

VOLUNTARY EUTHANASIA: A UTILITARIAN PERSPECTIVE

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ABSTRACT

Belgium legalised voluntary euthanasia in 2002, thus ending the long isolation of the Netherlands as the only country in which doctors could openly give lethal injections to patients who have requested help in dying. Meanwhile in Oregon, in the United States, doctors may prescribe drugs for terminally ill patients, who can use them to end their life – if they are able to swallow and digest them. But despite President Bush's oft-repeated statements that his philosophy is to 'trust individuals to make the right decisions' and his opposition to 'distant bureaucracies', his administration is doing its best to prevent Oregonians acting in accordance with a law that its voters have twice ratified. The situation regarding voluntary euthanasia around the world is therefore very much in flux.

This essay reviews ethical arguments regarding voluntary euthanasia and physician-assisted suicide from a utilitarian perspective. I shall begin by asking why it is normally wrong to kill an innocent person, and whether these reasons apply to aiding a person who, when rational and competent, asks to be killed or given the means to commit suicide. Then I shall consider more specific utilitarian arguments for and against permitting voluntary euthanasia.

UTILITARIANISM

There is, of course, no single 'utilitarian perspective', for there are several versions of utilitarianism and they differ on some aspects of euthanasia. Utilitarianism is a form of consequentialism. According to *act-utilitarianism*, the right action is the one that, of all the actions open to the agent, has consequences that are better than, or at least no worse than, any other action open to

the agent. So the act-utilitarian judges the ethics of each act independently. According to *rule-utilitarianism*, the right action is the one that is in accordance with the rule that, if generally followed, would have consequences that are better than, or at least no worse than, any other rule that might be generally followed in the relevant situation. But if we are talking about changing laws to permit voluntary euthanasia, rather than about individual decisions to help someone to die, this distinction is not so relevant. Both act- and rule-utilitarians will base their judgements on whether changing the law will have better consequences than not changing it.

What consequences do we take into account? Here there are two possible views. Classical, or hedonistic, utilitarianism counts only pleasure and pain, or happiness and suffering, as intrinsically significant. Other goods are, for the hedonistic utilitarian, significant only in so far as they affect the happiness and suffering of sentient beings. That pleasure or happiness are good things and much desired, while pain and suffering are bad things that we want to avoid, is generally accepted. But are these the *only* things that are of intrinsic value? That is a more difficult claim to defend. Many people prefer to live a life with less happiness or pleasure in it, and perhaps even more pain and suffering, if they can thereby fulfil other important preferences. For example, they may choose to strive for excellence in art, or literature, or sport, even though they know that they are unlikely to achieve it, and may experience pain and suffering in the attempt. We could simply say that these people are making a mistake, if there is an alternative future open to them that would be likely to bring them a happier life. But on what grounds can we tell another person that her considered, well-informed, reflective choice is mistaken, even when she is in possession of all the same facts as we are? The difficulty of satisfactorily answering this question is one reason why I favour preference utilitarianism, rather than hedonistic utilitarianism. The right act is the one that will, in the long run, satisfy more preferences than it will thwart, when we weigh the preferences according to their importance for the person holding them.

There is of course a lot more to be said about questions internal to utilitarianism. But that is perhaps enough to provide a basis for our next topic.

WHEN KILLING IS, AND IS NOT, WRONG

Undoubtedly, the major objection to voluntary euthanasia is the rule that it is always wrong to kill an innocent human being.

Anyone interested in an ethics that is free of religious commitments should be ready to ask sceptical questions about this view. Rule-utilitarians will not accept this rule without being persuaded that it will have better consequences than any other rule. Act-utilitarians will need to be assured that it will have the best consequences to follow the rule in *every* instance in which it applies.

The idea that it is always wrong to kill an innocent human being gains its strongest support from religious doctrines that draw a sharp distinction between human beings and other sentient beings. Without such religious ideas, it is difficult to think of any morally relevant properties that separate human beings with severe brain damage or other major intellectual disabilities from other beings at a similar mental level. For why should the fact that a being is a member of *our* species make it worse to kill that being than it is to kill a member of another species, if the two individuals have similar intellectual abilities, or if the non-human has superior intellectual abilities?

My claim that the wrongness of killing cannot rest on mere species membership is compatible with, but need not be based on, utilitarianism. Consider, for instance, the Kantian principle that it is always wrong to use someone merely as a means, and not as an end. Who is to count as 'someone' for the purposes of applying such a principle? Kant's own argument in support of this principle depends on autonomy, and our autonomy, for Kant, depends on our ability to reason.¹ Hence, it is fallacious to treat Kant's principle as equivalent to: 'Never use a human being as means to an end.' It would be better to read it as: 'Never use an autonomous being merely as a means.'

I can think of only one non-religious reason that has any plausibility at all, as a defence of the view that the boundary of our species also marks the boundary of those who it is wrong to kill. This is a utilitarian argument, to the effect that the species boundary is sharp and clear, and if we allow it to be transgressed, we will slide down a slippery slope to widespread and unjustified killing. I will consider slippery slope arguments against allowing voluntary euthanasia towards the end of this paper. Here it is sufficient to note that this argument effectively admits that there is no intrinsic reason against attributing similar rights to life to humans and non-humans with similar intellectual capacities, but warns against the likely consequences of doing so. For our present inquiry into the underlying reasons against killing human beings,

¹ See: I. Kant. *Groundwork of the Metaphysics of Morals*. First published 1785. Various editions: Part II.

this is enough to show that one cannot simply assume that to be human is to give one a right to life. We need to ask, not: what is wrong with killing a human being; but rather, what makes it wrong to kill any being? A consequentialist might initially answer: whatever goods life holds, killing ends them. So if happiness is a good, as classical hedonistic utilitarians hold, then killing is bad because when one is dead one is no longer happy. Or if it is the satisfaction of preferences that is good, as modern preference utilitarians hold, then when one is dead, one's preferences can no longer be satisfied.

These answers suggest their own limits. First, if the future life of the being killed would hold more negative elements than positive ones – more unhappiness than happiness, more frustration of preferences than satisfaction of them – then we have a reason for killing, rather than against killing. Needless to say, this is highly relevant to the question of euthanasia.

At this point, however, some further questions arise that suggest the relevance of higher intellectual capacities. Among these questions are: who is to decide when a being's life contains, or is likely to contain, more positive characteristics than negative ones? And what further impact will the killing of a being have on the lives of others?

Regarding the first of these questions, the nineteenth century utilitarian John Stuart Mill argued that individuals are, ultimately, the best judges and guardians of their own interests. So, in a famous example, he said that if you see people about to cross a bridge you know to be unsafe, you may forcibly stop them in order to inform them of the risk that the bridge may collapse under them, but if they decide to continue, you must stand aside and let them cross, for only they know the importance to them of crossing, and only they know how to balance that against the possible loss of their lives.² Mill's example presupposes, of course, that we are dealing with beings who are capable of taking in information, reflecting and choosing. So here is the first point on which intellectual abilities are relevant. If beings are capable of making choices, we should, other things being equal, allow them to decide whether or not their lives are worth living. If they are not capable of making such choices, then someone else must make the decision for them, if the question should arise. (Since this paper focuses on voluntary euthanasia, I shall not go into details regarding life-and-death decisions for those who are not capable

² John Stuart Mill. *On Liberty*. First published 1869. Various editions: Chapter 5.

of exercising a choice. But to those who think that, in the absence of choice, the decision should always be 'for life', I would add that even those who are most strongly against killing rarely insist on the use of every possible means of life-support, to draw life out to the last possible minute. In allowing life to end earlier than it might, they are effectively deciding for those who are not capable of making such decisions, and against life, not for it.³)

The conclusion we can draw from this is as follows: if the goods that life holds are, in general, reasons against killing, those reasons lose all their force when it is clear that those killed will not have such goods, or that the goods they have will be outweighed by bad things that will happen to them. When we apply this reasoning to the case of someone who is capable of judging the matter, and we add Mill's view that individuals are the best judges of their own interests, we can conclude that this reason against killing does not apply to a person who, with unimpaired capacities for judgement, comes to the conclusion that his or her future is so clouded that it would be better to die than to continue to live. Indeed, the reason against killing is turned into its opposite, a reason for acceding to that person's request.

Now let us consider the second question: what impact does killing a being have on the lives of other beings? The answer will range from 'none' to 'devastating', depending on the particular circumstances. Even in the case of beings who are unable to comprehend the concept of death, there can be a great sense of loss, when a child or a parent, for example, is killed. But putting aside such cases of close relationship, there will be a difference between beings who are capable of feeling threatened by the deaths of others in circumstances similar to their own, and those who are not. This will provide an additional reason to think it wrong – normally – to kill those who can understand when their lives are at risk, that is, beings with higher intellectual capacities.

Once again, however, the fact that killing can lead to fear and insecurity in those who learn of the risk to their own lives, is transformed into a reason in favour of permitting killing, when people are killed only on their request. For then killing poses no threat. On the contrary, the possibility of receiving expert assistance when one wants to die relieves the fear that many elderly and ill

³ For further discussion see: Peter Singer. 1993. *Practical Ethics*. Second edition. Cambridge. Cambridge University Press. Peter Singer. 1995. *Rethinking Life and Death*. New York. St Martin's Press.

people have, of dying in unrelieved pain and distress, or in circumstances that they regard as undignified and do not wish to live through.

Thus the usual utilitarian reasons against killing are turned around in the case of killing in the circumstances that apply in the case of voluntary euthanasia. But it is not only with utilitarian reasons that this happens. It is also true of the Kantian argument that to kill autonomous beings against their will shows a failure to respect them as autonomous beings. This is true, obviously, when they do not want to be killed; and it is equally obviously false when they have autonomously decided to hasten their death. In these circumstances, it is preventing others from assisting them in carrying out their considered desire that violates their autonomy. That Kant himself took the opposite view only shows that he was influenced more by the conventional Christian morality of his day than by a thorough-going application of his own fundamental principles.⁴

What of an argument based on a right to life? Here everything will depend on whether the right is treated as most other rights are, that is, as an option that one can choose to exercise or to give up, or if it is seen as 'inalienable', as something that cannot be given up. I suggest that all rights should be seen as options. An 'inalienable right' is not a right at all, but a duty. Hence the idea of a right to life does not provide a basis for opposing voluntary euthanasia. Just as my right to give you a book I own is the flip side of my right to keep my property if I choose to retain it, so here too, the right to end one's life, or to seek assistance in doing so, is the flip side of the right to life, that is, my right not to have my life taken against my will.

Against this, it will be said that we do not allow people to sell themselves into slavery. If, in a free society, people are not allowed to give up their freedom, why should they be able to give up their lives, which of course also ends their freedom?

It is true that the denial of the right of competent adults to sell themselves, after full consideration, into slavery creates a paradox for liberal theory. Can this denial be justified? There are two possible ways of justifying it, neither of which implies a denial of voluntary euthanasia. First, we might believe that to sell oneself into slavery – irrevocably to hand over control of your life to someone else – is such a crazy thing to do that the intention to do it creates an irrebuttable presumption that the person wishing to do it is not

⁴ See Kant's discussion of the 'first example' in Part II of the *Groundwork of the Metaphysics of Morals*.

a competent rational being. In contrast, ending one's life when one is terminally or incurably ill is not crazy at all.

A second distinction between selling yourself into slavery and committing suicide can be appreciated by considering another apparently irrational distinction in a different situation. International law recognises a duty on nations to give asylum to genuine refugees who reach the nation's territory and claim asylum. Although the recent increase in asylum seekers has strained this duty, as yet no nation has openly rejected it. Instead, they seek to prevent refugees crossing their borders or landing on their shores.⁵ Yet since the plight of the refugees is likely to be equally desperate, whether they succeed in setting foot on the nation's territory or not, this distinction seems arbitrary and morally untenable. The most plausible explanation is that it is abhorrent to forcibly send refugees back to a country that will persecute them. Preventing them from entering is slightly less abhorrent. Similarly, a law recognising a right to sell oneself into slavery would require an equivalent of America's notorious fugitive slave law; that is, those who sold themselves into slavery, and later, regretting their decision, ran away, would have to be forced to return to their 'owners.' The repugnance of doing this may be enough explanation for the refusal to permit people to sell themselves into slavery. Obviously, since no one changes their mind after voluntary euthanasia has been carried out, it could not lead to the state becoming involved in any similarly repugnant enforcement procedures.

Some will think that the fact that one cannot change one's mind after voluntary euthanasia is precisely the problem: if people might make mistakes about selling themselves into slavery, then they might also make mistakes about ending their lives. That has to be admitted. If voluntary euthanasia is permitted then some people will die who, if they had not opted for euthanasia, might have come to consider the remainder of their life worthwhile. But this has to be balanced against the presumably much larger number of people who, had voluntary euthanasia not been permitted, would have remained alive, in pain or distress and wishing that they had been able to die earlier. In such matters, there is no course of action that entirely excludes the possibility of a serious mistake. But should competent patients not be able

⁵ This distinction lies behind the deplorable *The Tampa* incident, in which the Australian government forcibly prevented refugees who had been picked up at sea by the Norwegian freighter *The Tampa* from landing in Australia. See: Refugees Stranded at Sea. *The Age* August 21, 2001. Available at: <http://www.theage.com.au/news/national/2001/08/28/FFX7ISR BVQC.html>.

to make their own judgements and decide what risks they prefer to take?

COMPETENCE, MENTAL ILLNESS AND OTHER GROUNDS FOR TAKING LIFE

We have seen that Mill thought that individuals are the best judges and guardians of their own interests, and that this underlies his insistence that the state should not interfere with individuals for their own good, but only to prevent them harming others. This claim is not an implication of utilitarianism, and a utilitarian might disagree with it. But those who, whether for utilitarian or other reasons, support individual liberty, will be reluctant to interfere with individual freedom unless the case for doing so is very clear.

It is sometimes claimed that patients who are terminally ill cannot rationally or autonomously choose euthanasia, because they are liable to be depressed. The American writer Nat Hentoff, for example, has claimed that many physicians 'are unable to recognize clinical depression, which, when treated successfully, removes the wish for death.'⁶ Even if this statement is true, it is not an argument against legalising voluntary euthanasia, but an argument for including in any legislation authorising voluntary euthanasia, a requirement that a psychiatrist, or someone else trained in recognising clinical depression, should examine any patient requesting voluntary euthanasia and certify that the patient is not suffering from a treatable form of clinical depression. Such a proposal is perfectly practicable, and when voluntary euthanasia was briefly legalised in Australia's Northern Territory a few years ago, the law did require that someone with a psychiatric qualification must certify that the patient was mentally competent to make the decision. Whether such a provision is necessary will depend on whether Hentoff's claim about the inability of physicians to recognise this condition is true.

In any case, not all clinical depression is susceptible to treatment. This leads to a different question, whether doctors should act on requests for euthanasia from patients who wish to die because they are suffering from clinical depression that has, over many years, proven unresponsive to treatment. This issue was raised in the Netherlands in 1991, when a psychiatrist, Dr Boudewijn Chabot, provided assistance in dying to a 50-year-old woman who was severely depressed, but suffered from no

⁶ Nat Hentoff. Challenging Singer. *Free Inquiry* 2002; 22: 1.

physical illness. When prosecuted, Chabot contended that the woman was suffering intolerably, and that several years of treatment had failed to alleviate her distress. He thus sought to bring the case under the then-accepted guidelines for voluntary euthanasia in the Netherlands. He was convicted, but only because no other doctor had examined the patient, as the guidelines required. The Supreme Court of the Netherlands accepted the more important claim that unbearable mental suffering could, if it was impossible to relieve by any other means, constitute a ground for acceptable voluntary euthanasia, and that a person suffering from this condition could be competent.⁷

From a utilitarian perspective, Chabot and the Dutch courts were correct. For the hedonistic utilitarian, what matters is not whether the suffering is physical or psychological, but how bad it is, whether it can be relieved, and – so that others will not be fearful of being killed when they want to live – whether the patient has clearly expressed a desire to die. Whether preference utilitarians would reach the same conclusion would depend on whether they are concerned with the satisfaction of actual preferences, or with the satisfaction of those preferences that people would have if they were thinking rationally and in a psychologically normal state of mind. It is easy to say: ‘If you were not depressed, you would not want to die.’ But why should we base our decision on the preferences a person would have if in a psychologically normal state of mind, even when it is extremely unlikely that the person in question will ever be in a psychologically normal state of mind?

Some cases of depression are episodic. A person can be depressed at times, and at other times normal. But if, having experienced many periods of depression, she knows how bad these periods are, and knows that they are very likely to recur, she may, while in a normal state of mind, desire to die rather than go through another period of depression. That could be a rational choice and one that a preference utilitarian should accept as providing a basis for assisted suicide or voluntary euthanasia. Given this, it seems possible to be rational about one’s choice to die, even when depressed. The problem for the physician lies in recognising that the choice is one that would persist, even if the person were, temporarily, not depressed, but able to see that he would

⁷ See: Arjan Schippers. How the Courts Allowed Euthanasia. <http://www.rnw.nl/society/html/courts010723.html>; and: Euthanasia in the Netherlands: Evidence of the Slippery Slope. <http://www.nrlc.org/news/1999/NRL999/slope.html>

again become depressed. If this can be ascertained, a preference utilitarian should not dismiss such a preference.

The application of this view is probably more frequent than we realise. The World Health Organization estimates that there are about a million suicides a year and that depression or other forms of mental illness, including substance abuse, are involved in 90% of them. Moreover, the number of suicide attempts is said to be up to 20 times greater than the number of successful suicides.⁸ The WHO and many other organisations focus on suicide prevention, and if by this is meant prevention of the causes that lead people to try to end their lives, then this focus is entirely sound. But if by 'suicide prevention' is meant simply preventing people from succeeding in killing themselves, irrespective of whether it is possible to change the conditions that lead them to wish to kill themselves, then suicide prevention is not always the right thing to do. It is possible that in a significant number of cases, suicide is the only way of escaping from unbearable and unrelievable suffering due to mental illness, and is in accordance with the rational preferences of the person committing suicide.⁹

Richard Doerflinger has argued that those who invoke autonomy in order to argue for voluntary euthanasia or physician-assisted suicide are not being entirely straightforward, because they defend the autonomy of terminally ill or incurably ill patients, but not of people who are just bored with life.¹⁰ A recent Dutch case raised that issue. Edward Brongersma, an 86-year-old former senator in the Dutch parliament, committed suicide with the assistance of a doctor, simply because he was elderly and tired of life. The doctor who assisted him was initially acquitted, but the Dutch Ministry of Justice appealed against the acquittal. This led to the doctor's conviction, on the grounds that what he did was outside the existing rules. Nevertheless, since the court recognised that the doctor had acted out of compassion, it did not

⁸ World Health Organization. Updated April 2002. Prevention of Suicidal Behaviors: A Task for All.

http://www5.who.int/mental_health/main.cfm?p=0000000140

⁹ Relevant to this topic are: J.H. Groenewoud et al. Physician-Assisted Death in Psychiatric Practice in the Netherlands. *New England Journal of Medicine* 1997; 336: 1795–1801; V.G. Hardcastle & R.W. Stewart. Supporting Irrational Suicide. *Bioethics* 2002; 16; and J. Young. Morals, Suicide and Psychiatry: A View from Japan. *Bioethics* 2002; 16.

¹⁰ Richard Doerflinger. 2000. Assisted Suicide: Pro-Choice or Anti-Life. In *Contemporary Moral Issues*. Second edition. Lawrence Hinman, ed. Upper Saddle River, NJ. Prentice-Hall: 169–70.

impose any penalty.¹¹ A utilitarian should not find anything wrong in the doctor's action, either because the desire to die was Brongersma's considered preference, or because no one was in a better position than Brongersma to decide whether his life contains a positive or negative balance of experiences. Of course, it is relevant that Brongersma was 86-years old, and his life was unlikely to improve. We do not have to say the same about the situation of the lovesick teenager who thinks that without the girl he loves life can never again be worth living. Such cases are more akin to a temporary mental illness, or period of delusion. Neither a preference nor a hedonistic utilitarian would justify assisting a person in that state to end his life.

The reason that the focus of debate has been on people who are terminally or incurably ill, rather than on people who are simply tired of life, may just be political. Advocates of voluntary euthanasia and physician-assisted suicide find it difficult enough to persuade legislators or the public to change the law to allow doctors to help people who are terminally or incurably ill. To broaden the conditions still further would make the task impossible, in the present climate of opinion. Moreover, where terminally or incurably ill patients who want to die are concerned, both respect for the autonomy of the patients and a more objective standard of rational decision-making point in the same direction. If permissible assistance in dying is extended beyond this group it becomes more difficult to say whether a person's choice is persistent and based on good reasons, or would change over time. From a utilitarian perspective, this is a ground for saying, not that it is necessarily wrong to help those who are not terminally or incurably ill and yet want to die, but that it is more difficult to decide when the circumstances justify such assistance. This may be a ground against changing the law to allow assistance in those cases.

PALLIATIVE CARE

I return now to another of Nat Hentoff's objections to the legalisation of voluntary euthanasia and physician-assisted suicide. Hentoff thinks that many physicians are not only unable to recognise depression, but also not good at treating pain, and that sometimes good pain relief can remove the desire for euthanasia. That is also true, but most specialists in palliative care admit that there

¹¹ Arjan Schippers. How the Courts Allowed Euthanasia.
<http://www.rnw.nl/society/html/courts010723.html>

is a small number of cases in which pain cannot be adequately relieved, short of making patients unconscious and keeping them that way until death ensues a few days later. That alternative – known as ‘terminal sedation’ – is sometimes practised. Some ethicists, even non-religious ones, do not consider it equivalent to euthanasia, despite the fact that, since terminally sedated patients are not tube-fed, death always does ensue within a few days.¹²

From a utilitarian perspective, it is hard to see that terminal sedation offers any advantages over euthanasia. Since the unconscious patient has no experiences at all, and does not recover consciousness before dying, the hedonistic utilitarian will judge terminal sedation as identical, from the point of view of the patient, to euthanasia at the moment when the patient becomes unconscious. Nor will the preference utilitarian be able to find a difference between the two states, unless the patient has, while still conscious, a preference for one rather than the other. Since additional resources are involved in caring for the terminally sedated patient, and the family is unable to begin the grieving process until death finally takes place, it seems that, other things being equal, voluntary euthanasia is better than voluntary terminal sedation.

But to return to the issue of whether better pain relief would eliminate the desire for euthanasia, there is again an obvious solution: ensure that candidates for euthanasia see a palliative care specialist. If every patient then ceases to ask for euthanasia, both proponents and opponents of voluntary euthanasia will be pleased. But that seems unlikely. Some patients who want euthanasia are not in pain at all. They want to die because they are weak, constantly tired, nauseous, or breathless. Or perhaps they just find the whole process of slowly wasting away undignified. These are reasonable grounds for wanting to die.

It is curious that those who argue against voluntary euthanasia on the grounds that terminally ill patients are often depressed, or have not received good palliative care, do not also argue against the right of terminally ill patients to refuse life-sustaining treatment or to receive pain relief that is liable to shorten life. Generally, they go out of their way to stress that they do not wish to interfere with the rights of patients to refuse life-sustaining treatment or to receive pain relief that is liable to shorten life. But the patients who make these decisions are also terminally

¹² See: Törbjörn Tännsjö. Terminal Sedation – A Compromise in the Euthanasia Debate? *Bulletin of Medical Ethics* 2000; 163: 13–22.

ill, and are making choices that will, or may, end their lives earlier than they would have ended if the patient had chosen differently. To support the right of patients to make these decisions, but deny they should be allowed to choose physician-assisted suicide or voluntary euthanasia, is to assume that a patient can rationally refuse treatment (and that doctors ought, other things being equal, to co-operate with this decision) but that the patient cannot rationally choose voluntary euthanasia. This is implausible. There is no reason to believe that patients refusing life-sustaining treatment or receiving pain relief that will foreseeably shorten their lives, are less likely to be depressed, or clouded by medication, or receiving poor treatment for their pain, than patients who choose physician-assisted suicide or voluntary euthanasia. The question is whether a patient can rationally choose an earlier death over a later one (and whether doctors ought to co-operate with these kinds of end-of-life decisions), and that choice is made in either case. If patients can rationally opt for an earlier death by refusing life-supporting treatment or by accepting life-shortening palliative care, they must also be rational enough to opt for an earlier death by physician-assisted suicide or voluntary euthanasia.

THE SLIPPERY SLOPE ARGUMENT

Undoubtedly the most widely invoked secular argument against the legalisation of voluntary euthanasia is the slippery slope argument that legalising physician-assisted suicide or voluntary euthanasia will lead to vulnerable patients being pressured into consenting to physician-assisted suicide or voluntary euthanasia when they do not really want it. Or perhaps, as another version of the argument goes, they will simply be killed without their consent because they are a nuisance to their families, or because their healthcare provider wants to save money.

What evidence is there to support or oppose the slippery slope argument when applied to voluntary euthanasia? A decade ago, this argument was largely speculative. Now, however, we can draw on evidence from two jurisdictions where for several years it has been possible for doctors to practice voluntary euthanasia or physician-assisted suicide without fear of prosecution. These jurisdictions are Oregon and the Netherlands. According to Oregon officials, between 1997, when a law permitting physician-assisted suicide took effect, and 2001, 141 lethal prescriptions were issued, according to state records, and 91 patients used their prescriptions to end their lives. There are about 30 000 deaths in Oregon

annually.¹³ There have been no reports of the law being used to coerce patients to commit suicide against their will, and from all the evidence that is available, this does not appear to be a situation in which the law is being abused.

Opponents of voluntary euthanasia do contend, on the other hand, that the open practice of voluntary euthanasia in the Netherlands has led to abuse. In the early days of non-prosecution of doctors who carried out voluntary euthanasia, before full legalisation, a government-initiated study known as the Rummelink Report indicated that physicians occasionally – in roughly 1000 cases a year, or about 0.8% of all deaths – terminated the lives of their patients without their consent. This was, almost invariably, when the patients were very close to death and no longer capable of giving consent.¹⁴ Nevertheless, the report gave some grounds for concern. What it did not, and could not, have shown, however, is that the introduction of voluntary euthanasia has *led to* abuse. To show this one would need *either* two studies of the Netherlands, made some years apart and showing an increase in unjustified killings, *or* a comparison between the Netherlands and a similar country in which doctors practising voluntary euthanasia are liable to be prosecuted.

Such studies have become available since the publication of the Rummelink report. First, there was a second Dutch survey, carried out five years after the original one. It did not show any significant increase in the amount of non-voluntary euthanasia happening in the Netherlands, and thus dispelled fears that that country was sliding down a slippery slope.¹⁵

In addition, studies have been carried out in Australia and in Belgium to discover whether there was more abuse in the Netherlands than in other comparable countries where euthanasia was illegal and could not be practised openly. The Australian study used English translations of the survey questions in the Dutch studies to ask doctors about decisions involving both direct euthanasia and foregoing medical treatment (for example,

¹³ Oregon Reporting 15 Deaths in 1998 under Suicide Law. *New York Times* February 18, 1999.

¹⁴ See: Ministry of Justice and Ministry of Welfare, Public Health and Culture. 1991. *Report of the Committee to Investigate Medical Practice Concerning Euthanasia. Medical Decisions about the End of Life (The 'Rummelink Report')*. The Hague; P.J. van der Maas et al. 1992. *Euthanasia and Other Decisions Concerning the End of Life*. Amsterdam. Elsevier Science Publishers.

¹⁵ P.J. van der Maas, G. van der Waal et al. Euthanasia, Physician-Assisted Suicide, and other Medical Practices involving the End of Life in the Netherlands, 1990–1995. *New England Journal of Medicine* 1996; 335: 1699–1705.

withholding antibiotics or withdrawing artificial ventilation).¹⁶ Its findings suggest that while the rate of active voluntary euthanasia in Australia is slightly lower than that shown in the most recent Dutch study (1.8% as against 2.3%), the rate of explicit *non*-voluntary euthanasia in Australia is, at 3.5%, much higher than the Dutch rate of 0.8%. Rates of other end-of-life decisions, such as withdrawing life-support or giving pain relief that was foreseen to be life shortening, were also higher than in the Netherlands.¹⁷

The Belgian study, which examined deaths in the country's northern, Flemish-speaking region, came to broadly similar conclusions. The rate of voluntary euthanasia was, at 1.3% of all deaths, again lower than in the Netherlands, but the proportion of patients given a lethal injection without having requested it was, at 3% of all deaths, similar to the Australian rate and like it, much higher than the rate in the Netherlands. The authors of the Belgian study, reflecting on their own findings and those of the Australian and Dutch study, concluded:

Perhaps less attention is given to the requirements of careful end-of-life practice in a society with a restrictive approach than in one with an open approach that tolerates and regulates euthanasia and PAS (Physician Assisted Suicide).¹⁸

These two studies discredit assertions that the open practice of active voluntary euthanasia in the Netherlands had led to an increase in non-voluntary euthanasia. There is no evidence to support the claim that laws against physician-assisted suicide or voluntary euthanasia prevent harm to vulnerable people. It is equally possible that legalising physician-assisted suicide or voluntary euthanasia will bring the issue out into the open, and thus make it easier to scrutinise what is actually happening, and to prevent harm to the vulnerable. If the burden of proof lies on those who defend a law that restricts individual liberty, then in the case of laws against physician-assisted suicide or voluntary euthanasia, that burden has not been discharged.

¹⁶ Helga Kuhse, Peter Singer, Maurice Richard, Malcolm Clark & Peter Baume. End-of-Life Decisions in Australian Medical Practice. *Medical Journal of Australia* 1997; 166: 191–196.

¹⁷ For further evidence of the practice of illegal, and therefore uncontrolled, euthanasia in Australia, as well as in the United States, see: Roger Magnusson. 2002. *Angels of Death: Exploring the Euthanasia Underground*. Melbourne. Melbourne University Press.

¹⁸ L. Deliens, F. Mortier et.al. End of Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey. *The Lancet* 200; 356: 1806–1811; see also: <http://europe.cnn.com/2000/WORLD/europe/11/24/brussels.euthanasia>

Those who, despite the studies cited, still seek to paint the situation in the Netherlands in dark colours, now need to explain the fact that its neighbour, Belgium, has chosen to follow that country's lead. The Belgian parliament voted, by large margins in both the upper and lower houses, to allow doctors to act on a patient's request for assistance in dying. The majority of Belgium's citizens are Flemish-speaking, and Flemish is so close to Dutch that they have no difficulty in reading Dutch newspapers and books, or watching Dutch television. If voluntary euthanasia in the Netherlands really was rife with abuses, why would the country that is better placed than all others to know what goes on in the Netherlands be keen to pass a similar law?

CONCLUSION

The utilitarian case for allowing patients to choose euthanasia, under specified conditions and safeguards, is strong. The slippery slope argument attempts to combat this case on utilitarian grounds. The outcomes of the open practice of voluntary euthanasia in the Netherlands, and of physician-assisted suicide in Oregon, do not, however, support the idea that allowing patients to choose euthanasia or physician-assisted suicide leads to a slippery slope. Hence it seems that, on utilitarian grounds, the legalisation of voluntary euthanasia or physician-assisted suicide would be a desirable reform.

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