

## Why Euthanasia is Unethical and Why We Should Name it as Such



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*'Unanimously, a declaration was adopted which simply says that euthanasia is unethical.'*

Thus read a brief initial note in the World Medical Journal of 1987 with reference to the key passage of a new WMA Declaration on Euthanasia adopted in the Madrid General Assembly of that year [1]. Concise as this message was, it announced the affirmation of a powerful, enduring medical dictum, and we believe it to be essential for us, today, to understand the context in which it came about.

The WMA was founded in 1947, in part to work for the highest possible standards of ethical behaviour and care among physicians. This was considered particularly important after the gross ethical violations observed, by physicians themselves during the Second World War (1939-45) [2]. In 1987, several members of the WMA, who had had personal experience with these atrocities, were still alive. One of them, Dr. Andre Wynen, who was then Secretary General, and a Nazi camp survivor himself, was a strong advocate of the formulation of the Declaration 'because protection of life was very important for him' [3]. These



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sentiments were echoed in a 1989 essay by then WMA President Ram Ishay from the Israeli Medical Association [4]. Dr. Ishay explained that the WMA had not seen the need to pass such a Declaration earlier, because it had already adopted policies laying out what it considered to be appropriate and ethical end of life care. However, given new positions emerging within some countries, it felt the need to break this silence, and passed the present Declaration unanimously. This robust vehicle was subsequently reaffirmed in 2005 and again in 2015.

The authors of this article are three Canadians – two are practicing physicians and the other a severely disabled individual – who have combined their efforts, here, in the hope of preserving, once again, the deep and timely precautions WMA has maintained all these years. We ask that the full language of the original Declaration – explicitly stating that euthanasia “is unethical” – be preserved.

### The nature of euthanasia

Voluntary euthanasia, simply put, is the medicalization of suicide. The use of euphe-



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misms such as Physician Assisted Death or Medical Assistance in Dying are misguided attempts to rebrand a practice which doctors have renounced for close to 2500 years. These terms should be rejected as linguistic deceptions.

The objective judgement of whether any suicide or assisted suicide is warranted is impossible because of the subjective nature of suffering. What is grievous, irremediable, or intolerable to one person, may not be so for another. And, unfortunately, the physician's opinion is no less subjective than that of the patient. An illustration of this comes from the review of psychiatric euthanasia in the Netherlands which demonstrated that, in 24% of cases, there was disagreement amongst consultants [5]. Having doctors validate and assist in suicide, therefore, is a distortion of our role as healers and makes us both accomplices and supporters – if not encouragers – of suicide.

We believe doctors should never be open to euthanasia and assisted suicide as solutions to our patients' suffering. It is our personal experience, backed up by multiple studies, that the majority number of requests for

the hastening of death are based on what we call 'existential suffering' which includes social, psychological and spiritual reasons such as loss of autonomy, wish to avoid burdening others or losing dignity and the intolerability of not being able to enjoy one's life [6,7]. Moreover, it is our position that, behind the fears caused by that existential suffering, there is also a call for help, to find meaning, even in the midst of such suffering. Hopelessness and the wish for death naturally arise in the course of human experience, but it should not be our role, as physicians, to judge of their validity (regardless of personal opinion), nor is it our role to give them satisfaction.

## The scope of euthanasia in theory and practice: a stark contrast

Euthanasia was purportedly introduced as a solution for 'rare cases' involving the very end of life where unbearable suffering could, supposedly, be ended only with death. But euthanasia is not only employed for such cases.

In Canada, physicians may provide euthanasia or assisted suicide for competent adults who clearly consent, who have a grievous and irremediable medical condition (including illness, disease, or disability) that causes enduring and intolerable physical or psychological suffering that cannot be relieved by means acceptable to the individual [8]. But as stated earlier, these are entirely subjective and elastic concepts. In practice, Canadian criteria are already so broad as to have permitted the administration of lethal injections to an elderly couple who preferred to die together by euthanasia rather than at different times by natural causes [9]. Moreover, court challenges and government studies are presently underway which could soon open euthanasia access to competent minors; to people who are non-terminal (death not "reasonably foreseeable"); to de-

mentia patients by advance directive; and to those with psychiatric disorders only [10]. In Ontario, only 15% of patients euthanized had a previous relationship with the euthanasia provider [11].

## Economic pressure towards euthanasia

Economics and resource management always play a critical role in health services. Dr. Wynen, as we know from his writings, definitely feared that legalised euthanasia would eventually be used to ration health care [3]. But even then, warning about the risks of abuse from euthanasia, due to financial reasons, was not new. Dr. Leo Alexander, who served as a medical consultant to the Allied prosecutors during the Nuremberg trials, wrote in his historic essay "Medical Science under Dictatorship", *New England Journal of Medicine* (1949):

*"Hospitals like to limit themselves to the care of patients who can be fully rehabilitated, and the patient whose full rehabilitation is unlikely finds himself, at least in the best and most advanced centers of healing, as a second-class patient faced with a reluctance on the part of both the visiting and the house staff to suggest and apply therapeutic procedures that are not likely to bring about immediately striking results in terms of recovery. I wish to emphasize that this point of view did not arise primarily within the medical profession, which has always been outstanding in a highly competitive economic society for giving freely and unstintingly of its time and efforts, but was imposed by the shortage of funds available, both private and public. From the attitude of easing patients with chronic diseases away from the doors of the best types of treatment facilities available to the actual dispatching of such patients to killing centers is a long but nevertheless logical step. Resources for the so-called incurable patient have recently become practically unavailable" [12].*

In Canada, a recent cost analysis concluded that 'providing medical assistance in dying

should not result in any excess financial burden to the health care system *and could result in substantial savings* [13]. It is obvious that those patients who opt for euthanasia do provide a saving to the health care system. Therefore, the danger of exerting a hidden pressure on vulnerable people is very real. For example, hospital authorities recently denied a chronically ill, severely disabled patient the care he needed, and – faced with his inability to pay – suggested euthanasia or assisted suicide instead [14]. On another occasion, a 25-year-old disabled woman in acute crisis in a Canadian Emergency ward, was pressured to consider assisted suicide by an attending physician, who called her mother "selfish" for protecting her [15].

Private financial interests are also important. Colleagues have voiced case reports where family members may be taking advantage of the law and creating vulnerable victims [16]. Elder abuse is endemic – in Canada as elsewhere – and one of the main forms of that abuse is financial. The conflict is obvious, and so is the potential for abuse.

## Breaking the promise: how euthanasia destroys trust in the medical profession

At the root of euthanasia lies an assumption that some lives are not worth living. But rational people disagree, both on the principle and on the application to each individual case. Severely disabled and chronically ill individuals disagree, also, on the value of their own lives. Some become suicidal; a greater number do not. But a critical factor in the choices they make results from the attitudes of friends, family, medical professionals and society at large. As philosopher Daniel Callahan has stated, "Euthanasia is not a private matter of self-determination. It is an act that requires two people to make it possible, and a complicit society to make it acceptable" [17].

Again, both Wynan and Ishay were concerned that people caring for patients would personally side with the logic of euthanasia, thus creating new risks for the abuse of patients, and especially the most vulnerable. It is our experience that in several cases the troubles of human relationships within families become accentuated, and problems of physician error and abuse in an already stressed medical system become exacerbated. In the words of President Ishay, “The main problem is to differentiate between what is really done for the benefit of the patient, and what is done out of comfort for the family or for the caring team. Killing can occur, not because the patient is suffering, but because the person caring for the patient can not take it any more” [4].

No wonder, then, that many doctors remain unsure of correct practice. Some emergency physicians in Quebec were, for a time, actually allowing suicide victims to die even though they could have saved their lives. President of the Association of Quebec Emergency Physicians later speculated that the law, and accompanying publicity, may have ‘confused’ the physicians about their role [18]. Dr. Damiaan Denys, President of the Dutch Society of Psychiatrists, has also recently voiced the possibility that euthanasia is causing a frustrating new therapeutic atmosphere in psychiatric treatment, lowering many people’s threshold for ending their lives and causing increased moral distress on the part of the doctor [19]. Canada’s largest children’s hospital has drafted a policy in preparation for the day when children could decide for themselves to be euthanized. On it, they entertain the possibility of not informing the parents until after the minor has been euthanatized [20].

We do not deny, therefore, that doctors performing euthanasia may sincerely believe themselves to be acting virtuously. But trust between doctor and patient depends, in the end, on public perception of the whole medical profession. When some doctors perform euthanasia, patients begin to worry

about the attitudes of *all* doctors, and trust is lost. In Canada, for example, we are personally aware that many patients, out of fear, are now directly asking for doctors who will not practice euthanasia. Already in 2005, it became apparent that some elderly Dutch were afraid that those around them would take advantage of their vulnerable state to shorten their lives. Having lost confidence in Dutch practitioners, they either went to German doctors or they settled in Germany, as reported in the 2008 French government report to the National Assembly [21]; or they carry cards with them stating that they don’t want to be euthanatized when seriously ill [22]. In a recent survey among Quebec physicians caring for patients with dementia, between 14% to 43% of doctors would provide access to euthanasia to patients with advanced or terminal stage dementia respectively even if no a prior written request existed [23].

### The true physician’s role

At the heart of modern medical practice, we expect to find the survival, welfare and comfort of the patient. It is this conscious devotion to life which is so urgently required from physicians by the vast majority of patients, whether they are suicidal or not. The declaration of Geneva holds as the first consideration, the health and well-being of our patients. The respect for the autonomy and dignity of our patients which is the next line of the declaration, should not ignore the first consideration, nor the third line of the declaration which includes the utmost respect for human life. Properly understood there should be no conflict at all [24].

One of us (Friesen) knows, first hand, the mental strain of suddenly being presented, as a young man, with serious post-traumatic disabilities which took months to fully understand, years to accommodate, and decades to accept. In his own words, “it is an illusion to believe that education, family re-

lations, economic status, or present health and happiness, can effectively protect people such as myself from the risk of euthanasia, because the most ordinary chances of life – the slightest relaxation of discipline in the maintenance of my physical state – would immediately (within months at most) place me in the intended category for that lethal procedure. And so, it is, for all surviving disabled and chronically ill.”

The good doctor, we believe, does not judge the value of such lives. Doctors are -- doctors must be unconditionally devoted to supporting *every* life, through all the phases of therapy and palliation.

And to conclude: “If I had not had such doctors to guide me through the first critical weeks of Intensive Care (and the long years of recovery which followed), I would not be here to write these lines today.”

### Euthanasia policy: a unique responsibility of the World Medical Association

Objectively speaking, nothing has changed in the facts of euthanasia since 1945. Our current debate has not been caused by real changes in the internal logic of medical ethics and practice. It is actually the result of those same political, social, and economic factors, which civilized medicine has rejected time and again: the attraction of economic savings, feared by Wynan and described at first hand by Alexander; the terrible possibility that doctors and families might choose their own convenience over the survival of the patient, as voiced by Ishay; the horrible notion that certain lives are objectively less valuable. When death becomes the answer, we as human beings – as doctors – have failed in our duty to sustain trust and hope. Amid the larger pressures we have described, a free, autonomous decision about euthanasia becomes impossible. Patient choice becomes a cruel illusion.



On the positive side, it is evident that most doctors will never be willing to personally practice euthanasia. This conclusion has emerged clearly from the four regional WMA symposia, held recently on the subject in Brazil, Japan, Rome and Nigeria [25]. From the records of these seminars, we are reminded that a majority of doctors, everywhere, wish only to foster the will to live, not to lay the seeds of suicidal despair. In those countries where it unfortunately becomes legal, law and policy should allow medical practice to remain largely unchanged. Those who support medical involvement should thus embrace the liberation of relinquishing such a painful technical monopoly for doctors and allow other 'experts' to do it.

Unwavering ethical guidance from the World Medical Association is of crucial importance in preserving this positive climate in global medical practice. Any compromising additions or modifications to existing WMA declarations can only bring harm to our patients and to our profession. A firm WMA refusal to accept euthanasia, on the other hand, will stand as a powerful aid to all doctors.

We hope the WMA will take this opportunity to make it clear that what is legal is not necessarily ethical. It is useful to note, that the WMA was recently willing to make this distinction by condemning the participation of physicians in capital punishment, even in jurisdictions where that practice is legal [26]. We believe that the WMA should also remain consistent in this principle with regard to euthanasia, and not confuse political expediency with medical ethics.

WMA policy, we hope, will continue to stand as a beacon to the world, bringing comfort to patients and physicians around the globe, proclaiming that – regardless of changing opinions from place to place – true medicine's first value is human life. Similarly, even if some particular society may devalue human life by promoting sui-

cide, medicine and medical practitioners should not.

We believe that euthanasia is, was, and will always be, unethical. The World Medical Association was *right* to say this in the past, and must continue for the future, firmly on the same path.

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## Ethics and Professional Autonomy



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*The concept of professional autonomy is core to most health professions understanding of their role, and any perceived diminution of that autonomy is always perceived and portrayed by health professionals as inimical to their status as professionals. Examples of trends that are sometimes characterised in this way include the growing use (portrayed as an imposition) of*

*clinical practice guidelines by insurers or governments, the growing role of managers in the health system (often not medically-qualified, but with considerable power to direct how care is delivered), and the oversight mechanisms that measure the delivery of care against a pre-determined set of process indicators or quality standards. In this sense, the concept of "autonomy" is complementary to, but also different from the well-known Beauchamp-Childress concept of respect for the autonomy of persons [1]. These principles are uniquely applicable to medical (or more broadly, health professional) practice, but the concept of professional autonomy is far more widely applied and appealed for, not always successfully.*

### Tracking the Concept Through WMA Declarations

The ways in which the concept of professional autonomy has evolved can be tracked when considering the evolving World Medical Association (WMA) policy positions, as expressed in a series of Declarations.

The Declaration of Madrid on Professional Autonomy and Self-Regulation was adopted by the WMA in 1987 [2]. The key statement here was that "the central element of professional autonomy is the assurance that individual physicians have the freedom to exercise their professional judgement in the care and treatment of their patients." This Declaration was subsequently rescinded and replaced by the Declaration of Seoul on Professional Autonomy and Clinical Independence, in 2009 [3]. The new WMA position emphasised the circumstances which might lead to an assault on professional autonomy, and in particular on clinical independence, stating:

"The central element of professional autonomy and clinical independence is the assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue influence by outside parties or individuals."

In particular, the Declaration went on to outline, briefly, who might be implied by such "undue influence". Point 3 targeted