

## GIVING DEATH A HELPING HAND

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# **Giving Death a Helping Hand**

## **Physician-Assisted Suicide and Public Policy. An International Perspective**

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# Preface

Interest in euthanasia has continually grown during the last decades all over the world, especially in the industrialised countries with their high standards of medical care. This growing interest seems to be in exact proportion to two tendencies: the increased capacities of modern medicine to maintain life-functions in states of terminal disease and severe impairment of bodily and mental functions; and the tendency of physicians to preserve life in situations of imminent death at the cost of severe suffering and loss of independence. Despite the evident similarities of the problems underlying the wish for euthanasia in all industrialised countries one finds striking differences in the extent to which this wish is recognised and reflected in public policy. A number of factors seem to work together to produce very different political responses to the widely held wish to make use of means by which, to quote Francis Bacon, "the dying may pass more easily and quietly out of life": cultural factors such as religion and the historical experience of the abuse of euthanasia in the hands of reckless physicians; the Hippocratic tradition forbidding any physician to use the means of medicine to actively bring about the death of a patient; and the great differences in the amount of pressure national "right-to-die"-societies have been able to put on legislators to make euthanasia a legally protected patient right. While in Great Britain the "Voluntary Euthanasia Legalisation Society" was founded in 1935, and in the USA the "Euthanasia Society of America" in 1938, most societies of this kind were established only some time after the Second World War, and in most countries – with the possible exception of the Netherlands and Switzerland – their political influence is still limited.

Euthanasia has many faces, and correspondingly diverse are the proposals coming from relevant patient groups, right-to-die-societies and other movements for the legal and institutional framework in which euthanasia is practically carried out. While the Hospice movement has defined its identity by the rejection, as a matter of principle, of active euthanasia and assisted suicide, the objectives of most euthanasia societies, at least in the long term, go a good deal further and include the legalisation both of (physician-) assisted suicide and of active euthanasia under what might be called the "paradigmatic euthanasia conditions": (1) The patient is in an irreversible state of terminal illness, (2) The patient suffers intolerably, (3) The patient explicitly wishes to die, (4) This wish is not only momentary but also constant. Demands for the legalisation of active euthanasia, however, have been notoriously

unsuccessful. In most industrialised countries, not only active euthanasia on request but also physician-assisted suicide is still either illegal and punishable by law or prohibited by the physicians' professional codes. At present, a legally regulated practice of active euthanasia exists only in the Netherlands and in Belgium, a legally regulated practice of physician-assisted suicide only in the Netherlands (where it is rarely practised), in Switzerland and in the state of Oregon, USA.

Prognoses are always a risky affair. But there seem good grounds to predict that if it comes to choosing between methods of last resort for severely suffering patients physician-assisted suicide will prove more acceptable as a method of last resort than active euthanasia both to patients, to legislators and to the general public. From the perspective of patients, physician-assisted suicide seems preferable to active euthanasia because it is a more unambiguous expression of the patient's autonomous will. From the legislator's perspective it seems preferable because it is less liable to misuse and abuse than active euthanasia where the physician takes a more active part. A further pro-argument is the consideration that the availability of assisted suicide, instead of shortening the life of a patient, might even prolong it. The certainty to be able to end one's life whenever one seriously wants to end it is often observed to lead to a heightened tolerance of temporary suffering and to effectively reduce the temptation to end one's life in a period of acute crisis. Only a small fraction of those who actively procure to themselves the means to end their life actually put these means into use.

Public policy on physician-assisted suicide has recently gained an unprecedented dynamic. In some European countries, especially in Switzerland and Germany, we are witnessing a largely unexpected change in the attitude of public bodies towards physician-assisted suicide, partly motivated by the wish to take the edge off the pressure for legalisation of active euthanasia. In Switzerland, where physician-assisted suicide has been legal for more than a hundred years, the Swiss National Ethics Commission in the field of medicine, in its statement of 2005, demanded that physicians and other medical staff assisting patients to commit suicide under conditions of irreversible suffering are exempted from moral reproach by their profession. In Germany, the *Deutscher Juristentag*, the assembly of German lawyers, after discussing the legal issues of euthanasia in its 2006 session, voted with a clear majority for the motion that the traditional disapproval of physician assisted suicide by the medical profession should make room for a more differentiated view. Physician assisted suicide should be tolerated as a legally and ethically sound procedure in cases of patients suffering from symptoms that palliative medicine is insufficiently able to alleviate. In 2005, a legislative proposal by a number of distinguished law professors had been published making a similar point. Though no doctor should be under an obligation to provide assistance in cases in which a patient in severe distress earnestly considers suicide, the professional code should no longer sanction physicians for providing assistance. Physicians unwilling to give assistance should be encouraged to transfer the patient to other physicians willing to give assistance whenever possible. It remains to be seen how far these suggestions from the legal quarter will be taken up by the medical community and its official representatives, especially against the background of an increasing "death tourism" from Germany to Switzerland.

The present volume focuses on public policy issues related to physician assisted suicide. Though public policy and legal issues are inextricably bound up with the ethical problems posed by the relevant practice, the book makes no attempt to deal with the ethical pros and cons of physician-assisted suicide directly and systematically. The contributions making up its first part show, however, that the public policy and legal issues related to physician-assisted suicide raise ethical problems of their own, such as the problem of whether maintaining the status quo in countries where assisted suicide is a criminal offence is consistent with the far more liberal regulation of withholding or withdrawing treatment in similar cases.

This book is divided into three parts. Part one addresses policy issues raised by physician-assisted suicide. Gerald Dworkin, a philosopher of the University of California at Davis, is presenting the case for legalization of physician-assisted suicide. He is doing so by challenging the common assumption that there is a morally and legally relevant difference between the firmly established practice of termination of medical treatment and the practice of physician-assisted suicide. Neil Levy, a philosopher at the University of Melbourne, questions the widely-held view that legalization of physician-assisted suicide is the first step on to a “slippery slope” that will inevitably lead us from physician-assisted suicide to involuntary euthanasia to the dreaded horrors of the Nazi era. German philosopher Dieter Birnbacher of the University of Düsseldorf analyses the moral justifications for the professional opposition to physician-assisted suicide, as expressed in the Declaration of the World Medical Association, the Guidelines for Assistance in Dying of the German Medical Association or the Code of Conduct of the Council on Ethical and Judicial Affairs of the American Medical Association. Margaret Pabst Battin, a philosopher at the University of Utah, explores the prospect of a cultural change on attitudes towards death and dying, predicting a future where physician-assisted suicide will be considered to be a proper part of medical practice and where patients will take control over the timing and manner of their own death. Timothy E. Quill, a palliative care specialist at the University of Rochester, Bernard Lo, a doctor of internal medicine at the University of California in San Francisco, and Dan W. Brock, a moral philosopher at Harvard University, compare the clinical and ethical differences of voluntary stopping eating and drinking, terminal sedation, physician-assisted suicide and voluntary active euthanasia. They consider all four practices to be acceptable palliative options of last resort and argue that the morality of these practices should be determined on the basis of the patient’s wishes and not on the basis of dubious distinctions, such as the classification of “active vs. passive” or “intended vs. unintended” acts.

Part two of the book offers a detailed analysis of the current legal standing and practice of physician-assisted suicide in various countries. American psychiatrist Linda Ganzini of the Oregon Health and Science University in Portland and German philosopher Edgar Dahl of the University of Giessen summarise the experience of nine years of physician-assisted suicide under the Death with Dignity Act in Oregon. John Griffiths from the School of Law at the University of Groningen compares the practice of physician-assisted suicide in the Netherlands and Belgium arguing that voluntary active euthanasia should only be offered if a patient is unable to resort to physician-assisted suicide. German legal scholar Gabriele Wolfslast of the

University of Giessen describes the rather complicated judicial status of physician-assisted suicide in Germany's criminal law. Alan Rothschild of the University of Melbourne reviews the most recent legislative reforms on end-of-life issues in Australia. Sheila McLean of the University of Glasgow describes the current law in the United Kingdom and comments on the ongoing debate over Lord Joffe's "Assisted Dying for the Terminally Ill Bill".

The third part of the book comprises narratives by professionals who have been involved in end-of-life issues for many years. The Dutch anaesthesiologist Pieter Admiraal of the Reinier de Graaf Hospital in Delft offers a personal account on how he got involved into the debate over voluntary active euthanasia and physician-assisted suicide and how he devised the world's first guidelines on the use of drugs for a humane and dignified death. Elke Baezner-Sailer, the former President of the Swiss Right-to-Die-Society EXIT, describes the practice of assisted suicide in Switzerland and the new guidelines on "Caring for Patients at the End of Life" by the Ethics Committee of the Swiss Academy of the Medical Sciences. Ludwig Minelli, the President of the Zurich based Swiss Right-to-Die-Society "Dignitas", presents some personal notes on how to improve suicide prevention and how the European Convention on Human Rights can be interpreted to include the right to an autonomous and dignified death.

We hope that the contributions to this book will further the public debate over physician-assisted suicide and will help to create legal efforts that will enable terminally-ill patients all over the world to die in a way that is consonant with their own values.



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**Part I**  
**Physician-Assisted Suicide**  
**and Public Policy**

# Should Physician-Assisted Suicide Be Legalized ?

Gerald Dworkin

## 1 Physician-Assisted Suicide and the Law

Let us assume, for the sake of argument, that we can find a plausible case for the view that it is morally permissible for medical caregivers, under certain conditions, to either provide their patients with means or information, so that they can take their own lives, or kill their patients. Let us assume, further, that patients have a moral claim to non-interference with such assistance.

Having established this much still does not settle a number of different issues concerning public policy. Questions such as: Should the law recognize such a claim? Should the institutions of medical practice, such as hospitals, have rules which require action in accordance with such a claim? Should the codes of the medical profession include such rules? Ought the profession sanction professionals who violate such claims? This class of questions is one about institutionalizing a right to aid in dying.

In the case of physician-assisted suicide, as in other cases, there are a variety of forms that institutionalization might take and the arguments appropriate to some may not hold, or carry as much weight, for others. For example, consider the issue of the legalization of physician-assisted suicide. This might encompass any of the following measures:

- (1) Maintaining the status quo – where assisted-suicide is illegal – but, explicitly or tacitly, encouraging prosecutors to exercise their discretion not to prosecute.
- (2) Maintaining the status quo, but allowing as a defense to a prosecution the defense of merciful motive.
- (3) Maintaining the status quo, but allowing consideration of motive to play a role with respect to sentencing.
- (4) Legalization of physician-assisted suicide.

Each of these policies may have different symbolic significance, different anticipated consequences, different probabilities of setting precedents. I am going to focus

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on the legalization issue only. If physician-assisted suicide were to be legalized, then for most patients *in extremis* their needs for an end to their suffering would be met. It is true that those who are not able to take measures to end their own life would not be helped, but since there is another option open to them – the refusal of nutrition and hydration – they would not be without any recourse.

## 2 The New York State Task Force on Life and the Law

One of the most thoughtful arguments put forward against the legalization of any type of medically-assisted dying is that contained in the report of the New York State Task Force on Life and the Law.<sup>1</sup> Although the task force consisted of individuals with different views about the morality of individual instances of medically-assisted dying, it was unanimous in its recommendation that the laws of New York State prohibiting assisted suicide and euthanasia not be changed. While there may be arguments that the report failed to consider, the list of arguments is sufficiently thorough that if we fail to find them persuasive we will have some confidence in our judgment that physician-assisted suicide ought to be legalized.

The Task Force's reasons to oppose legalization are the following:

- 1) Prohibitions on physician-assisted suicide are "...justified by the state's interest in preventing the error and abuse that would inevitably occur if physicians or others were authorized to...aid another person's death." (68)
- 2) "...to the extent that laws prohibiting physician-assisted suicide and euthanasia impose a burden, they do so only for individuals who make an informed, competent choice to have their lives artificially shortened, and who cannot do so without another person's aid...very few individuals fall into this group... (71)... legalizing... assisted suicide for the sake of these few – whatever safeguards are written into the law – would endanger the lives of a far larger group of individuals, who might avail themselves of these options as a result of depression, coercion, or untreated pain." (74)
- 3) "...laws barring suicide assistance...serve valuable societal goals: they protect vulnerable individuals who might otherwise seek suicide assistance... in response to treatable depression, coercion, or pain; they encourage the active care and treatment of the terminally ill; and they guard against the killing of patients who are incapable of providing knowing consent." (73)
- 4) Dependence of the patient on the physician and his recommendations. If we allow physician-assisted suicide, then although nominally the request must originate from the patient, physicians will exercise a degree of coercion and/or persuasion that is illegitimate. This is particularly likely in the current context where there is growing concern about increasing health care costs. "... it will be far less

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<sup>1</sup> *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*. The New York State Task Force on Life and the Law, New York, May 1994. All quotes are from this report unless otherwise noted.

costly to give a lethal injection than to care for a patient throughout the dying process.” (123)

The right of the competent patient to refuse or withdraw from medical treatment is firmly established in American jurisprudence.<sup>2</sup> My general strategy is to see if the differences which clearly exist between refusal of treatment and physician-assisted suicide warrant a difference in their treatment by the law. My claim will be that if the above arguments are good arguments against physician-assisted suicide, then they are equally good against allowing patients to refuse treatment. In both cases the physician may exercise a degree of control and influence which denies the autonomy of the patient’s choice. If a physician can manipulate the patient’s request for death, he can manipulate the patient’s request for termination of treatment. If the patient’s death is cheaper for the system, then it is cheaper whether the patient commits suicide or is withdrawn from a life-support system.

### 3 The Argument from Eligibility

One argument for distinguishing physician-assisted suicide and withdrawal/withholding is that the number of patients in a position to request withdrawal/withholding of care is much smaller than the pool of patients “eligible” for physician-assisted suicide, so that even if abuse is possible in both cases, the scope for abuse is much greater in the case of physician-assisted suicide. As I have heard this claim put forward in many conversations, “all of us are eligible for physician-assisted suicide.”

But whether this is true depends essentially on how the notion of “eligible for physician-assisted suicide” is being used. Opponents use it in such a fashion that if I enter a hospital to have a hangnail removed, I am eligible for assisted-suicide. But that is just silly. The relevant pool is the class of persons who will be patients suffering from a terminal or incurable, intractable illness, who will be competent and who are not in a position to die of withdrawal or withholding of medical care. The relevant empirical evidence is that this pool is not larger but smaller than the w/w pool. The Dutch statistics show that some 22,500 patients die as a result of non-treatment decisions whereas only 3,700 die as a result of physician-assisted suicide and euthanasia together.<sup>3</sup>

In any case, it is not as though defenders of the right to refuse treatment have argued that the potential for abuse is outweighed by the benefits of allowing refusal. Rather, they have argued that patient’s have a right to refuse treatment. But we are assuming for the purposes of this argument that patients also have a moral claim to the aid of a willing physician in assisted suicide. To argue that the potential for abuse means that we should not institutionalize that claim means that the legitimate moral claim of an individual to assisted suicide must be forfeited because of the possibility

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<sup>2</sup> This has not always been the case. It was quite common for many years for physicians and judges to treat such refusals as equivalent to suicide or homicide.

<sup>3</sup> Dan Brock was instrumental in clarifying my thoughts on this issue.



that *others* may abuse or be abused by such permission. Why does such an argument go through in the case of assisted suicide but not in the case of the claim of a patient to refuse treatment?

Here is one response. It is true that many of the same slippery-slope arguments, and ones about people being pressured, can be raised about withholding/withdrawal cases. But in those cases we have to accept the risks because to deny an individual the right to be withdrawn from a course of medical treatment, e.g., a respirator, is to claim the right to forcibly impose an unwanted invasion of the body upon a competent individual. It is to commit battery. Whereas to deny persons a right to assistance in dying is simply to leave them in the same state we found them in. That difference explains the asymmetry in public policy.

I concede that this is a morally relevant difference between the two situations. The question is how much weight does it carry. What is the significance of the fact that the denial of the right to removal of life-support involves an invasion of the body, whereas denial of assistance in dying does not? What is at stake in both cases *in the context of end of life decisions*, is the ability of a patient to end great suffering, and to control the manner of their death. It seems arbitrary for the society to allow one but forbid the other on the grounds that the denial of the former has an *additional* bad feature in one case but not the other.<sup>4</sup>

It is true that if what were at stake were less important, e.g., if the reason a person refused a medical treatment, say, a spinal tap, were simply a fear of needles, the right not to have invasive treatment might require us to not impose a treatment even though this will adversely affect the patient's health status. Whereas we might refuse their request to drive them home so as to avoid having the treatment. One might feel one doesn't have to cooperate with a foolish patient.

If one feels doing anything to enable a patient to die is wrong then it is a consistent view to think that one has to do so in the case of withdrawing life-support but not in assisting suicide. So I am not arguing that mere consistency requires that the two cases be treated alike. I am claiming that if one has reason to accept the claim that sometimes enabling a patient to die is desirable, then the asymmetry at issue is not one which requires disregarding the possibility of abuse in one case but not in the other.

The asymmetry might be exactly the thing to point to if one supposed that it made a moral difference. For example, if one thought that in sticking a feeding tube into you against your will I use you as a means (to your own good) but if I refuse you food (against your will) I do not do so. But if Kant is right that sometimes one uses a person as a means just as much when one refuses to help them accomplish their ends as when one thwarts their ends, then this distinction will not be determinative.

Another way of looking at this issue is to see that even if we are dealing with issues of what should be legal or not, i.e. issues of public policy rather than morality per se, the fact that we are limited in whatever we do by moral considerations means

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<sup>4</sup> It should be noted that the right not to have compulsory intervention on one's body is not an absolute right in any case. We require compulsory vaccinations and compulsory donation of blood samples in criminal investigations.