Euthanasia or a Peaceful Death

By Dr. K. F. M. Pole L.R.C.P. ,L.R.C.S. (Edinburgh) L.R.F.P&S. (Glasgow), M.D. (Vienna) M.R.C.G.P. (London), K.H.S.

Australian Catholic Truth Society No.1606 (1971)

(This pamphlet is based on an address presented to the 12th International Congress of Catholic Physicians at Washington, D.C., U.S.A. in October, 1970. Its author, Dr. K. F. M. Pole, has been Master of the Catholic Medical Guild of Saints Luke, Cosmas and Damian, England. He is at present practising medicine at Gillingham, Kent.)

INTRODUCTION

A peaceful and happy death is what we all desire. The very word euthanasia appears to promise it, and the advocates of legislation which would permit it under certain conditions thus receive support from people who, with their good intentions and emotional involvement, overlook how vaguely the term is used and what it may imply.

There are some who believe that the administration of pain-relieving medicaments comprises euthanasia, if by repeated dosage the patient's resistance is lowered and he dies earlier than he would otherwise have done; some speak of it when a patient is allowed to die peacefully without extraordinary efforts at resuscitation or when resuscitative measures, once started, are discontinued. If those two contingencies, sometimes referred to as "indirect" and as "negative" euthanasia, were all that was meant no one would object to euthanasia, nor would anyone think it necessary to have an Act of Parliament passed to legalize it. It is another usage of the word that gives it a sinister meaning; it describes the actual and deliberate killing of men and women, avowedly from motives of compassion, to end their suffering and, therefore, often referred to as "mercy killing". This is the sense in which euthanasia - even voluntary euthanasia - is forbidden by Church and Law alike, and for which permissive legislation is sought by its advocates.

For those who believe in God and see themselves as His creatures and stewards the principles are compelling; we are God's, we exist not for our own pleasure but for God, to give Him service, worship and glory which was the purpose of our creation. As St. Francis of Sales wrote: "Since we are nothing but by His grace, we ought to be nothing but for His glory" Life is not our own to do with it as we will, but rather something we hold in trust. Therefore we may not take any innocent life, not even with the victim's consent, nor must we ourselves renounce the right to life. This situation is not altered if any such renunciation is made concurring with the judgement of others. For the Christian then it should be self-evident that murder, suicide and aiding somebody else's suicide are all morally wrong; he cannot have any part in it.

However, in a society composed of groups with diverse religious, philosophical and cultural beliefs, we cannot expect the law to make punishable every act that is sinful. Thus suicide, adultery and homosexual acts between consenting males in private, though sins, are in Britain no longer subject to the criminal law, and the Church did not fight those issues. This gives the lie to the propaganda

by the advocates of euthanasia, that it is only religious bias which opposes it and that a minority thus makes an unjustifiable attempt to impose its religious views on a community which has largely abandoned organized religion. This is not so. In the case of euthanasia Catholics speak out, and have a duty to do so, because this is a matter of life and death not only for the individual but for all their fellow men. Accordingly, this pamphlet, though largely inspired by the thoughts of traditional Christian philosophy, is designed to examine the problem of euthanasia in its general ethical aspects, on a basis which should be acceptable to all, whether or not they subscribe to any formal faith; it further examines in considerable detail the individual and social implications of any permissive legislation.

I am writing as a doctor who practises in England, where the question of euthanasia is a very live issue, which, in little more than a year, has led to two attempts at introducing permissive legislation. The debates in the Houses of Parliament, arguments in public, in private and in the press have spot-lighted the manifold legal, medical, and social implications. It is from an examination of those implications which in a special Study Group I have undertaken, together with other Catholic men and women engaged in law, medicine and public life, that I put forward my views.

ETHICAL CONSIDERATIONS

Underlying the whole controversy about euthanasia is a different philosophical outlook on two fundamental matters: the value of human life and the merits of "traditional" versus "new" morality. There is a steady tradition not only of Christendom but of all civilized people that gives to human life a respect above that accorded to animal life, and of a different sort; on the other hand there are now those who dismiss that respect as not genuine. Thus J. R. Wilson writes: "We are all supposed to feel some deep inherent reverence for human life", ("The Freedom to Die" by J. R. Wilson - The Spectator, 7th February, 1969.) thus insinuating not only that some people do not feel such reverence, but also that there is at least an element of hypocrisy in those who profess to it. "People take the experience of killing very easily indeed; it is the disapproval of society which bothers them" the author adds obviously implying that a man's conscience is formed by nothing more than social prejudice. Not many people will go as far as Wilson, but will still accept "situation ethics".

This new morality challenges the axiom of traditional morality, that man's basic obligations do not change with public opinion, by denying the existence of universally binding ideas, principles and laws; they teach that moral laws are to be followed or violated "according to love's need". ("Morality and Situation Ethics" by D. and A. von Hildebrand (Franciscan Herald Press, Chicago, 1966)) This concept of situation ethics originated, in part at least, as a reaction against a tendency found here and there in organized religion to set up legality in the place of morality. Ignoring that true traditional ethics have always recognized that circumstances play a legitimate role in the making of moral decisions, (Moneylending (not usury which is defined as moneylending at excessive interest and is still forbidden) is an obvious example.) the advocates of situation ethics proceed to identify all traditional ethics with the aberration of so-called legal ethics, which they have no difficulty in demolishing. This false substitution of terms is designed to obscure - and often does so successfully - the fact that the easy victory seemingly won is not over traditional morality but over its counterfeit, the very pharaseeism that Christ castigated and the Church condemns, and in this way support is gained for the "new morality".

A similar manoeuvre is employed by the authors of the British Euthanasia Society's (recently re-named Voluntary Euthanasia Society) Plan for Voluntary Euthanasia (1962) when they write: "Even

the Roman Catholic Church has recently agreed that when a human life is ending in great suffering it is the doctor's duty to relieve that suffering even although the means taken may shorten life ... if that policy shortens the patient's life, even by a few hours, the doctor is, in fact, practising euthanasia, although not strictly voluntary euthanasia". Thus it is made to appear as if the Church had to alter its stand and make a concession to the advocates of the new morality. As a matter of fact the Church has always endorsed the view that the doctor's first task is to relieve pain and distress and Christian philosophers have always made a clear distinction between the active ending of life and the use of means for the relief of suffering, which may as a secondary result shorten life. Any decision should be guided by the principle of double effect, which is widely misunderstood and, therefore, often suspected of being a "Jesuitical" splitting of hairs. In fact this principle is a guide to every doctor of any or no religious belief, whenever the problem of undesirable effects arises with any treatment. In a way it is guiding every one of us in everything we do; many of our acts have more than one foreseeable consequence and if one or the other is undesirable we have carefully to weigh up one against the other when we consider what we should do. It is suggested that there are four criteria:

(1) The purpose must be to achieve the good result the ill consequence being only a side effect.
(2) The act itself must be morally good or at least indifferent. Never will the end justify the means in the sense that intrinsically bad means may be employed to achieve a good result. This is an old established principle of traditional philosophy which has assumed special importance in recent controversies when it was claimed by some that it was only the intention that mattered and not the means.
(3) The good effect must not be achieved by way of the bad, but they must both result from the same act.
(4) The bad side effect must not be so serious as to outweigh the advantage of the good effect.

The administration of medicaments with the intention of relieving pain is good, and if thereby life is shortened this is a side effect which may well be acceptable. But this will rarely occur; more often than not the benefit of rest and sleep and an untroubled mind will do the patient more good than heavy sedation will do him harm. (Case Histories vide "Handbook for the Catholic Nurse" by K. F. M. Pole (Robert Hale Ltd., London, 1964). On the other hand, to give an overdose of a medicament with the intention that the patient should never again wake is morally wrong; it is killing.

THE PRESENT LAW

The protection of innocent life is not only the concern of the churches, it is deeply entrenched also, in the criminal law. It was one of the accepted arguments against the death penalty in Britain that a man might be mistakenly convicted and executed. Essentially the same consideration must be given to any man who has done no wilful harm.

In English law to deliberately take a man's life is the crime of murder, and so - if it succeeds - is any action designed to shorten life; it is no less murder if death appears to be inevitable anyway in the foreseeable future as a result of illness. Causing someone's death by violence or negligence but without that intention is manslaughter, for which the punishment is variable within wide limits at the discretion of the Court. Such a verdict may also be substituted for that of murder on the grounds of diminished responsibility in cases where circumstances such as provocation, passion, the overbearing influence of a stronger personality or some abnormality of the mind appear to have

substantially impaired the accused's mental responsibility, whether permanently or for the relevant time.

In Britain to take one's own life, or attempt to do so, used to be classed as a crime. This was altered by the Suicide Act 1961. In contrast to France and Switzerland, however, where a doctor - at the request of a patient with a fatal illness - is permitted to provide, though not administer, poison, the latest amendment of the law in England retained criminal penalties not only for incitement to or counselling suicide, but also for aiding and abetting and for suicide pacts. Some people, of course, not only defend but actually extol suicide and consider the "indoctrination" against it as regrettable, (Euthanasia and the Right to Death" edited by A. B. Downing (Peter Owen, London, 1969) page 153.) but from the Facts just stated it is obvious that the law in Britain does not express approval of suicide, but merely abstains from prosecution out of mercy to those who attempt it.

Euthanasia, in Lord Cork and Orrey's phrase "suicide by proxy" ("Voluntary Euthanasia Rill" of 6th March, 1969 (Hansard 25th March, 1969, Volume 300, number 50, column 1180)). is in law either murder or manslaughter. Those who want the law changed often use the argument of Lord Listowel, who wrote in a recently published book on euthanasia "We can now urge that the moral right to a dignified and merciful death, from which the legal right will eventually flow, should be enshrined in the universal declaration of human rights adopted by the General Assembly of the United Nations". ("Euthanasia and the Right to Death" - Foreword.) This is one of those emotional appeals that lack foundation in fact. The right to a dignified and merciful death has, and always had, the approval of the law and of all the churches, and no new legal right is required. Furthermore, widespread support might well be expected for a declaration designed to clarify the circumstances - when the prognosis is hopeless - in which resuscitation or any extraordinary means of prolonging life should not be employed.

The much publicized instruction in a British hospital some time ago that patients above a certain age should not be resuscitated was misguided, because it was given as a general ruling without consideration of individual circumstances, which only the doctor can judge who attends a patient at the relevant time. The non-statutory declaration suggested by Rose Barrington (Ibid., p.171) by which the signatory may decline in advance "any treatment or sustenance" designed to prolong life is framed in too wide and, therefore, unsatisfactory terms, because treatment and sustenance in a conscious patient may sometimes not only prolong life but also provide relief from suffering. What the various past efforts to introduce legislation for euthanasia have always aimed at was not legislation for the right to die, but for the right to kill. This, even with the patient's consent or at his request (at least supposedly so) is a very different matter.

ATTEMPTS TO ALTER THE LAW

There is no country in the world whose laws permit euthanasia, and it is therefore not possible to examine the actual working of any such legislation. However, the various attempts to introduce such permissive laws allow one to trace the development of the thoughts behind them, and the obvious consequences of any such legislation. Britain took the lead in this macabre spectacle and here too were made the most recent attempts which were extensively debated in the Houses of Parliament as well as in the press and on many public and private occasions. Further attempts have been heralded which keep us on the alert, and it is from this vantage point that I venture to give my observations.

It all started with Dr. Millard's presidential address to the Society of Medical Officers of Health on 16th October, 1931, which was completely devoted to a plea for legislation to permit voluntary euthanasia and to the consideration of a draft Bill entitled "The Voluntary Euthanasia (Legislation) Bill". This provided for an application to be made by the dying person (the applicant) which was to be attested by a magistrate or commissioner of oaths, and together with two medical certificates forwarded to the euthanasia referee, a specially appointed official who would have the right to call and question the doctors and relatives. If satisfied he would issue a certificate which, together with the papers on which he had based his approval, would be put before a special court which again would have the right to examine all witnesses before issuing the decisive authority. Dr. Millard's draft Bill caused great controversy in the press and among the general public, which was on the whole not very enthusiastic, but those who supported him rallied round and founded in 1935 the British Euthanasia Society under the presidency of the late Lord Moynihan.

The committee of the Euthanasia Society was so confident of the public being ready to accept such a Bill, that it was introduced and debated in the House of Lords as soon as the 1st December, 1936, but the support for it had been overestimated. In particular the proposers had counted on being backed by Lord Dawson of Penn because he had said: "There has gradually crept into medical opinion, as it has crept into lay opinion, the feeling that one should make the act of dying more gentle, and more peaceful, even if it does involve curtailment of the length of life". (House of Lords official report, 1st December, 1936, column 481.) In fact, Lord Dawson strongly opposed the Bill, advancing that it was lawful to use drugs to alleviate pain even though it was foreseen that these would shorten life, provided that the alleviation of pain and not the shortening of life was the primary purpose of the drug; this is exactly the Catholic position. He added: "We have not in mind to set to work to kill anybody at all", and he also expressed horror at the invasion of the peace of the sick room by so many legal complexities. Lord Horder, too, opposed the Bill and, led largely by the view of its medical members, the House rejected it by thirty-five votes to fourteen.

In the following year, the idea of compulsory euthanasia having been given up for the time being, attempts were made in the U.S.A. to introduce Bills on similar lines to those in Britain, and here too they were defeated. It seems that the rumours of events in Nazi Germany (later confirmed by the Nuremberg trials) led to public suspicion that legalization for voluntary euthanasia might be the "thin end of the wedge". However, in 1950 Lord Chorley thought that a change of opinion in favour of "mercy killing" had taken place, and his motion "to call attention to the need for legalizing voluntary euthanasia, and to move for papers" was debated in the House of Lords on the 28th November of that year. Though Lord Chorley's proposal was again for voluntary euthanasia, he did say there was not only the patient to be considered but also those looking after him whose lives could be ruined by the need to do so. He reassured those who thought his motion did not go far enough by saying legislation in the matter would have to proceed step by step, starting with those who would give consent!! On the other hand he countered those who might argue that the safeguards against abuse were inadequate, with the assurance that he would deal with any specific inadequacies which were brought to his notice.

However, Lord Chorley had underestimated the opposition. The medical members who spoke rejected the idea, the Archbishop of York (Dr. Garbett) opposed the motion "for reasons both theological and social", and the then Lord Chancellor (Viscount Jowitt), appalled at the bureaucratic procedure envisaged to allow one man legally to kill another, emphasized that the criteria were all relative and could not be proved in court: Finally the motion was, by leave, withdrawn.

It was 1962 when "A Plan for Voluntary Euthanasia" was published by the Euthanasia Society, and this was superseded in 1968 by a draft Bill which, with some modifications, was presented by Lord Raglan to the House of Lords and debated on a second reading on March 25th, 1969. It was eventually defeated by forty peers voting for the Bill and sixty-one against, but the comparatively narrow majority and the trend of the debate provided some encouragement to the supporters of euthanasia. Consequently, as early as the 7th April, 1970, Dr. Hugh Gray, M.P., under the "ten minute rule" sought permission in the House of Commons to introduce a Bill on voluntary euthanasia. However, leave was refused without a vote being taken, as a chorus of "No" indicated a heavy defeat. There might have been several reasons for that mood of the House, but among them may well have played a major part the discovery of loopholes which led to much abuse of the Abortion Bill soon after it had been passed in 1967. There can be no doubt that other attempts to introduce permissive legislation will follow, and careful consideration of the last Bill and of the arguments used in the debate therefore appears imperative.

SOME LEGAL DIFFICULTIES

The main feature of Lord Raglan's Bill was that it had been designed to avoid the death-bed formalities which previously had encountered much objection. To this end an advance declaration was provided for, which any person could make - apparently even before reaching the age of majority - though it could not be executed before majority had been attained. Euthanasia was to be administered to a "qualified patient" defined as being over the age of majority and attested by two registered medical practitioners as suffering from a serious physical illness or impairment, reasonably thought to be incurable and expected to cause him severe distress or to make him incapable of rational existence.

The definition of "irremediable condition" does not state that the illness must be terminal or at the time actually causing distress which could not be relieved by treatment. As it stands the Bill might, therefore, be interpreted to include conditions like blindness or other permanent invalidity, or even a patient who had a coronary thrombosis. At what stage then would the patient be thought to qualify? Although suffering from an incurable disease, he might still be capable of leading a gratifying life for a long time. Who would decide and by what criteria when he would be liquidated? For cases like carcinoma of the throat, with difficulty in swallowing and breathing, the Euthanasia Society argues that though few express it "one cannot know how many have harboured the wish (for release) secretly". ("A Plan for Voluntary Euthanasia" 1962, p. 21.) To this it must be answered that we do not know either how many fear the end and might fear it more if they had signed a declaration and wondered at what stage their "will" might be executed.

Another difficulty which might well arise for the doctor is in deciding on the exact time for euthanasia, as in cases where relatives wrangle about a Will, he might well be blamed by those who were dispossessed and had hopes of a new Will being made, that euthanasia was carried out too early and, therefore, to their detriment.

The term "physical illness" can probably be taken to include senile degeneration of various organs, including the brain, even though the latter might clinically be manifest only as a disturbance of the mind, but it would not include mental illness in which no detectable structural damage of the brain is known to exist. However that may be, according to the Bill all that was required of the witnesses was to testify that the declarant appeared to appreciate the significance of the declaration and their belief that it was made by his own wish. Again, before administering euthanasia to a "mentally

responsible" patient it was provided that the doctor should make sure, to his reasonable satisfaction, that the declaration and all steps to be taken under it accorded with the patient's wishes. Nothing, however, was said about the eventuality of the patient being not, or not fully, mentally responsible.

The concept of diminished responsibility; which plays an important part in legislation concerning homicide and manslaughter, has been completely ignored in that recent Euthanasia Bill, though undoubtedly pain unrelieved on the one hand, and pain relieved by too much sedation on the other, would both lead to such diminished responsibility. As a matter of fact, the whole subject of pain relief, and the armoury at the disposal of the doctor for that purpose, is ignored in the Bill except in clause "8" which states that a patient believed to be suffering from a fatal condition should be entitled to be administered whatever quantity of drugs was required to keep him free from pain and, if he wished, continuously unconscious.

This concept of the patient's entitlement is contrary to the present one of the doctor's responsibility to judge what is the right treatment. Furthermore, nothing is said in the Bill about the "right" of the patient to euthanasia in cases where he is neither seriously distressed nor incapable of rational existence of which, for longer or shorter periods, he is deprived only by the treatment. Anyway, how is "rational existence" to be defined? It is a term unknown in British law. Many people appear to others to act irrationally in some phases of their lives, or in some particular respects; love and marriage are outstanding examples, but there are also many people in and out of hospital who lead happy lives though they would not be capable of sensibly running a business, or dealing with any more complicated financial affairs. Again, how are we to judge rational existence in people who have lost the power to communicate? How are we supposed to interpret a nod or blink of the eyelids, and what are we to do in case of doubt?

The safeguards concerning the validity of the declaration are further weakened by the uncertainty who should be responsible for the safe keeping of the document, and how will abuses be proven if the key witness - the patient - is dead? All these difficulties - and there are many more on which I, as a medical man, am not qualified to comment - appear to confirm the words of the Lord Chancellor in the 1950 debate in the House of Lords: "There can be no adequate safeguards where one human being is allowed to start killing another".

THE DOCTOR AND THE DYING PATIENT

Because of his key position in this matter the doctor would have a particular responsibility imposed upon him by euthanasia, and today's widespread abolition of the Hippocratic Oath does not absolve him from this responsibility; as was explained before, man's basic obligations do not change with public opinion. The Christian view is -- and a truly humanist view would be - that man in general has a right to life, and also a duty to sustain life and health as far as he reasonably can, and that the doctor has a corresponding duty to aid him. A change in law which permitted the active ending of life by the doctor would be completely alien to medical practice as we know it, and moreover a change which the profession as a whole neither asks for nor is ready to accept. This has been expressed in the resolution by the General Assembly of the World Medical Association in 1950 recommending to all national associations that they "condemn the practice of euthanasia under any circumstances".

That medical opinion in this country has not changed is clear from the doctors' opinions voiced in past discussions in the Houses of Parliament, and also at the last annual representative meeting in Aberdeen of the British Medical Association; there it was resolved "that this meeting in affirming

the fundamental objects of the medical profession as the relief of suffering and the preservation of life, strongly supports Council's view on the condemnation of euthanasia and instructs Council to give this view full publicity".(This instruction has since been implemented.) Moreover a recent questionnaire privately circularized to seventy consultants of varying, or no, religious belief at a London teaching hospital, produced fifty-six replies of which only four expressed themselves generally in favour of the Euthanasia Society's proposals. Fifty were against, and two did not express any definite opinion.

The amount of discomfort and suffering people can bear, and of the sheer effort they are able to put into the task of sustaining life and health, are variable but in each case clearly limited. The doctor who is essentially concerned with the well-being of the patient will therefore have a duty to make sure that all every-day measures and ordinary methods of treatment are employed. However, the use of extraordinary methods - which have been defined as those which are very dangerous, very painful, very distressing, very expensive or very unusual - will depend on the explicit permission of the patient, who would be morally as well as legally entitled to refuse them. In cases where a patient is unconscious or otherwise incapable of giving his consent, a doctor will use his judgement in the best interests of the patient when it comes to the decision what should be done to maintain life as long as there is a chance of cure or of a return to a reasonable condition of well-being. Treatment should never be carried out for its own sake or for the doctor's glory when it is clear that it is going to be virtually useless.

This brings us to the realm of experimentation. It must be accepted that without a trial of new methods medicine cannot progress and the care of patients cannot improve, but if the doctor explains to the patient what he wants to do he will almost always receive permission. The patient will readily understand that his doctor would not be trying a new form of treatment if he were not dissatisfied with the old ones. But no decision a patient makes will absolve a doctor from the duty to do what he considers right in his own conscience. It might actually be wrong for the doctor not to try a new line of treatment which offers even the slightest hope.

The definition of extraordinary means will have a different meaning at different times, and also according to place and with changing circumstances. Assessment will be different in a well-equipped hospital from that of an emergency situation in an isolated outpost, and it will also vary according to the patient's general state of health that underlies the acute danger situation; such contingencies may well affect the efficiency of a proposed treatment as well as the risks and the amount of distress involved. These Christian principles are re-emphasized here because of the power of medical science to sustain today some form of life in patients hopelessly near to death. It is cases such as those which are quoted in support of the contention that legislation for euthanasia is necessary, that euthanasia is being practised already and therefore should be regularized by law. It would appear from the debate on the Voluntary Euthanasia Bill in the House of Lords in March 1969 that even a man of the learning of the Anglican Bishop of Durham could be misled by the ambiguity of the term "euthanasia", for he said that one of the contexts in which this question arose was that of keeping people alive by highly artificial means. It must be emphasized again: this - though sometimes referred to as "negative" euthanasia - is not euthanasia in the sense proposed by the Euthanasia Societies of our countries.

There is no ethical merit in prolonging the process of dying, in fact the indefinite prolongation of life when the patient has no prospect of ever again being able to maintain his own life, or no prospect of leading a life rewarding to himself even with artificial aid, is a travesty of sound

medicine; it makes a mockery both of life and of the process of dying. But it is a logical error to equate an active termination of life with allowing someone to die peacefully. If the doctor is convinced there is no hope of reviving the patient to a satisfactory existence he is under no obligation to continue with measures of extraordinary treatment, but he might be under an obligation to discontinue them and thereby make the facilities free for the benefit of others. The decision to abstain from or end attempts to resuscitate a patient must be sad under any circumstances. However, it is the kind of decision the man in charge has to face in any rescue or search operation when it should be called off as hopeless...

Today the doctor has plenty of means to help him in his primary task of relieving a patient's pain and distress, whether it be physical or mental. The conquest of distress may not yet be complete, but even so, on the Euthanasia Society's own showing, in hospitals for terminal illnesses - most of them staffed by dedicated women belonging to some religious Order, many of whom are also trained in nursing - "Experience has shown that in the sympathetic and sometimes surprisingly cheerful atmosphere created by the women... they (the patients) are able to face death when it comes with a quiet mind - unafraid. Even if euthanasia were permissible to these patients probably very few would wish to avail themselves of it". ("A Plan for Voluntary Euthanasia", p.19)

It is claimed that these circumstances are exceptional, because there are few such terminal hospitals, and this is advanced as a reason for permitting euthanasia: What an indictment against our society to propose killing people because there is not enough sympathy and help for them! If the old are a burden on their relations, the solution is to make proper provision for them. This was pointed out by several speakers in the debate in the House of Lords on the Voluntary Euthanasia Bill, 1969.

In those cases where a patient "merely exists" it is not he who suffers but those around him. In the words of the Euthanasia Society's spokesman: "Dying is still often an ugly business". (Ibid., p.6) Indeed it may be ugly but, as has been shown, the patients themselves are usually contented when they are well cared for. They live for the moment, and their wants and desires are gradually reduced to the basic ones which, however, are not just for food, drink and physical comfort, but also for friendliness, patience and affection on the part of those who care for them. To the end, even when the deterioration of their mental powers is quite advanced, they remain very sensitive to the attitude of their surroundings and soon feel unwanted and rejected.

SOME MEDICAL IMPLICATIONS

Medical judgement is fallible, and with ever-increasing medical skill conditions may be curable tomorrow which are incurable today. The doctor will therefore be cautious in his assessment of a patient's condition as irremediable. To this the Euthanasia Society retorts that "the remote possibility of making a mistake is not a reason for doing nothing". (Ibid., p. 24) However, any liberty to die quickly must be carefully balanced against the life and liberty of those who would needlessly be killed in the process. The case of euthanasia must not be argued in abstract theory because, in this field, general principles cannot be separated from practicalities. Wherever the risk of error or abuse exists (as it certainly does in assisted suicide or "suicide by proxy") the question must be asked, how compelling is the need to implement the principle. The answer which would be relevant in every case must be scrutinized even more closely when the soundness of a principle is in doubt, and that it is in doubt concerning euthanasia even its supporters will surely admit; were it not there would be no argument. Kamisar rightly puts the question: "What is the need for euthanasia which

leads us to tolerate the mistakes, the very fatal mistakes, that will inevitably occur?" ("Euthanasia and the Right to Death" p. 103)

"I should like to die" may be a cry of despair from a depressed patient needing treatment. Pain-relieving, and in particular the modern anti-depressant, drugs often cause dramatic improvement in mood, but even without them a patient may change his mind and outlook in a very short space of time. Such cases are well known to doctors, and Lord Horder evidently had them in mind when, in the 1950 debate in the House of Lords, he said "An applicant for euthanasia in the morning could want to live in the afternoon". I myself shall always remember a case quoted by our Professor of Surgery when I was a student. It was one of his personal experiences as a young doctor, when he was attending a patient who was obviously dying from cancer, beyond hope of cure, and under considerable pain. The means of pain relief were then much more restricted than now, and in every moment of consciousness the patient was moaning and begging "I cannot bear it any longer. Let me die. Give me something to kill me!" Torn between his emotion of sympathy, his duty and his fear of the law which forbade killing even under the plea of mercy, the young doctor decided to find a way out for his suffering patient. "Look here Mr. Brown" he said, giving him a morphine preparation, "I will give you some rather strong drops which will relieve your pain, but mind you be careful and do not take any more than the fifteen drops prescribed because it might be rather dangerous". "I have never seen a patient count his drops more carefully" the Professor said "than this patient did for the remainder of his life; it has taught me a lot - and I hope it will teach you a lot - concerning the question of euthanasia".

Such cases underline the great danger of an advance declaration, which on the part of a young, healthy individual may be nothing more than a theoretical exercise in a field of which he has no knowledge, which he cannot even picture. What looked easy and acceptable from afar may look very different close to. However, once a person has signed a declaration, possibly even before he has signed it but when he knows the family expects him to do so, pride or a false sense of duty may prevent him from changing his decision even though he has changed his mind. Such change of mind may be due not only to a natural fear of death now the patient has actually to face it, but may well be due to an experience of conversion or recovery of faith. There are certainly many instances known of this so that clearly the spiritual state of a patient must not be assumed to remain static during a terminal illness. Moreover, where the patient's mind is clouded but still receptive, or his expression is impaired, how could an independent assessor become aware, or be made aware, of a change of mind when he has no access to information from the patient on which he can conscientiously base a decision which is both professionally and ethically sound?

Euthanasia would, without any doubt, damage the doctor-patient relationship. The supporters of permissive legislation assert the contrary, but their reasoning is patently fallacious. The patient places his trust and hopes in the doctor and so he should, for he knows that the doctor will give him all possible care. However overworked a family doctor may be, he will still have time for a heart-to-heart talk with his dying patient; knowing the family background he will reach his conclusions much more quickly and safely than an independent referee, and will give encouragement and comfort according to need. If ever he should be bound by law to execute a patient's orders which he considers are no longer relevant or applicable, though they have never been revoked, he will feel fettered in his actions. He might act under pressure from a patient who, obviously against his own feelings, insists that he wants to sacrifice himself for the financial or other benefit of his family. Furthermore, the doctor might be under pressure from the relatives (who normally will be his

patients too) and have no chance, without being suspected of exerting undue influence, to offer alternative solutions, though he may realize the patient feels as if he were "in the condemned cell".

There might be tensions anyway in the home of an incurably ill man, but there is a great difference between those which the healthy relatives may have to bear in struggling with their mixed emotions, and the tension which might arise between the patient and those surrounding him through a petition for euthanasia or, perhaps more often, by a failure to petition. Particularly children of vulnerable age would suffer from the effects of the discussions that would necessarily go on in a family before such a decision was made and which it would be impossible to conceal from them.

Today there is certainly more concern on the part of relatives that patients should not be allowed to linger in "unnecessary suffering" than there is on the part of the patients themselves; if euthanasia were to be legalized it would certainly increase the demand for euthanasia, but very likely the increased demand would not spring from a genuine desire for death on the part of the infirm, but from pressures, overt or covert, upon them.

SOME SOCIAL PROBLEMS

Experience teaches that once a principle is abandoned abuse cannot be kept out. However closely and carefully an Act might be framed in order to ensure that euthanasia was applied only in certain strictly defined circumstances, those conditions would in practice be read into every conceivable case by those who wished to practice euthanasia; those who declined to take such an easy-going view would be denounced as failing to implement the law of the land, or to give patients "their rights". Without doubt this is what happens in the case of the Abortion Act. Abortions can by law be performed only in certain circumstances laid down - albeit inadequately - in the Act. But though it was one of its avowed purposes to prevent just that, in practice almost any woman who wants an abortion can procure one, and doctors who decline to perform abortions in individual cases for whatever good medical reasons are, in certain circles, branded as cruelly unco-operative and also opposing the will of the people as expressed through Parliament.

Obviously, so long as there is no provision in law allowing a petition for death, forecasts of what might happen if there were must be speculative and no forecast concerning the long-term consequences of a Voluntary Euthanasia Act can be infallible. Nevertheless such a forecast can be fairly based on observations, and these suggest that the voluntary aspect of such an Act would not last long. This suspicion cannot be dismissed as scaremongering, the parallel with the consequences of the Abortion Act is too close for comfort. Pointers in the same direction are the words of Lord Ponsonby quoted earlier on: "We must go step by step", and Lord Listowel, in the book mentioned before, though pleading for voluntary euthanasia only, added the ominous words "...we cannot wish to preserve an anonymous individual who has been stripped of personality and reduced by incessant pain or physical deterioration to the animal or vegetable level". ("Euthanasia and the Right to Death" - Foreword.) Lord Listowel is here putting forward a highly coloured and rare picture as if it were commonplace. Moreover, as should be clear from what has been said earlier, the perpetuation of a merely breathing body is not advocated.

Furthermore it must be remembered that the clause 1 (i) (b) of the Abortion Act which allows for abortion in cases where "there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped" is, strictly speaking, a provision for involuntary euthanasia insofar as the clause is justified by the plea that no child should be allowed to be born to face life under such circumstances. If doctors and nurses were ever to

accept the principle of euthanasia the unspoken pressures, at present limited to the family circle, would become even stronger. Of necessity the attitude of the medical staff to those patients who they feel should ask to have their life ended would be coloured by their opinion; no doubt patients would sense this, and thus the voluntariness of the so-called voluntary declaration would become even more questionable. Patients in the late stages of their illness may consequently be deprived of the friendliness and care for their small wants which, as even the Euthanasia Society acknowledges, can make for happiness in terminal hospitals. It is an appalling thought that eventually this may well lead to the community providing only that type of terminal hospital which would encourage people to ask for death.

Supporters of euthanasia urge that the quality of life is more important than the quantity. This slogan misleads many people. What is meant by quality? What criteria can be used to judge it, and by what possible standards can anybody assess the level of quality below which life is worthless? Where human life is concerned, "usefulness" as the only criterion is unacceptable. Besides, how is uselessness to be defined? Many an old invalid person in the home, many a severely handicapped child, have formed a focal point for family love. I have seen mothers of mentally deficient children, although overburdened with work, fight for the life of those children, and all the brothers and sisters take their share of watching, nursing and entertaining not only willingly but happily, and I have seen their genuine grief on the death of the invalid. Parents and children have become better people for knowing about suffering and for having learned to give help. Lord Alwyn's argument in the House of Lords debate on Lord Raglan's Bill that those who believe in an after-life should agree that a suffering mortal be given the right to be wafted painlessly into it, can hardly be taken seriously; followed to its logical conclusion it would lead to the obviously absurd inference that the Church should allow babies to be killed as soon as they had been baptized, as that would guarantee their going straight to heaven!

The doctor is primarily concerned with individual patients, and then with the family who are intimately associated with the death. It is they who at first sight might be thought to benefit from "mercy killing" when they come to feel that the prolonged endurance of anxiety and of sleepless nights is beyond their strength. What is termed the agony of death concerns the watcher by the bedside rather than the person who is the subject of pity. But once we admit to the principle of killing anybody for the benefit of somebody else where is the borderline? The smallest step onwards would bring us to the argument that grandfather, aged 94, is using up all his savings instead of leaving them to the family who need them badly. There will be few I think who will go as far as that, but even so it may well be asked whether the relatives really would be pleased if euthanasia became generally accepted.

What might be the feelings of a woman who has reason to believe that she is incurably ill, or when she is old and no longer of any practical use to the community, if in her younger days she had experienced her grandmother being killed for so-called mercy's sake. Well known are cases of anxiety neurosis due to the mere suspicion that euthanasia might have been employed on a relative in the past, or was at least desired. On the other hand in dying, family rifts might be healed and peace of mind restored. In a realistic account of her mother's death Simone de Beauvoir recounts that she was terrified, but even so she was struck by her mother's "restored beauty" and the radiant smile of her young days, never since seen and now recovered which "expressed her inner harmony". There was harmony too between mother and daughter who had been estranged for many years. "I had grown very fond of this dying woman... the early tenderness which I had thought dead for ever

came to life again since it had become possible for it to slip into simple words and actions." There is no doubt that euthanasia would have robbed them both of something invaluable. For herself and her sister Simone sums up the benefit in very few words: "It saved us, it almost saved us, from remorse". ("A Very Easy Death" by Simone de Beauvoir (Andre Deutsch and Weidenfeld and Nicolson))

Society is made up of individuals; the family is society's primary unit in which love is - or should be - expressed and experienced. To those who believe in the brotherhood of man, whether from religious or humanist considerations, any antithesis between the ultimate good of the individual and of society must be a contradiction in terms. It was to the New York Psychiatric Society as long ago as 1936 that Brill, discussing the psychoanalytic implications of euthanasia gave the warning that the killing instinct had to be kept in check, and that "...mercy killing... would be bound to demoralize society". ("Reflections on Euthanasia" by A. A. Brill, J. Nerv. Ment. Dis. 1936 - 84, 1-2 (July)) Indeed, once the principle of the sanctity of human life is abandoned, or the propaganda accepted that to uphold it is old-fashioned, prejudiced or superstitious, the way is open to a demand for "mercy killing" of severely handicapped children, the mentally sub-normal, the severely crippled, the aged and ultimately of everyone who is a burden on the community services and the public purse. Their destruction might improve the appearance of population statistics, but it will aggravate, not ease, the tensions in the home and in the world. Let then euthanasia be seen for what it is - a tragic attempt to patch up our morbid society. To adopt it would be a further step in the decline of moral standards without which, as history amply confirms, civilization must decay and ultimately perish.

ACKNOWLEDGEMENT

In co-operation and a frequent exchange of views with the other members of a special Euthanasia Study Group whose findings are to be published soon by Chapmans of London in book form under the title "Your Death Warrant? - The Implications of Euthanasia", I have naturally absorbed and assimilated much knowledge which has become inextricably interwoven with my own. I wish here to express sincere thanks to my colleagues in that group - men and women engaged in law, medicine and public life - for having so willingly and encouragingly given permission for me freely to make use of any information and ideas I have thus made my own.

Mercy killing... or manslaughter? YOUR DEATH WARRANT? The Implications of Euthanasia Edited by Jonathan Gould and Lord Craigmyle Various attempts have been made during the last 35 years to pass through the British Parliament a Bill legalizing the killing, by doctor or nurse, of adult patients who might request death during the course of an incurable, disabling or very painful illness. Should the killing of one person by another ever be lawful? Should doctors and nurses be encouraged by the law to accept that the killing of patients is an acceptable way of 'treating' disease and suffering? Isn't the whole movement for euthanasia a tragic attempt to patch up a morbid society? The efforts of those who would like euthanasia to become law are accelerating; the matter was debated in Parliament in both 1969 and 1970. It is essential that public opinion become aware of what the implications of these efforts are. What on the surface may appear to be a humanitarian movement is, in fact, asking society to sign its own death warrant. ISBN 0 225.65822.5 To be published by Geoffrey Chapman Agents in Australia: Collier Macmillan International, Broadway, Sydney, N.S.W. 2007

Nihil Obstat: BERNARD O'CONNOR, Diocesan Censor. Imprimatur: J. R. KNOX Archbishop of Melbourne