

THE LEGALISATION OF EUTHANASIA

The legalisation of euthanasia is a constantly recurring topic for debate, in which the chief themes include the status of good medical and nursing care for the dying, its morality, legal detail and human rights, especially respect for personal autonomy and perhaps privacy, and the role of public opinion. Since there are deep divisions in society on all those issues, it is not surprising that the debate seems to rotate endlessly about them, without any reasonable prospect of consensus. Those for and those against the proposal are both unwilling to yield on what they see as immutable positions of principle.

If progress is to be made, a way needs to be found whereby personal views about the medico-social role of euthanasia can be excluded, while the subject is discussed on neutral grounds, capable of objective examination.

It is apparent now that such a neutral way has been discovered, though perhaps by chance, it has already been used several times and the results of that use have been published. I refer to the reports of the large government-supported committees of inquiry held in recent years, on four different continents, devoted to the consideration of the consequences of legalising euthanasia.

In sharp contrast to the usual lack of resolution on debate on this topic, every one of these committees independently reached the same conclusion, namely that legalisation would be unwise and dangerous public policy, because *unpreventable* abuses could not be eliminated. More astonishingly, when it is difficult to find at random even a small number of people who can agree on almost any aspect of euthanasia, three of these four committees reached this conclusion unanimously, though they all included individuals who held opposing personal views about euthanasia.

The committees and their reports were:

- Select Committee on Medical Ethics, House of Lords, January 1994.¹
- New York State Task Force on Life and the Law, titled *Euthanasia and Assisted Suicide in the Medical Context*, May, 1994.²
- Senate of Canada, June, 1995, titled *Of Life and Death*.³
- Community Development Committee, Parliament of Tasmania, titled *The Need for Legislation on Voluntary Euthanasia*, 1998.⁴

Of the fourteen members of the House of Lords Committee, only two were known at the outset to be openly opposed to euthanasia. The Chairman was reputed to be a medical consultant to the Voluntary Euthanasia Society and one Law Lord had previously decided in favour of 'passive' euthanasia in the case of Tony Bland. Another member had written a philosophical defence of both voluntary and non-voluntary euthanasia, a view thought to be shared by three or four other members. When it visited Holland, the Committee learned there of an alarming number of patient deaths without patient consent, and were openly told by Dutch advocates of euthanasia that effective safeguards against abuse had proved impossible to devise.⁵

The Committee of the New York State Task Force had 25 members, including some who thought that euthanasia and assisted suicide were sometimes ethical and compatible with good medical practice. This Committee issued a unanimous report rejecting legalisation, a most valuable compendium of important information.

In early 1997, the Tasmanian parliament established a committee to examine the need for legislation on voluntary euthanasia in that State. When she released the final report of this Committee in 1998, the Chairperson revealed that of its five MP members, four, including herself, had originally been in favour of euthanasia. This Committee unanimously found that 'it would be impossible to frame a law that included all the vital safeguards to protect the vulnerable, weak and disabled.'⁶

These reports, taken together, constitute an unexpected and valuable body of expert findings, all pointing in the same direction. Thus, any future proposal for the legalisation of voluntary euthanasia (VE) could reasonably be regarded as incomplete and inadequate unless it displayed familiarity with the arguments contained in those reports, and included effective solutions to the many difficulties they uncovered.

Regarding laws on killing, the House of Lords Report said 'The product of an adequate, legal framework should be public confidence that the law protects life...there can be no more important area in which the law's protection *should be complete and transparent* than where individual's lives are at stake'.

For a law to be unsafe, it does not have to be shown that it will be abused, merely that it is clearly open to abuse. The more open it is, the greater the likelihood that it will be abused.

A good deal of the reasoning in the reports may be summarised in this extract from the report of the New York State Task Force: 'For purposes of public debate, one can describe cases in which all the recommended safeguards would be satisfied. But positing an 'ideal' or 'good' case is not sufficient for public policy, if it bears little relation to prevalent social and medical practices. No matter how carefully any guidelines are framed, (assisted suicide and) euthanasia will be practised through the prism of social inequality and bias that characterises the services in all segments of our society, including health care. The practices will pose the greatest threats to those who are poor, elderly, members of a minority group or without access to good medical care'.

This paper cannot do justice to the whole of the content of the cited reports which need to be read in full, because they cover an extensive range of subjects. It will include:

- discussion of the essential incompatibility of any euthanasia law with the objectives of sound criminal law
- some discussion of the human rights thought relevant to euthanasia
- the role of public opinion in law making, and
- some of the medical factors that would make any such law unsafe.

Incompatibility of Legalised Euthanasia with existing Criminal Law

Since euthanasia is the intentional taking of innocent human life, it is a form of homicide, and even if it were legalised, it would be legalised homicide. The basic aims of criminal law are to provide **equal justice** for every citizen and to **protect the weak**. Additionally, the *consent of the victim* is by legal tradition no defence to a crime.

Equal. The criminal law of every nation holds that all innocent human life is inviolable, innocent persons being those who pose no threat, or have done no harm, to others. The value placed equally by law on each life is such that its intentional destruction is the greatest of crimes, deserving of the greatest penalty. Euthanasia law would provide the first exception to the prevailing universal protection of innocent life, by creating a category of persons whose lives may be taken intentionally, under certain conditions. It would thus constitute a precedent for repeating the process later to further enlarge the scope of the new principle, where no such precedent had previously existed. The concept of equality before the law would have been abandoned.

Justice. For a law to be just, it should be grounded in sound ethical principle capable of receiving general acceptance; its definitions and provisions should be set out in clear terms so they can be interpreted in the same way by all who read them. This would constitute a particular problem with euthanasia, since many of the phenomena associated with death are difficult to define with such precision; its provisions, particularly those intended to act as safeguards, must be capable of being realised and of being monitored, and it must contain no obvious avenues for abuse. If any of its important elements relied for their observance on opinion rather than fact, that would introduce arbitrariness and would be incompatible with justice.

A patient who requested euthanasia would have concluded that his/her life was no longer worth living, and a doctor who agreed to the request would have reached the same conclusion, by an independent but arbitrary judgment. In the same circumstances, different patients and different doctors would have come to different conclusions, depending on their personal values. Thus, under a euthanasia law that simply accepted these personal choices as grounds for lawful killing, the result would represent a kind of lottery of life, whereby a subjective request was met with a subjective response, and neither would be, or could be, objectively validated. The idea that legally taking life may be made dependent on the untestable choice or opinion of persons is at odds with any mature notion of justice.

Protection of the Weak

The lives of individuals or groups who are unable to participate fully in the life of the community are especially protected by the current law, because it allows of no exceptions. These groups include the poor, the aged and the very sick, and those who make heavy demands on the community's time or resources, such as physically or intellectually handicapped, or permanently unconscious, people. Once it had been decided in law that the equal right to life may be waived on account of a low quality of that life, it would seem, to some at least, that individuals in the above categories would be the most logical for the extension of that principle, should other circumstances seem to justify it.

Mutual Consent

Voluntary euthanasia involves one person asking and another agreeing to the taking of life. Though, in criminal law, consent is no defence to a breach of any of its provisions, with lawful euthanasia both parties would have acted in defiance of that principle.

It is instructive that the statute laws on killing in the Netherlands are much the same as elsewhere, and that the Dutch have to date preferred to try to justify their expanding euthanasia practices by case law or precedent, not by statute. They have wanted to have euthanasia regarded as an arguable exception to the legal principle that they see as vital to maintain, namely that innocent life *should* be regarded as inviolable. Most of those who promote lawful euthanasia elsewhere fail to see that the retention of this principle is needed to sustain the credibility and strength of the rest of the criminal law, for a person must at least be alive in order to be subject to its provisions.

Human rights and the Law

As outlined above, any proposal to legalise VE would constitute, not only an attempt to change the present laws, but to overturn them. If the proposal appealed to any human rights for its justification, they would have to be acknowledged natural rights, those derived from considerations of the nature of mankind. That right would also need to be properly defined and understood in the same way by all who discuss it.

Natural rights were originally conceived as the entitlements of citizens that would protect them against injustices. Respect for autonomy can be argued to be a genuine natural right, and as such, it would oblige its acceptance by others. Autonomy is the right of every person to decide freely the course of his/her own life, within the limits set by the competing genuine rights of others, and it will oblige compliance when it respects those rights. That is, autonomy involves both the privilege of choice and the duty to restrain one's choice, when that is required. Difficulties arise in relation to VE when (a) autonomy is not defined or not correctly defined, since clarity is essential when discussing such a contentious and emotional subject, and (b) when it is commonly discussed as though it were no more than a welfare right. Autonomy is now commonly presented as, and often thought to be, merely an individual's expression of preference, which is never claimed to be binding on others.

Welfare rights have a well deserved reputation for being divisive and confronting, because they tend to favour one individual above others. Natural rights, which place equal emphasis on furthering the well-being of both the individual and of society, promote harmony and friendship. The facts that rights are so often incorrectly understood and unequally applied led one observer to comment 'when rights come in, love goes out the door'.

Though any proposal to take innocent life has unarguably high moral content, any suggestion that this merits close examination is apt to be met with accusations of 'religious bigotry' or the like, as though secular morality did not hold similar claims to fundamental importance. However that may be, a common practice now is simply to ignore any discussion of it. When absolute morality is rejected, traditional ways of deciding morality become diluted, without any consistent ethic found to replace them. Questions of right and wrong can then be transformed into questions about individual rights, so that 'What is right?' becomes 'What are the rights?', an entirely different topic.

Autonomy is misunderstood or misrepresented when it is assumed to apply to whatever an individual may happen to want sincerely, or when it is assumed that the significance of the consensual killing of VE is a private matter, with no harmful consequences for others. Both assumptions are wrong. Further, it is widely but incorrectly assumed that choice itself is the

essence of autonomy, not what is chosen. Individuals have no entitlement at all to be given what they happen to want - that would be nearer to self-indulgence than self-determination.

Depicting euthanasia as no more than a private matter is dangerously naive, ignoring the fact that euthanasia law would set new and lower standards of respect for human life, because in the eyes of many, making a matter legal signifies it has the approval of authority. VE would then become one of the options that may be put to all vulnerable sick patients, and it would be proper to promote and encourage it. In light of the gross imbalance in power between doctors and their patients, some patients would then be powerfully and unfairly influenced. This would place an unnecessary burden on dying patients when they may already be seriously taxed and confused by so many aspects of their illness.

If the right to request death were a genuine right, it would oblige compliance, though VE supporters are careful always to point out that that is not their aim. A human right cannot be claimed at the same time to be genuine and yet only permitted to be exercised arbitrarily. To be consistent, if the right were genuine, VE should then be available to all who ask, sick or not, at any time, for any or no given reason. The young who now commit suicide in alarming numbers should no longer distress us, but be congratulated for showing how to take control of one's dying, as a matter of right.

Further, to depict VE as no more than an individual patient's wish is to ignore the presence of the person asked, the doctor. This second person is an independent moral agent who must make his/her independent and separate autonomous response, be required to justify it when asked, and take due responsibility for it.

The sum of these deficiencies in the common understanding of autonomy to justify VE means that the argument is distorted. No matter how often or how vehemently it is asserted that an individual's wish binds others to comply, just because that is what he/she sincerely wants, the mere expression of a wish is not autonomy. The wish, and all that may flow from it, must be closely examined within the context of its social and medical setting, and in this paper, some of those factors are discussed.

A different form of distortion, in the opposite direction, is the virtual exclusion from the debate of the right of every innocent person to his/her life, the genuine natural right on which the criminal law is founded. Not only must this right be included, logically it should be first.

The 1948 United Nations' Universal Declaration of Human Rights is the most widely acclaimed and accepted statement of human rights. It was compiled at a time when member states of the UN, horrified by their discovery of the then recent extent of the abuse of natural rights, were resolved to ensure that this should never happen again. It describes the right of each person to his/her life as equal, inherent, inviolable, inalienable and deserving of the protection of law. This means that the right is not to be made dependent on its quality at a particular time, there are no exceptions and the right may neither be taken away nor given away.

There is an urgent necessity for full consideration of this natural right to be reintroduced whenever the legalisation of euthanasia is being discussed, if the proper role of law in the governance of society is to be retained.

The doctrine of personhood is a relatively recently added plank in the platform for VE, and is now receiving broad assent. While it may not directly be connected with human rights, the concept is a denial of the right of every person to his/her life, and is therefore an attack on the ethical basis of law. 'Personhood' claims that the value and dignity of a person, which are the reasons that entitle every individual to be treated with equal justice, are said to depend on the prior development of certain currently usable psychological abilities. This raises questions as to which abilities there must be and how developed they must be. Since there are no standards by which every observer could reach the same conclusions, such questions can be answered only by *choosing* the criteria that will lead to the conclusion one wants. Thus, this will always be an arbitrary exercise, reliant on the values of the observer, and cannot be just.

If it were asked 'What benefits does this new idea confer on society in order to justify the displacement of the traditional understandings of who may be regarded as a person?', the answer can only be 'None, that do not permit and rely on the taking of the lives of certain individuals who are already unwanted by society, for other reasons, without their knowledge'. Those individuals will be some of the disabled, the senile, the seriously ill and the unconscious, whose lives are at present protected by law, and whose specific human rights are proclaimed in various declarations. When the malignant intention of personhood is realised, with its inherent disregard for both law and rights, its advocates' real lack of concern for all human life is exposed, to which is added duplicity when they also purport to appeal to other human rights.

The Role of Public Opinion in Law Making

One reason given for wanting the laws on killing changed is that a majority of the community have declared, via opinion polls, that that is what they want.

Opinion polls were developed to test views about political issues, but VE is clearly a moral issue, secular or otherwise. When an issue is as complex in almost every respect as VE is, no valid conclusions can be drawn from polls when the respondents' real understanding of them is both unknown and unknowable. To use such results as an argument to change part of the criminal law would be foolish and dangerous. This would be self evident if it were proposed to change other parts of the law, using the same mechanism.

Morgan opinion polls have been asking the following question in Australia since 1962: 'If a hopelessly ill patient, in great pain, with absolutely no chance of recovering, asks for a lethal dose, so as not to wake again, should the doctor be allowed to give the lethal dose?' The proportion of respondents answering 'yes' has increased from about 50% at first to nearly 80% now. As one commentator noted, it would be hard for an uninformed person to say 'no' without feeling negligent, dogmatic or insensitive.

But when the current ability of good palliative care to relieve the severe pain of terminal illness is known, though it is also known that such care is still not sufficiently available for many, the same question could be more accurately phrased 'If a doctor is so negligent as to leave a terminally ill patient in severe pain, severe enough to drive him/her to ask to be killed, should the doctor be able to compound that negligence by killing the patient, instead of seeking expert help?' The question is really about appropriate standards of medical care, not euthanasia.

It cannot be doubted that most of the community's information and opinions on VE have been obtained from the media which, almost without exception, give an emotionally charged and

partial, if not distorted, account. When opinion polls claim to show that most people are in favour of VE, the media, which have created this opinion by their advocacy and lack of balance, then cite these figures as evidence of the need to change the law to allow it! Such behaviour is self-serving and lacking in both truth and justice.

If such issues could really be settled satisfactorily by opinion polls or referenda, parliaments could largely be dispensed with, in favour of endless polling.

Some of the Medical Reasons Why Any VE Law Would be Unsafe

Draft VE laws easily become intellectual constructs within an idealised context, with a false appearance of safety, unless the medical environment in which they will operate is well understood. One of the most tragic medical facts, tragic because it is so remediable, is that, while palliative care is now able to mitigate most of the distresses of dying persons, large numbers of these patients still receive substandard treatment because doctors are uninformed about its practices and/or do not refer their patients to those who are more expert, when they have reached the limit of their own abilities.

The following points are to be found in the cited reports:

1. Necessity for adequate disclosure of medical detail

Since it would clearly be wrong to allow VE for dying patients with unrelieved symptoms that could be treated by good palliative care, but who had not received such care, information about the quality of their medical care should be an essential requirement before approval could be given for the taking of their lives. No draft euthanasia law in Australia (or elsewhere, as far as the author can discover) has required these facts to be available for scrutiny - it is usual to find only a requirement for medical certificates. These concern opinions, not facts. Thus, the doctor's actions would be unsupervised at the time and could not be reviewed later. Only open, expert scrutiny of a patient's medical care, before euthanasia was carried out, could satisfy the community's need to be assured of a doctor's good judgment and probity.

The community at present properly demands the highest standards of supervision, even when the state has the power to take life. Open hearings, legal representation, avenues of appeal and mechanisms for review are supplied before permitting any legal taking of life, even when deciding the fate of convicted criminals, such as serial killers. In contrast, draft euthanasia bills fail to offer more than token protection for the seriously sick. When examined, their only really effective safeguards are found to be those that protect doctors from civil or criminal action, after euthanasia.

2. Pain and suffering cannot safely be made the basis for taking life because they cannot be measured or compared

Although palliative care doctors insist that it is not necessary to take life in order to relieve pain, a common reason given by other doctors for wanting VE is to relieve pain. It must be presumed that

some doctors take life to relieve the pain that could have been relieved by experts, but who are not consulted. Even many advocates of VE now concede that unrelieved pain is probably no longer sufficient justification for taking life. Among the reasons given for euthanasia in the Netherlands, the relief of pain is not prominent.

If pain were a genuine reason to take life, it could not rationally be restricted to the pain of terminal illness, since many other causes of pain are equally distressing.

The mental anguish or suffering associated with life-threatening illness requires different strategies for its management, but it too usually responds to good emotional support. Suffering is evident in a wide range of human conditions, since it is an existential problem, not a medical problem. It has many causes, only some of which are of medical origin, even in those with terminal illness. Most of the causes of suffering are social, requiring understanding of the underlying social, relational and cultural factors.

If suffering were a genuine reason to take life, it could not be restricted to those with terminal illness, since many others causes of suffering are equally distressing. To allow it as a reason would not only be discriminatory, it would be tragic and a gross abuse to empower doctors to take life for what would commonly be chiefly social reasons.

Neither pain nor suffering can be objectively measured or compared between persons, and so, neither could be subject to the objective standards on which sustainable, just public policy would need to be based. What one person can bear, another finds intolerable. Everything would have come down to the opinion of the patient, based on his/her personal characteristics.

If VE were legalised while the prevailing standards of palliative care were as patchy and unpredictable as they are at present, it would be inevitable that some lives would be taken on account of the medical ignorance of the doctor, even though effective treatment was available. The conclusion is inescapable that such a situation is the probable cause of at least some of the known instances of illegal euthanasia at present, and this would not change, even though the law was changed, in the absence of a widespread correction of the present medical deficiencies in palliative care training and practice.

3. A right to involve another person in one's intentional killing does not exist

Autonomy has already been discussed, including the point that personal autonomy cannot be extended to others. A right to ask another person to take one's life is not found in any code of ethics or the law or in any statement of human rights. Despite this, such a right is often confidently asserted, even claimed to be 'sovereign' or 'supreme', entirely without warrant. The fact that it is not more often challenged is a reflection of how little is commonly known about rights. Failing its validation by argument, this putative right must continue to be seen for what it is - no more than a wish.

Nor is there a 'right to die', if by that one means a 'right to have one's life taken on request'. There is however a genuine right to die, by which dying persons are entitled to expect that they will be afforded every comfort in their dying, and when it is in their interest to die, not to have their dying unnecessarily impeded.

VE is sometimes said to be permissible as an expression of a claim to privacy, as though it were a matter only of importance between patient and doctor. If a doctor agreed to perform euthanasia, it could only be because he/she had concluded that that life had lost sufficient value - nobody would destroy a life they valued. But if a doctor became comfortable with the idea that it was acceptable for him/her to assign low value to certain patients' lives, backed by law, that could be fateful for others of his patients who were in a similar state, but who had not asked to die. He/she would be entitled to interpret any discussion of euthanasia in positive terms, ignoring the evidence that many such discussions are initiated by patients in their desperate need to have their lives affirmed, not rejected. It is well known that to-day's medical systems increasingly depersonalise patients.

4. It would never be certain that a request to be killed was voluntary

There are no criteria for detecting undue influence on another person, and doctors are no better able to do so than other people. When considering euthanasia in 1982, the Canadian Law Reform Commission observed that coercion would be 'an ever present possibility'.⁷ The report of the House of Lords declared 'It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of laws would not be abused'. Coercion, particularly if it were subtle, would be very difficult to detect with certainty, and would be impossible if concealment was really wanted.

But would it be likely? After a long inquiry into mental health, a former Australian Human Rights Commissioner said he had discovered that the sick were already 'the most systematically abused, and the most likely to be coerced'.⁸

To be seriously ill has been described as being in the 'quintessential state of vulnerability'. Doctors can act coercively even without intending it. Regarding the sexual abuse of patients by doctors, a newspaper editorial claimed 'Even apparent consent is coerced by the power of the professional person in whom the client has placed his or her trust'. The imbalance in power between patient and doctor is far greater than is usually supposed. Just as a doctor's response can forestall suicide, a doctor's ready acceptance of a patient's request to be killed can encourage that outcome, and make the patient feel abandoned.

In such an environment, a patient's request for euthanasia could never be guaranteed to be voluntary.

5. It would never be certain that a request was informed

Although a draft VE law may require a doctor to inform the patient of the different treatment options, their effects and their likely chances of success, this information will be given in private. Unless an independent, informed observer was present on every occasion, it could never be known whether the information was adequate, correct, unbiased and/or non-coercive. If anyone wished later to check, the only other witness would not be available. Many doctors do not know enough about palliative care - how could they give adequate information about it?

Doctors are often subject to significant stress in dealing with terminally ill patients and their families, arising from frustration at being unable to cure, from uncertainty when faced with difficult problems for which they have not been prepared by their training, and subject to competing and perhaps unfair pressures from distracted patient and family. To suppose that all

doctors will behave rationally in these emotionally charged situations is itself irrational, and it would be dangerous to presume it.

6. Even in terminally ill patients, a persistent wish to die is abnormal, while the diagnosis of the underlying psychological disturbance is hard to make and is often missed in those already under medical care

The true nature of a sustained wish to die, even in the dying, is widely misunderstood, too often being accepted as a natural response to the threat of death. Many persons with terminal illness have suicidal ideation at some time, but never attempt or commit suicide. The great power of fear was revealed in a study that found that more people over 50 committed suicide in the mistaken belief that they had cancer than among those who actually had cancer and committed suicide.

Factors that are consistently found to be strongly associated with a sustained wish to die include: unrelieved severe distress due to pain or other symptoms, previous psychiatric disorder or history of suicide attempt, and the presence of depression or despair. Depression is widely under-diagnosed and under-treated in the elderly, being mistaken for a natural response to aging or dementia. Treatment for depression can remove suicidal ideation in up to 90% of these patients.

The significance of these facts is only half grasped when it is supposed that having a psychiatrist see the patient will provide an effective safeguard. In a recent poll of psychiatrists, only 6% thought they could properly assess mental status in a single consultation. More importantly, only those psychiatrists with training with terminally ill patients will be able to make these diagnoses with confidence in these circumstances.

One experienced Professor of Psychiatry maintains that if these patients were always seen by a psychiatrist with the appropriate training, 'euthanasia would virtually never take place'.⁹ The scope for abuse in this area would be extraordinary.

Nor are doctors immune to the high emotional content of their patients' situation. A committee of psychiatrists, established in the Netherlands to assist and counsel doctors faced with requests for euthanasia, reported that 'without such consultation, the professionals would often have assisted suicide, even though viable treatment alternatives were available, because of an emotional involvement with the patients'. This caused an American psychiatrist, an expert on suicide, to comment: 'One suspects that those doctors who are most emotionally involved in euthanasia, and most interested in performing it, may be those whose own needs in the matter should disqualify them'.¹⁰

This important point was emphasised by the comment of a forensic psychiatrist: 'I have, on more occasions than I care to recall, failed professionally to recognise depression because I have been caught up in, and dazzled by, the tragedy of my patient's life. I have accepted their wish for death as a rational and proper desire only to see these desires melt away with their depression when...less involved colleagues treated the process in which the patients were trapped'.¹¹

7. Progression from voluntary to non-voluntary euthanasia would be simply logical

Non-voluntary euthanasia (NVE) is discussed more fully in a separate paper, but the core of the message in this title may be simply stated. While VE is regarded by many as a compassionate act, it is assumed that taking life without a patient's expressed wish or consent could only be motivated

by some degree of malice. How then could the known incidence of NVE in the Netherlands, United States and Australia be explained, since doctors are not malicious people?

It is because such life taking is seen by its practitioners as an exercise in beneficence. Once taking life on request is regarded as a benefit for that person, it can be thought unfair and discriminatory to withhold that benefit from others who are in a similar plight, just because they cannot ask. That view is logical, if taking life truly supplies a benefit.

No arguments have prevailed to prevent the spread of one practice to the other, and no guarantee could be given that such extension would not occur wherever and whenever VE was introduced. Lawmakers can never guarantee that the law they make will not be modified, perhaps in ways which they could not foresee and would oppose, by subsequent lawmakers. In fact, by making the first exception to the principle of universal protection for innocent human life, they would have created the first precedent for change.

It is sometimes heard that it would be better to have a law to regulate euthanasia practice, even though that law may not be perfect, than to persist with the present position, where euthanasia is practised in secret, without control. That raises several points.

First, there is currently a law to regulate euthanasia - it is the criminal code, which forbids euthanasia as a form of murder, though that law is not commonly invoked. This is because hard evidence is not easy to obtain and the community properly sees a distinction between mercy and malice, even though motive is not taken into account by the law. Thus, euthanasia is presently practised by lawbreakers, who put their own view of their duty above the law, while other practitioners find their duty in the same circumstances fulfilled by different means, such as good palliative care. The former respond to the patient's demands, while the latter look to the demands of the patient's illness.

Second, there is already a proven incidence of secret NVE at the hands of doctors who also carry out VE, because, as stated, they believe it to be compassionate also. Because they include NVE in their concept of duty to certain patients, there could be no guarantee that a law that allowed only VE would not also be disregarded by them. In fact, it would be foolish not to expect it.

Third, given the common finding by inquiries that the lives of other vulnerable sick people could not be protected by any VE law, the House of Lords Committee thought that more lives could be put at risk by such a law than is the case at present. Because abuse would be undetectable, often if not usually, it could then appear to observers that matters had improved, when they had actually deteriorated. To expose the most vulnerable patients to this risk should be seen as unacceptable.

Conclusion

A number of important factors, hitherto ignored or misunderstood in the debate about the legalisation of VE, have now been revealed in several large studies. They concluded that no such law could be guaranteed to be free of the possibility, if not the likelihood, of abuse, chiefly centred on the lives of other sick persons who did not want their lives taken. An especially dangerous aspect is that such abuse may be easily made undetectable. Thus, impartial observers may believe that a particular law was safe, while many or even every one of its subjects were in fact victims of abuse.

The medical loopholes listed above would alone have justified the common finding of the inquiries, that legalisation would be dangerous. Rather than seek recourse to medical life-taking, all doctors with responsibility for the care of terminally ill patients should accept their duty to deliver this care at the known best standards, as they are legally obliged to do in other branches of medical practice. That means they will familiarise themselves with the principles and practices of palliative care, at the standard required of their peer group, and when for any reason they cannot do that, they will refer their patients to others who can. If they have remaining doubts about the evidence regarding the abuse of euthanasia law, they should acquaint themselves with the contents of the reports listed in this paper, before supporting further attempts to legalise VE.

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