Opinion

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'Dances with Data': A Riposte

By Dr John Keown,
Lecturer in Law and Ethics of Medicine
University of Cambridge

Professor van der Maas, Dr van Delden and Dr Pijnenborg, authors of the survey *"Euthanasia and other Medical Decisions Concerning the End of Life"* (1992; hereafter 'survey') have argued that I (and a number of other commentators on Dutch euthanasia) have misinterpreted their findings about euthanasia in The Netherlands. ('Dances with Data' (1993) 7 *Bioethics* 323; hereafter 'Dances'). Their most important criticism, to which I shall limit myself in the interests of conciseness, is that I have inaccurately inflated the number of cases of euthanasia and assisted suicide disclosed by their survey. I here rebut that allegation.

The authors conclude that in 1990 there was 2,300 cases of euthanasia and 400 cases of assisted suicide. I conclude that their survey reveals 400 cases of assisted suicide and 10,158 cases of euthanasia.* What accounts for the discrepancy of almost 8,000 cases of euthanasia? The central explanation is the survey's unusually narrow definition of 'euthanasia'.

(i) 'Euthanasia': the survey's narrow definition

The survey defines 'euthanasia' as 'the purposeful acting to terminate life by someone other than the person concerned upon request of the latter' (survey, p.5). This definition, although common in Holland, is narrower than normal definitions in two respects: the need for *a request by the patient* and for a life-terminating act.

(a) euthanasia without request: A request from the patient to be killed is not an ingredient of standard definitions of 'euthanasia'. As Professor Singer points out, the dictionary definition of 'euthanasia' is simply 'a gentle and easy death', and the word is now used to refer to 'the killing of those who are incurably ill and in great pain or distress in order to spare them further suffering' (Practical Ethics (1979), p.127).

It is, of course, conventional to subclassify 'euthanasia' according to the presence or absence of a request. For example, having defined 'euthanasia' as above, Singer adds that, within that definition there are three different *types* of euthanasia: 'voluntary' euthanasia, 'that is, euthanasia carried out at the request of the person killed'; 'non-voluntary' euthanasia where a 'human being is not capable of understanding the choice between life and death'; and 'involuntary' euthanasia 'when the person killed is capable of consenting to her own death, but does not do

so, either because she is not asked, or because she is asked and chooses to go on living' (op cit, pp.128-130).

(b) euthanasia by omission: The survey's definition is also unusually narrow in its confinement of 'euthanasia' to life-terminating *acts*. But, it is, again, widely and rightly acknowledged that euthanasia can be carried out by *omission* as well as by an act. Hence the existence and widespread currency of the term 'passive' euthanasia. For what is central to the definition of euthanasia is the *intent to shorten life* and that intent can be effectuated by act or omission. If a doctor's intent is to kill his patient, it morally matters not whether he does so by (say) giving him poisoned food or by starving him. Indeed, in its report on euthanasia in 1984, the Royal Dutch Medical Association regarded as euthanasia 'All activities or *non-activities* with the purpose to terminate a patient's life...' (Emphasis added).

In other words, those omissions which are a means of carrying out a homicidal intent are euthanasiast. Those which are not (and are simply intended to spare the patient useless or excessively burdensome treatment) are not euthanasia.

(ii) Acts and omissions with the 'explicit' intent to shorten life

In the light of the cardinal importance of intention, the care taken in the survey to ascertain the intention of the doctors when making their 'decisions affecting the end of life' is welcome.

The survey distinguishes between three states of mind:
'(acting with) the explicit purpose of hastening the end of life;
(acting) partly with the purpose of hastening the end of life;
(acting while) taking into account the probability that the end of life will be hastened' (survey, p.21).

'Explicit' intent is explained as follows: 'If a physician administers a drug, withdraws a treatment or withholds one with the explicit purpose of hastening the end of life, then the intended outcome of that action is the end of the life of the patient' (ibid). In short, 'explicit' intent is synonymous with the natural (and legal) meaning of 'intent', as purpose, goal or aim (The definition of 'partial' intent is arguably unclear and is therefore ignored for present purposes).

The survey discloses that it was doctors' explicit intention to shorten life, by act or omission in 10,558 cases. This total comprises the 2,300 cases classified as 'euthanasia' in the survey; the 400 cases classified as 'assisted suicide' in the survey; 1,000 cases of administering drugs 'with the explicit purpose of hastening the end of life' without explicit request; 1,350 cases of the administration of opioids 'with the explicit purpose of shortening life'; 4,000 cases of withholding or withdrawing treatment, without explicit request, 'with the explicit purpose of shortening life'; and 1,508 cases of withdrawing or withholding treatment, on explicit request, 'with the explicit purpose of shortening life'. The authors' reasons for dismissing this total are weak indeed.

(a) intention: Their main reason is that 'intentions cannot carry the full weight of a moral evaluation on their own' because 'intentions are essentially private matters. Ultimately only the agent "decides" what his intentions are, and different agents may describe the same actions in the same situations as performed with different intentions'. And, they add, the agent's purpose may change over time, so what is to count as the 'definitive description' ('Dances', p.325)?

This is remarkable. For they *asked* the doctors what their intention had been, and the doctors *replied* that in over 10,558 cases it had been their *explicit intention to shorten life*. Why are the doctors' own answers not taken as the 'definitive description'?

The authors assert that no doctor who performs euthanasia does so with the sole intent to kill: 'His or her intention can always be described as trying to relieve the suffering of his or her patient. This is exactly what infuriates Dutch physicians when, after reporting the case they are treated as criminals and murderers' (ibid, 325). But while the doctor's *motive* may well be to relieve suffering, he *intends* to do so by shortening the patient's life. And that is precisely why, in most jurisdictions, the doctor who performs euthanasia is liable for murder.

They continue that it is wrong to rest the entire moral evaluation entirely on intention: 'For a moral evaluation, more is to be taken into account, such as the presence of a request of the patient, the futility of further medical treatment, the sequelae of the decision to stop treatment (eg will this cause heavy distress?), the interests of others involved such as family and so on' (ibid, 325-326). The authors are, yet again, muddled. For the question at issue is not the *moral evaluation* of cases of euthanasia but their *incidence*. And this is a matter of definition, not evaluation. And the standard definition regards as euthanasia cases where the doctor, by act or omission, intentionally shortens life.

(b) context: Their second argument is that, if the 'context' is taken into account, it can be questioned whether the intentions were euthanasiast. As an example they cite the 6% of cases of alleviation of pain and symptoms in which doctors stated that their explicit intention was to shorten life. The authors seek to distinguish these cases from euthanasia on the ground that they involve a failure of palliative care, followed by the use of higher doses which may lead to a point at which 'the physician realises that he or she actually hopes that the patient dies' (ibid, p.326). His or her intention is 'not necessarily' the same as with euthanasia, where the physician would surely try another lethal drug if the first failed, which would 'never' happen with the administration of opioids.

This line of argument is unpersuasive. First, in these 6% of cases doctors said it was their *explicit*, not partial, intention to shorten life. Secondly, when the authors say the intention was 'not necessarily' the same are they not implying it may well have been? Finally, the argument appears to rest on the unsubstantiated

speculation that, had the overdose failed to shorten life, the doctor would not have resorted to another method. Even if this were true, it is a *non sequitur*: if A intends to kill B by method C1, which fails, his decision not to resort to method C2 has no bearing on the intent with which he applied method C1.

The survey is a most important piece of empirical research and its authors merit praise for their painstaking, comprehensive investigation of medical decisions concerning the end of life. If they wish to limit their definition of 'euthanasia' to 'voluntary, active euthanasia' they are of course free to do so, but their criticism of those who apply standard definitions is misconceived. And there can be little doubt that applying such definitions yields a total of 10,558 cases in which it was the explicit intention of doctors to shorten life by act or omission or, in other words, of euthanasia.

(*For a complete analysis of the survey, see John Keown, "Down the Slippery Slope: Further Reflections on Euthanasia in The Netherlands in the light of the Remmelink Report and the Van Der Maas Survey' in Luke Gormally (ed) *Euthanasia, Clinical Practice and the Law* (1994) 219-240)