Empowering doctors to kill can have incalculable consequences. It is definitely worth debating.

Contemplating a Swift Ending

Every once in a while I enjoy revisiting misanthropic classics. I picked up Gulliver’s Travels the other day and thumbed through his adventures in Luggnagg. This destination is less famous than Lilliput, but has one memorable feature: the immortal struldbrugs. When he first hears about them, Gulliver rhapsodises about the wisdom, wealth, power and “sublunary happiness” which they must enjoy.

However, the inhabitants of Luggnagg set him straight. The struldbrugs have immortality, but not perpetual youth. When Gulliver examines them, he realises his error: “They were the most mortifying sight I ever beheld; and the women more horrible than the men. Besides the usual deformities in extreme old age, they acquired an additional ghastliness, in proportion to their number of years, which is not to be described.”

What I had forgotten was the attitude of the citizens of Luggnagg. At the age of 80, the struldbrugs are forced to become non-persons, maintained at the expense of the state with a scanty pension.

“... they are looked on as dead in law; their heirs immediately succeed to their estates; only a small pittance is reserved for their support; and the poor ones are maintained at the public charge. After that period, they are held incapable of any employment of trust or profit; they cannot purchase lands, or take leases; neither are they allowed to be witnesses in any cause, either civil or criminal.”

Are there any lessons for the 21st century in Jonathan Swift’s satire? Perhaps. Because of declining birth rates around the world, the proportion of octogenarians, nonagenarians and even centenarians is growing rapidly. Modern medicine may keep them from degenerating into struldbrugs, but they will inevitably become more dependent and lose their political and social influence.

The scariest thing would be if we were to become as misanthropic as Swift and to treat our elderly with contempt and bare tolerance, rather than respect their
contribution and their inalienable dignity. The struldbrugs “are despised and hated by all sorts of people,” he writes.

In a latter-day Luggnagg, euthanasia and assisted suicide begin to sound rather sensible. Perhaps we need a Struldbrug Pride movement to protect our elders from abuse.

Australia was the first country in the world where doctors could legally euthanise patients. In 1995 the Northern Territory passed the Rights of the Terminally Ill Act by a vote of 15 to 10. Four people died under this legislation over the next 9 months, all of them with the help of a then-unknown doctor named Philip Nitschke. There was an uproar and, after a long national debate, Federal Parliament quashed the Territory’s legislation.

This did not stop agitation for the legalisation of “assisted dying” in the states and in the ACT. Proposals pop up in state parliaments regularly, but until now they have all failed. Last year Tasmania came closest because the sponsors of a private member’s bill were then-Labor premier Lara Giddings and the Greens leader, Nick McKim. It was defeated by a vote of 13 to 11.

Overseas, there are passionate movements for euthanasia and assisted suicide in England and Wales, Scotland, France, Spain, India, Colombia, many US states and many other countries. But only in a few jurisdictions have they been legalised.

The first were The Netherlands and Belgium in 2002. In 1997 the US state of Oregon passed a Death with Dignity Act, which authorised physician-assisted suicide, followed by the neighbouring state of Washington in 2008 and Vermont in 2013. In Montana, courts ruled in 2009 that a doctor who helps a terminally ill person commit suicide cannot be prosecuted, but there is no law. The Canadian province of Quebec legalised euthanasia earlier this year.

Switzerland has become a destination for “suicide tourism” since the late 1990s, but its law is unique. Assisted suicide has been legal there since 1918, but contemporary developments have transformed how the law is applied.

It is good to recall that assisted suicide has a back story. While German tanks were rolling over the steppes of the Ukraine towards Moscow, audiences in Berlin were watching Ich Klage An (I Accuse), a soppy melodrama about a beautiful young woman who pleads for release from excruciating pain. The Nazis used this movie to work up support for Aktion T4, their program for euthanasing the mentally ill and physically deformed, which became a trial run for extermination camps.

“Aid in dying”, as its supporters often call it, covers two main areas. In assisted suicide the patient administers a lethal dose of medicine himself, but with the help of another person (who is exempted from prosecution). In voluntary euthanasia another person, normally a doctor, administers a lethal dose after he is sure that the patient has consented. Some jurisdictions permit euthanasia,
others only assisted suicide. For patients who have lost all their strength, there’s probably very little difference.

Unfortunately for the clarity of the debate, there is confusion, even among bioethicists, about definitions and distinctions. An important example is refusal of burdensome treatment. With injections, tubes, flashing lights and heart–lung machines, modern medicine can keep people going long after they have apparently lost their will to live. This can be an abuse of patients’ autonomy: they should have the right to refuse burdensome treatment. Doctors are not euthanasing them if they respect their wishes. Unfortunately, some people think that withdrawing treatment is always euthanasia, which leads to bitter disputes.

But the picture becomes much murkier if a comatose patient breathing by himself is not capable of giving consent. A common practice in Belgium and elsewhere is to give such patients “terminal sedation” and withhold food and water until they starve to death. Some call this palliative care; others call it euthanasia.

Rather than get bogged down, though, let’s move on to a key issue in most debates: will it ever be possible to have a humane law that will not be abused? Assisted dying is supposed to promise relief from the unbearable pain of terminal illness, but drafting a law that satisfies these expectations has proved fiendishly difficult. Many MPs who have no moral objection to assisted dying vote against it because they fear abuse would flourish.

**What Are the Main Problems?**

**Private supervision of killing**
Capital punishment, the only other legal way of killing people, is the responsibility of governments. But euthanasia takes place in private with one or two sympathetic witnesses. This is a momentous change in the criminal law and in the ethos of the medical profession, giving doctors unprecedented power – a power that other citizens do not have.

**Control of unbearable pain**
Palliative care has advanced so much in recent years that nearly all pain can be controlled. What seems unbearable may be due to incompetent medical care. If so, death seems like a heavy penalty for choosing a bad doctor.

**Definition of pain**
Assisted dying proposals always highlight physical pain. But after legalisation, there are normally calls to broaden the scope to mental illness or simply being tired of living. Is the pain of being old and lonely a good enough reason for euthanasia? In The Netherlands and Belgium the answer is “yes”.
Life expectancy for terminal illness
“Terminal illness” is not a medical term. Doctors can only guess at how much longer people have to live. There are numerous cases of patients who had “6 months to go” who lived for many years.

Making an autonomous decision
Many people say that the Nazi experience is irrelevant because the Aktion T4 program was not voluntary, let alone the extermination camps. But that is not completely true. The Nazis, initially at least, tried to dress up their atrocities with the fig leaf of parental consent, which is a kind of substituted autonomy. Even the autonomy of people who are not cognitively impaired can be manipulated through shame, fear or despair. The inescapable problem of euthanasia is that the only witness to whether it was truly voluntary is the person who carried it out.

Enforcement
After a law is promulgated it must be policed. This can be difficult. At the heart of euthanasia is the notion that directly killing patients is no longer a criminal matter but a medical one. But doctors dislike having their clinical acumen questioned by nosy-parker public servants. In the case of euthanasia in The Netherlands and Belgium, experience shows that many doctors simply neglect to report deaths because they don’t like the red tape.

Radicals
No matter how liberal an assisted dying law may be, it sets some boundaries. Some supporters of assisted dying constantly test these limits by helping people to die outside of the approved guidelines. They have proved remarkably difficult to prosecute. In Australia, Philip Nitschke has been taunting the police and the medical profession to prosecute him for years. In the USA, Jack Kevorkian helped at least 130 people to die before he was imprisoned. It is naïve to expect that a law will put an end to secret euthanasia, as some predict.

Bracket creep
Experience also shows that laws are interpreted more and more liberally as time goes on. There are two reasons. First, if assisted dying is regarded as a fundamental right, there will always be pressure to extend that right to new classes of people such as infants, children, the mentally ill and demented and so on. Second, key terms like “voluntary” or “pain” have shades of grey and are slowly reinterpreted.

Let’s examine the law in two jurisdictions and see how these dynamics play out.
Euthanasia in Belgium

Five people died of euthanasia every day in Belgium in 2013, the number of cases rising by 26.8% over the previous year. These figures, however, only include cases that have been reported to the government monitoring commission. A good number – no one knows how many – are not reported.

But it is not just the number of deaths that is astonishing. Euthanasia has expanded beyond the intent of the original law, especially in recent years. Here are some of the unexpected innovations.

Euthanasia for children
Earlier this year Belgium extended the right to euthanasia to children younger than 16 as long as they had the permission of their parents.

Euthanasia for organ donation
Euthanased donors now account for one in eight lung transplants from deceased donors in Belgium. The most valuable donors are those with diseases like motor neurone disease because their heart and lungs are healthy.

Euthanasia for prisoners
The first case took place last year. All of the conditions required by law had been carefully fulfilled: the prisoner had a terminal illness, he had made repeated requests for death, and three doctors had signed off on the request. When this happens, the boundary between euthanasia and capital punishment becomes blurred.

Euthanasia to cover up doctors’ mistakes
Last year a transsexual was euthanased in Belgium because doctors had botched a sex reassignment. Nathan (born Nancy) Verhelst told the newspaper Het Laatste Nieuws: “I was ready to celebrate my new birth. But when I looked in the mirror, I was disgusted with myself.”

Euthanasia to cover up doctors’ crimes
Ann G (her surname was not made public) suffered from anorexia nervosa and consulted a renowned psychiatrist, Dr Walter Vandereycken, who sexually abused her. Distraught, Ann G sought euthanasia and her request was approved by a second psychiatrist. She did not testify at investigations into Vandereycken.

Euthanasia for patients who have not consented
The Belgian Society of Intensive Care Medicine decided earlier this year that it is acceptable medical practice to euthanase patients in critical care who do not appear to have long to live – even if they are not suffering, even if they are not elderly, even if their relatives have not requested it, even if they have not requested it, and even if it is not legal.
Assisted Suicide in Oregon

Oregon’s 1997 Death With Dignity Act is often held up as a model for other jurisdictions. Under the Act, a patient must be an Oregon resident, at least 18, of sound mind, and suffering from a terminal illness that will lead to death within 6 months.

Detailed statistics are issued every year about the administration of the Act. It is true that not nearly as many people are dying there as in Belgium. In 2012, 85 died after their doctor prescribed a lethal dose of medicine; in 2013 the number was at least 71.

Recent research suggests that people find it easier to be killed than to kill themselves. However, the trend in deaths is definitely up and a number of problems have emerged.

Financial pressures
At least twice, the Oregon health department has told cancer patients that it would fund assisted suicide but not expensive drugs for their treatment. This fuels fears that bureaucracies might use assisted suicide as a cost-cutting measure.

Poor diagnostic skills
In Oregon, those who wish to die do not require a psychiatric examination. But researchers have found that some patients who took their lives were suffering from clinical depression. Depression is common in elderly people and it is treatable, but clearly the prescribing doctor had missed or ignored the signs when he prescribed the lethal drugs.

Terminal illnesses that don’t terminate
A close examination of the statistics reveals that some patients have lived for as long as 3 years after receiving their lethal prescription. Their doctor clearly made a bad prognosis.

Pain is not the problem
Intractable pain is the biggest selling point for assisted suicide. However, in 2013, 93% of patients who requested it cited “loss of autonomy”, 89% said they were “less able to engage in activities making life enjoyable” and 73% listed “loss of dignity”. Inadequate pain control, or even fear of it, accounted for only 23.7%. Half of these patients cited fear of being a burden on their families.

Elder abuse
In more than 80% of cases there were no independent witnesses. This is a recipe for elder abuse by people with a financial interest in a patient’s death. How would anyone know if a patient who had received a lethal dose had changed his mind?
Conclusion

The ethical and moral arguments over euthanasia and assisted suicide are involved enough for another article, even a book. But even for many in-principle supporters, legalisation is simply too dangerous. Years of experience in Belgium and Oregon show that there is an enormous potential for abuse.

Of course, the champions of every new bill promise that their law, unlike the others, will be watertight. But it never happens. And, unlike any other bad public policy, the victims will not be around to lodge complaints.