themselves on medical treatment, unless their decisions fall outside certain parameters, when the state may intervene.

We need to investigate these presumptions, because it seems that a presumption against state intervention in persons' decisions, a presumption which is desirable in the case of persons' rights to refuse treatment, is also being utilized to support claims to euthanasia, on the grounds that, likewise, the state should not interfere in these decisions.[234] One relevant distinction between these two situations concerns the definition of what constitutes medical treatment. It is proposed that it is incorrect to classify euthanasia as such. Therefore, a precedent that governs persons' decisions concerning medical treatment does not necessarily apply to euthanasia. This is not, in itself, an argument against euthanasia, but it is an argument against legitimizing euthanasia through legitimizing rights to or rights to refuse medical

232. *Cruzan* v. *Harmon*, supra, note 201.
233. Re *Quinlan*, 355 A. 2d 647 (N.J., 1976).
234. See, for example, *Notes: Harvard Law Review*, supra, note 27.

treatment, or the latter providing a precedent for legitimizing euthanasia. It is clear in the public debate that is taking place over euthanasia, that this route to legitimizing euthanasia through regarding it as medical treatment, has become a major strategy of persons who are pro-choice on euthanasia.

It is also argued that the state has no legitimate role in relation to decisions concerning euthanasia, because euthanasia is a private decision and, in a pluralistic society, the state has no moral justification for invading private decisions. While it is true that one's dying is, in many senses, an intensely private event, the involvement of third persons, which by definition is the case in euthanasia, means the decision is not merely a private one. Moreover, if euthanasia were institutionalized, which it would necessarily be by the passage of law allowing it, it cannot be simply a private decision, it has a major public aspect.

X. Seeking Insights: The Difference Between Being Anti-Euthanasia and Being "Pro-Life"

There are two senses in which there is a difference between being anti-euthanasia and being pro-life. The first is that not all or even, possibly, most persons who are anti-euthanasia would regard themselves as members of the pro-life movement, nor are their objections to euthanasia religiously based, as can be true (or at least is often assumed to be true) for members of the pro-life movement. Moreover, non-pro-life, anti-euthanasia persons, unlike some pro-life persons, advocate provision of necessary treatment for the relief of pain and other symptoms of serious physical distress, respect for valid refusals of treatment, and withdrawal of futile or "disproportional" treatment, even when any of these could or will shorten life. The second difference is that some anti-euthanasia persons in the pro-life movement would allow capital punishment, that is, they do not oppose all killing of other humans and in this sense, while they are anti-euthanasia, they are not uniformly pro-life.

What could one learn by comparing euthanasia and capital punishment, sadly, a form of killing legalized in some jurisdictions? There are four possible positions that persons could take: (i) that they are against capital punishment and against euthanasia; (ii) that they agree with capital punishment, but are against euthanasia; (iii) that they agree with capital punishment and euthanasia; or (iv) that they are against capital punishment, but agree with euthanasia. What underlying philosophy would each of these positions represent? The first is a true pro-life position, in that, it demonstrates a moral belief that all killing (except, usually, as a last resort in self-defence) is wrong. The second position represents the view of some fundamentalists,

namely, that to uphold the sanctity of life value requires prohibition of euthanasia, but capital punishment is justified on the grounds that this punishment is deserved and just according to God's law. The third position is that of some conservatives, who see capital punishment as a fit penalty on the basis that one can forfeit one's life through a very serious crime, but that one can also consent to the taking of one's own life in the form of euthanasia. The fourth view is that of some civil libertarians, that one can consent to the taking of one's own life but cannot take that of others.

Through such analyses, one can see where the various groups agree with each other and disagree. For example, the true pro-life persons and the fundamentalists agree with each other in being against euthanasia, and some conservatives and civil libertarians agree with each other in arguing for the availability of euthanasia. On the other hand, the true pro-life and civil libertarians join in their views in being against capital punishment, whereas the fundamentalists and some conservatives agree that this is acceptable. In short, with respect to the issue involved here, the taking of one person's life by another, various groups can coalesce and agree in certain instances in which this issue arises, while they may be radically divergent in others. We need to be aware of these possibilities of a mixture of consensus and divergence as between different groups, in assessing the political realities, public policy stances and analysis relevant to euthanasia.

XI. Seeking Further Insights: Anti Anti-Euthanasia and Anti "Pro-Euthanasia" Arguments

Although the aim is the same, and there is necessarily overlap between various arguments in both cases, there can be a difference in the content of the propositions used when arguing for allowing euthanasia, as compared with arguing against the anti-euthanasia position. The same is true with respect to arguing against the "pro-euthanasia" position, as compared with arguing for the anti-euthanasia one.

(A) Arguments Against the Anti-Euthanasia Position

(i) Suffering and mercy

Euthanasia is advocated as being suffering reducing by those in favour of its being allowed and, therefore, persons who are anti-euthanasia can be perceived as being pro-suffering. No humane person advocates suffering, but unavoidable suffering is not seen as entirely negative by everyone. Some cultures or religions attribute value to suffering. This is to propose that suffering is not always the greatest evil, such that actions, including euthanasia, aimed at relieving suffering are always a lesser evil and are, therefore, accept-

able. Not ending life is characterized by some pro-choice or euthanasia advocates as an act of infliction of suffering, rather than being seen as an example of our inability sometimes to relieve suffering. We need to ask whether this is, yet, another example of the "do something" syndrome. Not being able to act to try to improve a very distressing situation makes us highly anxious, and we do not accept that there are some situations in which we cannot or ought not to "do something". We assume that "doing something" is better than "doing nothing" and that "doing something" will improve the situation either in moral or practical (including not infrequently political) terms.

Physicians may experience and display an especially powerful version of the "do something" phenomenon. Physicians can be very uncomfortable, even highly anxious, if they feel unable to intervene to improve a patient's situation, especially if the patient is seriously ill, as all terminally ill patients are. One response to such patients can be to more-or-less abandon them - to visit these patients less often and to spend little time with them. Another response is "[t]he great temptation of modern medicine, not always resisted, . . . to move beyond the promotion and preservation of health into the boundless realm of general human happiness and well-being".[235] While physicians may do much good in trying to achieve such objectives, not all ways of doing so are acceptable or do more good than harm. In particular, "[i]t would be terrible for physicians to think that in a swift, lethal injection, medicine has found its own answer to the riddle of life. It would be a false answer; given by the wrong people."[236]

Being anti-euthanasia is also regarded by some persons as a non-merciful stance. It is difficult to argue against persons who see themselves as merciful and the persons opposing them as unmerciful. Proponents of euthanasia argue that it is unethical not to provide euthanasia, because this is unmerciful, that is, prohibiting euthanasia is not only non-beneficent, but also even maleficent. There is a stronger moral obligation not to do harm than to do good, although distinguishing whether a given situation should be characterized as one or the other can sometimes be difficult. Consequently, to argue that failure to provide euthanasia is unmerciful and that this is maleficent, is a stronger argument in favour of euthanasia than simply arguing that to provide it is to confer a benefit. It is, however, also argued that euthanasia is compassionate and beneficent, in particular, that it benefits the patient, the family, health care professionals and society.

235. Callahan, supra, note 179, p.55.

236. Ibid..

(ii) "Reasonably well or dead"

It is argued as well, that not to allow euthanasia contravenes the aim that persons be either "reasonably well or dead". It is true that, largely as a result of modern medical technology, we can now be very sick and live for a considerable time and that the "wellness curve", rather than gradually declining over a period of time, can be "squared" by euthanasia. In other words, euthanasia allows one to go directly from being reasonably well to dead. It is possible, however, also to "square" the morbidity curve by good palliative care and pain relief treatment, rather than euthanasia; that is, wellness or at least a sense of well-being, is not necessarily dependent upon the absence of disease.[237] Stated another way, in the vast majority of cases euthanasia should be unnecessary in the sense of being the only option for avoiding serious suffering, if good palliative care, including adequate pain relief treatment, is provided.

(iii) Liberty

It is also argued that euthanasia should be available to those who want to die, as a matter of respect for personal liberty and, therefore, that those who oppose euthanasia fail to respect important liberty rights. We need to be careful, however, with equating "wanting to die", in the sense that a person feels that he or she is ready for and even would welcome death, and "wanting to be killed". Many, and probably most, people at the end of their lives are "ready to die", but this does not mean that they "want to be killed".

Further, as noted already, the availability of euthanasia is not one-sided in its impact on liberty. While it can be regarded as extending persons' range of choice concerning how and when they die, its availability can also act as a pressure to request or agree to euthanasia, which is to restrict persons' liberty.[238] There is also a more subtle way in which the availability of euthanasia could interfere with liberty. At a recent conference, Denise Ross from the Dana Farber Cancer Institute, described a conversation she had with a young terminally ill patient about pain management. He raised the issues of assisted suicide and euthanasia. She discussed these with him, but told him she felt obliged to inform him that she would not assist him in these ways. He replied: "Of course not. I wouldn't feel comfortable talking to you about this, if you would."[239] It is possible that we need to have a trusted and

237. Moreover, in one sense, with rapidly emerging, highly sophisticated, medical diagnostic techniques, the well among us, are only the undiagnosed sick. I am indebted to Dr. Ken Flegel, M.D., MRCP(C), of the Royal Victoria Hospital, Montreal, for this insight.

238. See, Brock, supra, note 25, pp.17-18, referring to Velleman.

239. "Conflicts in Managing Intractable Pain and Suffering", American Society of Law and Medicine conference, supra, note 155.

trustworthy institutional forum in which to explore such matters, without fear of being subjected to the kinds of intervention that we discuss. The forum used to be organized religion, but for many persons now, medicine has replaced this. A liberty interest would be breached by not retaining such a forum. This is one argument why, even, if euthanasia were to be legalized, it should not become part of medical practice.

(B) Arguments Against the "Pro-Euthanasia" Position

(i) Precedent

It is accepted that, at an individual or micro level, persons of "good conscience" can believe that euthanasia is morally acceptable in certain circumstances, in particular, circumstances of intense, unrelievable suffering. It is argued, however, that even if one accepts this, euthanasia is unacceptable, because of the precedent that allowing it would set at the societal level. In this respect, can it be argued that it is even more important in a secularized world, than in a religiously based one, not to allow euthanasia, because our worldly acts are the only sources of our values? Further, what would happen in a secularized world with a shortage of health care resources, if we allowed euthanasia? Would persons be graded on a scale of "useless" to "highly useful" and resources allocated or, alternatively, euthanasia provided according to the relative degrees of perceived utility of the persons concerned? Would this give rise to a euthanasia line or continuum ranging from unethical or less ethically acceptable acts of euthanasia to more ethically acceptable ones? This ethical continuum can be compared with the law's "digital" approach to dealing with such a range of conduct. Unless all acts of euthanasia would be allowed, the law would require that a line be drawn across the range of acts dividing them into two groups. One group of these acts would be legally acceptable and the other group legally unacceptable, although the acts that make up each group would not be equally acceptable or unacceptable, respectively, from other perspectives, including most importantly, from an ethical perspective. Where would the law draw a line on the euthanasia continuum? Would some instances of euthanasia that most persons would regard as doubtfully ethical, or even unethical, be characterized as legal?

(ii) Other arguments

Further arguments against the pro-euthanasia position that have been explored by others, in particular, Singer and Siegler[240], Wolf,[241] Callahan,[242]

240. Supra, note 127.

and Capron,[243] will be simply summarized here. They include perversion of the proper aims of medicine, if physicians are the persons who carry out euthanasia. This would be to turn medicine from an aim of healing and caring to one of eliminating the person who needs care. Euthanasia will extend into *all* physician-patient interactions, not just those directly involving euthanasia.[244] In particular, euthanasia can desensitize and brutalize those who carry it out. This is a particularly disturbing possibility, when those same persons are our healers and caregivers - physicians and other health care professionals. Moreover, the major separation of the two roles of the witch doctor (the modern physician's ancient predecessor), that of healer and death inflictor, the most influential and important articulation of which is to be found in the two-thousand-year-old Hippocratic Oath, would be reversed. As Kass, so powerfully, states "the deepest ethical principle restraining the physician's power is not the autonomy or freedom of the patient; neither is it his own compassion or good intention. Rather it is the dignity and mysterious power of life, itself".[245] Euthanasia puts the "very soul of medicine" on trial.[246]

As has been discussed at various points throughout this text, the symbolism of euthanasia is unacceptable, even if it is carried out for the most humane reasons, as it constitutes the most serious derogation from the sanctity of life value. It has been well said, that sanctity of life has been unduly identified with and confined to the religious commandment. There are also secular reasons - moral, rational and medical - for respecting sanctity of life and rejecting euthanasia and these need to be explored.[247]

To allow euthanasia would inflict suffering and have potentially dangerous effects on certain already vulnerable groups, for example, handicapped persons or chronically ill persons. The same grounds on which euthanasia is carried out on others are often true of these persons and, even if they are not at risk of being subject to euthanasia, the fact that others in a similar position are subject to it, devalues their lives.[248]

241. S. Wolf, "Holding the Line on Euthanasia", *Hastings Center Report* 1989; 19(1)(Spec. Supp.):13-15.

242. Supra, note 202.

243. Capron, supra, note 11, p.32.

244. Ibid., p.32.

245. Kass as quoted in Brock, supra, note 25, p.17.

246. Ibid., p.16, quoting W. Gaylin et al..

247. Fenigsen, supra, note 50, p.24.

248. It has also been noted (see, for example, A. Trafford, "Wishing to die: are women really more open to assisted suicide?", *Washington Post*, reprinted in *The Gazette*, Montreal, Monday, March 15, 1993, p.D5) that *all* of the recent, highly publicized cases of physician assisted suicide in North America have involved the death of women - historically a vulnerable group.

There is also it is proposed a greater danger of abuse if euthanasia were legalized than if it is not. Even if this cannot be established, those advocating euthanasia should at least have the burden of proving the contrary. Possible abuses include that euthanasia could be involuntary, that is, carried out without consent or against the wishes of the person; or carried out secretly despite its being, indeed, because it is, legalized; or persons would be encouraged to seek euthanasia; or it could be so-called "surrogate euthanasia", that is, a person other than the one being euthanased, authorizes euthanasia; or euthanasia could be applied in a discriminatory manner in terms of the persons who are subject to it.[249] As Singer and Siegler state, these risks are especially serious in an era of "cost containment, social injustice and ethical relativism".[250]

The availability of euthanasia may also detract from developing better care for dying persons, as the quick and easy answer is to use euthanasia, rather than to carry out research in order to develop and improve such care. Indeed, it can be asked whether, if euthanasia had been available, we would have developed the often sophisticated palliative care techniques that we have today.[251] It would be interesting to examine the situation in The Netherlands in this respect, to determine the availability of palliative care resources and hospices and to see whether or not the euthanasia response was, or is, related to the unavailability of or inaccessibility to such care. The availability of euthanasia could also create pressure to accept or to request it to relieve burdens on one's family and society.

Euthanasia would also be likely to interfere with current legal approaches to refusal of treatment. As Wolf[252] points out, the courts would be reluctant to stay out of decisions at the end of life, if euthanasia were one option. Moreover, we might not have developed mechanisms such as "advance directives", if euthanasia had been an option.

Most contentiously, perhaps, one can argue that euthanasia interferes with the final stage of our human development - dealing with death. Euthanasia is a short-term, simple, easy in some senses, appealing to some, solution. But we need long-term perspectives on euthanasia, which may be more complex and difficult in many respects. Through these, we are more likely to work out the mystery and complexity of our dying and with this our living, because the latter is necessarily related to the former.

Finally, euthanasia would set a precedent of universal application, be-

249. Singer and Siegler, supra note 127, p.1882.
250. Ibid., p.1833.
251. Wolf, supra, note 241.
252. Ibid..

cause, at some point, each of us must face death. This universality can be regarded as beneficial from the point of view that there will be strong personal identification with the possibility that, if euthanasia were legalized, it could be applied to us, which should make people think very seriously about whether or not they agree with the precedent that legalizing euthanasia would set. At some stage, each of us would be the person on the other side of "the veil of ignorance" to whom the euthanasia decision could apply - the veil behind which Rawls suggests we should make difficult decisions, on the basis that we do not know, at the time of the decision, which actor we will be when the decision is implemented.[253] The universality of the application of a euthanasia precedent is also immensely frightening in the potential extent of its use.

There are some fine lines which we should never cross and, it is proposed, one of these is that separating euthanasia, as defined, from other interventions or non-interventions at the end of life.

CONCLUSION

We are not only logical, rational beings, we are also emotional, intuitive, spiritual (which is not the same as religious) ones. Our "ways of knowing" are complex, diverse and vast.

Much of the argument for euthanasia is logical and rational (for example, that there is no difference between actively killing and allowing to die), but it can also be emotional (for instance, that we have obligations to be merciful and to relieve suffering). The arguments against euthanasia are also logical (for example, the "slippery slope" argument) and emotional (for instance, the sanctity of human life). For some persons, the arguments are also religious or possibly just spiritual.

Euthanasia (as defined) should be seen as different in kind not just degree from other acts or omissions that could or do shorten life. It is argued that one crosses a great divide in undertaking intentional killing; that while pain and other symptoms of serious physical distress should be relieved, it must always be the pain or other symptoms that one seeks to eliminate and not the person with the pain or symptoms. Moreover, even if euthanasia were to be justified in an individual case, the societal level effect that legitimizing this would set, especially legitimation through authorizing legislation, is unacceptable.

When we disagree, it is important to delve below the level of our disagreement and to try to find a deeper consensus. To start from consensus and

253. J. Rawls, *A Theory of Justice* (Cambridge: Belknap Press, 1971), pp.12, 137 et seq.

move to disagreement, has a different effect than starting from disagreement. The two poles of the euthanasia argument are clear: pro-choice on euthanasia - no interventions, including infliction of death, aimed at reducing or eliminating suffering should be prohibited; pro-life - all interventions that could or would shorten life should be prohibited. It is much more difficult to belong to the middle of this debate and to draw a line somewhere in the grey (or purple-pink[254]) zone between the poles, and to argue that some actions that shorten or fail to prolong life are prohibited and others, even those with the same outcome as a prohibited action, are allowed. Where we should agree is that none of us is pro-suffering and none of us is anti-death when "its time has come". Where we disagree is the means that may be used to reduce suffering or to cause or to allow death to occur.

The euthanasia debate is an immensely important one, which is likely, more than any other current issue, to set the legal and ethical tones of our societies as they become societies of the 21st century. We will learn and need to learn much along the way, because this is a complex debate, with micro and macro impact; unconscious origins; conscious realizations and insights; major effects on symbolic and value factors; and links to many other societal issues outside the context of euthanasia, including balancing rights or claims of individuals which conflict with rights or claims of the community. Is prohibition of euthanasia an example of sacrificing the individual who desires euthanasia, for the good of the community which would be harmed by the precedent set in allowing euthanasia? Is euthanasia the final act of love of caring individuals and a caring society? Or is euthanasia an isolation ritual whereby the individual is expelled from the collective, the members of which bond to each other through shared guilt?[255] To decide such questions will take wisdom, compassion, courage and hope - the antithesis of despair, which so often is, but need not be present in situations involving euthanasia. How we deal with euthanasia is likely to be one of the most important mirrors of ourselves, our society and our relationships - both as intimates and strangers. We need, therefore, to take great care in fashioning the lyrics of the songs that we sing about it, because these lyrics will play a crucial role in determining the reality regarding euthanasia, that gives rise to these reflections. Moreover, our decisions and actions in relation to euthanasia will create not only immediate reflections, but also themes and echoes of enormous importance for those who come after us to live in the world of the future.

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254. See, Somerville, supra, note 43.

255. D. Schulman, "Remembering Who We Are: AIDS and Law in a Time of Madness", (1988) 3 *AIDS and Public Policy*, 75-76.

ADDENDUM

"The Song of Death: The Lyrics of Euthanasia"
Doctor Margaret Somerville

The term futile is used to include both medically useless treatment and that in which benefits, if any, of the treatment are minimal and are clearly outweighed by its harms. It is recognized that such determinations unavoidably involve value judgments, which is often so source of criticism of approaches depending on these. The solution is not to avoid such approaches when these are otherwise the best ones (as it is proposed is truth with, respect to determinations regarding when treatment is futile), but to surround them with sufficient safeguards. See also, infra pp.61-62.