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## **Euthanasia: Comparisons and contrasts in the ethical, political and legal developments in the USA and Australia**

by James Keenan, SJ

In considering my task, to compare the ethical, political and legal developments with respect to euthanasia in both Australia and the United States, I am reminded of the movie, "All About Eve." On seeing Marilyn Monroe enter a dinner party, Bette Davis remarks to a group of fellow revelers standing by a staircase, "You better buckle your seat belts, we're in for a bumpy night."

In a brilliant article in *Theological Studies*, M. Cathleen Kaveny notes:

*"No longer at the forefront of the discussion is the question when, if ever, it is morally right for dying or seriously ill individuals intentionally to take their own lives. Instead, the issue occupying center stage is whether they should have a legal right to do so, and if necessary to enlist the aid of a physician willing to prescribe the lethal dose".<sup>1</sup>*

In this issue we publish the full text of a talk first delivered by Fr James Keenan SJ on 24<sup>th</sup> May at the University of Sydney. Fr Keenan, a guest of the Order of Malta, Catholic Healthcare Australia and the Australian Jesuits, subsequently gave the same talk in Brisbane, Adelaide and Melbourne. We are also delighted to be able to publish the vote of thanks, delivered by Sir Gerard Brennan, on the same evening.

With this issue at center stage, I will narrate six significant stages of legal developments from the United States, commenting on political, rhetorical and ethical issues along the way. We will examine (1) the important decision regarding the removal of hydration and nutrition from Nancy Cruzan, (2) the decision by the Ninth Circuit Court of Appeals to claim a constitutional right to 'physician-assisted suicide' (PAS), (3) a similar decision by the Second Circuit Court of Appeals, (4) the Supreme Court's unanimous decision to overturn both Circuit Court decisions, (5) the

recent arrest, conviction and imprisonment of Dr. Kevorkian and (6) the Oregon *Death with Dignity Act* and its first year in effect.

In following this legal route, I regret that time does not let me pursue more strictly theological concerns like my work, and Anthony Fisher's, on the sanctity of life<sup>2</sup>, Liz Hepburn's writings on the relationship between technology and medicine<sup>3</sup>, or Stephen Lammers concerns about Christian notions of suffering<sup>4</sup>.

As I move through these developments I hope to make the case that no new law will ever bear the burden of the euthanasia debate. That is, the fears that anti-euthanasia persons have about incompetent, depressed, disabled or otherwise vulnerable people not being protected from laws permitting PAS are valid. Inevitably the only ones who will benefit from a change in law are neither terminally nor chronically ill patients but, rather, those physicians committing euthanasia who fear censure, liability, or punitive sanctions. No less than the founder and president of the Hastings Center for Medical Ethics, Daniel Callahan writes: "*It is impossible in principle and in practice to regulate either euthanasia or PAS successfully.*"<sup>5</sup> Callahan makes this claim because fundamental legal concepts like terminal illness, competency, voluntariness, restrictions of eligibility, suffering, pain, and consent, are so historically fluid and regionally diverse that they could never be used with any success to maintain any distinctions. Eventually a law that would level the distinction between withdrawing life support and hastening death would level all other distinctions. After arguing that such laws could never protect us from abuses, Callahan concludes: "*The only purpose that will be achieved by these laws is to protect physicians and health care facilities from any liability for their actions in connection with PAS.*"<sup>6</sup> Besides providing protection to physicians, the only other effect of any introduction of PAS will be what Callahan calls the "*deregulation of euthanasia*".<sup>7</sup>

I state this at the outset because this is precisely the strategy of PAS advocates both in the United States and in Australia. PAS advocates have changed their strategy in light

of the Dutch experience. There in 1984 the Netherlands' highest court struck down the criminal conviction of a physician who performed PAS. Subsequent to that decision the courts and the Royal Dutch Medical Society articulated strict guidelines for providing PAS. Then in 1990 and again in 1996 the Rummelink Report published results of how those guidelines have been observed. The Rummelink Report acknowledges that none of the initial guidelines that the Royal Dutch Medical Society set are presently holding. The Report shows that annually 9700 requests for PAS are made and about 3600 actual requests are met, accounting for over 2 % of all deaths in that country! But, over fifty percent of all cases of PAS and euthanasia go unreported. Furthermore, of the 3600 cases, about 1,000 were non-voluntary: the physician took the patient's life without an explicit request from family or patient.

Other developments are more disturbing. In 1993 a Commission of the Royal Dutch Medical Society recommended that mercy killing should be made available to psychiatric patients. In 1995 the Dutch courts vindicated the mercy killing of an infant suffering with spina bifida. Three of the eight Dutch neonatal units now have active euthanasia policies.<sup>8</sup> So striking are the statistics that lawyers Martyn and Bourguignon write: "*The creep towards involuntary euthanasia and mercy killing in the Netherlands has gone unchecked, despite legal conditions designed to guarantee voluntariness.*"<sup>9</sup>

The experience of the Netherlands is important for the American and Australian debates. In light of the Dutch experience, American and Australian advocates are no longer arguing for the simple decriminalization of euthanasia.<sup>10</sup> Rather they are looking for positively-articulated legislation that permits PAS or euthanasia only under certain restrictions that usually involve voluntariness, consent, and, at times, though not always, terminal illness. They propose that the law will keep us from the abuses that their opponents invoke. Helga Kuhse and Peter Singer, for instance, believe

that legalizing voluntary euthanasia will be the best way for regulating existing unreported euthanasia practices.<sup>11</sup> I do not believe, however, such laws can be made.

If these laws will not succeed in regulating euthanasia practices, then their only benefit will be to protect doctors engaging in these practices. This is evident from the writings of PAS advocates themselves. For instance, seven Melbourne doctors wrote in an open letter to the Victorian Premier, Mr. Jeffrey Kennett, *"For the sake of all those who may be unfortunate enough to be trapped in suffering and anguish, we ask you to put an end to the uneasy hypocrisy of our law and to allow us to work without fear of prosecution."* The only effect of new legislation will be that the deregulation of euthanasia will leave physician advocates of PAS no longer inhibited by the law.<sup>12</sup> I now turn to the six stages of legal developments in the United States.

### Nancy Cruzan

The case of Nancy Cruzan<sup>13</sup> concerned the assumption that by the constitution's liberty interest competent adults are free to refuse medical procedures including life-saving procedures and artificial hydration and nutrition. Interestingly, Cruzan, who was in a persistent vegetative state, was a Roman Catholic, as were her parents who were seeking to remove their daughter from artificial hydration and nutrition. In fact, many law suits in the United States that sought the removal of life supports as extraordinary procedures came from Catholics as, for instance, the famous case of Karen Quinlan whose parents sought to remove her from a ventilator. Quinlan, Cruzan and others represent progressive legal developments that prevented hospitals from prolonging the dying of those who do not want their dying prolonged.<sup>14</sup>

### Ninth Court of Appeals

Ironically, the Ninth Circuit Court of Appeals used the Cruzan case to claim a constitutional right to die. In the United States, the Circuit Court of Appeals which encompasses broad geographical jurisdiction represents the second highest level of the

judiciary branch of government. When the state of Washington passed legislation to allow for physician-assisted suicide, an injunction was sought and granted by a local federal judge. Proponents of the legislation sought to overturn the judge's decision and so appealed to the Ninth Circuit Court. The Ninth Circuit Court of Appeals not only overturned the judge's injunction, but also declared a constitutional right to die. This extraordinary judicial activism was reminiscent of the Supreme Court decision regarding *Roe v Wade* on abortion. In that case, Americans suddenly woke up one morning to learn that the abortion controversy which had not yet been brokered in state or federal legislatures was instead decided by a few active Supreme Court judges. In a similar manner, the Ninth Circuit argued that the PAS debate was over and that PAS was legal. Their decision, articulated by Judge Stephen Reinhardt, claimed: *"Cruzan, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one's own death."*<sup>15</sup>

Kaveny notes that Reinhardt made an inappropriate use of Cruzan, a decision that was based on the "long-standing common-law prohibition against battery". As Kaveny writes: *"To put the matter bluntly, [Cruzan] ensures that a competent individual will not be strapped to a gurney, intubated, sedated, and medicated without her consent ... The fundamental concern of the liberty interest assumed by Cruzan is not the 'right to die,' but the right to live unencumbered by unwelcome medical treatment."*<sup>16</sup>

Reinhardt's position is based on the famous PAS argument of moral and (in this case) legal equivalency, that is, that there is no difference between withdrawing life-support and hastening one's death. Professors Helga Kuhse and Peter Singer employ the same argument. Like Judge Reinhardt, they neglect the intentional activity of the physician and declare that the two actions are morally equivalent. Moreover, in their study of what Australian doctors do in treating terminally ill patients, Kuhse and Singer, believing that

the difference between the two is futile, make their assumption normative by erasing any difference between the two intended actions in their interviewing and reporting.<sup>17</sup> Rightly Anthony Fisher, John Fleming and others observed this and objected that "the authors...confuse good medical practice according to traditional medical law and ethics with other practices which are illegal and clearly contrary to medical ethics."<sup>18</sup> As an outsider, I wonder about the *Medical Journal of Australia's* editorial board judgment in publishing documentation that methodologically ignored existing legal standards.

Curiously, despite Fleming, Fisher, and the others' attempts, Kuhse and Singer did not believe that they actually ignored any relevant distinctions.<sup>19</sup> If, while still needing to make a case that euthanasia should be legal so as to prevent abuses, Kuhse and Singer are unable to represent our concerns about the fundamental distinction between withdrawing and hastening, why would any subsequent law that they endorse ever employ conceptual frameworks that satisfactorily represent our concerns? If they level distinctions now when they are still trying to win, why would they not continue to level other distinctions when they have a law for PAS? Kuhse and Singer's argument on moral equivalency proves Callahan's concerns legitimate. The argument of moral equivalency levels not only the distinction between withdrawing life-support and hastening death, but eventually also the distinction between PAS and euthanasia, between competency and incompetency, and between voluntariness and involuntariness. For this reason when the Ninth Circuit Court ruled in favor of this moral equivalency, those of us in the United States were on the one hand stunned by the great leveling of a fundamental distinction, but we were equally convinced that the Supreme Court would overturn the case.

### Second Court of Appeals

Around the same time as the Ninth Circuit Court's decision, the Second Circuit Court of Appeals made a similar claim. This court did

not rule that there was a constitutional right to hasten one's death; rather, it overturned a New York law that prohibited PAS and claimed that the government had no right to outlaw PAS. In *Vacco v. Quill*<sup>20</sup>, a suit filed by the physician-advocate of PAS, Timothy Quill, the Second Circuit Court of Appeals invoked the equal protection clause of the fourteenth amendment which demands that all persons in similar situations be similarly treated. Thus, the court ruled that inasmuch as those who are on life support systems are allowed to hasten their deaths, similarly those who are not should not be prohibited from hastening their own deaths. Here again legal equivalency was advanced.

### Overturing by Supreme Court

On June 26, 1997, the Supreme Court in two decisions overturned both courts with rare unanimous decisions. The court held simply that the constitution did not extend as the lower courts argued. The constitution does not protect a right to commit suicide. In making this they declared that the legal equivalency arguments did not apply either for guaranteeing a right to suicide or for denying a prohibition against suicide. However, while the courts denied the claims of the appeals courts, they also left to the states the prerogative to make decisions regarding PAS.<sup>21</sup>

From these historic unanimous decisions, Kaveny, in another article, draws three interesting conclusions. First, the courts rejected the equivalency argument and instead examined how unequal people's situations are. That is, the court asked the question: how well protected from harm are all people, especially the most vulnerable? Here, they showed a particular sensitivity to the fact that rarely are all people who are facing disability and/or terminal illness in equivalent situations. Listen to the depth of their concern: "The State's interest here goes beyond protecting the vulnerable from coercion, it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and societal indifference."<sup>22</sup> This is exactly the same interest that we find in Kevin

Andrews's introduction to the *Euthanasia Laws Bill* that "the people most at risk are the people most vulnerable".<sup>23</sup>

This extraordinary reversal of the application of equivalency is important. As Kaveny notes: "One community-constituting lesson we might take from Glucksberg is that protecting the equality of our most vulnerable members should be at the center of every effort to rethink our current policy on assisted suicide and euthanasia."<sup>24</sup> Thus, though they might have entertained whether there was any necessary, logical connection between withdrawing and hastening, the Supreme Court saw the effectiveness of the distinction between withdrawing and hastening as a significant important social standard.<sup>25</sup> They dismissed the moral and legal equivalency argument in both court decisions.

A second issue follows from this. In the judgment of the Supreme Court practical experience superseded philosophical theory. For instance, the well-known pro-euthanasia "Philosophers' Brief" written by Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon and Judith Jarvis Thompson was not once cited. More interestingly, Judge Souter, a justice very sympathetic to the theoretical claims of PAS, consented to the majority position because he wondered whether the state could in fact protect the more vulnerable by such permissive laws and wrote, "the capacity of the State to protect the others...is...subject to some genuine question, underscored by the responsible disagreement over the basic facts of the Dutch experience".<sup>26</sup>

The Court's decision in general and Judge Souter's words in particular are important: the debates about PAS cannot be primarily about religious, philosophical or logical ideologies. Rather they have to be about the hard data that we can assess in the light of the legal developments that affect our lives. Here I recall the words of Jim Dominguez's when he realized that in the debate, "the main principles were not religious, but dealt with the quality of life".<sup>27</sup> The court rightly is concerned

not about theories of intentionality, but rather about the significance of existing laws in shaping the common good and, in particular, in protecting the interests of the most vulnerable.

Toward that end, I note Kaveny's third insight. In entertaining the question of death with dignity, the court raised the issue of whether the judiciary branch should ever rule in favor of PAS and proposed the case of a person in unbearable pain. They did so because, like all their experiential concern they wondered aloud, could the law be discriminatory against those who in terminal stages are in extraordinary pain? But Justice O'Connor noted that such patients are already protected: "A patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians to alleviate that suffering even to the point of causing unconsciousness and hastening death."<sup>28</sup> Aiming to alleviate a terminally ill patient's pain is already a legitimate practice in every instance.

Thus, again the court looked to the specific rather than the theoretical and found that laws did not inhibit physicians from treating their patients in pain. In a way, they rightly noted, as the advocates of palliative care, like Dr Roger Woodruff do, that the question of pain management is not a question for PAS. In my notes I provide more than enough evidence of this<sup>29</sup>, but we need only refer to the study of "seven deaths in Darwin" where we find these words: "Pain was not a prominent clinical issue in our study. Fatigue, frailty, depression and other symptoms contributed more to the suffering of patients."<sup>30</sup> These findings are consistent with every other study of pain and terminal illness. As Ezekiel Emanuel notes: "No study has ever shown that pain plays a major role in motivating patient requests for physician-assisted suicide or euthanasia."<sup>31</sup>

#### Dr Kevorkian

With the Supreme Court decisions, the judicial activism of the Ninth and Second Circuit Courts were turned back, and on another positive note, Dr. Kevorkian was

arrested, convicted, sentenced and imprisoned. Dr. Kevorkian had been arrested and tried frequently, but always acquitted. Now, however, he videotaped his practice of euthanasia. By actually administering the drug to his "patient," Kevorkian crossed the line between PAS where a doctor merely prescribes lethal medication and euthanasia where the physician administers the lethal dose. Any of the word-smithing that Kevorkian's lawyers had done in previous trials was to no avail, now that the tape was in the court's hands.

Kevorkian's trial, then, was an important moment in the move away from euthanasia to PAS. The dividing line between the two exists so as to argue that the latter die at their own hands and are competent to do that. The line is drawn, then, both to demonstrate that only those who are competent are seeking to exercise their self-proclaimed right to die and to assuage critics that the incompetent would not be victims of such assisted suicide. But, as we will see, PAS is a legal and rhetorical fiction. Nonetheless, to maintain the fiction, Kevorkian's sentencing was welcomed by PAS advocates.

Though he was an embarrassment to the PAS movement, few members of the movement have verbalized it until now for fear that they would alienate Kevorkian's followers. So now, for instance, Dr. Timothy Quill welcomes his being stopped, calling him a "sideshow or a distraction".<sup>32</sup> I must pause here and comment on Dr. Nitschke, a man who admired the "courage," of Dr. Kevorkian.<sup>33</sup> Inasmuch as trying to understand a person from another culture, the best one can do is use analogy, I did not know whether Dr. Nitschke was more like Dr. Quill (a rather formidable exponent of PAS) or Dr. Kevorkian (a bizarre sensationalist whom the PAS supporters eventually abandoned). After many essays on Nitschke I found a very telling one by Nitschke regarding the sentencing of Kevorkian. Ingenuously, Dr. Nitschke drew an analogy between "Dr. Death" and the British Suffragette, Christabel Pankhurst.<sup>34</sup> The analogy was astonishing. The most credible opponents of

Dr. Kevorkian have been feminists, because Dr. Kevorkian's first eight patients were all women and none had terminal illness. When this criticism was raised, Dr. Kevorkian found a male patient who had a terminal illness. This was Kevorkian's ninth killing, but the first incident involving a person with a terminal disease. As Stephanie Gutman wrote in 1996: *"Most of Kevorkian's men were declared terminally ill by their own doctors... We see that most of the Kevorkian women were not diagnosed terminal and had not been complaining of severe or constant pain. We see conditions like breast cancer (for which there is now great hope), emphysema, rheumatoid arthritis and Alzheimer's (a condition that usually burdens relatives more than the people who have it)... In all-too-typical female fashion, the patient often seems to have been most worried about the disease's impact on others. Is it possible that a certain type of women – depressive, self-effacing, near the end of a life largely spent serving others – is particularly vulnerable to the rational, heroic solution so forcefully proposed by Dr. Death?"*<sup>35</sup>

Dr. Nitschke's incredible ignorance of the longstanding feminist critique of Dr. Kevorkian in particular and PAS in general extends beyond his analogy-making. Feminist concern about violence aimed against vulnerable and marginalized women<sup>36</sup> ought equally to embrace both Dr. Kevorkian and Dr. Nitschke. Of sixty patients contacting Dr. Nitschke for euthanasia in 1997, 65 per cent were women. An article about these patients reports that Dr. Nitschke *"was unsure why women were more likely to ask for assistance to die than men, but one explanation might be that women were more comfortable generally asking for help from the medical profession"*.<sup>37</sup> I find this assumption preposterous. In the United States we had an equally high percentage of women wanting Dr. Kevorkian's assistance, not because they were "more comfortable with the medical profession," but precisely because they were not. The experience of women with the medical establishment is that they are wary of their wishes being respected, they have seen how burdensome to family long-term health care is and they have become depressed about a chronic condition that makes them dependent on others. (Again, I

provide significant documentation in my notes.<sup>38</sup>) Instead of addressing the depression and hopelessness of these women, the so-called compassionate Dr. Kevorkian and Dr. Nitschke kill them. Truly, in the United States many of us on both sides of the debate are delighted with the imprisonment of a sensationalist who capitalized on the isolating depression of so many.

### Oregon Death with Dignity Act

We turn now to the final legal development on the American scene, the Oregon Death with Dignity Act. In November 1997, voters in the state of Oregon voted to retain the Death With Dignity Act by a margin of 60-40%. In a rather peculiar instance of Orwell's double speak, the Act states that ending one's life in accordance with the law does not constitute suicide. Moreover the act legalizes physician-assisted suicide but specifically prohibits euthanasia (in which a physician or another person administers a medication to end a person's life). To receive a prescription, a person must be over the age of 18, a state resident, mentally competent, and diagnosed with a disease that leads to death within six months. The patient must make two verbal requests to his or her physician separated by fifteen days and by a written request; two physicians must confirm the diagnosis and prognosis; both must determine competency; if either physician believes that the patient is suffering from a psychological disorder such as depression, the patient must be referred to counseling.

On February 18, 1999, a study was released of the first year of the Act being in effect. During 1998, only 23 persons received prescriptions for lethal medications. Six died from underlying illnesses; two others were still alive at the end of the year; fifteen died after taking the medications. Of the fifteen, seven were women, eight men.

The study found that hospice programs in Oregon are extraordinarily good, ranking third among the fifty states. Moreover, none of the fifteen patients referred to financial issues. Rather, the extraordinary feature

about these fifteen is how extraordinary their personal concern for autonomy was: "Patients who chose physician-assisted suicide were seven times more likely to be concerned about loss of autonomy and nine times more likely to be concerned about loss of bodily functions than control patients."<sup>39</sup>

There was good and bad news in this report. The good news was, above all, the relatively few numbers. Moreover, unlike other studies, the patients were not depressed. Inasmuch as depression is often the primary motivator for those seeking PAS, the law's exclusion of these persons was remarkable. Furthermore, the state's successful commitment to palliative care meant that patients with terminal disease had significant options. Indeed, one wonders what these numbers would be like were not palliative care so efficient and available. Finally, the profile of the patient was of a rare breed: highly autonomous Oregonians. Like its neighboring state, Washington, Oregon is a state always known for embodying the value of autonomy.

On the down side, as *The New York Times* noted, "Oregon had become the only place in the world in which assisted suicide was legal"<sup>40</sup> More disturbing is the surety that these findings gave to the question of whether we can adequately establish a law that will not lead to slippery slope abuses. Indeed, this study was released at roughly the same time as a series of investigations about the Netherlands and its slippery slope in the February issue of *The Journal of Medical Ethics*. Therefore, there was much enthusiasm over the difference between the Netherlands' action of removing legal restraints in euthanasia practices and the Oregon situation that legally governs the practice<sup>41</sup>. There was a belief that a modest, fairly restrictive law could successfully keep us from the downward, slippery slope. But there was another alarming problem with the Oregon law. The review committee was unable to track any non-compliance with the law. As Callahan commented before the review's admission, "Oregon's procedural safeguards cannot change the fact that there is no legally meaningful self-limiting practice of PAS"<sup>42</sup> Inevitably acts of PAS will lead to acts of euthanasia practiced first on competent but disabled patients, then on incompetent, but

previously competent patients, and finally simply incompetent and therefore never voluntary patients. Oregon gives us false assurances of its "success". It does not tell us where the law is being broken, of where euthanasia is practiced or of where non-terminally ill patients are receiving lethal drugs. The myth of its success is disturbing, it pretends to be regulating euthanasia practices precisely when euthanasia practices are going unreported. This is a fatal flaw, the most conservative, most restrictive and apparently most well-written flaw still fails to acknowledge what Kuhse & Singer claim to be the reason for liberalising euthanasia laws, that is, to have clear reporting of legal and illegal practices.

In tracking American legal developments, the policies for legally permitting PAS are presently extraordinarily restrictive in arguably the one state most known for the autonomy of its citizens. The success of that law evidently depended on treating rather than accepting depression, a very successful palliative care program, the requirement of terminal illness, and the acknowledgment of a difference between PAS and euthanasia. The broad based euthanasia policies sought by people like Dr. Kevorkian and Judge Reinhardt in the US or Drs. Nitschke, Kuhse and Singer in Australia did not occur. On the contrary, their attempts have been thwarted on a number of fronts. However, as Dr. Callahan warns us, once we legalize PAS regardless of its restrictions, those restrictions will not stay, for PAS is a rhetorical fiction: eventually without proper regulatory guidelines and punitive sanctions, doctors in Oregon will, if they are not already, practice PAS on chronically ill persons and euthanasia on others. The question for the United States right now is: will we learn of the inevitable abuses before other states pass laws modeled on Oregon. For if we do, we will be able to acknowledge that the instinct of the medical and moral tradition to distinguish between withdrawing life support and hastening death has been a distinction well safeguarded. If we do not, then the law in Oregon will only lead unfortunately to the deregulation of euthanasia. Unfortunately, regardless of PAS proponents' claims, it is a legislative all or nothing issue.

## References

1. M. Cathleen Kaveny, "Assisted Suicide, Euthanasia, and the Law", *Theological Studies* 58 (1997) 124-148, at 125.
2. See Anthony Fisher's comments in *Senate Legal and Constitutional Legislation Committee, Euthanasia Laws Bill 1996* (Canberra: Commonwealth of Australia, 1997) 65-66. Hereinafter: *Euthanasia*. See my work, "Sanctity of Life and its Role in Contemporary Biomedical Discussion", in K. Bayertz (ed.) *Sanctity of Life and Menschenwürde: Ethical Conflicts in Modern Medicine* (Dordrecht: Kluwer Academics, 1996) 1-18; "The Moral Argumentation of *Evangelium Vitae*", *Choosing Life: A Dialogue on Evangelium Vitae* ed. Kevin Wildes (Washington, DC: Georgetown UP, 1997) 46-62.
3. Liz Hepburn, "It's a Matter of Life and Death," *The Australian Catholic Record*, 75 (1998) 271-285.
4. Stephen Lammers, "How Do We Wish to Die: The Controversy Over Assisted Death," *Religious Studies Review* 25 (1999) 35-41.
5. Daniel Callahan and Margot White, "The Legalization of Physician Assisted Suicide: Creating a Regulatory Potemkin Village", *University of Richmond Law Review* 30.1 (1996) 1-84, at 2.
6. *Ibid.*, 68.
7. *Ibid.*, 69.
8. This information is culled from Ezekiel, *Whose Right to Die?* *The Atlantic Monthly*, (March, 1997) 73-79 and Martyn and Bourguignon, *Physician-Assisted Suicide*, *California Law Review*, 85.2 (1997), 410-19. See also "Euthanasia in the Netherlands" in *Euthanasia Examined* ed. John Keown (New York: Cambridge University, 1995) 261-96.
9. Martyn and Bourguignon, *Physician-Assisted Suicide*, 417.
10. For one Australian proponent of the Dutch procedure see Mr. John Bailey's very odd comments of keeping euthanasia illegal but not prosecuting doctors in Chris Ryan, "Territory Politician Hopeful of New-Look Euthanasia Bill", *Sydney Morning Herald* April 14, 1997.
11. Helga Kuhse and Peter Singer, "Control of Euthanasia", *The Weekend Australian* February 20-21, 1999. Helga Kuhse, Peter Singer and P. Baume, "End of Life Decisions in Australian Medical Practice", *Medical Journal of Australia* 166 (1997) 191-195. As Kuhse wrote three years ago: "The best way of preventing abuse is to make all medical end-of-life decisions transparent." Helga Kuhse, "Euthanasia: The Judgment," *The Australian*, (October 28, 1996) 9.
12. Nick Davies, "Helping Patients to Die," *The Age* (March 25, 1995) 1, 6, at 1.
13. *Cruzan v Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).
14. On the history of American Bishops statements on artificial hydration and nutrition, see James Keenan and Myles Sheehan, "Life Supports", *Church* 8 (1992) 10-17.



15. As quoted in Kaveny, 129, from *Compassion in Dying v State of Washington*, 79 F.3d 790 (9th Cir. 1996) at 278.

16. Kaveny, 129.

17. Helga Kuhse, Peter Singer and P. Baume, "End of Life Decisions in Australian Medical Practice," *Medical Journal of Australia* 166 (1997) 191-195.

18. Anthony Fisher, John Fleming, Anna Krohn, Nicholas Tonti-Filippini, "Matters Arising: End of life decisions in Australian Medical Practice," *Medical Journal of Australia* 166 (1997) 506. See also interview with Fleming in Andrew McGarry, "Euthanasia Survey Ideological: Ethicist," *Australia* 25/2/97. Also see the perceptive article, Robert Manne, "How Data on Death Became a Numbers Game," *The Australian* (February 17, 1997) 11.

19. Kuhse, Singer and Baume, "Matters Arising," 507.

20. *Vacco v Quill*, 80 F.3d 716 (2nd Cir. 1996).

21. *Washington v Glucksberg*, 117 S.Ct 2258; *Vacco v Quill*, 117 S.Ct., 2293; See M. Cathleen Kaveny, "Assisted Suicide, the Supreme Court, and the Constitutive Function of the Law", *Hastings Center Report* 27.5 (1997) 29-34.

22. *Glucksberg*, 2273. In Kaveny, "Assisted Suicide, the Supreme Court, and the Constitutive Function of the Law," 30

23. Quoted from David van Gend, "Andrews Bill Ends Euthanasia...for Now," *News Weekly* April 5, 1997, p.6.

24. Kaveny, "Assisted Suicide, the Supreme Court, and the Constitutive Function of the Law," 30. See also her "Managed Care, Assisted Suicide, and Vulnerable Populations", *Notre Dame Law Review* 73 (1998): 1275-1310.

25. Margaret Sommerville also highlighted the importance of the social effectiveness as opposed to the logic of the distinction, *Euthanasia*, 65

26. *Glucksberg*, 2293. In Kaveny, "Assisted Suicide, the Supreme Court, and the Constitutive Function of the Law," 33.

27. Michael Gordon, "Holy Alliance," *The Australian* March 29, 1997, 19. See Dominguez, "Legal cornerstone that protects us all," *The Australian* April 16, 1999.

28. *Glucksberg, Quill*, p. 2303 (J. O'Connor, concurring). Kaveny, 31-32. Likewise, Justice Breyer argued that "the avoidance of severe physical pain connected to death would have to comprise an essential part of any successful claim." *Glucksberg, Quill*, p. 2311 (J. Breyer, concurring). Kaveny, 32.

29. Pain relief is notoriously poor in the United States. Christine Gorman noted: "Look behind today's headlines about physician assisted suicide and the right to die, and you'll find that what people are really talking about is the management of pain. Or rather, the mismanagement of pain." Christine Gorman, "The Case for Morphine", *Time* (April 28, 1997) 64-65, 64.

In a recent study of 4,000 patients who died after hospital interventions, 40% were reported to be in severe pain most of the time (J. Lynn, J. M. Teno, R. S. Phillips et al, "Perceptions by Family Members of the Dying Experience of Older and Seriously Ill Patients", *Annals of Internal Medicine* 126 (1997) 97-106). This commonplace failure is recognized by nearly every medical organization. The Institute of Medicine, for instance, recently criticized doctors for their failure to deal with preventable pain and stress at the end of life. The Institute argued: "The experience is so poorly managed by doctors and other health workers, as well as insurers, that many people see death as a degrading, painful episode that leads to talk of assisted suicide." (W. Leary, "Many in US Denied Dignified Death", *The New York Times* (June 5, 1997) A14.) These complaints are not because pain relief is not available; on the contrary, the complaints are because available pain relief is not delivered to patients needing it. In 1994, the *New York State Task Force on Life and the Law* reported: "Taken together, modern pain relief techniques can alleviate pain in all but extremely rare cases. Effective techniques have been developed to treat pain for patients in diverse conditions." *New York State Task Force on Life and the Law*, "When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context", 1994, at 40, as quoted in Susan Martyn and Henry Bourguignon, "Physician-Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions", *California Law Review* 85.2 (1997) 400.) Ada Jacox claimed in the *New England Journal of Medicine* that pain can be managed by relatively simple means in 90% of the cases of those suffering from cancer (Ada Jacox et al., *New Clinical Practice Guidelines for the Management of Pain in Patients with Cancer*, *New England Journal of Medicine* 330 (1994) 651). The failure of the American medical establishment to provide adequate palliative care is, then, astonishing. The famed SUPPORT study that spent five years and twenty-five million dollars to assist the American medical community to improve end-of-life care concluded in failure: the study members were unable to help the medical establishment more effectively use do-not-resuscitate orders, ICUs and pain relief. (The SUPPORT Principal Investigators, "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)", *Journal of the American Medical Association* 274 (1995) 1591-8).

Pain relief, in fact, plays a minor role in motivating those pursuing PAS. The medical ethicist Ezekiel Emanuel writes on euthanasia practices in the Netherlands. Emanuel reports that pain relief played a role in only 32% of the requests for PAS. He adds that in another study, of Dutch nursing home patients, pain relief was cited as a reason in 29% of the cases and was the primary reason in only 11% of the cases (Ezekiel Emanuel, "Whose Right to Die?", *The Atlantic Monthly* (March 1997) 73-79, at 75). Others report that in a study of terminally ill patients in the state of Washington (which with Oregon has the strongest PAS constituency) fewer than a third cited pain relief as a reason for pursuing PAS (Anthony Back et al., "Physician Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses", *Journal of the American Medical Association* 275 (1996) 919, 921-22). In fact in a study of cancer patients in Boston, patients with pain were more likely to oppose PAS than others and, in fact,

were more likely to change doctors if they learned that their physician had performed PAS (Ezekiel Emanuel, "Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists and the Public", 347 *Lancet* (1996) 1805, 1809).

30. David Kissane, Annette Street and Philip Nitschke, "Seven death in Darwin: Case Studies under the Rights of the Terminally Ill Act, Northern Territory, Australia", *Lancet* 352 (October 3, 1998) 1097-1102, at 1102.

31. Emanuel, "Whose Right to Die?" 75.

32. Pam Belluck, "On Assisted Suicide, Kevorkian is Seen as a Distraction," *The New York Times* (March 30, 1999) A.17.

33. Carina Tan-Van Baren, "AMA: Probe Euthanasia Tapes Claim," *The Western Australian* (November 28, 1998) 30

34. Philip Nitschke, "Ill Judged Response to Public Act of Mercy," *The Australian* (April 16, 1999) 13. Similarly, Samela Harris, "The Dead Hand of the Law," *The Advertiser* (April 16, 1999) 18.

35. Stephanie Gutman, "Death and the Maiden: Dr. Kevorkian's Woman Problem", *The New Republic* 214 (1996) 20-24, at 21.

36. As Susan Wolf also noted: "The analogy to other forms of violence against women behind closed doors demands that we ask why the woman is there, what features of her context brought her there, and why she may feel that there is no better place to be." Susan Wolf, "Gender, Feminism and Death: Physician-Assisted Suicide and Euthanasia," in *Feminism and Bioethics* ed. Susan Wolf (New York: Oxford University Press, 1996) 282-317, at 293. Barbara Logue, *Last Rights: Death Control and the Elderly in America* (New York: Lexington Books, 1993); Alexandra Kaplan and Rona Klein, "Women and Suicide: The Cry for Connection," in *Suicide: Understanding and Responding* ed. By D. Jacobs and H. Brown (Madison, Conn., International Universities Press, 1989); Howard Kushner, "Women and Suicide in Historical Perspective", *Signs: Journal of Women in Culture and Society* 10 (1985) 537-552.

37. Gay Alcorn, "Sixty wanted to join queue for euthanasia," *Sydney Morning Herald*, March 26, 1997.

38. Why are women at risk in the pro-euthanasia movement? As Dr. M. Cathleen Kaveny has shown, 60% of those older than 65 years of age and 75% of those over 80 years are women. Longevity is not the only reason why women are more representational; it is also because they are poorer. Seventy five percent of all poor people over 65 are women. Thus in a country where the poor are particularly left without health care, it is not coincidental that women would be among the more likely candidates for PAS. Finally, the fact that depression affects 15 million Americans, that women are twice as likely to suffer from it than men and that depression is among the leading reasons

for PAS, forcefully explains why women are more representational for the case of PAS. [M. Cathleen Kaveny, "Kevorkian and Women", *USA Today* (October 21, 1996) 19A; and, (with John Langan), "The Doctor's Call," *The New York Times* (July 15, 1996) A11.]

The likely candidate is usually women often suffering from depression. The overriding reason for pursuing PAS seems to be a fear of being a burden to others, as 93% of Oregon physicians polled thought. [Melinda Lee et al., "Legalizing Assisted Suicide - Views of Physicians in Oregon", *New England Journal of Medicine* 334 (1996) 310, 312. Noted in Martyn and Bourguignon, *Physician-Assisted Suicide*, at 395.] In a study from the state of Washington 75% of terminally ill patients surveyed cited concern about being a burden. [Anthony Back et al., "Physician Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses", *Journal of the American Medical Association* 275 (1996) 919, 921-22.] Clive Seale and Julia Addington-Hall studied why people want to die earlier and found that distress and dependency were the primary concerns. They concluded, "These findings have important implications for the public debate about euthanasia... If good care is to obviate the desire to die sooner, it needs to address the problem of dependency as well as provide the symptom control in which hospice practitioners have developed such impressive expertise." [Clive Seale and Julia Addington-Hall, "Euthanasia: Why People want to Die Earlier", *Social Science and Medicine* 39.5 (1994) 647-654, at 654.]

The marginalization of women from health care is pretty common: Steven Miles and Allison August studied the records of incompetent patients whose cases were adjudicated by the courts. After hearing families who testified to knowing that a patient's wishes were to be removed from life support, judges ruled in favor of the patient, if the patient was a man, in 75% of the cases. If the patient was a woman, the judges ruled in favor of the patient in less than 15% of the cases! The authors demonstrated that, in the court opinions, the judges regarded the male decisions as rational and the women as unreflective, emotional and immature. [Steven Miles and Allison August, "Courts, Gender and the Right to Die," *Law, Medicine and Health Care* 18 (1990) 85-95. See also how the courts regularly over rules women's wishes in obstetrics in Veronica Kolder, Janet Gallagher, and Michael Parsons, "Court-Ordered Obstetrical Intervention", *New England Journal of Medicine* 316.19 (1987) 1192-96. I want to thank Maria Houghton for pointing out these essays to me.]

39. Arthur Chin, Katrina Hedberg, Grant Higginson, David Fleming, "Legalized Physician Assisted Suicide in Oregon: The First Year's Experience", *New England Journal of Medicine* 340 (1999) 577-583.

40. "Assisted Suicide, In Practice," *The New York Times* (February 27, 1999) A.30.

41. Sam Howe Verhovek, "Oregon Reports 15 Legal Suicides in Law's First Year", *The New York Times*, February 18, 199, A.1

42. Callahan, 24.

# A Vote of Thanks by Sir Gerard Brennan AC KBE

In a pluralist society and in an age of technological progression, bioethical problems present the community, the law and the courts with the most difficult and anguishing issues.

In this country, we desire assistance in resolving those problems from the experience of other countries which share the same basic legal traditions and which have faced similar bioethical problems. Tonight we are most grateful to have been given the insights of so scholarly and articular a speaker as Fr. Jim Keenan SJ.

He comes here under several auspices. The Australian Province of Society of Jesus is celebrating its sesquicentenary of work in this country. The Jesuits have been involved in the education of the community in bioethical and other moral issues. The Order of Malta celebrating its 900<sup>th</sup> anniversary and the Silver Jubilee of its establishment in Australia, together with the Australian Catholic Healthcare Association, have offered real and compassionate help to those who encounter bioethical problems. We are indebted to each of those institutions for bringing Fr. Keenan to address us.

The Lecture is only the beginning. This lecture has not been just a pleasant, stimulating, perhaps comforting, way to spend an evening. It is a lecture which must find a resonance in our own reflections and moral judgements. The concepts Fr. Keenan has mentioned must be made relevant to our own environment.

We do not have the same legal frames of reference as the Supreme Court of the United States. We do not speak of "state interests" in legislative objectives nor of "liberty interests" under the Constitution. We do not have a 14<sup>th</sup> Amendment in our Constitution.

And so the concepts which go to inform the terms used in constitutional controversies in the United States must find a somewhat different context in the laws of this country.

We do distinguish between assisting suicide and withdrawing treatment - as does the Supreme Court of the United States in *Vacco* - on grounds of causation and intent. But when we speak of causation in relation to withdrawing treatment, our law is likely to focus on the question of whether there is a duty to maintain treatment.

In turn, a duty to maintain treatment is likely to depend on the difference between heroic and ordinary treatment - a difference noted by Justice Scalia in *Cruzan* - and that that classification of treatment is responsive to the condition of each patient at the relevant time. However, the concepts which inform constitutional debate in the United States are, for the most part, the same concepts as those which are relevant to the law in this country. But they are seen in different frames of reference.

However, we have one basic point of departure from the United States: our law makes no distinction between the value of lives. Each person's life has an equal right to preservation. Perhaps that is not so in a society that allows capital punishment. At all events this was the approach taken by Justice Stevens in *Vacco* when referring to the constitutional validity of laws allowing capital punishment.

*"The State does have the power to place a lesser value on some lives than on others; there is no absolute requirement that a state treat all human life as having an equal right to preservation."*

However that may be, the concepts with and by which the law must solve bioethical problems are to a great extent common to both our societies.

We gain immeasurably from insights as perceptively stated as Fr. Jim Keenan has stated them. We are most grateful for his address and I ask you to join me in thanking him.

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# NOTEBOOK

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## Advance Notice of Intensive Bioethics Courses

*"Testing the Boundaries:  
Contemporary Issues in Health Care"*

Topics will include

- \*physician assisted suicide
- \*evidence based medicine and the challenges from alternative therapies
- \* managed care arrangements - ethical challenges
- \*making healthy babies: the genetic revolution

### Bathurst

**30th July - 1st August, 1999**

St. Vincent's Hospital, Gormans Hill Road,  
Bathurst, NSW  
(Weekend Course)

### Canberra

**27th August - 29th August, 1999**

Calvary Hospital, Cnr Haydon Drive & Belconnen Way,  
Bruce, ACT  
(Weekend Course)

Included with this edition of *Bioethics Outlook* are registration forms for both of the above courses.

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